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For one drop of blood

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

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CHAPTER VII:

WOMEN EMPOWERMENT AND HYMENOPLASTY

7.1 Article Title

Telling the Truth and Looking into the Mirror: Hymenoplasty Consultations Framed as Efforts of Empowerment by Dutch Physicians

7.2 Abstract

This paper looks at the effort of empowerment Dutch doctors provided their hymenoplasty patients during medical consultation on the procedure. The empowerment efforts Dutch physicians offer their patients are informed by 'deficiencies' they consider their patients to be in. These deficiencies boil down to two main aspects: (1) patients' perceived lack of knowledge about the hymen and virginity and (2) patients' deemed inability to rectify her dilemmatic social situation. Dutch doctors aim to rectify these lacks during their hymenoplasty consultations. Through closely examining different approaches and techniques of empowerment employed by the physicians when interacting with patients, different concepts of empowerment are revisited. Ultimately, this article looks at the kind of woman subject that is created through empowerment efforts attempted by Dutch physicians in hymenoplasty cases.

7.3 Introduction

This paper looks at the effort of empowerment Dutch doctors provided their hymenoplasty patients during medical consultation on the procedure. Hymenoplasty is a surgery often requested by women who wished to ‘repair’ a membrane in their vaginal canal, commonly known as the hymen, which they believe to have been ‘broken’ due to penile penetration (Ayuandini 2017b). The procedure is done by physicians and it is aimed to alter the shape of the hymen, usually by minimizing the aperture (Ahmadi 2013, Renganathan, Cartwright and Cardozo 2009, Cook and Dickens 2009). In the past 15 years, the demand for the operation has been increasing in the US, in European countries, as well as in Canada and China (van Moorst et al. 2012, Amy 2008, Steinmüller and Tan 2015). In the Netherlands, the operation is often requested by Dutch women of migrant ancestry who are often expected to ‘prove’ their virginity during the wedding night (Ayuandini 2017a, van Moorst et. al. 2012, Loeber 2015). Surgery seeking women dread the failure of fulfilling the expectation, fearing unwelcomed consequences, ranging from being shunned by their family to experiencing physical harm, including death (Eich 2010, Amy 2008).

Literature on hymenoplasty have often emphasized on the ‘subordination’ of women as the root cause of the desire for the operation (Bhugra 1998, Paterson-Brown 1998, Kogacioglu 2004, Parla 2001, Helgesson and Lynoe 2008). Hymenoplasty seeking women are perceived by scholars and medical professional alike to have to navigate sexual norm double standard. Men of their ancestry are often lauded for their sexual adventures, including pre-marital ones, while women are expected to keep their chastity before marriage (Loeber 2015, Bhugra 1998, Wild et. al. 2015). Due to this concern, opponents of the procedure urge doctors to abstain from performing the surgery, fearing promulgation of women ‘oppression’ as a result of service provision (Raphael 1998, Raveenthiran 2009, Roberts 2006). Those who recommend medical professionals to at least meet with women contemplating the procedure reason that they are in the perfect position to provide help and to prevent future possible harm to the women (Paterson-Brown 1998, Ross 1998, Logmans et al. 1998, Ahmadi 2015, Ross 1998, Juth and Lynöe 2015, Kaivanara 2016).

In the Netherlands, doctors performed hymenoplasty and consulted patients requesting the operation despite the recommendation of the Dutch professional body of obstetric and gynaecology to do otherwise (Fietsma and Kagie 2004). Physicians claim to be compelled to provide assistance, based on their understanding that the women might be in trouble if not assisted (Ayuandini 2017b). The help they offer is framed by these doctors in the rhetoric of empowerment and the physicians aim to assist surgery seeking women beyond what might be needed medically. In this context

of advices provided in a clinical setting, this article answers the following questions: (1) What assumptions about surgery seeking women inform Dutch physicians' understanding of the needed empowerment provided during hymenoplasty consultations? (2) What goals are hoped to be accomplished by the doctors through providing empowerment to their patients? (3) What roles do Dutch doctors see their patients play in influencing the rate of demand for the operation? And ultimately (4) How are women as a subject shaped and reshaped through hymenoplasty consultation and the effort to empower by Dutch physicians?

In the process of answering these questions, this article will revisit different concepts of empowerment—particularly that of women empowerment. Drawing from feminist theory, Freire's idea of pedagogy and from neoliberal perspective, I examine which repertoires of empowerment resonate with the case of hymenoplasty consultations. It is important to acknowledge that this article by no means is intended to be normative let alone determine whether a certain doctor's practice in the case of hymenoplasty is right or wrong. It is however aimed to be analytical and find parallels between different theories of empowerment and the routines of hymenoplasty providers in the Netherlands. By ultimately looking at the creation of specific women subject this article also touches on the contrast between two different understandings of an empowered subject: that of the feminist lens and from a neoliberal perspective.

Empowerment as Process – A Brief Overview of Theories of Empowerment

Empowerment as a focus of research have been undertaken by scholars from different study concentration, ranging from development studies to social work to psychotherapy (Mosedale 2014, Bransford 2011, Pease 2002, Mattsson et. al 2000, Gutierrez 1990, GlenMaye 1998, Bransford and Bakken 2002). Empowerment is mostly framed in the scholarships as a process with some studies declaring it to also be a result (Gutierrez 1995, East 2000, Carr 2003, Staples 1990, Conger and Kanungo 1988). One of the more explored processes of empowerment concerns that of women empowerment in which the feminist theory of the issue takes center stage. Feminist theory recognizes knowledge as a central element in the process of empowerment and emphasizes on the concept of women as the ones who are the most knowledgeable of their own body (Jordan 1997, Gartner and Riessman 1982, Kline 2010). However, what is more paramount to have followed from this point of view is a notion of claims of knowledge that are diverse, contextual but also have potentials to be in conflict with one another (Harding 2004). It is a recognition that one own's experience of being a woman is simultaneously different yet similar with those of other women (Mosedale 2014). This understanding of knowledge also signifies an acknowledgement that any

position or situation a woman is in, including her marginalization or oppression, contributes to the production of valuable knowledge which potentially “nourishes one’s capacity to resist” (hooks, 1990, 150).

However, feminist theory argues that women empowerment cannot be achieved simply by women possessing knowledges as a result of their unique position. It is equally important for women to be aware of their singular situation and positionality which have led to the production of such knowledge (Carr 2003). What follows is a concept of consciousness-raising, an idea that was put forward by Freire in pedagogy (1970). Freire argues that for the oppressed to be emancipated it needs to start from building their own awareness of the structure of oppression they are in. Reflections of one’s position is critical which will lead to necessary actions for change. Freire further emphasizes on the need for both reflection and action to be done individually as well as collectively in a dialectical process. It is also crucial that the process is started by the oppressed themselves and by those in solidarity with them. Outsiders involved in the process cannot impose or dictate how change needs to happen as it will negate the entire spirit and progressions of emancipation itself.

Freire’s ideas were taken up by the second wave feminism particularly in the late 1960s and early 1970s and continued to be practiced by third wave feminism of today (Carr 2003, Sowards and Renegar 2004). The development of consciousness raising was often attributed to Sarachild who assembled small groups of women who were facilitated to share their experience through verbal personal testimony in order to relate to one another (Rosen 2000, Sarachild 1970). This deliberately cultivated rhetoric strategy was aimed to relieve women of self-blame in looking at their situation and to recognize common and shared experience between them (Kamen 1991). Again, we see the duality of awareness as a part of empowerment here: simultaneously better understanding one own’s situation while being cognizance of the wider context of collective marginalization of women (Worell and Remer 1992, Bricker-Jenkins and Hooyman 1986). By equally acknowledging the singularity of one’s experience while realizing commonalities in it with others, women identify the political dimension of their personal problems. This complex awareness is the very basis of the concept of consciousness raising, arguably one of the most important cornerstones of feminists’ understanding of women empowerment (Carr 2003).

The idea of consciousness raising cannot be divorced from the understanding of “the personal is political” (Hanisch 1969) which recognizes power relationships in every individual’s experience. The recognition of one own’s sociopolitical situation is therefore identified as a paramount step in the process of empowerment (Zimmerman 1995, East 2000). What this understanding then brings is the notion of praxis in which empowerment is achieved through dual approaches of action and reflection

(GlenMaye 1998, Carr 2003, Mies 1983, MacKinnon 1989, Maguire 1987). Reflecting on one own's position and its sociopolitical nature is an active strategy and the first step to taking action into moving towards other possibilities (Carr 2003, Alcoff 1994). Therefore, the recognition of one own's position has a certain goal which is to assume control of one's situation and to take action that will ultimately result in change (Zimmerman 1995).

