

Research Article

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Rethinking Agency in the European Debate about Virginity Certificates: Gender, Biopolitics, and the Construction of the Other

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Abstract: Several European countries have taken measures to discourage or ban physicians from issuing virginity certificates to migrant women, with the stated aim of protecting these women from oppression. Arguments against the practice are centred around questions of medical ethics, gender inequality, and autonomy. What underpins these arguments is an evaluation of whether women have a choice in matters related to their sexuality. This article shows that the reasons provided for why virginity certificates should not be issued can similarly be applied to the prescription of erectile dysfunction medication, yet the latter practice remains largely unquestioned. It argues that the discrepancy in approaches to both practices points to an *a priori* understanding of migrant women as non-agentic, grounded in racial gendered norms, and that agency is mobilised as a biopolitical tool to Other migrant women and communities. Current approaches towards virginity certificates thus replicate the oppression of the migrant women they (cl) aim to liberate.

Keywords: agency, harmful cultural practices, virginity certificates, erectile dysfunction medication, autonomy

Introduction

In 2018, the World Health Organization (WHO), together with the UN Human Rights Office and the UN Women, published a statement calling for the eradication of virginity testing because of its immediate and long-term impacts on women's physical, psychological, and social wellbeing (World Health Organization). The statement thus posits that virginity testing is a harmful cultural practice (HCP) that sustains and reinforces the oppression of women and that violates women's human rights. HCPs are cultural practices and behaviours that are viewed as harmful to people's physical and mental health, yet are considered normative in the cultures, communities, and countries that practice them (UN Office of the High Commissioner for Human Rights (OHCHR)). They most commonly affect women and are thus presumed in dominant narratives to be grounded in unequal gender norms (UN Office of the High Commissioner for Human Rights (OHCHR)). Female genital cutting/mutilation is the most well-known example, but other examples include hymen (re)construction, forced marriage, honour-based violence, denial of reproductive

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autonomy, and, as of 2018, virginity testing.¹ The discussion of HCPs has largely been centred around women in the Global South; however, due to increasing migration, both the term and the practices have become more prevalent in the Global North (Longman and Coene 51), which has instigated the political, social, and ethical debates in several European countries about how best to address these practices.

Virginity testing consists of an examination of a (child or adult) woman's genitalia to ascertain whether she has had vaginal penetrative intercourse. The procedure is grounded in the view that women should remain pure until marriage, and is commonly performed with the goal of proving to the woman's family, future family-in-law, and/or future husband that she is a virgin, as the family's honour depends on women's chastity (Gorar). While virginity testing is traditionally practiced in countries in the Global South, in recent years the practice, just like other practices under the banner of HCPs, has become more prevalent in countries in the Global North due to increasing levels of migration (Crosby et al.; Longman and Coene), with migrant women requesting a virginity certificate from their physicians, a statement that provides evidence of their virginity status, rather than virginity tests as such.

Recent debates in Europe about the best way to respond to migrant women's requests for virginity certificates from physicians have, implicitly and explicitly, been structured around the question of whether the request is the outcome of an autonomous choice made by an autonomous subject. The general consensus in dominant political and public approaches to the issue is that it is not, and thus that physicians should not issue such certificates, unless when in extreme circumstances a woman's safety is at risk. In this article, my intention is neither to resolve the question of whether or not migrant women have a choice in their requests for virginity certificates, nor to engage with the question of whether or not choice or autonomy is ever truly possible. Instead, my primary intervention in the debate is to explore the ways in which discourses of autonomy and choice are mobilised, and their effects on how certain subjects and practices are read and responded to, and thus produced.

As Longman and Coene have argued, HCPs have come to the fore as cultural difference increasingly came to be viewed as problematic against a backdrop of increasing xenophobia and Islamophobia in the Global North since 9/11, and the ongoing disadvantaged socio-economic position and educational levels of migrant minorities compared to majority groups (51). Indeed, they argue, as policies that were designed to enhance the status and inclusion of such groups were considered "failed" at the start of the millennium, they were replaced with "more nationalist discourses and policies of forced integration, assimilation, and citizenisation" (51). Farris thus points out the rise in femonationalism in the European context, an ideology that emanates from the convergence of right-wing, some feminist, and neoliberal politics and that positions women's rights as national values that are under threat from the non-Western Other. Against this backdrop, cultural practices that were "deemed incompatible with liberal notions of gender and sexual inequality have received heightened public and policy attention" (Longman and Coene 51). One might thus consider the cultural context of the sudden attention to virginity certificates as part of a discourse that positions the choosing subject as central, yet simultaneously aims to achieve assimilation.

