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Honour-related threats and human rights: A qualitative study of Swedish healthcare providers' attitudes towards young women requesting a virginity certificate or hymen reconstruction

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ABSTRACT **Objectives** To investigate the preferred actions of healthcare staff, as well as their reasoning and attitudes about young females' requests for a virginity certificate or hymen restoration. **Method** A qualitative study, consisting of semi-structured interviews of healthcare providers from different parts of Sweden and from different medical specialties and professions, who had experience of women who asked for a virginity certificate or a hymen repair. **Results** Using content analysis, ten themes emerged regarding healthcare personnel's attitudes and reasoning about young female patients and their requests for demonstration of virginity. The themes logically were categorised as *values*, *beliefs*, and *cultural affiliation*. **Conclusions** Responders had a more pragmatic and permissive view than the restrictive, official Swedish policy opposing hymenoplasties within the public healthcare system. There were degrees of willingness to accommodate such requests, due, for example, to different moral beliefs and medical concerns. Responders expressed frustration over the difficulty of following up patients, a situation likely due to the restrictive policy. The patient-centred approach adopted by a Dutch team of health professionals would probably better enable quality assurance.

KEY WORDS Attitude; Culture; Honour; Human rights; Hymen; Hymen reconstruction; Values; Virginity; Qualitative study

INTRODUCTION

In this article, we focus on what happens when a woman wishes to follow the 'traditions of honour' from her culture of origin and encounters modern Swedish

healthcare institutions. More specifically, we are interested in the honour-related norm that a woman should be a virgin at the time of marriage¹. One illustration of this is the requirement that a young woman prove

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her virginity by bleeding on the wedding night. The punishment for transgressing this norm may, in extreme cases, be death by the hands of a male relative².

When families with these values and behaviour move to countries with a different life-style, conflicts can arise between family members who differ in their adaptation to the new culture. Some young women adopt the habits of the host country, including sexual relations before marriage. Caught between the customs of two cultures, these young women sometimes turn to the healthcare system for help in solving their dilemma. Typically, they request one of two things: a virginity certificate or a hymen reconstruction^{1,3}.

A woman may ask for a virginity certificate to protect her own- and, thereby, her family's honour. If the doctor refuses to provide the certificate she may risk being severely punished. Therefore, some physicians are willing to write these certificates, even though there is no medical examination that can reliably establish whether or not a woman is a virgin³⁻⁵.

At other times, a hymen restoration is requested. This is done in order to bleed on the wedding-night. Less than half of all women bleed during their first sexual intercourse^{5,6}. In spite of this, it is an established belief in some cultures that the hymen of every woman is torn when she has sex for the first time, and that this always causes some bleeding. Sheets stained with blood are considered to show that the bride was a virgin, and both families concerned are then satisfied. If she is unable to stain the sheets, the marriage can be declared invalid, which brings disgrace and shame to her family. The family's honour is deemed to be restored by expelling the young woman or even killing her¹.

Hymen surgery has been on the agenda in Europe for quite some time but is dealt with in different ways in various countries. In Holland, healthcare providers have recently presented a protocol in which they apply a patient-centred approach, stressing the autonomy and integrity of the young woman⁶. The latter is initially assured that she will get a hymenoplasty if no other alternative satisfies her. She may be given a clinical examination and information about genital anatomy, engage in motivational conversations, or be shown different tricks to produce red spots on the sheets and to appear vaginally tighter during the wedding night intercourse. However, if she declares that she will only feel secure after an operation, the surgery will be performed. This inviting listening-strategy has enabled these Dutch healthcare providers to follow up

the young women, and to evaluate the effects of both the counselling and the hymenoplasty⁶.

