

## Valuing Health, Negotiating Paradoxes

### Medicalization of Hymen, Hymenoplasty, and Women's Healthcare in Ontario

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#### Introduction

Female sexual abstinence until marriage still plays a crucial role in diverse sociocultural contexts worldwide—for instance, in Asian countries, the Middle East, African and South American countries, and their respective diaspora communities. Unmarried women affected by the virginity imperative and suspected of having “lost” their hymen may face bullying, verbal and physical violence, death threats, and femicide. By reconstructing the hymen through hymenoplasty, a woman may be able to avoid such negative socio-cultural sanctions. Yet the medical procedure of repairing a hymen places medical practitioners in an ethical bind: on the one hand, hymen medicalization and the participation in a secretive procedure may lead to charges of “virginity fraud” and thereby perpetuate gender-based discrimination; on the other hand, hymen repair may be a deliberate decision and an act of sexual self-determination, which are considered human rights.

In the Canadian universal healthcare system, neither virginity testing nor hymen examinations and related services are regulated by the Society of Obstetricians and Gynaecologists of Canada (SOGC), nor are there published procedural recommendations from the Royal College of Physicians and Surgeons. Hymen repair requests are neither paid for by Medicare nor criminalized, as is the case with female genital mutilation or cutting. Hymeno-

plasty, also known as hymen repair or hymenorrhaphy, is considered an elective cosmetic surgery, offered by plastic surgeons in private practice, hence available only to those who can pay the steep surgery costs.

During my field research in Toronto exploring hymenoplasty practices related to virginity imperative pressures, I was in contact with many health-care providers. The engagement with these interlocutors, combined with the realization of the lack of attention to women who proactively request help, led me to ask a series of questions: How is the value of women's health negotiated by medical practitioners confronted with a patient whose requests were hitherto unknown to the health system as a whole, and which appear to be in opposition to prevailing values? How do practitioners inside Toronto's fast-paced healthcare system respond to possibly controversial requests of hymen repair and related virginity examinations? In what follows, I address these questions in three sections: First, through relaying the refugee journey of Hala, I briefly introduce how the hymen may transform from an inconspicuous membrane into a sociomedical issue. Second, I contextualize refugee healthcare services within the Canadian universal healthcare system in Toronto. Third, I detail the work of two medical professionals who treat uninsured refugees in the Greater Toronto Area and are regularly confronted with patients requesting hymenoplasty and hymen-related virginity examinations.

In doing so, I investigate principles of everyday healthcare decision-making and thereby complicate the narrative of the well-resettled refugee and the immigrant body within Canada's universal healthcare system. Exploring regimes of exclusion and inclusion within refugee healthcare, I seek to give voice to women whose stories would otherwise not be heard: women like the young refugee Hala and dedicated medical practitioners like Sandra and Samira, who work with and advocate for refugees.

## Methods

Research for this chapter was conducted in Toronto and the Greater Toronto Area between February 2017 and December 2018. During these months, I conducted forty-four formal in-depth interviews and informal conversations in English. I interviewed plastic surgeons, gynecologists, general practitioners, counselors, a practical nurse, and a physician's assistant, all of whom have had experience with virginity imperative patients. In addition, I interviewed young women between the ages of eighteen and thirty-five, who shared their refugee and immigration stories concerning their sexuality and related body perceptions. I collected additional data through limited participant observations in two clinics serving refugees and uninsured residents in Toronto and the Greater Toronto Area. Research participants were found

mainly through snowballing and personal recommendations within medical practitioners' circles, and poster advertisements to recruit young women as interviewees outside clinics. For institutional support and legitimation during the research, I was affiliated with the Department of Anthropology at the University of Toronto. In order to fulfill local North American standards of ethically responsible research, I sought the approval of the University of Toronto's Research Ethics Board (REB) for the duration of the entire project. Participant observations were limited to medical practitioners and administrators, since the REB protocol did not allow for patient contact inside clinics. The names of all participants have been changed and anonymized.

In light of the fractured manifestations of the phenomena studied and their secretive, intimate, and intimidating character, I opted for a multisited (Falzon 2009; Marcus 1998), glocalization research approach (Gingrich 2002: 228). My research strategy and decision-making embraced an inclusivist approach that informed my way of thinking about the phenomena I studied and how I made research decisions (Lock and Nguyen 2010).