The notion of reflection, action and change as the ultimate aim of empowerment in feminist theory is particularly unique as it aims for a collective nature of the goal (Stein 1997). Empowerment as praxis is seen by feminists as an interpersonal process in which dialogs and acts towards positive transformation are collective and social (Carr 2003). This is not to say that change is not aspired within individual's situation but it is to emphasize the importance of connection building between and among women. It is also to highlight how transformation to betterment needs to be mindful of structural and sociopolitical context of the collectives that extends beyond personal situation of any singular woman. The responsibility for change does not solely lie on any individual woman's shoulder (Butler 2004, Scott 2007, McRobbie 2009).

In some contrast, the concept of neoliberal empowerment has always been centered around the idea of a self-governing individual (Cruikshank 1996). Each of these empowered individuals are then capable to be a fully functioning citizen which is an essential element to achieve the goal of "free market, good governance, democracy and the rule of law and rights" (Sharma 2008: 17). The philosophy of neoliberalism is based on a three pronged strategy of empowerment, self-help and self-esteem which creates neoliberal subjects who voluntarily participate in the process of self-regulation motivated by their own self-interest (Sharma 2008, Rose 1996). This concentration on the self is not to neglect the focus on the collective but rather to merge the two as fulfillment of individual goals is equally seen by neoliberalist as a social obligation (Cruikshank 1996: 232). Empowered individuals who are each actualizing their own self-interests aggregately results in a society with an enhanced collective well-being (Sharma 2008).

This article looks at the case of hymenoplasty in the Netherlands where surgery seeking women are considered by Dutch physicians to be in need of being empowered. This situation is a rich case study to look at how empowerment is attempted in an institutional context of medicine. Through closely examining different approaches and techniques of empowerment employed by Dutch doctors particularly during hymenoplasty consultations, different concepts of empowerment are revisited. Ultimately, this article looks at the kind of woman subject that is created through empowerment efforts attempted by Dutch physicians in hymenoplasty cases.

7.4 Methodology

The study was conducted in two medical establishments in the Netherlands. The first establishment is a public teaching hospital and the second is a private clinic. The hospital is located in one of major Dutch cities while the clinic can be reached by train about an hour ride away from the capital. The hospital receives around 30-50 hymenoplasty patients a year while the clinic sees double that number of patients. All excerpts presented in this article come from observations conducted in these two establishments except for one. One vignette was taken from an observation done in a third, another hospital in the same city as the first hospital. Permission to conduct the study was also obtained from this hospital. However, during data collection period, there was only one hymenoplasty consultation observed in this establishment. This is mainly due to the lead doctor's extended leave of absent which did not allow many opportunities to meet with patient. Hence, this article will only focus on hymenoplasty consultations done in the first hospital (henceforth: hospital) and in the clinic. The one vignette from the third establishment is however important to be included as it illustrates the situation under discussion.

Findings presented in this article come mainly from participant observation of hymenoplasty consultations from 2012-2015 in the Netherlands. In total, 70 hymenoplasty consultations were observed. Since the 1970s, observation of doctor-patient interaction has been viewed as a productive method in the (social) study of medicine (see for example Korsch and Negrete 1972, Pilnick and Dingwall 2011 and Arora 2003). However, due to the high need for discretion to protect identity of patients, ethnographic observation of hymenoplasty consultations has never before attempted and therefore unique to this study.

Hymenoplasty patients were identified as they make appointment to meet with doctors. In the hospital, this was usually either through contacting the receptionist or by means of a referral from their huisarts (a general practitioner akin to a family doctor). In the clinic, patients tend to phone in to schedule an appointment. When patients visit the establishment and before they meet with the doctors, they are asked of their consent for their meeting to be observed. Consent is done verbally to ensure no superfluous documentations link patients' identity to their intention of undergoing the surgery. This consent process is approved by Washington University Institutional Review Board and by the hospitals' ethical board. A different consent was sought for the consultation to be recorded. Without patients' agreement, extensive notetaking takes place instead. Excerpts presented in this article comes from transcribed recordings and carefully reconstructed field notes, both translated from Dutch to English.

Analysis is done immediately after the collection of findings and cyclically to feed immediate discoveries back into data gathering. In line with the spirit of qualitative research and constant comparative method, the progress of explorations was closely informed by emerging key themes and concepts (Glaser 1965, Boeije 2002). Grounded theory approach was then used in later stages of the study as a basis of formation of main arguments (Strauss and Corbin 1994). A computer-assisted qualitative data analysis software Atlas.ti was used when necessary to support a more thorough examination of data. Codebooks were developed both in vivo and with abstractions to aid the process of synthesis and the writing of this article, specifically (Kelle 2004).

7.5 Findings

Compelled to Help

Dutch doctors involved in the provision of hymenoplasty are commonly with the understanding that women who seek the surgery do so because they are in a difficult situation. Not infrequently it is the women themselves who volunteered information of the social dilemma they are in. Women contemplating hymenoplasty often desire the surgery because they see themselves as no longer sexually untouched while at the same time they will be required to ‘prove’ their virginity, customarily during the wedding night. Inability to fulfill this expectation—in most cases by failing to bleed after the first sexual intercourse with the newly wedded husband—can result in unintended consequences ranging from being ostracized to experiencing physical repercussions. Laila, a Dutch woman with South Asian ancestry told the doctor almost as a matter of fact of what awaits her if she does not to bleed in her wedding night.

Doctor: *“... Let’s say [...] you don’t bleed. What will you do then?”*

Patient: *“Then I’ll go to another world.”*

Rik: *“Then you’ll be dead?”*

Patient: *“Yes.”*

Laila’s predicament might sound extreme but her story is not unique. Through years of practice Dutch physicians are aware of similar dilemmas some Dutch women, typically of migrant descent, are facing as they are getting married. Doctors then feel compelled to lend a hand in order for the patients to overcome the problems they are in. In fact, the physicians I talked to almost always claim that the reason they consult on and/or perform hymenoplasty is to help patients. This is commonly the rationale behind doctors in the Netherlands still offering the surgery despite being aware of the recommendation by their professional association to abstain from the provision (Feitsma and Kagie 2004).

In providing help to these women, Dutch doctors' actions are motivated by a set of assumptions and logic that in turn shape the kind of assistance that is offered. It is important to note here that the doctors are offering solutions to the patients in the aim to not only 'fix' a biological 'problem' the patient is having, i.e. having a perceived 'unintact' hymen, but they ultimately target to remedy the social dilemma the patient is facing. Accordingly, physicians' ideas about factors that lead to the existence of the (social) dilemma the patients are in color the advice they are giving during hymenoplasty consultations. One of the most common perspective Dutch physicians have about women seeking hymenoplasty is that they are in the position of deficiency. This position leads them to be in the problematic situation they are in and simultaneously trigger the desire for the operation. Therefore, doctors' recommendations address such perceived lack in order to rectify it.

Two main deficiencies are frequently considered by Dutch physicians to lead to their patients wanting the operation: (1) Women's lack of understanding of the 'medically correct' knowledge of virginity and the hymen and (2) Women's inferior position within her immediate social circle that makes her subject to burdening sexual expectations. Hymenoplasty consultations become an opportunity to remedy these deficiencies. Hence, Dutch doctors often identify their meeting with patients who are contemplating the surgery as not only a medical appointment but also a counselling session. More importantly, they also see it a means to empower the women they are consulting. In line with the two perceived deficiency of hymenoplasty patients, Dutch doctors' efforts to 'empower' focus on two aims: (1) To educate women with the 'right' knowledge of the hymen and virginity and (2) To equip women with the skills and attitude that will rectify her inferior positions in her immediate social circle.