In Sweden today, hymen reconstruction is not explicitly covered by public healthcare. Official recommendations have been issued on how healthcare providers should respond to requests for a virginity certificate or a hymen restoration^{7,8}. They propose that neither the certificate nor the surgery should be offered. These are merely recommendations from the authority National Centre for Knowledge on Men's Violence against Women⁷ and do not have the status of a binding law. However, since the Centre is commissioned directly by the government and their recommendations were officially supported by the government's minister for gender equality⁸, it serves as an official policy. Some arguments in support of this recommendation are based on empirically established facts: it is difficult to certify whether or not a young woman is a virgin, and hymen reconstruction is considered to be futile or, at least, its effects lack evidence⁷. Explicit value-based arguments are also given: a virginity certificate or a hymen restoration would support patriarchal traditions that violate young women's human rights, and healthcare personnel are encouraged to inform these patients about their rights^{7,8}. If a woman's life is threatened, it is recommended that health professionals contact the police and social authorities⁸. However, how this would help women to protect their human rights is not made explicit.

In Sweden, young women are offered different treatments by different healthcare providers: some are prepared to offer hymenoplasties while others are not⁹. Little is known, however, about how Swedish medical personnel think about responding to 'requests of honour'. The major aim of the present study was to investigate healthcare staff's attitudes, values, reasoning and preferred actions when young women in distress request a virginity certificate or hymen restoration.

METHODS

The informants were recruited continuously during the project, in accordance with the snowball principle¹⁰. The sensitive nature of the issues made it difficult to recruit in other ways. We interviewed seven healthcare providers from various parts of Sweden and from different medical specialties and professions: most of them were from the Stockholm region, but one was from northern Sweden. The group included five

physicians (four gynaecologists and one general practitioner), and two psychologists. Six were female and one, a male, and all were ethnic Swedes. The respondents worked at clinics which specialised in dealing with patients requesting hymenoplasties or virginity certificates, like youth clinics, and clinics for migrants or clinics for abused women. All worked within the public healthcare system, had 20 years or more of work experience, and were 50–65 years old. As a common denominator they all had experienced women asking for a virginity certificate or a hymen restoration. The number of interviewees was not set from the beginning but was to be decided depending on the amount of material needed in order to answer our questions and reach saturation.

The recruitment and interviews were conducted during 2011. The initial contact was in writing by e-mail. The oral interviews took place at the informant's workplace with the exception of those of subjects not working in Stockholm, of whom one was questioned over the telephone. The former were conducted by the first and the last author together, and the latter by the last author alone. The interviews were between 45 and 75 minutes long. They were recorded and a summary was written. The latter was sent to the respondents so that they could correct possible misunderstandings and add comments.

We used a semi-structured interview technique with four standard questions: (i) 'Have you had personal experience of female patients reporting that they were subjected to a honour-related threat of violence?'; (ii) 'Do you consider Swedish healthcare providers to be sufficiently knowledgeable about honour-related threats and violence?'; (iii) 'What did you do when asked to write a virginity certificate or perform a hymen restoration?'; and (iv) 'How do you think women subjected to honour-related threats should be received and treated within the Swedish healthcare system?' Sometimes follow-up questions were added to encourage interviewees to elaborate. Many participants cited specific cases and experiences.

The interviews were analysed using qualitative content-analysis in order to extract categories and themes from the manifest content in the interviews, i.e., the interviews were taken at face value; no attempt was made to identify latent meaning¹¹. In the first step, meaningful units or themes were identified. This analysis was done inductively, without pre-set categories, by the first and last author independently of each

other. Then the same two investigators continuously discussed the interpretation of the interviews, going back to them in case of disagreement. Ten themes emerged and were logically grouped into three categories. The themes were explained and supplemented with quotations from the participants.

The study was approved by the Regional Ethics Review Board at Karolinska Institutet, Stockholm (Dnr: 2012/534-31/5). The informants were informed that they could withdraw their participation at any time, both when recruited and in the beginning of the actual interviews. They were again explicitly reminded about this opportunity when presented with the summary of their interviews. We also assured that the results would be presented in a way so as to safeguard the anonymity of the participants. One informant agreed to be interviewed, but not recorded. This decision was respected.

RESULTS

All informants had experience of patients aged 14 to 22 who most often came from Africa or the Middle East and who were concerned about demonstration of virginity. Several participants estimated that the number of requests for a virginity certificate or a hymenoplasty was decreasing and they proposed, as a likely explanation, that some private clinics perform hymenoplasties without asking any questions. The cost for such an operation in a private clinic was estimated to amount to about 15.000 Swedish crowns (approximately 1500 Euros).