Within this context, I define the hospital/clinic as a site of complex and multifaceted relationships, a place of ultimate concern, a "condensation of everyday life" (Long, Hunter, and van der Geest 2008: 73), and a site of everyday routine interactions between doctors, patients, and staff (Van der Geest and Finkler 2004). In doing so, this research aims to shed light on the (re)constructiveness of biomedical technology occurring every day. I take Lock and Nguyen's stance that

biomedical technologies are not autonomous entities, the effects of which are essentially uniform whenever they are put into operation. Professional choices about the use of specific technologies—when exactly to put them into practice, and how to interpret the results and effects that they bring about—are combined with broader societal variables including culturally informed values and constraints, specific local and global objectives, economic disparities, and inconsistent or non-existent regulations. (Lock and Nguyen 2010: 5)

Despite a growing body of literature on hymenoplasty and an array of general research on asymmetric doctor/patient interaction (e.g., Pilnick and Dingwall 2011), little is known about the everyday experiences and perceptions of medical practitioners confronted with hymenoplasty demands. How are such patient requests handled during relevant doctor/patient interactions—in other words, how are related ethical and moral values enacted?

After conducting research on hymenoplasty practices in Beirut (Kozmann 2013), I was interested in continuing to explore the related ethical challenges of the hymen and female virginity issues in a Western, metropolitan context. The city of Toronto, with its growing Middle Eastern and Muslim communities, had not yet been the subject of published empirical research on hymenoplasty and related virginity issue patients.

## Transformation: Self-Determined Sexuality and the Social Hymen

When Hala and I met for the first time, she was in her mid-twenties and had just arrived in Toronto a few months before as a legal, state-sponsored Syrian refugee. The third child of a Palestinian couple forced to leave their home country more than twenty years ago, Hala had lived most of her life in Syria when she became a displaced person during the Syrian war, a conflict that forced millions of people out of their homes. Leaving Syria on her own, she was separated from family and friends and from her religious community at just twenty-one years old. Before arriving in Toronto, Hala had lived for a few years in two neighboring Arab countries in North Africa. Along the way, she learned English and French, and received training and worked as an accountant, translator, and tourist guide. Nonetheless, she remained without many future prospects.

As Hala shared her refugee journey, it became apparent that she saw both challenges and opportunities as plentiful. “Toronto is the place to be,” she gushed. Toronto offers more than mere asylum—as a state-sponsored refugee, Hala is a welcomed newcomer; she has been allowed to work, study, and move freely since the day of her arrival. Toronto is also her adopted new home, far away from Syria, where she lived a life embedded and sheltered among her family and friends, her school, and her religious community. Between then and now, she has been exposed to a multitude of new and different lifestyles. This exposure has fostered the development of a sense of independence and individualism in her. She had decided to explore these new lifestyles in all directions, including premarital sexuality—acting in diametrical opposition to the values of her upbringing. “Virginity is [a] sacred thing,” she explained. “It’s like, without it, you are dead, right?” The “virginity thing” she was referring to is commonly known as the “membrane of virginity” or, by its biomedical name, the hymen. When deemed proof of female virginity, the hymen gains its sociomedical importance from the combination of the “right” physical state *and* its sociocultural significance. This is the case in diverse sociocultural contexts worldwide, including various communities now resident within Western societies. Thus, the hymen is transformed from an inconspicuous membrane to a body part heavily charged with meaning and a potentially efficacious, gendering category: the “social hymen,” as the Egyptian gynecologist and feminist Nawal El Saadawi (1980) termed this phenomenon in her writings in the late 1970s.

For Hala, preserving her virginity was synonymous with maintaining the intact state of the hymen. To her, as to her Syrian friends and family, this was not a private matter, nor an individual choice, but part of what was expected from her, part of her upbringing and part of her everyday life as a girl in Syria:

Well, I've been raised on [this] since the first day of my period. I was only twelve . . . I've been exposed to this world so early. So, the first thing first: you got your period, you become a woman. And mom didn't have to talk a lot because, in Syria, all the media, all the TV series, like any culture came from the regime. It would be about [the] bad girl who loses her virginity, [and the] good girl is who kept it, right? So, it's not just a family [matter]. It's a culture. It's a political thing. It's like through the TV shows, the drama, the books, the stories, the concepts. So, it's the most important thing. Like you find many, many [movie] scenes [where] an actor [is] holding a knife and [is] going to kill his sister because she slept with someone. So that's very scary for a little kid. But that was in my head.

