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### For one drop of blood

*Virginity, sexual norms and medical processes in hymenoplasty consultations in the Netherlands*

Ayuandini, S.P.

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## **CHAPTER II:**

# METHODOLOGY

## **2.1 The Timeline of the Study**

Exploratory study for the dissertation was done in summer 2012 where access to the hospital, one of the two main locations of the eventual study, was gained. The main goals of this period were twofold: (1) to clarify the aim and intention of the study with the doctors whom I would be working with in due course and (2) to test the feasibility of the intended method, particularly the viability of having an ethnographer sitting in during patient consultation. During this period a separate access to conduct the study in a second hospital was also attempted. Permission was finally acquired in the fall. However, during the time of the eventual dissertation study, the head doctor took an extensive leave of absence due to a personal reason. As a result, there was only one observation of hymenoplasty consultation conducted in the establishment. Hence, from now on in this dissertation, the word ‘the hospital’ refers exclusively to the first hospital unless indicated otherwise.

In the summer of 2013, I conducted preliminary study where I refined research methods including the way informed consent was obtained from the patients. I have started to conduct several observations of consultations at the hospital including

having a follow-up interview with one patient. Administrative requirements with the hospital was also taken care of and met. The main study period for the dissertation was started in February 2014 and completed in August 2015, amounting to 18 months continuous research period. This main research interval also encompassed the conduct of in depth interviews not only with doctors involved in the provision of hymenoplasty but also with people of similar ancestry with the patients. I particularly conversed with young women of patients' age, older women of patients' mother generation and young men.

In August 2014, I acquired an access to another hymenoplasty providing establishment. This establishment is a private clinic where hymenoplasty consultations are provided by a general practitioner. In this clinic, patients' hymenoplasty appointment with doctors are often set up back to back. Due to this set-up, an immediate follow up interview with patients were not feasible to be done. Additionally, due to the clinic's effort to ensure high confidentiality environment for its patients, a follow up interview at a later time was also considered to be problematic. Consequently, none of the patients from the clinic was contacted for a one on one meeting with me.

## **2.2 The Sites of the Study and Hymenoplasty Procedures at Each Site**

Data were mainly elicited from two establishments: a hospital located in one of the major cities in the Netherlands and a private clinic located around 1 hour train ride from the capital. As has been mentioned before, access to conduct the study was also granted by another establishment. This last establishment was also a hospital, located in the same city with the first one. One hymenoplasty observation was conducted in this establishment and a one on one interview was done with the head doctor before she took a leave of absent. This second hospital observes a similar procedure with the first hospital when conducting hymenoplasty consultations.

### **The Hospital**

Hymenoplasty consultations at the first hospital (henceforth: the hospital) were provided under the department of obstetrics and gynecology. This department also encompasses the sexology department. The head of the department who is also the head doctor in hymenoplasty cases is a sexologist. Dr. Zeeman (a pseudonym) has consulted with hymenoplasty patients for the past two decades. Together with colleagues from other hospitals, Dr. Zeeman established the current protocol for hymenoplasty followed in the hospital. This protocol consists of hymenoplasty patients having to go

through 3 appointments with the doctors before a final decision about the operation is made. The first and the last appointment are conducted by Dr. Zeeman while the second appointment is with a gynecologist.

Patients are regularly referred to an appointment with Dr. Zeeman by their huisarts (a general practitioner akin to a family doctor). In the Netherlands, a huisarts is usually the first source of medical help whenever an individual has health issues or needs medical attention. Although any patient can also decide to contact the hospital on her own without a referral to arrange a meeting. Whenever a patient chooses this latter method, she will reach a receptionist who will then book the appointment for her. It is not uncommon for this kind of patient to simply ask to meet with Dr. Zeeman without particularly explaining her intention to consult on hymenoplasty. However, all receptionists have been briefed that whenever a patient does not state her intention it is most likely that such patient is looking to consult on hymenoplasty. These patients also usually tend to request to have no physical letter to be sent to their home addresses. I will then be notified of the appointment time in order for me to be able to sit in during the consultation. On average, the hospital has 1 to 2, sometimes 3, hymenoplasty consultations a month.