Educating Women of the Hymen and Virginity

Many Dutch physicians are convinced that the desire for hymenoplasty stems from a misunderstanding of the hymen and its connection to observable virginity. The majority of women meeting the doctors to contemplate hymenoplasty imagine an 'intact' hymen to be either a wall like structure that blocks the vaginal canal or a ring like membrane with annular and regular edges. The use of the word imagine here is intended as most, if not all, patients have never observed their own hymen. Although some admitted to have seen either photos, pictures or illustrations of it, commonly on the internet. Dutch physicians' professional experiences, particularly from doing pelvic exams, present a different understanding of the hymen. The membrane does not have a 'standard' shape and its condition can be very different from one woman to the next, regardless of her sexual history. An 'intact' hymen, a vaginal membrane that has not yet experienced penile penetration, does not always lend to it appear-

ing 'tidy' with annular edges and a small opening. Some women that are sexually untouched possess a hymen membrane with small amount of tissue, relatively larger opening and/or notches and clefts on the edges. The hymen is also highly flexible in nature which means sexual penetration does not always result in its integrity being compromised. Hence conversely, women who had had sexual intimacies previously can be proven to have 'an intact looking' hymen, absent of clefts or large aperture and with plenty of tissue. Doctors and physicians around the world have often maintained that due to this high variability of the hymen's shapes and forms, discerning a woman's sexual history through observing her hymen is far from definitive and, in an overwhelming majority of the cases, highly unlikely (Ayuandini 2017a, Adam, Botash and Kellogg 2004, Edgardh and Ormstad 2002, Bravender et. al. 1999).

Women contemplating hymenoplasty and people in their immediate social circle tend to view the hymen and virginity in contrast with the physicians' perspective. Many are under the impression that the hymen will always 'break' following the first coitus, resulting in bleeding. Hence, the view that a virgin woman bleeds after her first sexual penetration prevails and blood on the marital bedsheet being considered as a sign that the bride was sexually untouched is a common view across the globe (Logmans et. al. 1998, Buskens 1999, Skandrani et. al. 2010, Cinthio 2015, Ghanim 2015). This perspective and the customary practice to check the marital bedsheet for the sign of blood to 'confirm' the newly wedded woman's chastity are what often compelled hymenoplasty patients to seek the surgery. Many patients consider themselves to be no longer sexually untouched. They perceive their hymen to already be 'broken' which makes them unable to bleed during the wedding night. They then turn to hymenoplasty to 'restore' their hymen and their ability to bleed.

In contrast, Dutch physicians and many doctors around the world consider the connection between chastity and an 'intact' hymen to be weak (Ayuandini 2017a, Adam, Botash and Kellogg 2004, Edgardh and Ormstad 2002, Bravender et. al. 1999). Doctors are also still in disagreement of what the biological function of a hymen is. Furthermore, studies have shown that women do not always bleed the first time they experience penile penetration (Raveenthiran 2009, Hegazy and Al-Rukban 2012, Christianson and Eriksson 2013). Dutch physicians have also learned from their decades of experience providing hymenoplasty, that the operation does not guarantee bleeding during the first coitus after the surgery (van Moorst et. al. 2012) Consequently, hymenoplasty is seen by physicians and other medical professionals to not only be absent of any medical necessity (Ayuandini 2017a) but also ineffective to serve patients' goal which is more often than not to be able to bleed during their wedding night.

Coming from this position, some Dutch doctors are convinced that if only the women who are contemplating the surgery share their professional knowledge about

virginity, the hymen and hymenoplasty, then they would decide to no longer seek the surgery. It is important to stress that Dutch doctors' reluctance of performing the operation mostly stems from their point of view that the surgery is medically unnecessary. Some physicians even call it nonsense in few occasions, which makes the act of incising a healthy body to be considered too severe and that it compromises bodily integrity needlessly. This basic reason is important to underscore and I will come back to this point later on in the article.

Therefore, during hymenoplasty consultations, Dutch doctors constantly impart information about the hymen particularly debunking the connection between its perceived intact condition with virginity and that virgin woman bleeds at first coitus. The following conversation is a typical exchange between a doctor and a hymenoplasty patient.

- Doctor: *"What do you know about the hymen?"*
 Patient: *"Not a lot."*
 Doctor: *"What is often said is that people can see whether someone is a virgin or not. You can't see it."*
 Patient: *"You can't see it?"*
 Doctor: *"No. I have examined thousands of women and I cannot see whether or not they're virgin."*

As apparent, the doctor here is convincing the patient that a woman's virginity cannot be discerned by examining her hymen. This statement is sometimes made as a response to the patient making a comment that a physician, or a senior older woman she has heard about, can 'tell' whether or not a woman is sexually untouched just by 'looking'. Dutch doctor also explains how hymenoplasty is done and what can or cannot be expected from the surgery. They emphasize that the operation is not a guarantee for the ability to bleed during the wedding night. The imparting of this information is often also supplemented with visual aid. Computer slide show or a brochure or a pelvic model is used to explain to the patient what the hymen looks like, where it is located and the differences of it in shapes and form, independent from the sexual history of the woman who owns it.

In most cases, hymenoplasty consultations in the Netherlands also include a gynecological examination. This examination is normally done by a female physician—both due to patients' requests as well as because the gynecologists involved in the provision of hymenoplasty in the medical establishments at which I did my study happened to be all women. The gynecological examination has two aims; one practical and the other educational. In the case where surgery is to be performed, it is necessary for the physician to be familiar with the condition of the patient's hymen in order to be able to know what needs to be done during the operation itself.

However, gynecological examination is still strongly recommended by some Dutch doctors to their hymenoplasty patients as a part of the entire hymenoplasty procedure regardless of whether or not the patients lean towards getting the operation. This is particularly true if the patients are still unsure of the decision regarding the surgery. Gynecological examination is used as another tool to ‘educate’ the patients to rectify the lack of knowledge that is perceived by Dutch doctors to lead to them wanting hymenoplasty. In this case, patients are ‘taught’ of their own body, their intimate organs, and about how to ‘control’ them. As has been mentioned earlier, many hymenoplasty patients have never seen a hymen, particularly their own. Some Dutch physicians are convinced that if the patients see with their own eyes how their own hymen looks like, they will at the very least cease to be under the impression that their hymen is ‘broken’ or ‘loose’. Dutch doctors have narrated to me how patients become empowered after inspecting their own vaginal canal, simply because now they are equipped with a knowledge they did not have before. This is also due to the relief they experienced upon finding out that their hymen is not as ‘broken’ as they thought it was.

During the gynecological examination, patients are encouraged to observe through the mirror their own hymen. This exercise at times creates some distress to the patients as many prefer not to look at their intimate organs. The following fragment illustrates such situation.

Gynecologist: *“Okay, we will do the examination now. We will see what it looks like down there.”*

Head Doctor: *“And you have to see it yourself.”*

Patient: (Laugh) *“Noooo, I don’t want to see it. I don’t want to see anything!”*

Gynecologist: (Performing examination on the patient)

Patient: *“Can you tell whether I’ll bleed or not?”*

Gynecologist: *“No.”*

Patient: *“I don’t want to see anything.”*

Gynecologist: *“Have you seen it yourself?”*

Patient: *“No.”*

Head Doctor: (Picking up a mirror) *“You have to look into the mirror. If not, you’d see nothing. See how it is closed? That’s your external. And that’s your internal. See how there’s no big hole? See how small it is? There, that folded thing. Do you see that? So small. It is not entirely closed, of course. Now, let’s try to contract your muscle.”*

As much as seeing the hymen being considered by Dutch doctors to be an important empowering experience for the patients, the aim of the gynecological examination does not stop there. As can be seen from the last sentence uttered by the head

doctor, the examination also provides an opportunity for the patients to practice contracting and relaxing their pelvic muscles. This exercise is seen by Dutch physicians to be important for the patients to understand. Many of the patients not only hoping that hymenoplasty will help them bleed during the wedding night, they also wish for the operation to 'tighten' their vaginal canal. Patients are often under the impression that their vaginal opening has been 'loosen' due to the sexual penetration they experienced, especially if done multiple times. Dutch physicians are keen to 'debunk' this point of view. They inform patients that the tightness of the vaginal canal comes from the contraction of the pelvic musculatures. They also emphasize that a sexually inexperienced woman tends to be 'tighter' because of the anxiety of experiencing sex for the first time which results in subconscious contraction of the pelvic muscle.

To further ground this point of learning, Dutch doctors introduce to their hymenoplasty patients how to achieve the contraction and the relaxation of the muscles. During gynecological examination and by using a mirror to show the effect, patients are encouraged to contract and relax their pelvic muscles. While patients are doing the exercise, physicians draw attention to how the vaginal opening seem to narrow and to widen accordingly. Patients are then advised to repeat the exercise at home, using one finger inserted into the vaginal canal to discern the tightness of the muscles. The thinking behind this recommended exercise is for the patients to then be quite used to control the narrowing of their vaginal canal. It is hoped that they can then do so easily come the time of coitus with the husband during the wedding night, giving the impression that they are still virgin.