It is perhaps not surprising, then, that the statement about virginity testing published by the WHO garnered a response from medical associations and governments in Europe, which have taken measures to discourage physicians from issuing virginity certificates. In 2019, for instance, the Belgian Orde der Artsen [Order of Physicians] urged physicians to no longer provide virginity certificates to patients (Orde der Artsen), while in the Netherlands the KNMG [Royal Dutch Medical Association] advised in 2018 that physicians should only write virginity certificates in situations where the woman in question faces immediate danger (Semeijn and Elfering). In France, the *Loi confortant le respect des principes de la république* [Bill Reinforcing the Principles of the Republic], passed by the French government in August 2021 to combat radical Islamism and separatism, has banned physicians from issuing virginity certificates by rendering it an offense punishable with fines and prison sentences. In response to this bill, a number of Members of the European Parliament raised the question if the European Union intended to condemn and

¹ The positioning of such practices as inherently tied to patriarchal norms and harmful to women and girls has been met with criticism. For critiques in the context of female genital cutting, see for instance, Gruenbaum, Earp, and Shweder; Earp; Njambi.

ban virginity certificates and if it would recommend to its member states that they “impose penalties on the preachers who promote such practices and the family members who insist on such examinations being carried out” (Bruna et al.). The media coverage of the responses to virginity certificates shows that such sentiment is not an exception and has broader cultural support (BBC News; vrt NWS).

What is striking, however, is that institutional calls in Europe that seek to discourage or ban the issuing of virginity certificates claim to respond directly to the call in the WHO’s statement on virginity testing (Bock; Bruna et al.; Mitchell; Orde der Artsen), even though this statement makes no mention of virginity certificates and is solely concerned with the practice of virginity testing. The reasons cited for why physicians should not issue virginity certificates similarly replicate those given by the WHO for why virginity testing should be eradicated. Such equation of virginity testing and virginity certificates is also evident in the media coverage of the issue, in which both terms and practices are often referred to interchangeably as though they are one and the same (BBC News; Davies). One might, indeed, argue that these practices are inherently linked and that, as such, banning virginity certificates will automatically result in the eradication of virginity testing. Considering the consensus in western medicine that a physical examination that is able to determine virginity does not exist, there is, however, no reason why writing a virginity certificate should be preceded by a virginity test, nor to assume that it commonly is. It is, furthermore, not clear that virginity certificates have the same or similar harmful health outcomes for migrant women in the Global North as virginity testing in the Global South, which forms the cultural and geographical focus of the WHO statement, nor that virginity certificates and tests in different locations have the same meanings and purposes. Such responses to virginity certificates, then, present cultural and gendered practices related to virginity as one and the same and as ahistorical and universal. Furthermore, they presume that virginity certificates have inherent meaning that is not contextually specific at both the structural and individual level and, as such, halt a thorough interrogation of the grounds and consequences of the ways in which virginity certificates requested by migrant women are interpreted in the Global North.

The reasons provided by professional medical associations, physicians, and media for why virginity certificates should be banned are largely related to medical ethical standards, gender inequality, and/or autonomy. Despite the significant amount of attention virginity certificates have received in Europe since at least 2018, literature on the topic in the area of bioethics is sparse, particularly in comparison with other virginity-related practices such as hymen (re)construction (see, for instance, Cook and Dickens; Essén et al.; Juth and Lynøe; Leye et al.; Van Moorst et al.). The existing bioethical literature on virginity certificates (and, by extension, other virginity-related practices) focusses implicitly and explicitly on evaluating whether physicians should grant the requests of women and, if so, under which circumstances and conditions (see, for instance, de Lora; Helgesson and Lynøe; Juth and Lynøe, “Zero Tolerance”). As in the political, medical, and public debates, here, too, the conditions that are evaluated relate to questions of medical ethics, gender inequality, and/or autonomy.

The general consensus is that virginity certificates should not be provided because they infringe on gender equality and/or go against the rule against fraudulent diagnoses, except in extreme circumstances, such as when a woman’s life is in danger, or she is at serious risk of violence. Much of the debate, however, appears to be underpinned by the question of whether requests for virginity certificates should be interpreted as evidence of restriction of migrant women’s sexual autonomy or as an expression of autonomous choice, with the aim of protecting migrant women from their oppressive cultures, religions, and/or families. I, however, want to move away from this framework, because I suspect that what underpins the debate is an *a priori* understanding of migrant women as non-agentic. In this article, I engage in a thought experiment of sorts. Specifically, I juxtapose the practice of issuing virginity certificates and issuing prescriptions for erectile dysfunction medication. I demonstrate that the reasoning behind why migrant women should not be able to access virginity certificates is similarly applicable to erectile dysfunction medication, even though the latter remains largely unquestioned in the political and public debates.² In doing so, I aim to

² See, for instance, also comparisons of female genital cutting/mutilation and genital cosmetic surgery that highlight the discrepancy in how dominant approaches perceive the agency and victimisation of the women involved (Essén and Johnsdotter; Braun; Shahvisi).

render visible the problems with the ways in which agency is mobilised in debates around virginity certificates. The discrepancy in approaches to both practices, as I will show, demonstrates that to be recognised as an agentic subject and to have one's choices recognised as agentic, one must cite the governing gender norms of the cultural context in which one lives.