At the hospital, the first hymenoplasty appointment with a doctor is an intake meeting. This meeting generally lasts for about 45 minutes to an hour. In some occasions, it is as short as 30 minutes. During this appointment, the motivation and the drive behind the patients' desire for hymenoplasty are explored by Dr. Zeeman. The intake meeting is also the time when specific goals for the surgery are also identified. Not all hymenoplasty patients desire the same outcome of the surgery. Some of these patients wish to bleed as a result of the operation while others hope the procedure will lead to their vaginal opening to be 'tighter'. A number of them seek the surgery as a means of psychological closure. Apart from finding out their exact intention for the operation Dr. Zeeman also uses the intake meeting as an opportunity to impart knowledge and information. The doctor shares with surgery seeking women 'medical knowledge' about virginity, the hymen and the operation in which the patients are at times are not familiar with. Some of the information provided include the variability of the shape of an unpenetrated hymen which renders visual observation of its condition to be an inconclusive determinant of a woman's virginity. Patients are also informed that the 'tightness' of the vaginal opening comes from the contraction of the pelvic musculature rather than from an 'intact' hymen.

The second meeting the patients need to go through is an appointment with a gynecologist where a gynecological examination takes place. This examination is done particularly to observe the condition of the patient's hymen in order to know what needs to be done in cases where surgery is to be conducted. The gynecological

appointment is also the time when patients are given the chance to ‘exercise’ their pelvic muscles under the observation and aid of the gynecologist. This exercise is done in order for them to be able to voluntarily contract and relax the musculature, resulting in a tightening and loosening of the vaginal opening accordingly. This exercise is often accompanied with the patients observing firsthand the working of the muscle by looking at their own vaginal opening through a mirror. The gynecological appointment is also used, although more infrequently, to consult the patients of sexual transmitted diseases (STDs) as well as the use of contraceptive methods.

The third appointment is again with Dr. Zeeman. At this appointment, patient notifies Dr. Zeeman what she finally decides to do in regards to the surgery. 1 out of 3 patients who go to the hospital at the end chooses to not undergo the operation. Those who are going ahead with the procedure will have to make a new appointment for the surgery to be done, usually within 2 weeks of the wedding day. The operation is performed by the same gynecologist who did the gynecological examination whenever possible. The price for the operation is around €1500 and is paid out of pocket by the patients. The lead doctor at the hospital explained to me that the expenses can be covered by insurance if there are other medical indications present which necessitate surgery.

Despite the formal procedure that stipulates hymenoplasty patient must go through 3 appointments with the doctor first before deciding for or against the operation, in practice some modifications can be made. Patient can choose to inform Dr. Zeeman of their choice regarding the surgery by phone instead of meeting face to face with him again. If time is of an essence, gynecological examination and surgery can be done in the same day. More importantly, whenever a patient is very sure of her decision whether to undergo or forego the surgery after the first meeting, subsequent meetings can be waived.

### **The Clinic**

Hymenoplasty provision at the clinic is mainly provided by one head doctor, Dr. Linden (also a pseudonym). When Dr. Linden is unavailable, a substitute doctor will conduct the consultation as well as the operation. The clinic where Dr. Linden works is a small clinic that was originally dedicated for abortion purposes. It has now been for a while expanded to also provide health services relevant to sexuality and sexual issues, including consultations for contraceptive methods and/or STDs.

There are a number of doctors practicing at the clinic. Each physician usually practices for 2 to 3 days a week. Doctors can use consultation rooms available in the establishment to meet with patients. These consultation rooms are on the second floor of the building. The one Dr. Linden usually uses is adjacent to an examina-

tion room. On the first floor, the clinic has a room that serves as a receptionist and several operation rooms which can be used free of charge by doctors working there. Dr. Linden makes use one of these operation rooms whenever she performs hymenoplasty with a help from a nurse. This nurse will need to be informed ahead of time to be present during the operation. The nurse does not work at the clinic on a daily basis.

A potential patient can call the clinic to book an appointment with Dr. Linden. When it is a hymenoplasty appointment, patient is asked to come either on Thursday afternoon or Friday morning. On occasions, Dr. Linden chose to move her appointments to a different day due to either personal and professional reasons. Surgeries are usually done on Thursday mornings although Dr. Linden has been known to schedule the operation at a different day, even on the weekend, to accommodate patients who are pressed for time. There are a lot more hymenoplasty appointments at the clinic compared to the hospital, amounting to 3 to 5 a week.

Unlike at the hospital, the clinic does not formally have a procedure a patient needs to follow when contemplating hymenoplasty. Despite this, patients usually meet with Dr. Linden in several occasions, particularly when they are going through with the operation. The first appointment with Dr. Linden is comparable to that of Dr. Zeeman; it is an intake meeting where Dr. Linden explores the motivation of patients to undergo hymenoplasty. This appointment generally lasts for 20 to 30 minutes, shorter than the ones at the hospital. Dr. Linden's main aim for the intake meeting is to learn the specifics of goals that the patient wants to achieve through the surgery. In clarifying how such goal can be accomplished through her medical care, Dr. Linden also explains various information about the hymen, virginity and the surgery itself.