Knowing Your Body

The notion of women as the most knowledgeable of their own body has been argued and demonstrated often in many studies. These studies range from Jordan's critique of hospital births that alienate women from their own bodily information during labor (1997) to studies that looks at the core principle of feminist clinics of self-help and know-your-body (Gartner and Riessman 1982, Kline 2010). The most famous example of literature on self-knowledge is arguably a book called *Our Bodies, Ourselves*, first published in the 1970s, now in its fifth edition (2011). The book was originally a result of discussion papers written collectively by a group of women later known as the Boston Women's Health Book Collective, gathering for the first time in 1969 (Davis 2002). Since then, the collective has also incorporated views from women from different places in the world. The book becomes a compilation of critical knowledge of the women's body, by women and for women. It celebrates a universal understanding of what it means to be a woman while at the same time acknowledging the plurality of individual woman's experience (Kline 2010, Davis 2007).

The basic premise of all of these writings are similar: “women’s experience ... represented the most empowering, most liberating source of knowledge” (Kline 2010, p. 42). To bring it back to the context of hymenoplasty, pelvic examination done during gynecological visit as a part of hymenoplasty consultation has been framed often in other studies to be a potential source for empowerment (Larsen, Oldeide and Malterud 1997, Mattsson 2000, Wijma and Siwe 2004). Specifically, the practice of observing your own vaginal canal has been argued elsewhere as an empowering experience. Kline (2010), upon writing on the historical account of pelvic exam, recounts a pelvic exam instructor’s comment on the process, “We encouraged every doctor to have a mirror on hand—it is a really exciting experience to see one’s cervix and vagina, especially for the first time” (p. 54). This statement was made during the time when pelvic exam went through modification of conduct in order to provide better respect and a more dignified experience for women who undergo them.

What is intriguing in the case of hymenoplasty is that we are observing women being deemed to not knowing their body enough which leads to them resorting to extreme measures such as surgery. In the Netherlands, physicians then act as motivators and facilitators to allow patients to ‘experience’ their own vagina and hymen and therefore the ‘right’ understanding of them. As arguably these surgery-seeking women have had sexual encounter even coitus and therefore have ‘experienced’ their intimate organs previously, we are witnessing the championing of knowledge even bodily experience in the framework of clinical setting. To understand the significance of this context, it is important to highlight that the ‘wrong’ knowledge women have about their hymen. This ‘wrong’ knowledge is either their understanding that the hymen is closed wall like structure or that it is always wounded after the first penile penetration. However, this ‘knowledge’ only becomes problematic when it leads women to see the situation as a predicament and want to fix it, particularly through surgery. Hitherto, there is no systematic information on whether women who do not desire hymenoplasty have the ‘right’ knowledge of the hymen. But since these women do not attempt to go under the knife, it has not turned into an unproblematic situation at least for the physicians. Dutch doctors do lament that the circulation of ‘incorrect’ knowledge of the hymen and virginity contributes significantly to the desire for hymenoplasty. In this context, even non-surgery seeking women have a part in the propagation of the knowledge. However, what is crucial to note here is that the surgery itself becomes the focal point in the perception of the problem of lack of knowledge of women about the hymen and virginity. In other words, if the demand for surgery ceases completely, the lack of knowledge might not be flagged as problematic either by scholars or medical professional alike.

In general, hymenoplasty scholars have been vocal in recommending ‘education’

to increase knowledge of the surgery seeking women and also people in their social circle about the hymen, virginity and the surgery itself as an answer to the increasing demands for the operation (Christianson and Eriksson 2013, Wild et al. 2015, Essen et al. 2010). It is believed that with ‘medically correct’ knowledge of the hymen and virginity, women will refrain from getting hymenoplasty. A study has argued that there are at least correlations between two as only one third of hymenoplasty patients in the study decided for the surgery after series of consultations designed to impart knowledge of the hymen and virginity (van Moorst et. al. 2012). Some Dutch doctors even consider their hymenoplasty consultations successful if the patients ultimately decide to not go forward with the surgery. What these doctors then recommend are ‘alternative solutions’ or what the physicians often refer to as ‘tricks’ (Ayuandini 2017b). These tricks will allow patients to achieve the goal they commonly hope from hymenoplasty which is to produce blood stained bed sheet on their wedding night without having to resort to surgery. The ‘tricks’ range from pricking own finger with a needle to taking out own blood to be put into a vial which can then be spilled onto the bedsheet at an opportune moment.

The introduction of these ‘tricks’ are also seen by Dutch physicians as necessary as the surgery does not guarantee a 100% chance of bleeding. In some occasions, the ‘tricks’ are considered a ‘better’ solution to what the patient hopes to achieve during her wedding night. For these reasons, even Dutch doctors who do not have a fundamental objection to performing the operation inform their patients of the existence of the tricks. However, for physicians who consider the surgery as ‘nonsense’, the ‘tricks’ are welcomed alternatives. They allow doctors to persuade patients not to undergo an operation they consider medically unnecessary. What is clear from the Dutch physicians’ choice of actions in consulting on hymenoplasty thus far is that their aim to ‘empower’ women through the imparting of ‘medically correct’ knowledge about the hymen and virginity is to eventually dissuade women from getting the operation. Patients are considered more empowered when they possess the ‘medically correct’ knowledge of the hymen and virginity. However, that empowerment should serve as a means to achieve the ultimate condition of being empowered: no longer wanting the operation.

Consequently, when patients who meet with the doctors demonstrate that they possess all ‘medically correct’ knowledge of virginity and the hymen but insist on getting the operation nonetheless, some Dutch physicians are left astounded. The following exchanges illustrate this:

- Doctor: *“But now the case is you want to be operated even if you know well that blood loss is not guaranteed.”*
- Patient: *“No, that’s correct.”*

- Doctor: *“And that being tight is something you can make sure of by yourself.”*
- Patient: *“Yes, correct. But I still choose the operation.”*
- Doctor: *“And why?”*
- Patient: *“Yeah, my cousin underwent it. I have heard a good story about it. And I choose for it.”*
- Doctor: *“Even though it’s nonsense.”*
- Patient: *“Yes, it is nonsense. But I need to protect myself against my fiancé.”*

It is clear that the doctor in this case was baffled by the decision of the patient who still desires hymenoplasty despite understanding that the surgery might not provide her with the result she was hoping for. The doctor ended up ‘granting’ the patient the surgery, keeping his promise at the beginning of the consultation that if the patient still desires the operation after the consultation is completed, she will be operated.

The request for hymenoplasty is not always granted and Dutch physicians have refused to operate on patients in their career. One doctor recalled a situation when she almost refused a hymenoplasty request from a patient. She remembered the patient well. The woman was, according to the doctor, “[v]ery modern, very open, very sexual[ly] experienced.” The patient came with her sisters, laughing all the way through the consultation and admitting to multiple consensual sexual encounters before being engaged with her current fiancé. The patient did not come across as being in distress or in any danger of unintended repercussions because of her past. The doctor was very troubled with the patient’s decision for wanting the surgery and considered strongly to refuse her request. The patient finally decided against the operation so the doctor was saved from having to reject her. A different doctor has also rejected patients before. One he particularly remembered was a Creole woman in her 40s with one adult child. The woman was marrying her longtime boyfriend who she has been intimate with in the last 10 years. She desired to bleed during her wedding night and wanted the operation for that purpose. Her request was denied.

Men Do Not Know

From the last exchanges between the doctor and the patient, it is important to draw our attention to the patient’s last sentence, “But I need to protect myself against my fiancé.” One particular doctor who has been performing hymenoplasty two even three times a week for the past four years has heard similar statements from other patients. Because of this, the doctor argues that ‘educating’ the patient with the ‘right’ knowledge of the hymen and virginity is not sufficient to help her overcome the problem she might be facing at home. The patient might be ‘enlightened’ but other people in her immediate social circle, particularly her future husband, are still not aware of

the ‘medically correct’ knowledge about the hymen and virginity. As such, they will still demand the patient to ‘demonstrate’ her virginity during the wedding night. This particular doctor tends to view hymenoplasty differently than other physicians in the Netherlands. She considers hymenoplasty medically unnecessary but has no fundamental problems in performing it, equating the operation as just another ‘trick’ to put blood on the bedsheet. The doctor claims that providing the operation is what really empowers the patient, not by simply ‘educating’ her.