Finally, I turn to the history of HCPs. I discuss critiques from postcolonial and Third World feminists of the term itself, and of the implications of the use of this term for the ways in which migrant women's agency is conceptualised. I also position the responses to virginity certificates within broader discourses of assimilation in the European migration context. I thus argue that agency functions as a biopolitical, normalising tool for managing normative gender and migrant women.

Mobilising Agency: Virginity Certificates and Prescriptions for Erectile Dysfunction Medication

The reasons most commonly cited for why physicians should not issue virginity certificates are as follows: issuing virginity certificates keeps myths in place, it constitutes deception, it violates women's and/or patient autonomy, it is medically not indicated and/or necessary, it sustains a double standard, and it constitutes complicity in violence against and control of women. I show that each of these reasons also applies to the prescription of erectile dysfunction medication by physicians, yet, while virginity certificates are much debated, prescriptions for erectile dysfunction medication are rarely questioned in the political and public debates. My aim here is not to suggest that these practices are inherently similar or that they are intrinsically different. Instead, it is to highlight the mechanisms that render virginity certificates and erectile dysfunction medication and the individuals who request them as categorically different (Sullivan, "Transso-matechnics"), and in doing so to argue that access to either certificate is conditional upon one's ability to be recognised as an agentic subject, which in turn is conditional upon one's performance of normative gender.

Myths

One of the arguments for why physicians should not issue virginity certificates is that it keeps in place two dominant myths surrounding virginity (Saharso and Dekker; Semeijn and Elfering 13).

First, the issuing of virginity certificates, it is argued, creates the false impression that there are tests that can determine if a woman has had vaginal penetrative intercourse, commonly through an examination of the hymen. Second, the belief in such tests, in turn, creates the impression that the hymen is a membrane that tears when a penis first enters the vagina and that women bleed upon first penetration. Hence, the logic goes, when the membrane is intact, the woman in question has not had intercourse and is a virgin, and when it is torn, she is not a virgin. Virginity certificates thus assist in controlling women's sexuality (BNNVARA) because they support the notion that women are by nature virginal until marriage, whereby aberration from nature is positioned as wrong. Issuing virginity certificates, then, in this logic, justifies punishment of women who have strayed, and makes one complicit in the negative consequences of such myths for the social wellbeing of women in cultures that place high importance on women's virginity. As such, physicians should refrain from issuing such certificates, and should instead understand that migrant women have misconceptions about the hymen and virginity, and educate them about these matters (Buxant quoted in Bock; Semeijn and Elfering).

While I agree with the premise of such arguments, they require further nuance. First, in positioning education as the solution to the problem, physicians presume that migrant women do not know the workings of their own bodies and the physical and scientific aspects of virginity. It is, however, not clear what the evidence-base is for this assumption. It may be precisely because of the myth that virginity can be determined through tests that migrant women can go out to explore their sexuality and engage in penetrative vaginal sex. If women know that no test can veritably determine virginity, and, furthermore, given

that tests are not required in order to provide certificates, then instead of controlling women's sexuality, it may be the case that the myth and access to virginity certificates liberate them from this control. Moreover, as Pekgul argues, virginity interventions can assist in the gradual wearing away of virginity norms, in that it becomes ever more difficult to know who is a virgin and who is not. Pekgul has, furthermore, argued in the context of hymen (re)construction – but this equally applies to virginity certificates – that tax funding for such procedures gives young migrant women a signal that society supports their freedom to live their own lives. The arguments in favour of banning virginity certificates because they support myths, then, are premised on the assumption that migrant women are easily fooled, do not know their own bodies, and are easily controlled. Such notions are incommensurable with an ideal western liberal femininity, which shapes the ways in which their requests are read as non-normative and non-agentic, and thus impermissible. Because virginity certificates do not align with a white normative sexually liberal femininity, myths related to virginity are, then, considered only oppressive, and critics ignore that the existence of such myths might enable opportunities for agency for women in oppressive conditions.

Applied to the context of requests for erectile dysfunction medication by men, the issue with physicians' refusal to issue virginity certificates due to the myths they keep in place becomes even clearer. One might argue that erectile dysfunction medication keeps in place the myth that for men sexual arousal is, by nature, always accompanied by an erection. It thus reinforces the powerful myth that men can always "perform" sexually and that they are, by nature, sexual beings (Bordo). When men cannot perform, they are viewed as having failed, as inferior, as pathological (Wentzell, "Ideologies of Repair"). This narrative, then, functions to control men's sexuality and behaviours, in that they must be able to perform, even if it means taking medication. Furthermore, it keeps in place the myth that "real sex" involves penetration. Myths related to the role of penetration in sex and what it means to be a man are not considered problematic and go unnoticed, because by requesting erectile dysfunction medication men confirm notions of masculinity structured around men's active role in sex through penetration and the centrality of the phallus.