Dr. Linden's hymenoplasty consultation commonly encompasses a gynecological examination which is done in the room adjacent to the consultation room. This examination lasts for only about 5 minutes as the main aim for it is to observe the condition of the patient's hymen in order to know what needs to be done in the case of surgery. Dr. Linden offers two types of hymenoplasty procedure: a temporary suture aimed to assist the patient to bleed during the wedding night and a more elaborate procedure usually with a goal to reshape the hymen membrane. The condition of the patient's hymen sometimes determines which of these two operations can be performed. In contrast with the procedure at the hospital, pelvic muscles exercise for the patient is not always part of this examination. The practice of looking through a mirror at one's own vaginal opening is only done if the patient specifically asks for it.

After the gynecological examination, patient and Dr. Linden sit back in the consultation room where patient can then decide whether to go on with the surgery or not. About 60% patients decide to continue on with hymenoplasty. When this is the decision, patient books a time for the surgery with the receptionist on the first floor.

The price of surgery in this establishment is €150, a mere 10% of the expenses at the hospital. The price is set deliberately low as Dr. Linden considers performing hymenoplasty as a form of providing the necessary help for women in need.

If the type of the operation to be done is the temporary one, surgery is mostly done within the week of the patient's wedding day based on Dr. Linden's recommendation. The second kind of operation—the one that is more elaborate—can be done at any given time according to the patient's request. For patients who choose the more elaborate surgery, Dr. Linden recommends they come back for another appointment around one month after the procedure was performed. At this appointment, another gynecological examination is done to see how well the wound is healing and how good the result of the operation is. A surgery is considered successful when the hymen tissue healed well and either the hymen's opening is smaller than before or the edges are more annular and uniform. In cases where the surgery is considered unsuccessful, patients discuss with Dr. Linden what to do next. Decisions after this consultation ranges from undergoing the temporary surgery to devising alternative ways to bleed during the wedding night.

Patients can also initiate a follow up meeting with Dr. Linden whenever they feel the need. Patients who experienced discomfort after the operation have been known to do this although there has not been any case where the surgery resulted in bodily harms to the patient. Some patients who underwent the elaborate surgery had the operation performed months before their wedding date. Because of this, a number of them decided they want Dr. Linden to re-observe their hymen's condition closer to the day of the nuptial. Patients usually want to ensure that the successful result of the surgery has not been undone despite Dr. Linden's continuous reassurance that such scenario will not come to pass. The only occasion where Dr. Linden refuses a follow up gynecological examination after the surgery is when the patient underwent the temporary operation. Dr. Linden reasons that the examination involves to a degree an opening up of the vaginal canal which might cause the suture to break and the surgery to be futile.

### **Profiles of Physicians**

All the doctors I talked to in this study were of Dutch “native” upbringing except for one gynecologist who was of migrant ancestry with Muslim background. I talked evenly with senior doctors, younger doctors, those who were still in their internship period and those who were no longer in practice. Most of the physicians were female except for two, in which one was the lead doctor of the hospital where I conducted my observations. In my writings, I have chosen to generally omit the gender of the physicians. This is particularly the case in my first article in which I compare hymeno-

plasty procedure in the two main establishments from where I gathered my data. The decision to exclude the gender of the physicians was made deliberately. I have found that with the inclusion of the gender, the attention and curiosity of the readers tend to focus on how the different gender of the physicians might influence the way they consult patients. Presently, I do not have an answer to this question. My findings do not give me specific insights to extrapolate how physicians' gender might influence their hymenoplasty consultation. Inferring otherwise, even if only to hypothesize, runs the risk of me falling into gender stereotypes. Therefore, in comparing and contrasting the practice of the two establishments, I have chosen to analyze the doctors' procedures, actions and utterances instead.

One particular observation is worthy of note at this point. My first article shows that the surgery rate of the hospital with a male lead doctor is half of that in the clinic where the main physician is female. However, based on a previous study, the rate of surgery in a different hospital, where the lead doctor is also a female physician, is closely similar to the one in the hospital of this study (van Moorst et al. 2012). What is similar between the two hospitals, which in turn is different from the clinic, is the procedure employed in consulting hymenoplasty patients. I therefore maintain in the first article that it is these differences in procedure that lead to the contrasting surgery rate between the hospital and the clinic. I also further argue that the procedure stems from the consulting doctor's philosophy of hymenoplasty itself. Hence, I posit that it is the physicians' point of view of the surgery that ultimately results in the difference in hymenoplasty consultation outcome in the Netherlands.