For Hala, virginity is not a theoretical concept, but a reality, a sociocultural factor of her upbringing, one she is expected to embrace and embody, even living abroad. Thus, deciding to explore sexuality in all aspects means not only giving up the "sacred" hymen but also distancing herself, both from this internalized sociocultural expectation and from her family. And she risks being shunned, bullied, and even physically attacked. Were she ever to need hymenal proof of her virginity, as is common when getting married, she is aware that she would not be able to provide it. Additionally, she knows about the option of reconstructing the hymen through hymenoplasty, having heard about young women who took advantage of this surgery. She explained that it would not be something she personally would opt for at this point of her life, but she might in the future. Asked about her sources of information concerning the physicality of women's genitalia, female virginity in general, and the hymen in particular, she replied that she would prefer to consult with a medical professional but had so far failed to find one. This left her somewhat isolated on her journey, attempting to navigate between two very different worlds.

Hala's story is one of many refugee and immigration stories I had the privilege to hear during my field research. It encapsulates many of the themes this chapter and my research overall touch on. By telling the story of her struggle and journey, I aim not only to humanize this intimate and polarizing topic but also to highlight the importance of taking patients' requests seriously. I argue in the following that refugees like Hala are in need of confidential medical advice to help them overcome uncertainties related to these secretive, intimate, intimidating, and potentially shame-generating subjects. I argue further that medical practitioners may be well suited to inform and accompany women throughout this process.

## **Hymenoplasty: A Global Phenomenon in Toronto**

Spread by migration, the internet, and medical tourism, hymenoplasty is considered transregional, making the issue of the virtue of female virginity a

global one (Franklin, Lury, and Stacey 2000; Lindisfarne 1994). The metropolitan area of Toronto is home to about 5.9 million residents, and Toronto is the biggest city in Canada with about 2.7 million residents, 75 percent of whom are immigrants and their children. The province of Ontario is said to host 29 percent first-generation immigrants, and Canada prides itself on being made up of more than 250 ethnic groups. Canada is also proud to be a shelter and new home for refugees and immigrants (Statistics Canada 2013). Currently, Syrians represent the most prominent Middle Eastern refugee group, with more than 50,000 admissions since 2015—a trend that will likely continue in the coming years. Although virginity imperative requests are commonly presumed to be linked to the presence of Arab, Muslim, and North African immigrants and refugees, physicians shared with me that hymenoplasty requests are by no means limited to Muslim women, but include requests of women with diverse backgrounds, including Korean, Chinese, and South American. In its last published national household survey of 2011, Canada showed a total population of 1,053,945 Muslims (out of a national total population of 33,476,688). The province of Ontario is home to 581,950 Muslims (total population 12,651,795), mainly of Indian, Pakistani, Iranian, and Egyptian/Arab background. Greater Toronto's overall female population is 1,336,805 (total population 2,576,025), and its female Muslim population is 105,920 (total Muslim population 212,345). The growing Muslim population is currently the third largest religious community in Canada (after Christians and nonreligious residents), a trend that is expected to continue due to political upheaval in the Middle East (Statistics Canada 2013).

The Canadian universal healthcare system is designed to serve all legal residents. Established under premier Pierre Trudeau in the 1970s, its five principles were detailed in the Canadian Health Care Act of 1984: first, accessibility—the reasonable access to health services; second, the public administration of publicly funded and privately delivered healthcare; third, the portability of services within Canada; fourth, the comprehensiveness of necessary health services; and fifth, universality—all insured residents are entitled to the same level of healthcare.

Officially, refugees are entitled to medical insurance starting at the time of arrival. However, as I learned through limited participant observation in two clinics for refugees and the uninsured over a period of seven months, not all newcomers receive publicly funded health insurance immediately. Numerous administrative and non-administrative barriers can get in the way, such as document completion, language unfamiliarity, healthcare system navigation, disruptions to routines, availability of transportation, lack of trust in the new order, recurrent trauma, and worries about loved ones left behind. At best, newcomers may wait ninety days after arrival to start using regular healthcare services, but waiting times can be as long as two years.

To shorten the wait time, teams of health workers and physicians have taken the initiative to create refugee and uninsured clinics inside Toronto

and around the Greater Toronto Area. These clinics are often run on a shoestring, staffed by volunteers, and reliant on private donors or small grants directly from the city of Toronto. One of the two clinics I visited regularly accepts patient requests related to hymenoplasty and the virginity imperative. Sandra and Samira are two dedicated medical practitioners who work in these clinics. In their everyday work, they prove how a healthcare regime of inclusiveness may be enacted as they manage patient requests such as virginity examinations and hymenoplasty.