Deception

Another argument made against the issuing of virginity certificates is that it requires doctors to engage in deceptive practices (de Lora; Helgesson and Lynöe; Juth and Lynöe, "Zero Tolerance"; Saharso and Dekker 13). Because virginity cannot be diagnosed as such, the logic goes, writing a virginity certificate consists in the deception of the woman's family, her future husband, and her family-in-law, regardless of her sexual history. Physicians would thus be expected to write a false declaration, which is punishable by law in many jurisdictions (Semeijn and Elfering). However, physicians can, and do, write "diplomatic certificates" (Buxant quoted in Bock; Juth and Lynöe, "Estimations of Female Patients' Need"; Saharso and Dekker; Semeijn and Elfering), which can state: "I have not been able to determine that the patient is not a virgin," and as such reflect the truth. Helgesson and Lynöe have, furthermore, argued that to speak of deception implies that the patient and/or her family(-in-law) are looking for the truth of her virginity (136). This is not always the case, since such practices have evolved into mere social convention so that it is the certificate itself that is the point, and its content is no longer regarded seriously.

Writing prescriptions for erectile dysfunction medication, too, could, by this logic, be viewed as deception. By enabling men to have erections through chemical means, physicians may be assisting their patients in misleading or deceiving their sexual partners, for instance with regard to their physical capabilities and performances such as the ability to get an erection, its duration, and its strength, as a quick internet search clearly demonstrates (Feelinglost95; Adela Aarons; Gemma Bendon). One might argue, then, that both virginity certificates and prescriptions for erectile dysfunction medication constitute complicity in the deception of others as to people's sexual activity and histories. However, as erectile dysfunction medications allow men to perform normative masculinity, they disappear in their presumed naturalness. Conversely, virginity certificates become the topic of debate in that they are considered to stop migrant women from performing normative western femininity.

(Patient) Autonomy

Another set of reasons why physicians should not issue virginity certificates is related to autonomy. Such arguments point out that the request for the certificate does not usually come from the woman herself but from her family(-in-law), future husband, or from her culture or religion (Kruijen in Bock; Bruna et al.; Orde der Artsen). Thus, it harms her autonomy. Another point that is raised is that virginity certificates harm women's bodily integrity or, in other words, that this involves processes that violate her ability and right to exercise control and self-determination over what happens to her body due to external pressures (Kruijen in Bock; Bruna et al.). This presumes that virginity certificates are preceded by virginity testing when it is not clear that is the case and is a consequence of the conflation of virginity testing and certificates. My point here is not to question that family and culture influence women's requests but, instead, to argue that such a blanket approach not only fails to acknowledge that no actions are ever fully autonomous but are always socially and culturally embedded, and that to deny women virginity certificates overlooks the different ways in which they do and can exercise agency, despite living in culturally embedded and constrained conditions. Indeed, as several scholars have argued, women can and do exercise agency, even in oppressive contexts (Cense; Khader; Mackenzie; Saharso). For instance, in making the distinction between the hymen as a social construct and as an anatomical feature, Cinthio demonstrates that even though young migrant women in Sweden have the scientific and anatomical knowledge to understand virginity and the cultural, religious, and familial demands placed on them through the virginity myth, they actively negotiate different cultures and identities, but may ultimately decide to, at least on the surface, subscribe to the myths valued by their families and cultures.

Conversely, questions of autonomy are rarely if ever raised in public and medical discussions of men's requests for erectile dysfunction medication, and the men requesting this medication are not considered to be victims of oppression from their cultures or the people in their lives such as sexual and/or romantic partners and friends. The interplay of expectations of masculinity, medical and pharmaceutical discourses, and neoliberal thinking, however, places significant demands on men to achieve erections. Penis size and performance are critical to hegemonic masculine subjectivity (Brubaker and Johnson; Potts), and successful masculinity is traditionally associated with penetrative sex (Wentzell, "Aging Respectably" 113). Masculine identity is thus constantly under threat due to the centrality of the phallus (Brubaker and Johnson). As such, pharmaceutical and medical discourses of erectile enhancement have created a crisis of masculinity while simultaneously providing a solution to resolve it: a bigger and more powerful penis through pharmaceutical means (Brubaker and Johnson). Tiefer argues, "[m]en will remain vulnerable to the expansion of the clinical domain so long as masculinity rests heavily on a particular type of physiological function" ("In Pursuit of the Perfect Penis" 463). Simultaneously, through the rise of sexual medicine and an explosion of (s)expertise published in magazines and online, bodily changes have been reframed as erectile dysfunction, while emerging neoliberal discourses of health have constructed categories such as "lifestyle medicine" and "lifestyle drugs" (Letiche), and such as the "worried well" or patients without symptoms (Webster), as part of a new market. With their masculinity in crisis and at risk of demasculinisation (Marshall, "The New Virility"), men are thus encouraged to engage in processes of "virility surveillance" (Brubaker and Johnson 355) as their "bodies are reconstructed as sites for biomedical intervention and incorporated in consumerist lifestyle projects" (Brubaker and Johnson 357). In Foucaultian terms, then, these men discipline and regulate their own bodies in accordance with the norms of masculinity through technologies of the self, which "permit individuals to effect, by their own means, a certain number of operations on their bodies, their own souls, their own thoughts, their own conduct, and this in a manner to transform themselves, modify themselves, and to attain a certain state of perfection, happiness, purity, and supernatural power" (Foucault, "Sexuality and Solitude" 367). In other words, cultural discourses shape the ways men experience their own bodies, and thus inform their requests for prescriptions for erectile dysfunction medication from physicians. It, furthermore, shapes the expectations others have of them, such as their (imagined) sexual partners, their friends, and society at large (Grace et al.; Gershon), which physicians are implicated in by prescribing this medication. While men's requests for erectile dysfunction medication are not autonomous, then, unlike migrant women who request virginity certificates, these