Other doctors have not been entirely in agreement with this point of view. In one of the semiformal gatherings of Dutch sexologists conducted every six months or so, arguments broke between the doctor and another physician on this issue. The other physician is concerned that the consultation the doctor does is too short in duration for the patient to fully consider her options and to receive proper counselling. As a result, patients lean towards getting the operation most of the time. This other physician is one of Dutch doctors who strongly views educating and imparting ‘medically correct’ information about the hymen and virginity to the patients as a means of empowerment to those patients.

The doctor disagrees. “What they’re doing is dissuading the women from getting the surgery. Well, is that really empowerment? These women, they want to move on. They want to get married and have kids. And not being a virgin is the only thing that blocks them from doing that. So I see this as helping them to be able to do that. That’s empowerment,” the doctor stated to me the day after the gathering. Here we see a different view of what empowerment is. Empowerment in this case is seen as providing a way for another person to be able to experience change for the better which will allow her to then achieve goals in her life. Hymenoplasty for this particular doctor is a way to provide this ‘better’ situation to the patient. Hence, hymenoplasty is framed by the doctor as empowering.

Even if other Dutch physicians I work with do not agree with how ‘freely’ the doctor is seen to provide service to perform hymenoplasty, they do see a change in the life situation of their patients to also be something preferable. Addressing this, Dutch doctors provide recommendations and advices to their patients on what can be done to improve the situation the patients are in. Among the advice, doctors commonly promote certain characteristics they believe if possessed and demonstrated by the patient will help them to achieve a ‘good’ life. Some of the more common characteristics to be encouraged are being highly educated, staying in school and having paid employment. These traits are considered very important by Dutch doctors, it is not uncommon for them to check with the patients whether they will still be able to possess or do them after marrying. The following vignette illustrates this:

Patient: *“Well (smiles) I’m still busy with my study. I’m not working yet.”*

- Doctor: *“Your fiancé is also okay with you studying and wanting to work?”*
- Patient: *“Yes, he works too. [...] So he understands. My father also said that it’s important for him that his daughter finishes her study.”*
[...]
- Doctor: *“I have seen a lot of modern women after marriage simply stay at home.”*
- Patient: *“Yes, but you change after you are married. You have more responsibility.”*
- Doctor: *“Yes, but what I meant was autonomy [autonomie].”*
- Patient: *“Yes. Yes... I think. It’s still possible.”*

The doctor’s last sentence in the above excerpts is particularly important. Dutch physicians highly value formal education and paid employment for their patients because they believe it will allow the patients to have autonomy in their life. Autonomy is seen by Dutch doctors to be a significant factor that will allow the patients to have more control in their life and in turn the patients will not have to always submit to other people’s demands. This will ‘free’ patients from requirements such as that of virginity before marriage that puts them in the difficult situation they are in currently.

Among all the people Dutch physicians perceive the patients to be beholden to, it is the future husband they considered to present the biggest potential future problems. Future husbands are also the ones they see to be the source of most patients’ current predicament. Accordingly, Dutch doctors question their patients from time to time whether they are sure of their choice of spouse.

- Patient: *“I don’t think he [future husband] is a virgin. I want to tell him [about my past] several times but he always has such strong reaction and maybe he will think that it’s bad.”*
- Doctor: *“Women find it hard to explain because they are not sure how the men would react.”*
- Patient: *”Yes, I don’t know how he would react.”*
- Doctor: *“Still you want to marry him?”*
- Patient: *“Yes. (laughed)”*

In the above exchanges, the doctor acknowledges the difficulties in explaining about one’s past to the intended man. However, interestingly, ‘talking’, particularly to one’s betrothed is still a very frequent advice Dutch doctor will give to their hymenoplasty patients to amend the situation they are in.

Talk to the Man

Dutch doctors are in agreement that the virginity demands put upon their patients by people in her immediate social circle are undesirable and often unfair. This

is in part due to their understanding that men with similar ancestry to the patients are not held to the same standard of chastity before marriage. But also because they have often come across patients whose loss of virginity was due to an episode of sexual violence. Therefore, Dutch doctors are often of the thought that if only people in the patients' life, particularly their boyfriend or fiancé, can understand and be accepting of the patients' past, the patients will no longer be in a difficult situation. Accordingly, as it is important for some doctors, the patients will no longer require surgery. Dutch physicians reason that one of the best ways to achieve this understanding is by patients having conversations about their sexual past not only with their betrothed, but also with other people in their social circle.

'Talking' is one of the most frequent advices Dutch doctors suggest to their hymenoplasty patients in order to rectify the dilemma the patients are in. This recommendation comes in the context of patients often admitting that they and their boyfriend or fiancé have never actually talked about intimacy or sex. This is despite the patients being aware or suspecting that their intended will expect them to 'showcase' their virginity during the wedding night. Dutch physicians frequently entertain the idea that there is a chance the fiancé or boyfriend of their patients might not actually expect the patients to 'prove' their chastity and that his suspected demand is 'incorrectly' deduced by the patients themselves. Accordingly, Dutch doctors encourage their hymenoplasty patients to clarify this expectation. "Telling him is another option," said one Dutch doctor to a patient, "... I have also talked to women who did talk to their boyfriend and found that it's [not bleeding] not a problem at all." Another physician remarked, "I have met some women. Also from Muslim background. They say, 'Well, I will just say the truth. If it becomes a problem than he is not worth it'"

Talking or telling the truth is also considered by Dutch physician as empowering. This is particularly because talking is seen by them to have the power to rectify the difficult situation the patients are in. Apart from that, as can be partly discerned from the last doctor's statement, talking is considered a way for patients to recognize and announce their own worth to the other person hence becoming brave and confident in doing so. Talking or speaking up has long been recognized as a means of empowerment for women. This is specifically true in women empowerment programs that are organized and promoted by the government, aid agencies or international organizations as parts of development initiatives in countries often referred to as 'the third world'. Talking or speaking up is advocated in this context to build up the 'agency' of women, "the ability to define one's goal and act upon them" (Kabeer 1999, p. 438). Being able to speak up in itself is also frequently considered to signify greater level of empowerment of any individual woman, especially when the talking is done on a public forum (Burnet 2011, Baily 2011).

The importance of ‘talking’ as empowerment for women can be traced back to black feminist thinkers such as bell hooks or Carol Boyce Davies where the importance of ‘voice’ for black women is highlighted as historically entrenched. Davies states, “... Black women were seen/are seen/have been seen as having nothing important to say” (1994, p. 5). In advocating for black women to open up about their experience and to not keep certain things secret in the effort to not inconvenience others, bell hooks coined the term ‘coming to voice’ (1989, p. 12). Drawing from her own revelation she writes, “In all this talking, I was concerned that I not lose myself, my soul, that I not become and object, a spectacle. Part of being true to me was expressed in the effort to be genuine [...] to be real [...]” (hooks 1989, p. 3).

However, talking is not always considered by hymenoplasty patients to be preferable, particularly because talking can come at a price.

Doctor: *“Is it not possible to tell your fiancé about your past?”*

Patient: *“No, he wants a virgin woman.”*

Doctor: *“So if a woman is violated, that’s her fault?”*

Patient: *“No. But she’s not a virgin anymore. I’m not sure how he would think of it. [...] Maybe I’m just afraid to lose my fiancé.”*

Patients are often worried that speaking up or even vaguely inquiring about the expectation of virginity before marriage might alarm their fiancé. It might then cause the man to be suspicious which might lead to him severing the relationship. A boyfriend of a patient, who wanted the surgery because she was required to marry a different man by her family, exclaimed in anxiety when the idea was introduced during consultation with the doctor. “But you can’t bring it up! (speaking to his girlfriend) If you did he will definitely suspect something. I would. (Turning to speak to me) Men are like that. If she said anything, they will immediately finish everything [break the relationship].”

Dutch doctors are aware of this predicament. They also recognize that the expectation to ‘prove’ virginity is also often particularly required of patients by others in her social circle and not specifically by the fiancé. However, the physicians’ recommendation to rectify the situation remains similar: talking. Patients are also encouraged to talk to their family, particularly their mothers, with the same logic that if only the family fully understands the dilemma the patients are in, they might help amend the situation, changing it for the better. Talking is seen by Dutch doctors as the first step to make changes and therefore it is also perceived as the patients taking action and responsibility to improve their situation. Both signify the patients being empowered. Talking is also ‘prescribed’ to patients to address other sources of problems in their life. Patients who are still haunted by their sexual violation are advised to talk about their trauma to a psychologist. Patients who are dealing with emotional distress are

suggested to open up. “Talk to your family doctor (huisarts). Tell her that, ‘I’m occupied with sadness.’ Tell your huisarts that your mother wants you to get pregnant. [...] You need to talk about it with someone,” recommended one doctor to a patient who was visibly upset during her hymenoplasty consultation.