## Medical Practitioners: Enacting Inclusion

Sandra, a practical nurse, closes the door behind us for one of our conversations, and the sounds of the bustling refugee clinic—children, parents, and families waiting for appointments, the multiprofessional medical team, administrators, and translators attending to patients speaking in English, French, Arabic, and Turkish—melt into the background. We sit in her office, next to the office of the clinic’s founder and only doctor. The atmosphere is professional, as expected, but also strikingly positive, friendly, and familial. There is a lot of laughter, patients are greeted on a first-name basis, and children run around playing. More than once, I witnessed a child storming straight through the corridor to hug Sandra’s legs, followed by proud mothers or by both parents. Sandra started working in this refugee clinic two years ago and now attends to everything related to women’s and reproductive health. The doctor thought it would be better to have a woman attending to these issues, as he felt his female patients were not entirely comfortable with him. A few years ago, he started the clinic with fewer than ten patients. Now they are reaching 4,000 patients, while continuously expanding. Sandra explains that one reason for the rapidly growing patient numbers is the way that access to Canadian healthcare is organized. To enter the universal healthcare system, you must have access to a general practitioner, who then refers you to specialists as needed. Most of Sandra’s patients traveled straight from the Middle East to Canada, and the last newcomer wave included mainly Syrians.

Asked about it directly, Sandra shares with me her introduction to virginity and hymen testing. She says that this is her first job as a practical nurse and that it took some time to earn her patients’ trust. Once she had established her authority next to the doctor, she started to see more and more female patients. Now she is the authority on everything related to women’s and reproductive health in the clinic. Clearly, Sandra is a young professional passionate about her job. While she talks, my gaze wanders from the children’s drawings pinned on the walls, past the examination table near the window, to two trees moving peacefully in the wind, and back

onto her desk, which is dominated by a large computer screen. The digital calendar organizing her patient visits is open, showing the appointments of the day; next to it another tab is open, showing the webpage SexandU.ca. Created by the SOGC, this webpage is the tool she relies on to illustrate information about women's bodies when her patients ask about their genitals, sexuality, reproductive health, and healthy relationships. "Hymen" or "virginity" are unfortunately not searchable keywords, a circumstance she did not even recognize until about six months ago, when patients started to request consultations regarding the state of the hymen, female virginity, and hymen reconstruction.

In comparison, she says, female genital mutilation is something she sees almost daily. It was an issue with which she was familiar, almost expecting, but requests related to female virginity and hymen examinations took time to arise during consultations. In comparison to genital mutilation or cutting, this was not a topic during her years of studying, and it is not visible during gynecological examinations or addressed directly during routine consultations. It took many months of working in her position before the first woman approached her asking to see her teenage daughter for a checkup, which turned out to mean to examine the state of her hymen and to make a statement about possible related sexual activity. Since then, a growing number of patients have requested her professional opinion on female virginity, hymen examinations, and hymenoplasty, which she refers to as hymen repair. She concludes from these encounters that her patients first had to build trust. Now they do not ask for the doctor anymore; they ask for her. She narrates the story of a patient she perceives as a model of integration, highly informed but still needing trusted consultations on this sensitive topic:

She was in her late thirties. But she had never been married, had never been sexually active. She was considering an engagement, and she was very, very sort of Canadianized, had been here for quite some time. Excellent language capacity, excellent system navigation. And so really like a model of how we'd love all of our patients to be when they've been here for several years, right? And very well informed and educated. But not regarding this specific issue of virginity and sex and healthy relationships in a marriage. And so, she came to me, and she said, "I've decided to not listen to my aunties and not do random searches on the internet. I want to have a discussion with a healthcare provider who can give me an informed perspective on this."