## 2.3 Data Gathering Method

The main data collection method for this dissertation is participant observations of hymenoplasty consultations conducted in the hospital and the clinic. This participant observation is complemented with a follow up interview with patients whenever consent is obtained. I also conducted in-depth interviews with a number of doctors involved in the provision of hymenoplasty. To provide the context for the study, I likewise conducted interviews with different people of similar ancestry with the patients. In the spirit of anthropological and sociological study, every interview is also seen as an opportunity to refine questions. Immediate findings from observations of the consultations and from other interviews informed the line of inquiries. Later interviews explored further important elements of data that are considered to be the key findings of the study. Each of the data collection methods will be further detailed below:



### **Participant Observation of Hymenoplasty Consultation**

Having its root in sociology and arguably being the quintessential method of anthropological study, participant observation is a well-known and well-established data gathering technique in social sciences (Musante 2014, Jorgensen 2015). Participant observation is a powerful method of qualitative research to investigate experiences, feelings, meanings and thoughts of people resulting in rich and complex findings of study (Jorgensen 2015). In the case of exploring sensitive and controversial social phenomenon, such as research on hymenoplasty, participant observation has been known to allow better rapport with study participants thus making it possible for investigators to find insights into information that might be otherwise hidden, concealed or considered as taboo (Gruenbaum 2005, Power 2013). Having gained access to hymenoplasty consultations, I considered participant observation to be the most productive method of study to be employed.

To conduct participant observation in my study, I sat in during hymenoplasty consultations to observe exchanges between patients and physicians. Consent for me being present in the room was obtained from patient prior to her meeting with the doctor. This consent is done verbally to avoid superfluous documentation that can link patient to hymenoplasty. For the most part, I am a silent observer of the conversations between the doctor and the patient although occasionally I provided minimal aid to both. From time to time, I was brought into the conversation either by the doctors themselves, by the patients or by the persons accompanying the patients. I have also used down time during consultations—such as when the doctor needs to use the computer—to initiate a short conversation with the patient or with the person accompanying the patient.

Whenever consent was obtained, consultations were audio recorded. This was only done in the hospital as permission was not obtained in the clinic. Whenever audio recording was refused by the patient, extensive note taking took place in substitute. Recordings were then transcribed and field notes typed into the computer. Both were eventually translated from Dutch to English prior to using excerpts for writing purposes.

### **Follow-up Interviews with Patients**

Each patient whose appointment was at the hospital was requested for a follow up interview. One out of three patients agreed for a one on one meeting with me. In total, I met with 7 patients in private. It was the patient's decision when and where this follow up meeting was to occur. The majority of the patients decided for the meeting to take place at the hospital itself. This is either directly after their first appointment or at a later date—usually coinciding with their gynecological examination.

The rest desired for our meeting to be held outside of the hospital in a place that is the most convenient to them.

The aim of this follow up meeting is to explore further patients' narrative that lead them to contemplate the surgery. This includes information about their fiancé and the circumstances of their engagement and upcoming marriage, their conviction and the extent of their knowledge on virginity, the hymen and hymenoplasty, sexual expectations put upon them as well as the network of people with whom they discuss sexuality. The interview also aims to solicit patients' thoughts on their experience meeting with the doctors and their eventual decision in regard to the surgery.

Initial design of this study aims to have a series of follow up interviews with patients with one interview held after each patient's appointment with doctors. Every interview was planned to address a different set of questions according to what the patients might have experienced during their meeting with the doctor. One last interview is designed to be held about a week after the wedding to explore patient's experience during their first night. This interview is planned to find out whether the patients used certain methods to give the impression that they were still a virgin, the reaction of their husband and particularly for those who underwent the surgery, whether their expectations of the result of the surgery were fulfilled.

However, patients turn out to be more reluctant to have continuous engagements with the study than previously expected. The majority of patients were quite comfortable having me sit in during the consultation but most declined my request for a follow up interview. The majority of those who granted me a follow up interview felt one interview is plenty enough and were generally reluctant to have any additional one. This reluctance came in the context of the one interview granted by the patient not being held directly after the first appointment with the consulting doctor. Any patient had a choice to have the interview at any time that was the most convenient to her. The decision to alter the timing of the interview to suit the patients' time helped increase their willingness to be interviewed. However, it rendered the initial design of serial interviews to miss its goal to an extent. Hence, both due to patients' disinclination and the initial design turning less functional, it became more productive to only pursue one follow up interview with a consenting patient.