Change the Expectation

What is important to note here is that it is almost implied by the doctors that it is the responsibility of the patients to make the family understand of their situation. Patients are seen to have the potential to make alterations in their circumstances, both in regards to her current predicament and to her future state. Moreover, patients are also seen by Dutch physicians to be able to affect change in a context bigger than just her own personal life. When it comes to the desire of having hymenoplasty, Dutch doctors consider the root cause of it to be closely intertwined with the sexual norms, beliefs and values circulating among people of similar ancestry with the patients. Patients are then perceived by the physicians to be able to amend this cultural context, chiefly by (again) ‘talking’ with others. Patients are expected to relay the ‘medically correct’ knowledge they just received about the hymen and virginity to inform people they know. Accordingly, the aim of Dutch physicians in imparting information of the hymen and virginity to their patients is not simply to ‘enlighten’ only the patients. Doctors aspire for their consultation to also ‘educate’ other people of the patients’ ancestry—starting with the patients’ intended and her immediately family—with the patients as the messengers to spread the ‘education’.

One doctor alludes to this ‘spreading of information’ when pondering about the recent demographic of hymenoplasty patients in one public hospital in the Netherlands. This doctor claims to have observed a decline in numbers of patients particularly among those coming from Moroccan and Turkish background. The doctor’s assertion is that hymenoplasty protocol that includes enough time to counsel and ‘educate’ the patients might have made an impact among Dutch Turkish and Dutch Moroccans, resulting in fewer patients seeking hymenoplasty. The doctor assumes that this is partly because former patients might have spread the ‘medically correct’ knowledge of the hymen and virginity to the people of their ancestry. To make sure that patients do relay the information they receive in the consultation room, Dutch doctors from time to time actively encourage their patients to do so, as can be seen in the following fragment.

Patient: *“He thinks that a virgin is completely closed. So when he found out about the hymen from the internet he asked me, “Oh, so there’s actually a hole there?” I replied, “Well, where do you think menstruation blood comes from.”*

Doctor: *“Good for you. [...] You have to enlighten him.”*

Some doctors even attempt to inspire the patients to do something even more drastic: a complete overhaul of the cultural norms the physicians perceive to have informed the desire for the surgery. “Yeah, culture you make yourself,” replied one doctor to a patient who referred to her ‘culture’ for the reason why women of her ancestry are expected to abstain from sex before marriage while men are not. Exchanges below, with the same doctor but a different patient, further illustrate this.

Patient: *“If it depends on me, I find it very bullshit [sic] but yeah... But I can’t do anything about it, I can’t change that. It’s the culture.”*

Doctor: *“But over time all Moroccan women and men can stand up (in opstand komen) together.”*

Patient: *“I don’t know whether that would be possible. Yeah, my sister said, “Moroccan women they are all a bit...” yeah how do you say that...”*

Friend: *“Didn’t dare...”*

Patient: *“Yeah, even for people who were born here... it’s the same”*

Doctor: *“Yeah, I know a Moroccan woman who has, after we met, considered it and said, “Yeah, this is all bullshit [sic] And I will tell that to him [fiancé]. And if he reacted badly I will tell him that it’s [bleeding after first coitus] a myth.””*

As evident here, patients are seen by Dutch physician to have a significant role to play to deal with the root cause of requests for hymenoplasty and that it is the patients that should take action to initiate the change. Empowerment efforts Dutch doctors see them providing for the patients ultimately aim to not only change the patients for ‘the better’ but also to influence a change of perspective of other people of patients’ ancestry, particularly on the issue of the hymen and virginity.

Shaping Future Generation

The extent of the patients’ ability to affect change, as perceived by Dutch physicians, does not stop there. Not only that the patients are encouraged by the doctors to influence other people who are currently in their life, they are expected to also influence those who will be in their life in the future: their unborn often yet to be conceived children. Dutch doctors aspire to make sure that the next generation of the patient’s ancestry would not buy into the same ‘false’ understanding of the issue of virginity and the hymen as their parents or grandparents. The patients are then casted in the role of educators for the future generation and inseparably, in the role of mothers. Patients are expected to educate their children, particularly their sons, to not only understand the ‘medically’ correct knowledge of virginity and the hymen, but also to

not have different sexual expectation for women and men.

Patient: *"I have to convince him [her fiancée] that I'm a virgin."*

Doctor: *"Is he [patient's fiancé] a virgin?"*

Patient: *"I don't think so. I really find that not so nice."*

Doctor: *"Well, you can raise your children differently."*

The same doctor remarks to a different patient, "In any case, you need to raise your children differently. Respect should not come from whether or not someone bleeds." When it comes to how Dutch physicians bring patients' future daughter into the picture, the conversation takes a slightly different tone. Patients are often asked by the physicians, "What will you tell your daughter?" or queried about how they will react if their daughter tell them that she is no longer a virgin. These questions are not only aimed to ensure that the 'medically correct' knowledge of the hymen and virginity reach the next generation of women, they are also meant to 'prevent' the patients themselves to be the future 'demander' even 'oppressor' of this next generation women.

Empowering Migrant Women

The case of hymenoplasty consultations in the Netherlands come with the context of the patients being almost exclusively Dutch women of migrant ancestry. Women with migrant background in the Netherlands have increasingly been the focus of Dutch integration outlook, efforts and policies in the past 20 years. It is perceived by policy makers that the integration of people of migrant descent in the Netherlands are not complete until migrant women in the country have the same level of freedom enjoyed by their Dutch counterpart (Roggeband and Verloo 2007, Ghorashi 2010). The assertions of these policies are based on the idea that spouses and family of a migrant women are the main obstacles to the women's autonomy (van den Berg and Schinkel 2009, Schinkel 2011). This is the reason why the condition of migrant women is seen by policy makers to be the hallmark of whether or not the integration of people of migrant descent into Dutch society can be considered successful.

With this perspective, women of migrant ancestry are casted in the role of the victims who are passive, oppressed by men and are lack of skills to fully participate in Dutch society or to find solutions to their own problems (Lutz and Moors 1989, Spijkerboer 1994, Ghorashi 2010). Men of migrant background, particularly Muslim men, are perceived to be the oppressor, not only in the Netherlands, but generally across Europe (Ewing 2008, Razack 2004, Scheibelhofer 2012). People of migrant ancestry's ways of life, customs and culture, particularly those that are perceived to be patriarchal and championing conventional gender roles, are considered in national conversations to be incompatible with the 'Western' or European ideals (Adamson, Triadafilopoulos and Zolberg 2011, Stolcke 1999, Hollomey 2011). Women of migrant background,

especially their body, becomes the demarcation between liberation, which is European, and oppression, which is foreign (Razack 2004). In the Netherlands specifically, these women are seen by policy makers to be in need of help and empowerment to be as ‘fully emancipated’ as the Dutch ‘native’ women (Roggeband and Verloo 2007).

What is also worthy of note is that women of migrant background, particularly in the Netherlands, are often casted into a dual role: as a passive victim but also as the key to rectify the ‘oppression’ (Koffman, Saharso and Vacchelli 2013, Roggeband and Verloo 2007). This is particularly because women of migrant ancestry are considered to be future mothers who will be responsible of the education and upbringing of the next generation Dutch. These young people are in danger of also not acquiring the skills needed for participation in Dutch society as their elders (Joppke 2007). With the motto of ‘if you educate a woman, you educate a family’, mothers of migrant background are also seen by political parties in the Netherlands to be the person who will be able to instill the ‘right’ values and norms, including that of sexuality and gender equality, to their children (Prins and Saharso 2008, van den Berg and Duyvendak 2012).

How women are viewed and assisted in hymenoplasty consultations reflect very closely the wider context of migration in the Netherlands. These women are considered to be in need of help and should be empowered in order for them to not only be able to get out of their ‘oppression’ but also to be able to fully participate in Dutch society. Hence, it is not enough to inform them of the ‘medically correct’ knowledge of the hymen and virginity, they also need to be encouraged to pursue higher education and to have paid employment. Furthermore, women contemplating hymenoplasty, seen by Dutch physicians to be the future mothers of the next generation Dutch, are then expected to ‘educate’ their unborn children. This is in order for these young people to not continue to ‘believe’ a ‘mistaken’ view about the hymen and virginity. Surgery seeking women are also persuaded to not continue the ‘oppression’ on women of migrant ancestry by not expecting their daughters to stay a virgin before marriage.