Most commonly, respondents reported that personnel were approached by a young woman planning to go to her family's country of origin, where she would marry a man belonging to the same culture. These women asked for hymen repairs since they were afraid they would not bleed during the wedding night. Some interviewees had received such a request only a few times, while others had been approached on average twice a month in this respect and also had performed the operations. Only a few participants had been asked to write virginity certificates. Requests for these were usually the result of relatives being suspicious about the young woman's sexual life.

The themes and categories that we identified are summarised in Table 1. The themes are presented in the subsequent text under the headings of the three categories.

Table 1 Summary of the themes and the categories derived from the present study.

Themes	Categories
Listening without condemnation	Values
Negotiation	
Surgery as last resort	
Pragmatic approach	
Scepticism within health care	Beliefs
Bleeding at first coitus	
Psychosomatic surgery	
Lack of quality assurance	
Double cultural affiliations	Cultural affiliation
Different cultures – similar attitudes	

Category 1: Values

The theme ‘listening without condemnation’

One informant with long experience of hymen restorations emphasised the importance of letting patients explain their situation and carefully listening to them. To encourage women to tell their stories, it is vital that physicians avoid questioning the emotional and cultural issues that gave rise to the request for surgery. Not until mutual confidence is established would it be appropriate to bring up value issues. A gynaecological examination was considered to be an opportunity to address a patient’s questions regarding her sexuality, which might eliminate the request for hymenoplasty.

A well-performed gynaecological investigation can be a golden opportunity to solve a patient’s concerns.

But according to the same gynaecologist one should never forget that sometimes women approach a healthcare provider to get help in life-threatening situations.

The theme ‘negotiation’

A key theme mentioned by several informants was negotiation. As one of them said:

It is important to secure elbow room for negotiations.

If a young woman made a telephone call asking for hymen surgery, it was considered important not to immediately promise such an operation. Doing so would remove the opportunity to negotiate and find

alternative means to obtain a red spot on the blanket, such as pricking oneself, using a small pouch of animal blood, or timing the withdrawal bleeding following intake of sex steroids. Some participants mentioned the Internet homepage Hymen Shop that sells an ‘artificial hymen’ in the form of a pouch containing a red liquid to be inserted into the vagina before coitus¹².

The theme ‘surgery as a last resort’

Surgery was considered by most participants to be an option only when everything else fails. First, gynaecological examinations, information about the anatomy, discussions with the future husband, and the aforementioned alternative solutions, should be considered. One of the reasons why surgery was only seen as a last resort was its controversial nature. One informant reported that the issue was a hot topic among gynaecologists and claimed that some of them would be prepared to sacrifice young women to show that society and the healthcare system strongly oppose patriarchal honour-related norms, and that the latter should never be accepted.

Hymenoplasty... is the exception in order to make the patient feel safe – like a caesarean in case of fear of childbirth.

The theme ‘pragmatic approach’

Although informants considered hymen surgery to be the ultimate step that should be contemplated, none would have abstained from using surgery in a life-threatening situation. Some of them expressed reluctance, but mainly because the anatomical result of the operation was doubtful. However, in the perceived presence of a vital indication, caused by the threatening attitude of the family or by a risk of suicide, no respondent hesitated to offer hymen surgery:

We ought not to apply absolutistic ethics if a woman’s life is in danger.

A similar line of reasoning was expressed regarding virginity certificates. Accordingly, some of the interviewed physicians had testified in writing, without making unsubstantiated claims, that, for instance, “when examining the patient P, I found nothing that indicated that she was not a virgin”.

The theme 'scepticism within healthcare'

Some reported that the financial and medical managers of their clinic were disinclined to use resources for medical treatment for what they considered were not medical problems. The practice was tolerated as long as the gynaecologists kept a low profile. If the issue received media attention, then they were supposed to discontinue offering hymen surgery. Other respondents said that members of their unit had visited special clinics for youths and women with long experience of the problem, and they also referred to the National Centre for Knowledge on Men's Violence against Women in Uppsala, which has issued recommendations on the treatment of these patients. All participants said that knowledge was lacking on how to follow up these patients and on the effects of the treatment or non-treatment options.