men's autonomy is rarely in question. I argue this is because, on the one hand, it has been decided in advance that migrant women are by definition oppressed and do not have agency, whereas men are considered active agents. On the other hand, the request for virginity certificates goes against a western sexually liberal femininity and thus cannot be interpreted as agentic which, in a circular logic, confirms the *a priori* assumption of migrant women as oppressed as correct, while a request for erectile dysfunction medication constitutes a choice in line with the norms of an active masculinity, and as such, confirms men's role as active agents.

Medically (Not) Indicated

A point that is raised regularly is that virginity certificates are medically not indicated. Since there is no test that can determine whether or not a woman has had vaginal penetrative intercourse, it is not the role of the physician to write such certificates (Saharso and Dekker). A second argument is that there is no medical reason that necessitates the issuing of virginity certificates, since virginity is not a medical problem and virginity certificates are unnecessary for women's health – on the contrary, such certificates, it is argued, harm the wellbeing and health of women (Orde der Artsen). This point, however, is grounded in a conflation of virginity testing and virginity certificates. What is displaced from view in such arguments is that health and wellbeing extend beyond physical health. Not being able to access virginity certificates may have emotional, psychological, and social consequences for the women in question, as they may be excluded from their families and communities or may become victims of honour-related violence. Some critics of virginity certificates have, indeed, conceded that in rare and extreme circumstances where women are at serious risk if they cannot prove their virginity, physicians should provide them with a certificate (ANCIC in BBC News; Ghada in Mitchell; Semeijn and Elfering) as a “pragmatic emergency solution” (Helgesson and Lynöe 134). Such approach itself, however, may be the cause of ongoing stress for women, who do not know whether or not they will be able to access such a certificate or may be forced to disclose information they are not comfortable disclosing. In other words, this emergency approach continues to place the woman at the mercy of her physician, as a victim, rather than being considered a capable decision-maker who is able to evaluate her own needs.

While virginity is not considered a medical problem, the popularity of erectile dysfunction medication suggests that erections are. An inability to get an erection may have underlying physiological causes; however, a closer look at the history of erections and erectile dysfunction medication shows that both the medical character of erectile dysfunction as a particular kind of *disorder* and the medical *necessity* to treat it with medication are produced rather than inherent. It was not until the 1980s that male erections came to be viewed as a physiological vascular event, after it was discovered that they could be induced through the injection of chemicals in the penis (Baglia 1). What was largely known as impotence, which had psychological causes, thus came to be understood as a physiological and thus a medical and pharmaceutical event (Marshall, “Pharmaceutical Imagination”). It was, however, not until the accidental discovery of Viagra, a drug initially developed to treat a range of heart-related chest pains but which, it was discovered, induced erections, that decreased erectile function fully came to be medicalised and known as a disorder, treatable through pharmaceutical means. To put it differently, rather than having developed a drug to treat a medical condition, it is the unanticipated drug effect that constitutes the starting point from which bodily processes related to erection came to be viewed as pathological (Marshall, “Pharmaceutical Imagination”). Croissant thus argues that “the discovery of the drug predated the production (scientific, rhetorical, discursive) of ED as a ‘disorder’ that required medicalization to achieve a ‘normalization’ of the sexual functioning” (337). Since 1998, when Viagra first entered the European and US markets, decreased erectile function came to be known globally as biomedical erectile dysfunction, a pathology treatable through drugs. Thus, the “normal,” “healthy,” “originary” body to which erectile dysfunction medications will restore the “diseased” patient is itself the outcome of a “medical gaze”

(Foucault, *The Birth of the Clinic*) as a particular way of conceptualising erections and male sexuality in medical terms.

The notion of medical necessity, then, as Njambi argues in the context of female genital cutting, “assume[s] that what is medically necessary is a universal reality that is not produced through specific cultural, political, and historical values and interest, as opposed to practices deemed unnecessary” (292). In other words, such thinking positions decreased erectile function as universally and ahistorically a medical concern, while requests for virginity certificates are considered an oppressive mechanism that migrant women, if only they were educated enough, would realise negatively affects their health and wellbeing. In response to the question of whether a physician should provide referral information to an anonymous caller who asks for a referral for hymenoplasty, Shweder argues that, in practice, most doctors already expand the definition of what counts as medical and practice social medicine, which includes “any practice aimed at shaping the body in socially functional ways” (179). He provides the example that most doctors would provide the contact details of a physician to an anonymous caller who requests a referral to get a prescription for Viagra “to enhance his libertine lifestyle as a medical benefit” (179). In the context of erectile dysfunction, then, medication is legitimated since what counts as medical already includes the social and relational wellbeing of the patient. This, Shweder argues, opens the door to broaden out the notion of the medical to include other socially functional disabilities in order to make a positive impact on a person’s sense of wellbeing by improving or enhancing their body such as in the case of requests for hymenoplasty and, I would argue, requests for virginity certificates.