Sandra is convinced that she gets to see a side of her patients that colleagues in other clinics might not get to experience, since this is an intimate and potentially shameful topic. She sees the difference she can make in building sustainable, trusting relationships with individual patients. This is not the rule in the fast-paced public healthcare system, which pays clinics according to their number of consultations. Within the system, she explains

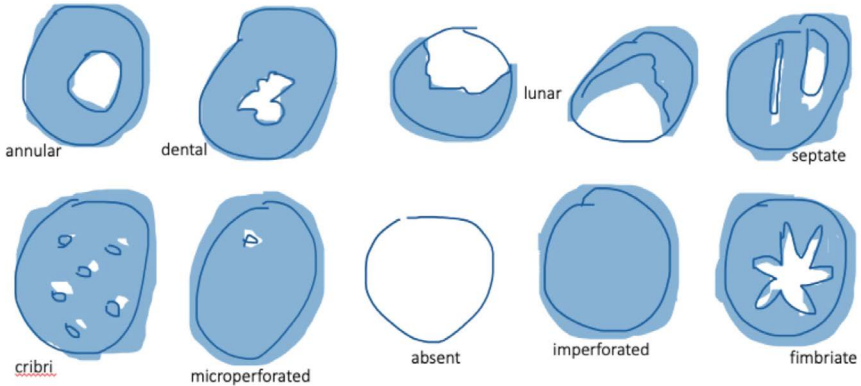


that patients usually have about ten minutes or so to talk to their clinicians. Sandra's work schedule is different: "You won't find a poster on this wall encouraging patients to make separate appointments for different health concerns." She has the time resources to keep the door closed and continue a consultation, even if it takes longer than scheduled. Here she does not need to rush through patients. If the door is closed longer than expected, nobody will come, knock, and interrupt. Instead, a colleague will take on the next patient for her. This approach is part of the clinic's mission to acknowledge refugees as being an especially vulnerable group of patients, potentially suffering from flight-related traumas, which can be triggered at any moment. When they are, adequate time should be taken to address them. She concludes that this is also the kind of flexibility that is needed by patients who request hymen and virginity examinations during an appointment, because women would never declare the real reason for their appointments at the time of booking.

Sandra's clinic is not representative of how healthcare is provided in Toronto, operating at the margins in various ways and filling in some of the universal healthcare system gaps. As noted earlier, in the Canadian universal healthcare system, the costs of virginity testing, hymen examinations, and hymen repair services are not covered, and the procedures not taught as part of professional training or regulated by the SOGC. Officially, hymenoplasty, virginity testing, and hymen examinations do not exist as healthcare concerns. Hymenoplasty is considered an elective cosmetic surgery offered by plastic surgeons, to be paid for privately. This, I argue, reflects a particular biomedical approach.

## **The Hymen: A Biomedical Approach vs. Medicalization Requests**

Current biomedicine has little to say about the hymen's physical properties. To take just one example, *Stedman's Medical Dictionary* describes it as "a thin membranous fold highly variable in appearance which partly occludes the ostium of the vagina prior to its rupture (which may occur for a variety of reasons). It is frequently absent (even in virgins) although remnants are commonly present as hymenal caruncle tags" (Stedman 1995: 821). What Stedman's (1995) dictionary kept in parentheses curiously reflects what biomedicine still claims not to do—grant a sociomedical meaning to bodies and body parts. Against long-prevailing beliefs that the hymen must "tear and bleed" during the first penetration, this membrane is described neither as containing blood vessels nor as necessarily tearing as expected. Instead, medical dictionaries categorize several different hymen forms—that is, various forms of permeability (see figure 12.1).



**Figure 12.1.** Different Forms of Biomedical Hymen Permeability Categories. Figure drawn by the author.

In addition, the hymen also exhibits a broad spectrum of elasticity: it may tear easily or may be flexible enough to be found intact until the first childbirth. Also, there might be some bleeding, or there might be no blood at all, as the hymen itself is not considered to have any blood vessels (e.g., Emans et al. 1994; Dickens and Shaw 2015). From a biomedical perspective, there is generally no indication for treating this body part. However, women who approach medical professionals concerning virginity imperative-related pressures seek to overcome not a biomedical issue, but a sociomedical one—they are requesting medicalization. As Peter Conrad explained the term, medicalization means

a problem [is] defined in medical terms, described using medical language, understood through the adoption of a medical framework, or treated with a medical intervention . . . . It is important to remember that medicalization describes a process . . . . Thus, we can examine the medicalization of . . . menopause or erectile dysfunction . . . . Active agents are necessary for most problems to become medicalized. Social movements, patient organizations, and individual patients have also been important advocates for medicalization. (Conrad 2007: 5–6)

Medicalization enables biomedicine to answer patient requests. A successful hymenoplasty surgery makes any rupture invisible. Thus, it is impossible to tell the difference between an originally intact and a surgically manipulated hymen. Therefore, the procedure may adequately conceal premarital intercourse. Paradoxically, it is the physician's triple role of being part of the biomedicine community, a trusted authority by the society/community, and secret ally to individual women that evokes ethical considerations of medical professionals (e.g., Juth et al. 2013). This seems especially

true in Western contexts such as Toronto, where a gynecologist working in a mainstream hospital shared with me that, yes, he and his colleagues are approached in this respect but are relieved not to be required to make decisions on their own, as the service would not be paid for anyway and is thus categorically denied. In light of this, how do Sandra and her colleague Samira relate to this paradox?