Category 2: Beliefs*The theme 'bleeding at first coitus'*

Several of the participants also commented on the fact that many women do not bleed during their first sexual intercourse. Some of them had been told that in Middle Eastern countries it is generally believed that women always bleed during their first coitus. Informants considered this as a matter of fact and reported that the view is supported by physicians from the area.

The theme 'psychosomatic surgery'

Some hospitals and clinics have decided not to offer hymen surgery. One participant who disapproved of this policy suggested an analogy between a young woman who fears the consequences of not being able to stain the sheets and a young woman who is afraid of delivering the baby and therefore wants a caesarean section. In the latter case the healthcare system is prepared to offer a caesarean section (eventually, if the anxiety cannot be treated with other means), in contrast to the former case where the request is turned down. However, in both cases surgery is used to solve a psychological or psychosocial problem by medical means.

None of the informants were prepared to offer more invasive measures than superficial surgery, i.e., putting a few sutures on the edges of the hymenal remnants. The reason given for this was that more invasive interventions could potentially harm the patient. However,

it has to be noted that superficial surgery may not cause the woman to bleed on penetration.

Pelvic muscles exercise is often considered a means to bringing about bleedings...

However, even if there was no guarantee that the surgery would cause bleeding on the wedding night, the main point of the interventions was that it made the patient feel more secure and reduced her anxiety, according to some respondents. Some interviewees called this kind of surgery 'pseudo-surgery' or 'psychosomatic surgery'.

The theme 'lack of quality assurance'

Several informants spontaneously disclosed that it is almost impossible to assess the effects of counselling, writing certificates or performing hymen reconstructions. Since doctors are supposed to provide effective and safe treatment, several of the gynaecologists found it frustrating that there was no follow-up of the interventions.

I've never experienced a patient getting back to tell how things went that wedding night.

Category 3: Cultural affiliation*The theme 'double cultural affiliations'*

A common experience reported by responders was that most of the young patients were not inclined to break with their families or their cultural affiliation. If a woman wishing to leave her family encounters difficulties, she can ask the social authorities, and if necessary the police, for assistance and protection. But this rarely happens. In effect, without help, many of these women are forced to live a double life, according to our interviewees. When they come to a healthcare unit, they have a double agenda:

They want to be able to appear as virgins and at the same time they may request a pregnancy test or ask for an abortion.

The theme 'different cultures – similar attitudes'

Even though we did not ask about a comparison with ethnic Swedish culture, several participants spontaneously compared the situation of women from traditional

Middle Eastern cultures to that of women born and grown up in a traditional Swedish culture. A number of them described having encountered young Swedish women who feared that their parents might find out that they had undergone an abortion. One respondent also stated that ethnic Swedish men sometimes acted with 'honour' as a motive when physically attacking or raping a woman to punish her for alleged transgressions of norms, for instance that condemning promiscuity.

Also women from traditional Swedish culture are abused because the man suspects infidelity.

Another interviewee mentioned a young woman from a strict Christian Swedish family who was maltreated because she had had sex with a man. According to that informant, such cases are rarely discussed openly in Sweden and if they become publicly known they are not associated with honour norms, in spite of this being the case. The same participant also stressed that young people in general could perceive a young sexually active woman to be a 'whore', in contrast to sexually active young boys who might be seen as admirable.