The very last interview that was planned to be conducted around a week after the patients' wedding date was also largely not done. It is important to highlight that this follow up is the one the medical establishment themselves consider to be the most relevant to them. Both the hospital and the clinic attempted to contact their hymenoplasty patients after the wedding. They were particularly interested to find out the efficacy of the surgery. The physicians were also curious of the success of the alternative ways to bleed during the wedding night, if any of these methods were chosen

by patients. However, it has proven very challenging even for the medical establishments themselves to contact the patients after the wedding. This is particularly true for patients who married outside of the Netherlands and decided to stay in the new country with their husbands afterwards. For the rest, it was not uncommon for their phone number or email address to become unreachable after the wedding. Doctors have hypothesized that this might be due to the patients' effort to sever any ties to the procedure. This is in order to ensure the possibility of discovery of their hymenoplasty quest to be as low as possible. In the case of this study, only one out of the patients who agreed to a one-on-one follow up meeting with me was willing to be interviewed after her wedding.

As has been mentioned previously, it was not possible to have a follow up meeting at the clinic. However, the set up of hymenoplasty procedure in said establishment involves possible recurring meeting with the head physician. As such, it was feasible for me to sit in during the second and, more rarely, the third appointment the patient had with the doctor. In total, I sat in multiple appointments of 9 patients at the clinic.

### **Interview with Providers of Hymenoplasty**

14 physicians who were involved in the provision of hymenoplasty service to one degree or another were also interviewed for the purpose of this dissertation. About half of the doctors interviewed worked in the establishments that are the sites of this study while the rest practiced in different medical establishments across the Netherlands. Interviews with these medical professionals were meant to solicit their views on the surgery itself. Studies have shown that provision of hymenoplasty is fraught with ethical dilemma. This includes whether performing the surgery means physicians are agreeing with the idea of women surgically altering their body to fulfill the expectation of others (Bekker et. al. 1996, Raveenthiran 2009, Cooks and Dickens 2009). The interview also aimed to learn physician's experience in the provision of the surgery. It likewise meant to understand better their perspectives on the issue of virginity and sexuality in general, making it possible to draw parallels and comparisons with the view of the patients.

To complement data collection in medical establishments and to gain a more thorough understanding of hymenoplasty, virginity and other issues related to sexuality in general, I also conducted in depth interview with people of similar ancestry with the patient. Hymenoplasty patients in the Netherlands are almost exclusively of Dutch migrant background with parents or grandparents born and raised outside of the Netherlands. The majority of women seeking hymenoplasty in this study have either Moroccan or Turkish, including Kurdish, descent. The rest come from Afghani, Iraqi, Pakistani or Armenian ancestry. For the purpose of this dissertation research,

I was able to have conversations with different people of Moroccan, Turkish, Afghani and Iraqi descent. I particularly conversed with young women of patients' age, older women of patients' mother generation and young men.

### **In-depth interviews with women of patients' age**

As the drive to undergo hymenoplasty is often informed by specific societal values on virginity and sexuality, it is necessary to have an understanding of sexual norms and sexual expectations a Dutch young woman of migrant ancestry might be subjected to. I conducted in-depth interviews with close to 40 young women of Moroccan, Turkish, Afghani, Iraqi and Iranian descent. These women were mostly in their early to mid -twenties and were born in the Netherlands or came into the country when they were very young. They were identified through a network I previously established during my preliminary and pilot research. I also received help from my research assistants to find young women who were willing to discuss with me about my research topic. Since contact with these young women was established through strings of recommendations, I was able to talk to women from different parts of the Netherlands as well as from various levels of education.

Interviews with young women mainly aimed to explore their understanding and views of the importance of virginity in a woman's life, their stance on different issues of sexuality, how they perceive different forces in their life—such as religion and culture—to influence that stance and how living in a Dutch society affects their views on virginity and sexuality. The topics of conversations with these young women also include their preference in partner choice, their experience in dating or other romantic relationships as well as their knowledge and views of hymenoplasty.

### **In-depth interviews with women of patients' mother generation**

Based on pilot and preliminary studies, Dutch young people of migrant background, both male and female, indicated that they were informed of expectations surrounding the issues of sexuality by their mother. It is therefore important to have conversations with this generation of women particularly on their relationship with their children and how communication surrounding the issue of sexuality was done or not done between them. Topics of conversations also included their views of virginity and their stances on different issues of sexuality. We also talked about their expectations and hopes for their children, including who and how they wanted their children to marry. Additionally, since hymenoplasty is mostly done to be able to bleed during the wedding night, the women's own experience of their wedding night and their marriage in general, including how they met their partner, was also discussed. The women were also asked about their opinions of hymenoplasty.