## Practicing Inclusiveness: A (Neo)Liberal Concern

Sandra was introduced to hymen examinations only due to her work with Middle Eastern refugees. Her colleague Samira, who works as a refugee counselor in the same clinic, has a different story to tell. Born in the Middle East, she became a refugee herself as a young girl, first migrating with her family to a neighboring country, then to Northern Europe before she found her long-term home in Ontario. As a Middle Eastern woman personally affected by the female virginity imperative, she overheard her mother and her aunt, a doctor, talk about hymenoplasty. Now, as a counselor, Samira is regularly asked to mediate between parents and daughters, and encourages individual women to think through the consequences of having their hymen repaired. If they decide to undergo the surgery, she helps them find the right plastic surgeon in downtown Toronto who otherwise, she says, would not want to have anything to do with the refugee clinic. However, the surgeon accepts patients who can pay the steep price of CAD 3,000–5,000. Another recommendation is using an artificial hymen tissue and inserting it just before the wedding night act. “It all depends on the nerves of the woman,” she commented dryly. While Samira’s recommendations are manifold, she emphasizes that her counseling always aims at helping the individual woman find the best way to handle her specific situation, which varies between cases and families.

Sandra’s and Samira’s perceptions on how to medicalize the hymen differ not only in how they were personally introduced to the issue. Their experiences with embodied female virginity also vary given their medical training and position in the medical profession. Presented with the same bioethical issue, they represent two sides of the same approach in finding suitable solutions and bridging sociocultural differences. They employ the often (neo)liberal-labeled “informed choice” option (Jeffreys 2005: 37) as a silver bullet, though somewhat differently from the World Health Organization’s recent recommendation. In October 2018, the World Health Organization (2018) categorically condemned hymen testing in relation to female virginity testing as a practice constituting violence against women.

The need to increase international awareness is generally recognized. Sandra and Samira’s everyday work experiences demonstrate that the simple refusal to work with women seeking medical advice is not enough. The

categorical condemnation of all hymenoplasty practices and virginity examinations may not lead to the elimination of the issue as desired. Instead it may further marginalize individual women who find themselves in need of urgent help. Their inclusive approach—categorizing requests for surgery, and related examinations as symptoms of an underlying problem and not as its source—allows for much-needed differentiation and a broader range of strategies for responding to individual patient needs, which are not decided on the patient’s behalf but together with her.

## Conclusion

Medical professionals can choose to conceptualize hymen repair as an individual woman’s deliberate decision. Denying this decision has the potential to (re)construct female refugees and immigrants as mere subordinated and passive victims of a culturized, static rule. Writing about hymen repair means working with two separate but interlocking categories: hymen repair practices—that is, medicalization processes—and notions about embodiments of virginity or the hymen. In line with this, I suggest reframing hymenoplasty and virginity imperative-related requests as a symptom of, not as the origin of, potential discrimination against self-determined sexuality. Perceptions concerning (re)creating the social hymen by the factual reconstruction of the physical hymen may be understood as meaningful and empowering (re)integrations of the individual into the social and political body. The categorical refusal to grant the surgery would not change the status quo of virginity imperatives but potentially discriminate twice against the woman asking for it, forcing her to find other solutions to her intimate and intimidating problem. While the medicalization of the hymen may empower and aid some women (Purdy 2001), this practice also has the potential to feed into the continuation of discrimination against women. Yet, as the perceptions, experiences, and daily practices of medical practitioners such as Sandra and Samira show, there might be a productive way to frame these requests. Perceiving virginity testing, hymen examinations, and hymenoplasty consultations as opportunities to provide female patients with the information needed to make informed choices may forge a path where female refugees and immigrants can build bridges of trust, fostering not only their transitions into a new health-care system but facilitating the transformation of the healthcare system itself.

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tate a complex, controversial and often polarizing topic, in need of further unpacking.

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