“[S]haping the body in socially functional ways” for Shweder, however, simply means to enhance a person’s “social functioning in different cultural traditions” (179). I add to this that the distinctions made between what is medically necessary and unnecessary also shape bodies in socially functional ways through the ways in which it operates as a normalising process. Locating erectile dysfunction medication as a medical necessity reinforces phallus-centred masculinity as the norm, while positioning virginity certificates as medically unnecessary confirms a femininity structured around liberal sexuality as normative. As a consequence, men and women who do not subscribe to such norms are considered aberrant, abnormal, unhealthy, and disempowered, and in need of integration into the norm. In summary, then, the category of medical necessity is thus, first, inconsistent in its approaches in terms of what it considers to be medically necessary; second, may in fact be causing the harms it says it wants to alleviate; and third, is implicated in shaping normative categories of gender which function to Other those who do not subscribe to them.

Double Standard

Virginity certificates should, it is argued, be banned because they reinforce a sexist double standard around virginity for women and men (Bock; Jadoul in Bock; Cammu in De Morgen; Orde der Artsen). Women are expected to remain virgins until marriage, while no such expectations are held of men – at least not in the strict or practical sense. It is not my intention to question criticisms of this double standard to which men and women are held, and I do not deny that this double standard can have significant harmful consequences for migrant women. To ask, then, whether issuing virginity certificates renders one complicit in maintaining this double standard is important. There are, however, three related points that should be considered. First, and as I mentioned earlier, access to virginity certificates may precisely protect women from the consequences of such double standard. Second, the assumption that virginity certificates uncomplicatedly reinforce and maintain the unequal *status quo* relies on the simplistic presumption that migrant women blindly accept the demands placed upon them by their cultures while virginity certificates may in fact allow them more freedom to move between the different cultures that make up their lives. Third, the more prevalent virginity certificates become, the more virginity itself becomes an elusive notion and as such, the virginity norm, and thus the double standard may, with time, wear away (Pekgul).

Prescribing erectile dysfunction medication is also implicated in sustaining a double standard for men and women. Men are held to a cultural standard in which they must not only be sexually active, but also must be so in very specific and narrow ways: they must be aroused easily, prove their arousal through an erect penis, and use this erect penis to take on an active penetrative role in sex with women (Potts). These expectations are widely disseminated through popular culture and advertising. In such representations, men who cannot “perform” become the butt of jokes and their masculinity is questioned (Gershon). Erectile dysfunction medication, and the medical and pharmaceutical treatment of erections by physicians through prescriptions for such medication, aids in further cementing these standards for men. Not only does this have negative consequences on men’s social and psychological wellbeing, but in a system of binary gender, masculinity and femininity gain their meanings from one another in hierarchical ways: to be masculine is to be not feminine (Connell). If a sexually active role is coded as masculine, this constructs the feminine as sexually passive and virginal with “slut shaming” as a common occurrence when women move beyond such norms of femininity. Simultaneously, within this sexually active role for men, women are expected to be sexually available to men or risk being labelled prudes. Not only does erectile dysfunction medication, then, cement expectations of masculinity, it simultaneously cements expectations of femininity. This is telling of how the notion of a normative western femininity structured around liberal sexuality functions not so much as a reality but as an ideal and positions migrant women specifically as passive victims. The discussion of virginity and virginity certificates can therefore not be viewed outside of the ways in which standards of masculinity operate in broader social contexts.

Violence and Control Used to Subordinate Women

A final point raised by those who seek to ban virginity certificates is that they function as a form of violence and control to subordinate women (Orde der Artsen). Indeed, virginity norms and standards can and do lead to honour-related violence. The question is whether banning virginity certificates will eradicate such violence or may place women at greater risk of honour-related violence. While negative certificates that state that a woman is not a virgin may increase the likelihood of such violence against women, negative certificates could only be produced in cases where a doctor either knows through conversations with the patient that she has had penile penetrative sex and is willing to put her at risk, or if they based their decision on a physical examination that leads them to believe the patient is not a virgin despite the consensus in the west that such examinations are invalid and should therefore not be performed. Diplomatic certificates would not have such effect. The virginity norm does, of course, exercise control over women’s sexuality, but as I argued earlier, virginity certificates may in fact release women from such control and allow them to negotiate competing demands from their different cultures and their multiple intersecting identities. What is assumed here, however, is that women who request a virginity certificate have no agency over their own sexuality and are unknowingly implicated in their own oppression and the physicians who go along with the request, by extension, thus encourage violence and control of women’s sexuality.