Conversations with these women were assisted by research assistants who acted as an interpreter whenever the women felt more comfortable communicating in their mother's language. Although quite a number of women chose to converse with me in Dutch. Research assistants also helped me making the first contact with the women. In total, I interviewed 20 women from Moroccan, Afghan, Turkish, Iranian and Iraqi descent.

### **Interviews with Dutch young men of migrant background**

To fully explore women's decisions and practices of sexuality and reproduction, it is crucial to incorporate the point of view of men as well (Sargent 2006). The ideal men to be interviewed are those who are the future spouses of the surgery candidates. However, since young women seeking hymenoplasty keep this procedure a secret from their future husband, interviewing the spouse of the surgery-seeking women could be proven ethically and pragmatically problematic. Hence, I engaged with other men with similar ancestry of the patients as a proxy for the husband's point of view. Access to these young men were gained through recommendations from my established contacts from the pilot and preliminary studies.

The interviews with men mostly looked at their ideas and expectation of virginity, both for men and women of their social circle as well as how living in a Dutch society affects their view on sexuality. These interviews also aimed to uncover the possible roles virginity plays in these men's decision in engaging in or abstaining from pre-marital sex as well as in choosing a life partner. In total, I managed to have conversations with 12 men of Moroccan, Turkish and Afghani background.

## **2.4 Addressing Invisibility – A Word on Access**

It is of the serendipitous nature that I gained my preliminary access to the first medical establishment. Having interest in the sociocultural issues surrounding the operation, the lead doctor of the obstetrics, gynecology and sexology department of a teaching hospital in one of Dutch major cities welcomed me to conduct my study there. Dr. Zeeman was even the one who suggested for me to sit in during consultations as a way to meet with surgery seeking women. Soon after, I was likewise welcomed in a second establishment, also a hospital in the same city. As has been mentioned previously, due to the head doctor's extended leave of absence, I only observed one hymenoplasty consultation here. I finally gained access to the third establishment, a private clinic in a smaller city in the Netherlands about six months into my dissertation research. I traveled regularly to this small city twice a week to observe Dr. Linden's hymenoplasty consultations.

Patients did not always consent to me sitting in during their exchanges with doctors. Equally in the hospital and in the clinic, patients have refused to have me be present in the consultation room. However, when they did allow me to sit in, it is not lost on me that their agreement might be partially due to my own identity markers as an individual. Being a young woman of non-Dutch descent who grew up with Islamic tenets and traditions makes me a direct contrast to the doctors who are, in this study, exclusively Dutch, white and not Muslims. As my attire does not immediately announce my Muslim upbringing, patients learned of it as the doctors informed them or when I mentioned it myself. Without failure, when the patient was of Islamic faith herself, there was an expression of recognition and relation when she learned that I was too a Muslim. “You know how it is,” or “In our religion...”—referring to me as part of “our”—are some of the phrases they used when addressing me. This is in some contrast to what they said to the doctors which clearly delineated them as belonging to a different group of people than the physicians. Not infrequently, the patient themselves were the ones who were curious of my religious background. “Are you a Muslim?” asked one patient to me as she stopped herself from telling me her story. She then continued after giving a nod of acknowledgment to my “yes.”

I am also aware that being a woman might have helped me being accepted to sit in during consultations. The sensitive nature of the operation and the intimate information patients are divulging during consultations lead me to believe that patients might have felt more comfortable that I, like them, am a woman too. Patients have often asked, particularly in the hospital, whether the pelvic examination they have to undergo will be conducted by a female doctor. When assured of it, patients noticeably relaxed and was further visibly relieved upon hearing that the operation, if they decided for it, would also be performed by a female physician. I too am cognizant that being a non-Dutch person might have given me a certain leeway. Although without me especially venturing in finding out why this was my experience, I am less able to pin down the rationale for it. As a whole, I realize that my identity markers are potentially what have given me the opportunity to gain this never before achieved ethnographic access to observe exchanges between physicians and patients surrounding a secretive and sensitive surgery.

During consultations, I consciously made an effort to be as quiet and as invisible as I could. I had two reasons for this decision. Firstly, realizing the sensitive nature of information the patients might be sharing with the doctors, I consider it as a sign of respect for me not to pry or to be over curious about what the surgery seeking women are revealing. Strategic wise, understanding that patient at any point can decide to eject me out of the room, which fortunately never happened, I took it as wiser to not draw too much attention to myself. I am after all an additional person that can poten-

tially be seen by the patients to be the source of possible ‘leakage’ of information of the status of their sexual purity. Having no real added value to their quest of getting the operation, it is not inconceivable that patients could see me as an extra unneeded individual that is best to not be present. Because of this, I consider being quiet and mostly invisible, to be the best policy. More than that, I take it as beneficial for me to be a quite observant which allows the patients to get used to me being around without potentially feeling intimidated, worried or threatened. This I have hoped to make them feel more welcoming to the idea of talking to me one on one later on.