7.6 Discussion—Shaping the Women Subject

Recognizing the dilemma their hymenoplasty patients are in due to the virginity expectation the patients anticipate to have to fulfill during the wedding night, Dutch doctors are compelled to provide help. The help the physicians are offering during consultations is perceived and framed by themselves in the rhetoric of empowerment. So passionate are Dutch doctors about empowering women through their hymenoplasty consultation, they disagree and debate each other on the best way to provide

this empowerment. Instead of evaluating whether or not the attempts of empowerment Dutch physicians claim to do in their hymenoplasty consultations are successful, it is more productive to interrogate what assumptions the doctors have about the patients, who are almost exclusively women of migrant ancestry. It is also important to look critically at the goals Dutch doctors have for the patients they are consulting. The discrepancy between the assumptions, stemming from an evaluation of the current condition of the patients, and the aspiration for the patients' immediate and future situation inform and shape each of Dutch physicians' efforts in empowering their patients. In turn, it is equally important to investigate what kind of women subject are shaped and reshaped through the assumptions and the resulting consultations (Sharma 2006).

A few things are apparent from the assumptions and the assistance, or what Dutch doctors also considered empowerment, in the case of hymenoplasty patients. When the patients first meet with the doctors and express their intention to undergo the operation, they are immediately, almost automatically, considered to be incompetent to make such decision. The patients are perceived by Dutch physicians to be unable to have the 'right' solution to the dilemmas at hand. This point of view is again parallel to Dutch policy makers' view of a woman of migrant ancestry in the Netherlands in which she is considered incapable to come up with her own solution to her 'problems' (Ghorashi 2010). What this means is that the only way for a woman of migrant ancestry to have a better situation is to be helped by others, in which in this case by Dutch physicians. This mindset is reminiscence of both Spivak's critic of 'white men saving brown women' (1988) and Abu-Lughod's challenge of views that see Muslim women to always need saving (2002).

To be precise, the patients are perceived by Dutch doctors to yet have the abilities to come up with her own solution. In order for them to gain these abilities, they need to be empowered. When they are considered more empowered, albeit simply by going through the consultations with the doctors, the patients are viewed by Dutch doctors to be more able to make a decision on what to do to deal with her problems. However, some Dutch physicians ultimately hope for the patients to make the 'right' decision: forgoing the surgery. When they do not and still desire the operation, some doctors are often left confused and at times disappointed. Even more telling is the doctors' decision when a patient who desires the operation seems to require it although she is not in any 'difficult' situation. As has been illustrated before, Dutch doctors are inclined to refuse this type of hymenoplasty request and have rejected patients of this nature in the past.

It can be discerned from the decision to reject hymenoplasty requests that the operation is seen by Dutch doctors to be acceptable to be performed if and only if it is

done in the context of potentially helping the patients. This decision has to be viewed in the context of, again, doctors avoiding what they consider an unnecessary compromise of the integrity of a healthy body through the act of incision. Hence, to take into account medicine code of ethics, the act can only be seen justified if it is done in the name of beneficence, a medical ideal that champions providing help for a patient in need (Beauchamp and Childress 2012). It is an important element to highlight that a request of hymenoplasty made without a condition of distress tends to be seen as unfounded and denied by Dutch physicians. This is where the logic of empowerment used by Dutch doctors during hymenoplasty consultation comes to its peculiar circle. The distress a hymenoplasty patient is experiencing is considered by Dutch physicians to signify a condition of ‘powerlessness’, therefore it is in need of addressing through the effort of ‘empowerment’. If after the ‘empowerment’, which takes the form of medical consultation, the patient still requires the operation, her request is granted, albeit with some bafflement on the side of the doctor. However, a hymenoplasty patient who is not in distress seems to still not seen by Dutch physicians as able, or at least justified, to make the decision to undergo the operation.

In short, the doctors’ assessment on whether or not a surgery is needful seems to be the determining factor to hymenoplasty to be performed on a patient. As the procedure itself is considered to be absent of medical necessity, Dutch physicians look to ‘social’ needs to ‘justify’ the surgery. The ‘social’ needs mostly take the form of the patient being in a difficult situation, having a possibility of experiencing unintended consequences if the operation is not performed or at least contemplated. Without this ‘social’ need, Dutch physicians see no just cause exists to move forward with the procedure. The patient’s wish to undergo the surgery, unaccompanied by distress, is considered by the doctors to be an insufficient ground to perform the operation. With this line of thinking, in the eye of the Dutch physicians, there is almost a formulaic dynamic between a doctor and a hymenoplasty patient in the Netherlands: the former to provide help, the latter to be helped; the former offers empowerment, the latter is in need to be empowered. Without this dynamic, surgery is seen to be superfluous and medical engagement between the two is terminated. Hence, it can be said that the Dutch doctors themselves pick and choose which woman can then be a patient or a candidate for hymenoplasty. By choosing only women who are in distress to be patients, Dutch doctors firmly cast women in the context of hymenoplasty in the position of inferiority. Ultimately, the ‘empowerment’ effort provided by Dutch doctors to their hymenoplasty patients can be argued to be more driven by the physicians’ need to empower rather than the patients’ need to be empowered.

What might be ironic is that the empowerment provided to the patients are meant for them to be able to ‘help’ themselves out of the difficult condition they are

currently in. Hymenoplasty seeking women are seen, at least by the physicians, to be self-responsible to alter her life situation that is causing them problems. The extent of the help provided by the doctors, accordingly the limit of empowerment effort and the physicians' responsibility, stops as the patient exits the medical establishment. Dutch physicians understandably have a limited engagement with the patients. Due to the high need for secrecy, doctors' exchanges with the patients are constrained both spatially as well as socially. It is not possible for the doctors, often specifically per request of the patients themselves, to engage with people in patients' life. Surgery seeking women are then addressed by Dutch doctors as both messengers and 'fixers'. They are expected to relay the knowledge received during consultation to others and in doing so, 'fix' the social situation that leads to them desiring hymenoplasty in the first place.

Two things are discernable at this point. Firstly, surgery seeking women are seen by Dutch doctors to be able to help themselves after, and I will argue only after, they are helped and empowered by the physicians. In this context, women are not perceived to be capable to decide how they are to address their own situation, particularly the first time they meet with the doctor. Women's ability to choose to undergo a surgery is dismissed, either temporarily for those who are in distressed or permanently for those who 'simply' want one. Whether the desire for the operation is deemed by the physicians to have come from the position of lack of knowledge or lack of power or something else, it is clear that there is something perceived insufficient in a woman who contemplates hymenoplasty to then be 'allowed' to make that choice.

The perceived insufficiency could also potentially be informed by Dutch physicians' assessment of the sociocultural situations of the surgery seeking women. Hymenoplasty patients are seen by Dutch doctors to suffer from unequal gender expectations, particularly in terms of virginity and pre-marital explorations of sexual intimacy, from the people of their immediate social circle. Through their direct and indirect demand of the patients regarding the maintenance of chastity, patients' in-laws, mothers and particularly the men the patients are marrying are understood by Dutch doctors to be the source of patients' problems. Doctors I talked to never used the terms 'oppressed' when talking to me about their patients, however physicians' way of framing the fundamental reason why women were contemplating the surgery alluded to such understanding. In the reasoning of Dutch physicians, it was the situation the patients were in that caused them to be unempowered.

Secondly, surgery seeking women are considered by the doctors to ultimately bear the responsibility to change the situation she is in. Aiming for a change to take place is reminiscent of feminist theory that views empowerment as a process and as praxis (Carr 2003, Abu Lughod 2002, East 2000, Gutierrez 1990). This idea of positive change is commonly linked to the notion of consciousness raising in which the efforts

to empower need to also enable women to be aware of the (political) dimension of their struggle (Freire 1970, Alcoff 1994, Carr 2003). The double process of reflection and action allows women to see their position in the wider context of social and political life which in turn will make it possible for them to move towards other options, positions and alternatives in their personal lives (Carr 2003, GlenMaye 1998).