As should be clear by now, erectile dysfunction medication also functions to control men’s sexuality by demanding that they take the active, penetrative role in sex, and that they prove their masculinity through an erection. The lack of public acknowledgment of the ways in which men’s sexuality is also controlled is simultaneously preconditioned by, and reinforces, men’s status as active subjects in society. Their request for erectile dysfunction medication, then, is interpreted as men agentically taking active steps to work on themselves and take control of their wellbeing and sexuality. It is not, however, read through the frame of the cultural imperative for men to conform to normative sexuality. While an inability to achieve an erection does not subordinate men in the binary hierarchy between men and women, as is the case with the virginity norm for women, it does subordinate them in relation to other men grounded in their inability to perform in accordance with governing standards of masculinity (see Connell). Men’s inability to achieve normative masculinity has been shown to lead to acts of violence, between men, but also against women, as a resource

for achieving masculinity (Messerschmidt and Tomsen). Indeed, as Tiefer has argued “gender politics [are] constituted and reflected in erotic relations” (*Sex Is Not a Natural Act & Other Essays* 136). One might argue that prescriptions for erectile dysfunction medication can serve as a protective factor against violence. However, the potential violent consequences of contributing to a gender hierarchy is not a topic of debate in dominant understandings of prescriptions for erectile dysfunction medication, while it is a key factor in dominant reasoning for why virginity certificates should be banned.

My intention here is not to suggest that men’s sexuality is controlled in the same way as that of (migrant) women, or that they experience the same kinds and intensity of violence. Instead, it has been to argue that men’s requests surrounding matters of sexuality are read as agentic requests coming from an agentic subject outside of the realm of control and violence. The requests of migrant women, however, are read as the outcome of external control that includes the threat of violence and, as such, cannot be recognised as agentic choices made by agentic subjects, an interpretation that is grounded in the *a priori* assumption that migrant women are cultural dupes with no room to move. This differential treatment of requests for virginity certificates and erectile dysfunction allows the West to present itself as saviour in an attempt to achieve assimilation of non-Western approaches to gender through Othering practices, and in doing so, to control migrant women’s sexuality. Thus, in treating these two practices as discrete, the harm being done under the guise of liberation is able to go unnoticed.

Agency as a Normalising Tool

My analysis shows that the reasons provided by those who seek to discourage or ban the issuing of virginity certificates also apply to the prescription of erectile dysfunction medication. In each of the reasons provided, migrant women are denied a position from which they can exercise agency. Requests for virginity certificates are read as evidence that migrant women do not have the scientific and anatomical knowledge to understand how virginity and their bodies work, that they blindly accept sexist standards, that their sex lives are entirely dictated by culture, religion, and family, and that they are complicit in their own oppression and others’ control of their sexuality. Such issues are not raised in relation to men’s requests for erectile dysfunction medication, and these requests are able to proceed unnoticed.

I argue that the differential evaluation of migrant women’s and men’s agency in these practices is related to normative gender. Specifically, my analysis draws attention to the fact that agency is conditional upon one’s enactment of gendered norms: to have one’s agency recognised, to be recognised as a subject capable of making choices and have those choices acknowledged as valid choices, one must cite the regulatory norms of gender of the dominant culture in which one lives. Virginity certificates contradict – and threaten – the norms of a (neo)liberal western femininity structured around the white, sexually liberated, female subject, and are thus rendered not only non-normative but also oppressive and wrong; therefore, the individuals requesting them are positioned as oppressed and thus non-agentic. Conversely, erectile dysfunction medication allows men to (re-)enter the sphere of normative masculinity and, as such, men who request them are considered immune to external forces, as though the request originates from within men’s individual selves, assisted by the dominant view that men are by nature rational active agents.

Migrant women in white western contexts have historically been positioned as non-agentic victims oppressed by their cultures and, as such, (their requests for) practices that do not align with the norm of western femininity are *a priori* viewed as the outcome of their oppression. Two key things must be noted here. First, the debate around virginity certificates has taken place in the context of HCPs due the conflation of the practice with that of virginity testing. Since HCPs first entered the human rights agenda in the 1950s, the term and its meanings have been criticised by postcolonial and Third World feminists who point out that it operates as a colonial mechanism of control, in that it has been used almost exclusively in the context of the Global South with a focus on non-Western practices and non-Western women, including migrant women in the Global North (Longman and Bradley 11). Mohanty and Narayan (“Essence of Culture and a Sense of History”) thus point out that Third World women have been represented as an uneducated,

victimised, ignorant, homogenous group whose lives are limited both as women and as Third World citizens, in direct opposition to the (self-)representation of white western women as educated, modern, autonomous, emancipated individuals who exercise control and freedom over their lives, bodies, and sexuality. The Third World woman, then, as a distinct category, lacks agency and subjectivity in what Narayan refers to as the “package picture of cultures” (“Undoing the ‘Package Picture’ of Cultures”).