Secondly, I wish for the exchanges to mostly occur between doctors and patients. I do however fully realize that by simply being there, I have probably altered the nature of interaction between patients and doctors. Nonetheless, aspiring to observe the dynamics of this interaction, I consider it more fruitful for the analysis if the conversations between physicians and patients are largely without interference from a third party, let alone a researcher. I wanted to observe what questions are asked and what statements are brought up without me having to prompt them either by putting forward the query myself or by volunteering a comment. Regardless of this, I was nonetheless not uncommonly brought into the picture, more often by the doctors but also by the patients or by the persons who accompany them. The sleeve of my sweater was often a way to illustrate the flexibility of the hymen by the doctor at the hospital. I have been dispatched to fetch envelopes, papers and other stationaries at the clinic. I was tasked with helping patients schedule their next appointment. Once, I held a patient’s hand as she was nervous and needed assurance when a nurse took out her blood with a sterilized syringe. The blood was to be put in a vial which she would spill during her wedding night. Patients and people accompanying them have chatted with me in the consultation room, particularly when the doctor was out taking care of administrative matter or getting some medical equipment. They asked me of where I came from, shared with me their worries and even often were curious of my project. “Is it only Muslims who do this?” one sister of a patient asked me. “Did you meet people who’s not from the Netherlands?” inquired a different patient. These conversations were brief as the doctor was only away not more than 5 minutes at a time. But during that short moment, I was more than a mere quiet invisible observer.

In my writing, at the very least in these articles included here as chapters, I am also mostly invisible. Part of this is because it reflects the consultations where I strive to be silent and inconspicuous. It is also my intention to bring attention mainly to the exchanges between physicians and patients themselves. Mostly writing myself out of the narrative emphasizes my role as the discreet observer despite inevitably being a participant even if in the smallest sense. I have however taken care that I indicate where my involvement is apparent. This is including when I was the one who prompt-

ed a certain answer or putting forward a particular question that was otherwise unasked. During consultations, unless the patient was the one who initiated it, my questioning usually only happened towards the end of the meeting. The consulting doctor often would turn to me and invited me to address the patients just in case there was still things I would like to specifically know. Otherwise, probably comparable to how often I use of the pronoun “I” in my writings, my interjections were infrequent.

## 2.5 Data Analysis

In the spirit of qualitative study and constant comparative method, preliminary analysis was done immediately and cyclically. Findings were fed back to the data collection effort in order to hone in discoveries and to develop the exploration to be closely in line with emerging themes from field research (Glaser 1965, Boeije 2002). Later stages of the study used grounded theory approach to identify important concepts and key findings as the bases of the overall analyses and the main arguments (Strauss and Corbin 1994). A computer-assisted qualitative data analysis software (CAQDAS) Atlas.ti was used whenever necessary to support a thorough examination of data. Codebooks were developed both in vivo and with abstractions to aid the process of synthesis (Kelle 2004). Preliminary codes used at Atlas.ti were developed based on emerging and immediate findings from the field, rather than determined a priori, and these codes were developed into a code book using technique comparable with those outlined in Bernard and Gravlee (2014) and Miles and Huberman (1994).

## 2.6 Limitation of the Study

It is to be acknowledged that the study can still be seen as relatively small scale as it involves mostly two medical establishments and two lead consulting doctors. This number is due to the high sensitivity and secrecy of the topic in which ethnographical observation is rendered almost impossible. However, conducting similar study in different medical establishments or different countries will allow a richer understanding and should be aspired to as a future endeavor.

The sensitivity of the study and the need for confidentiality demands the study to be the most accommodative to patients' need for secrecy. This renders a more extensive engagement with them, e.g. recurring meetings or following them to their place of residence or work, impossible and potentially unethical. I have also consciously made the decision to never find or recruit any potential or former hymenoplasty patients



from my non-surgery seeking participants. To avoid accidental discovery as well as to ensure no suspicion is ever casted on any person agreeing to have an interview with me, I have kept observations at the medical establishments and interviews with people of migrant ancestry in two separate social and spatial domains. Having learned through pilot and preliminary study that the slightest speculation of a woman's virginity might cause her unnecessary adversary, I consider the above outlined measures to be highly necessary. However, I would encourage any study that was able to find ways to have more thorough views of potential or former hymenoplasty patients to be pursued as this will allow insights that this study is unable to provide.