Dutch doctors' effort to 'enlighten' women of 'medically correct' knowledge of the hymen and virginity can be framed in the context of consciousness raising where women are provided an alternative view of the (absent of) link between the membrane and a woman's chastity. Demands put on the patients by people in their social circle to 'demonstrate' their virginity during the wedding night is closely related to the understanding that sexual purity and an 'intact' hymen are connected. What Dutch doctors expect to accomplish is that breaking the linkages between the two allows women to entertain alternative course of action to surgery to produce blood stained bed sheet. Blood stained bed sheet is a mark that is still considered as proof that the hymen of the newly wedded bride is 'intact' before penile penetration with the husband, signifying her a virgin (Ayuandini 2017b). The physicians then further hope that the patient will choose to resort to one of the alternatives and, in the process of doing so, take the first step to finally take matters into their own hand. Dutch physicians see deciding to prick their finger or using a vial of blood to create blood stained bedsheet signifies the patients being courageous and in control of their fate. This is in contrast to wanting the surgery because undergoing the operation is not only seen as a passive 'solution', it is also perceived, as has been mentioned before, to come from a position of ignorance and powerlessness.

Consciousness raising Dutch doctors attempted to do might be minimum and mostly confined to providing 'medically correct' information about the hymen and virginity, but it is done with a logic to trigger action through instilling bravery. What is important to underscore here is that with this kind of point of view, Dutch doctors not only inculcate courage, but they also advocate responsibility to their patients to do something about the situation they are in. After being 'empowered' surgery seeking women are casted to be self-responsible to deal with the problems they are facing even to the extent of making sure it ceases to exist. This view of responsibility is close to the notion of a neoliberal subject where one is responsible of one's situation regardless of the constraints one are faced with (Walkerdine, Melody & Lucey 2001). A neoliberal subject is built on an emphasis of the individual; one who understands oneself fully and in control of one's fate (Davies et. al. 2006). This individual is perceived to be calculative, rational and capable of self-regulation (Gill 2008).

A neoliberal subject is often seen by scholars to be in par with a postfeminist one whose championing of sexual freedom seems to be unattached to its circumstantial

expression, neglecting political and historical context of the action, relegating diversity to the background (Butler 2004, Scott 2007, McRobbie 2009). This view of a responsible sexually free woman is closely reminiscent to those advocated by Dutch physicians during hymenoplasty consultation. Empowerment provided by Dutch doctors is absent of consideration of the wider Dutch political situation, particularly that which is related to people of migrant ancestry and their offspring. The empowerment efforts are also missing a critical reflection of the doctors' own position both as the authority and medical experts as well as outsiders to the experience of the surgery seeking women. Dutch physicians' attempts to empower are in direct contrast to Freire's notion of pedagogy of the oppressed (1970). The case of hymenoplasty does not see empowerment that is initiated by those aspire to emancipate themselves. It is started by the physicians with a top down approach. This dictation of change by outsiders, according to Freire (1970), is counterproductive to the process.

Cruikshank cautions the importance to acknowledge that the process of empowerment is inherently imbalanced in which "[d]espite the good, even radical, intentions of those who seek to empower others, relations of empowerment are in fact relations of power in and of themselves (1999: 70). Cruikshank further emphasizes that accordingly, empowerment is always (1) a relationship established by expertise, (2) it is typically initiated by the one seeks to empower, (3) depends on the [lack of] knowledge of those to be empowered and (4) a relationship [that] is simultaneously voluntary and coercive (1999: 72). In the context of negligence of this reflection and understanding of empowerment, engagement between doctors and patients as well as advices provided was made under the "illusion of equality" (Pease 2002: 138). This illusion maintains the hierarchy of power between the two and brings up question whether the urge to empower eclipses the potential of physicians to help patients to decide the best way to empower themselves (Bransford & Bakken 2002, Simon 1994). Empowerment in this case is provided within the patriarchal framework and sustains the place of patients in the position of inferiority (Longwe 1998).

What is also important to emphasize here is that surgery seeking women are considered by Dutch physicians to be responsible actors in dealing with their own problematic situation, simultaneously being casted as victims of problems but also as solvers of such problems. They are also encouraged to be cognizant of their role in the life of the next generation Dutch. Again, in this regard, hymenoplasty patients are perceived by Dutch doctors to play a dual role: that of an educator and another of a potential oppressor. Patients, who are virtually exclusively of migrant descent, are considered by the doctors to have the capability to sustain or halt the continuity of regrettable customary traditions of their ancestry, particularly that which demands women to 'showcase' their virginity in the time of marriage. In this context, the phy-

sicians can be seen to attempt to save women from themselves; preventing future Dutch women to experience similar dilemma of their parents but also stopping surgery seeking women themselves from turning into the source of the problems. Here, we are reminded of scholars' critiques of tension between 'protecting' women and simultaneously 'policing' them (Pliley 2014, Odem 2000, Wynn and Trussell 2006).

7.7 Conclusion

Patients who come in to meet with the doctors to contemplate hymenoplasty in the Netherlands are commonly seeking the surgery with a certain amount of concern. If the fact that they are no longer sexually untouched is found out by people in their social circle, they worry that they will face unintended consequences ranging from ostracization to physical harm (Ayuandini 2017a, Eich 2010, Amy 2008). Hymenoplasty is the patients' way to avoid such consequences; their solution to the problem at hand. Dutch physicians consider this choice of solution to be problematic. They see the surgery to be medically necessary, hence the act of incising a healthy body becomes superfluous. More importantly, they consider the desire for the operation to come from a position of deficiency, in which if 'fixed' will result in the women no longer coveting the surgery. Dutch doctors reason that women are still contemplating hymenoplasty due to two lacks: (1) lack of the 'right' knowledge about virginity and the hymen and (2) lack of social ability to avoid possible unintended consequences.

To address the first lack, Dutch physicians use their consultation time to inform the patients of the 'medically correct' knowledge about virginity and the hymen. The knowledge includes, chiefly among others, how sexual history of a woman cannot be definitively discerned from the condition of her hymen, that the first coitus with a virgin does not always result in her bleeding and that the perceived 'tightness' of the vaginal opening of a virgin is due to muscles contraction rather than an intact' hymen. The imparting of information is mostly done verbally but strengthened with exercises including contracting pelvic musculatures and using a mirror to observe one own's vaginal canal. To address the second, Dutch doctors promote characteristics they believe if possessed by the patients will give them greater possibility for emancipation from people who have been 'oppressing' them. These includes, among others, working towards a high degree in formal education, having paid employment and having autonomy in one's life. Patients are also encouraged to talk to people who they consider to be the 'demander' of chastity requirement in order to change the other person's point of view of the demand.

In the effort to empower, it is important to underscore that for some Dutch doc-

tors, successful consultations are those where patients ultimately decide against the surgery. This is due to their point of view that hymenoplasty is medically needless and the desire for it comes from misrecognition of issues surrounding female virginity. The focus on avoiding surgery is also apparent in their refusal to patients who require it without seemingly being under difficult social situation. Sans social dilemma experienced by the patients, Dutch physicians lose their justification to take on a hymenoplasty case. This highlights how empowerment provided during consultation to be mostly motivated by the doctors' urge to help rather than the patients' need to be assisted in a particular way.

Empowerment efforts provided in the context of hymenoplasty consultations by Dutch physicians also demonstrate how surgery seeking women are evaluated not only of their present but of their potential future. In the context of future generation Dutch, surgery seeking women are seen by Dutch doctors to be future mothers, capable to either 'help' or 'hinder' their children. Simultaneously seen as prospective educators and likely oppressors, patients are encouraged to be the former and prevented to become the latter. In the context of patients' own immediate future, they are encouraged by the physicians to pass along their newly acquired 'medically correct' knowledge of virginity and the hymen to others in their social circle. Once empowered, patients are casted to be self-responsible to 'fix' their own problems and to even initiate a complete overhaul of customary view of virginity among people of her ancestry. Ultimately, empowerment provided to surgery seeking women in the case of hymenoplasty consultations in the Netherlands are shaped by physicians' perceptions of the patients. These perceptions are inextricable from the doctors' locally informed point of view of the 'plight' of a migrant woman in which her heritage presents the source of the problems and she needs to be helped to be able to help herself. This neoliberal postfeminist perspective on empowerment neglects the political context of the position of women of migrant descent in Dutch society, relegates the diversity of women's experience to the background, neglects physician's needed reflection of own's position of power and executes empowerment in a sustained patriarchal context.

7.8 Bibliography

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