This historical relation between HCPs and agency is, however, rarely acknowledged in medical, public, and political debates on virginity certificates, even though such discourses underpin the simplistic responses towards and understandings of migrant women’s requests for virginity certificates. As such, it is key to recognise that approaches to practices such as issuing virginity certificates and writing prescriptions for erectile dysfunction medication are not separate from broader colonial historical, cultural, and political processes.

Second, the French *Loi confortant le respect des principes de la république* (2021), while perhaps extreme yet not alone in labelling virginity certificates a separatist practice of radical Islam (Bruna et al.; Mitchell), shows that the European approach towards virginity certificates cannot be viewed as external to and unaffected by an immigration politics structured around assimilation. Diprose argues that

[t]he regimes of social regulation which dictate the right way to live, implicitly or explicitly seek to preserve the integrity of every body such that we are compatible with the social body. Not only do these thereby dictate which embodied existences can be transformed, by whom, and to what end, but, as it is here that comparisons are made and values are born, not all bodies are counted as socially viable. In short, the privilege of a stable place within that social and political place we call the ‘common good’ is secured at the cost of denigrating and excluding others. (121)

The excessive response towards virginity certificates is indicative of how they are perceived to constitute a threat to the common good. Virginity certificates, then, are used as a tool to exclude migrant communities by positioning migrant women as victims in need of protection by the west. Indeed, women “are the first to be targeted in violence against a group’s particularity” (Rao 119) and their bodies become “a battleground in the determination of cultural identities and the enactment of border politics” (Sullivan, “The Price to Pay for Our Common Good” 407). The unequal distribution of agency in approaches towards prescriptions for erectile dysfunction medication and the issuing of virginity certificates thus functions as a biopolitical tool of normalisation that distributes bodies to categories such as, respectively, normal and abnormal, healthy and pathological, and proper and improper, grounded in these bodies (non-)performance of western norms of femininity and masculinity. In doing so, current approaches to virginity certificates reinforce an us-vs-them mentality that Others migrant women and their communities.

Conclusion

What I have demonstrated in this article is that understandings of, and approaches towards, the practices of issuing virginity certificates and prescribing erectile dysfunction medication, and the individuals who engage in these practices, are not merely truth found through objective observation (Haraway, “Situated Knowledges”; Haraway, *Simians, Cyborgs, and Women*). Rather, they are the outcome and effect of a historically, socially, politically, and culturally situated optics that produces meanings and bodies as particular kinds of subjects (Alcoff). My intention in this article has not been to suggest that migrant women do not experience oppression in relation to their requests for virginity certificates and more broadly. Instead, in comparing two seemingly disparate practices, I have shown that whether or not one is viewed as agentic has significant effects on the ways in which one’s requests are read. When one’s agency is disabled in advance, in a circular manner, what is found is read as evidence of one’s status as non-agentic. This process takes place in relation to the performance of normative gender in a context of assimilation. This is important because by positioning migrant women as non-agentic, current approaches to virginity certificates that seek to discourage or ban the practice in order to protect migrant women ultimately replicate the oppression of the women they (cl)aim to liberate. This is problematic, because, as Gatens

has argued, “if human rights are to come to accommodate women’s rights then women’s quintessentially human capacity for agency and imagination will need to be recognised and valued by the various communities and nations to which they belong” (293).

Approaches in which agency hinges on the performance of normative gender are unable to recognise the complex ways in which migrant women negotiate their multiple competing identities and cultures. Denying the agency of migrant women denies their voices in matters directly related to their lives, and as such will ultimately only replicate the oppression of the women involved. Current approaches are, as Sullivan, drawing on the work of Alcoff, argues, evidence of epistemological blindness to the specificity of one’s own ways of seeing and knowing [which] is characteristic of white optics: it (re)affirms and naturalises western norms and ideals regarding subjectivity, gender, sexuality, the body, pleasure, organs, the common good, and at the same time constructs the “other” woman as an unenlightened and passive victim in need of rescue (“The Price to Pay for Our Common Good” 406).

The point, then, is that we need to seriously consider the ways in which notions of agency, and our perception of agency, are always intertwined with governing norms and, as such, with history. Medical and policy interventions thus do not simply identify practices and individuals as oppressed and non-agentic, but are also implicated in producing them as such. Medical associations and practitioners, bioethicists, and governments would do well to consider the criticisms of postcolonial and Third World feminists around HCPs to avoid (re)producing the oppression of the women they (cl)aim to want to liberate and (re)instating an us-vs-them mentality that places migrant women and communities as inherently Other and backward in relation to the “advanced” “liberal” west. Rather than focussing the debate on the arguably disingenuous question of whether migrant women who request virginity certificates have agency, then, we must draw attention to and be cognisant of the ways in which agency is allocated and denied to particular groups in the context of particular practices. Awareness of such processes can enable a different conceptualisation of agency that centres the lives, voices, and needs of those involved.

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