DISCUSSION

Principal findings

All our informants had been consulted by women requesting a hymen restoration; some had also received requests for virginity certificates. They were all rather restrictive with regard to these measures, but to different degrees, reflecting their own biases, values and beliefs. Some would emphatically suggest alternatives before considering surgery or a certificate, and considered information and information-strategies to the young woman and her family to be the most appropriate option. Others saw it as unproblematic to write a certificate confirming that the woman's genitalia had the appearance to be expected in a woman of her age who has not had vaginal intercourse. All interviewees were willing to perform or recommend a superficial hymen repair if a woman's life was at stake; some of the gynaecologists also carried out such operations. Respondents with extensive experience of women asking for hymen restoration tended to be more tolerant than those who had less or no experience of such patients. But even the less restrictive informants were eager to stress that in order to gain time for negotiation, it is important to be somewhat ambiguous in

initially promising anything when a woman calls the clinic with a virginity-related request. This rather restrictive approach is, at least partly, explained by the sceptical attitude against helping patients with such requests expounded by some colleagues, especially those in managerial positions. The approach also contrasts with that reported from a Dutch University Hospital, where the patient is promised from the outset that hymenoplasty will be done if she should still desire it after counselling⁶. Even though some of our interviewees underlined the importance of listening to the young women and initially not questioning the honour-related norms and values, they did not refer to any protocol or guideline stressing the patient-centred approach, motivational interviews and respect for the patients' autonomy, as the Dutch guidelines do⁶.

As the informants indicated, there are different values at stake. Maybe, a young woman's life might be in jeopardy if the healthcare provider abstains from offering an operation; at least, it is a situation, as many responders focused upon, where it would be problematic not to help the patient in question. On the other hand, helping such a young female asking for a virginity certificate or hymen reconstruction has also been interpreted as if the Swedish healthcare system would be supportive of patriarchal norms and values, since it would be considered to play along with these norms rather than openly reject them^{7,8}. There was a perception among the participants that many doctors, especially in leading positions, do not wish hymen surgery to take place at all in Swedish healthcare. This contrasts with the statements made by some of our informants that they could never accept such absolutistic rules if a young woman's life is in danger. When considering more closely what is at stake, there seem to be differences not only in value assumptions but also in factual assumptions in issues such as what might happen if hymen operations are performed. For instance, from our participants' responses, those who are more willing to perform these operations are, apparently, less inclined to believe that doing so will promote patriarchal honour norms.

Due to the specific topic of our investigation we did not ask questions about honour-related crimes in the Swedish majority culture. However, interestingly, several of the informants brought up that issue spontaneously, which is summarised in the theme 'different cultures – similar attitudes'. Their comments illustrate a common theme in the international discussion on

honour-related violence, namely that the selective use of terms like 'honour culture' and 'honour-related crimes' for immigrant minorities contributes to the discrimination of these minorities¹³. Crimes committed by members of certain immigrant minorities are described as effects of their culture, whereas similar crimes committed by members of the majority culture are interpreted as individual deviations from the cultural norm; this 'split vision' as regards offensive behaviour has been noted, for instance, in the legal literature¹⁴. However, almost everywhere, allegations of pre- or extramarital sexual activities constitute the commonest motive for deadly violence against women, although in Europe, such violence is mostly committed by husbands, partners, or ex-partners, whereas in the Middle East it is by male relatives^{15,16}. About a fifth of the Swedish homicide victims are women in the majority culture who are killed by a man with whom they had a close relationship¹⁷. Wounded male honour is an important motive of these crimes within the ethnic Swedish community. The healthcare system has considerable difficulties in dealing with all forms of honour-related family violence, whether it is among native Swedes or within the immigrant populations¹⁸.

Strengths and weaknesses

During the recruitment process, we learned that the issues of hymen surgery and virginity certification are considered taboo and, accordingly, rather difficult to discuss openly among healthcare staff in Sweden. Hence, it was difficult to recruit knowledgeable interviewees who were willing to talk about the issue. We started the project by approaching a specialised clinical unit for abused women, expecting them to have some experience with these issues. We continued by using the snowball principle¹⁰, asking each new informant about advice on where to recruit new participants. This recruitment method might explain the rather homogenous group of informants our study includes: they were all ethnical Swedes and very experienced healthcare personnel, who were prepared under certain circumstances to offer hymen surgery or write a virginity certificate. We cannot preclude that another recruitment method would have provided more diverse informants and, perhaps because of this, more diverse opinions and themes¹⁹. The fact that the issues under study are considered to be taboo across all cultures in Sweden might also explain the limited number of

young informants²⁰, who might have more willingly participated if they had a stronger position in their workplace.