The relatively low number of engagement with men in this study provides another potential point of exploration for future research. The view of men is undoubtedly crucial in the issue of expectations and maintenance of virginity of unmarried women in hymenoplasty cases. As this study focuses more on the clinical setting and the experience of women, men's point of views were solicited as a supplement. Men's perspectives help illuminate context and to provide a more thorough understanding of the issue of virginity and sexuality in general among Dutch people of migrant ancestry. Understanding more thoroughly men's view point allow a richer comprehension not only on hymenoplasty and the quest of women for the surgery but also on various societal norm on virginity particularly and sexuality in general.

## 2.7 Protecting Privacy and Ensuring Confidentiality

I have obtained research clearance from Washington University Institutional Review Board as well as from the ethical boards of the two hospitals to conduct this study. This includes from the second hospital where I ended up only doing one hymenoplasty consultation observation. All institutions have thoroughly made sure that my methodologies guarantee the privacy and confidentiality of my informants.

Realizing the sensitivity of the topic and the need of the patients for discretion, I have put in place several measures to maintain the highest ethical standards during and after the research. I only interacted with patients after their explicit consent has been given. I have experienced occasions where patients were unwilling to have me in the consultation room and they were informed that their treatment would not be affected by this choice. I did not interact with patients under such circumstances. Patients could opt out from the research at any point without any effect on their treatment and they were informed of this.

My engagement with people of similar ancestry with the patients was in separate spatial and social domains from my interactions with the patients. To ensure this

separation even further, I intentionally avoid finding surgery seeking women or those who have done hymenoplasty through my engagement with people outside of the medical establishments. Moreover, people of migrant ancestries in the Netherlands are not situated in one geographical location nor are they clustered in one neighborhood. I engaged with people from different cities in the Netherlands as well as from various residential areas in these cities. Furthermore, my contacts with the Moroccan and Turkish people, in particular, in the Netherlands were first established through my preliminary research. This research focused on marriage, divorce, and sexuality in general and not particularly on virginity only. This line of inquiry was continued during main dissertation data collections allowing interviewees to be more at ease during the interview. Rapport between the interviewee and me was also better developed came the time the topic of conversation turned to virginity. These widening of the focus of exploration as well as the broad geographical coverage of informants ensured the dilution of sample and further avoid unintentional overlapping between the patients and their social circle.

Any distribution of confidential materials will only be done with a removal of direct and indirect identifying information. No name of cities will be identified in relation to locations including that of the two main establishments of the study. Any names used for the purpose of publication are pseudonyms including the names of the doctors involved. Particularly to protect the identity of the patients the following were observed: (1) Age of any patient was only given in a range rather in specifics, (2) No indication of specific dates of any single doctor's appointment or surgery was provided, (3) No indication of specific dates of any wedding celebration was provided, (4) Visual descriptions of any patient were intentionally vague and (5) If a patient comes of migrant ancestry other than that of Turkish or Moroccan, no specific country's name was used to signify her background. To further ensure the confidentiality of the informants, an identification number was assigned to each of the participants. A file that contains the correspondence of this code to the informants' names is kept in an encrypted password-controlled file.

Due to the sensitivity of the subject, informed consent process was a crucial aspect of the research. Being fully aware of the priority to meet patients' need of confidentiality, the consent process was made deliberately in layered fashion. Permissions were sought separately for observations of consultations, audio recording and one-on-one follow up conversations between the ethnographer and the patient. Since all patients were able to drop out of the study at any point, some have chosen to participate only in one certain occasion but not in others. For example, patients were willing for their conversations with the doctors to be observed but not to have a one-on-one interview with me. Consent for the observation was obtained prior to the patients'

first meeting with the doctors and it was conducted in person at the medical establishment. This consent was done verbally to avoid any unnecessary documentation of patients' name linked to the surgery. A separate consent was then obtained to audio record the consultations and whenever patients refused, extensive note taking took place. Audio recording only took place at the hospital. The consent process for audio recording did involve the patient signing a document agreeing to the recording as the hospital required such documentation. However, the patients were not asked to affix their real name or any name for that matter to the signature which the hospital allowed. Informed consent for a follow up meeting with me was again done verbally.

For doctors, young women and young men interviewed, a document of informed consent was used in which a signature was required to signify agreement to participate in the research. Signed informed consent was waived for older women. My early research period has proven that older women of migrant ancestry in the Netherlands were very wary of signing any documents. This was mostly due to their often far than pleasant experience when migrating to the country. Verbal informed consent was then obtained as the alternate.

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