Compared to other qualitative studies about this subject, we had few respondents⁶. However, we were able to reach saturation. Since we presented only four questions and listened to the respondents' additional comments, we applied a simple version of content analysis. Despite having asked few questions, informants were eager to talk and expand on issues and, therefore, the interviews were rather long and gave us rich material for the study. Moreover, as far as we can tell, this is the first qualitative study of its kind, focusing on the point of view of healthcare staff.

Our results indicate that clinicians with experience of women requesting virginity certificates or hymen reconstructions tend to be pragmatic and are not willing to alienate a young woman and cause her distress in order to maintain strongly held values or absolutistic ethics. Our findings are in line with those of another Swedish study⁹, and we do not know whether a large survey might produce different results. This would be an interesting study to conduct in the future.

Practical implications

Under the assumption that an operation makes the young woman feel calm and free from anxiety, and accordingly increases her well-being, the intervention, whether it be obtaining a certificate of virginity or having a hymen reconstruction, makes a significant positive difference, regardless of its potentially life-saving effects⁶. Another positive result from the point of view of the young women is that the operation enables them to keep their double cultural affiliation.

However, in Sweden we do not have any data on record regarding the effects of the different interventions. The difficulty in identifying the effects of different interventions in a Swedish context seems to depend on the lack of a systematically implemented patient-centred approach, which is what made an evaluation possible in the Dutch setting⁶. Moreover, a previous Swedish study showed that healthcare providers differed in their approaches, one of which was never to offer hymen operations, an option which would mean that the young woman receives no help at all⁹. The conclusion is that for women seeking demonstration

of virginity in Sweden, the offer of help is rather arbitrary.

We see no reason, in principle, why the Swedish healthcare system should not adopt the approach used by van Moorst et al. in Amsterdam⁶. Sweden has accepted interventions that are solely based on patients' and relatives' private and religious values, such as the circumcision of young boys. However, it cannot be maintained that the Swedish healthcare system supports old patriarchal Abrahamic norms. The official justification of the current policies is that they prevent operations from being performed by non-medical professionals in less than optimal clinical environments, with a higher risk of infections and other complications⁵. Controlling virginity by examining sheets for blood stains is also an old Abrahamic tradition (Deuteronomy XII, 20–21)⁶. One can only speculate on why the Swedish healthcare system has adopted different standards regarding these two issues presenting evident analogies, male circumcision and hymen restoration. Perhaps the resistance against performing the relatively low risk superficial hymen operations depends on this being a new issue introduced by immigrants who are generally considered with suspicion for holding beliefs that are unfamiliar in the Swedish culture. The resistance could also be based on the fact that female sexuality is still a somewhat taboo area, at least in a clinical context.

CONCLUSIONS

The official Swedish policy is that no hymen restorative operations should be provided nor should virginity certificates be issued within the public healthcare system^{8,9}. Our study has shown, however, that such operations *are* performed and such certificates *are*, in

rare cases, issued. It is a moot ethical question to what extent the healthcare system should concede to demands like the ones discussed in our study. If they are rejected, then the women in question may run an increased risk of honour-related violence²¹. If they are accepted, then the healthcare system becomes implicated in a kind of dishonest medical practice. Moreover, doing what these women request might in some cases strengthen objectionable (from the perspective of Swedish healthcare policy) family relations.

We have not attempted to recommend which approach the public healthcare system should adopt. However, we have shown that unless more is known about the consequences of the current Swedish legal recommendations and common practice, it is not possible to assess these from an ethical point of view. We need to know more about what happens to the women who get the hymen reconstruction they demand as well as what happens to those who do not obtain certificates or do not have the requested surgery. Unfortunately, the standards which are currently prevalent in Sweden make it difficult to evaluate the available treatment options. In contrast, the Dutch approach seems to reflect a greater coherence between official guidelines and clinical practice and takes into consideration the culture and values of immigrants.

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