**Hymen Interrupted:  
Negotiating body, markets and consumerist modernity in India**

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**Abstract**

*In this article I contend that in a context that is marked by a slow but steady rise in sexual liberalism around the ideals of female sexuality and desire, the pressure to remain virginal manifests itself through a potent nexus of markets and moral economies of gender and intimacy. Drawing on qualitative interview material on physicians specializing in female genital aesthetic surgeries, particularly hymenoplasty, in the Indian cities of Delhi, Ahmedabad and Bangalore, I show how restorative cosmetic surgeries on the healthy body are proffered through the language of duty, autonomous choice and the (neoliberal) market. Further, by building on the sociological concepts of moral consumption and progress through pleasure, I show how the seductive promise of consumerism-led modernity makes pleasure a ‘biopolitical burden’ and the cosmetic industry, a regulatory vehicle, disciplining female sexuality by means of male codes of honor. I ask on what this holds for the sexual and reproductive health politics for young people in India marked by pervasive asymmetries of socialization, gender relations and sexual experience. I conclude with a call to unsettle the social-moral ideals around female sexuality as well as to rethink the medical-legal frameworks around the cosmetic industry so that the young people are not unwittingly co-opted in their own production of ideal patriarchal subjects.*

**Keywords**: *hymenoplasty; moral consumption; desire; India*

**Introduction**  
In many cultures including India, female virginity is often associated with chastity, purity, and sexual respectability, capable of shoring up individual and family honor. In fact, female virginity works as a “social category” (1) where social relations are either forged or abandoned. This social meaning-making around female virginity assumes remarkable significance in the context of (arranged) marriages in India, where appropriate parental approvals and social sanctions are the norm. In this piece I contend that in a context, that is marked by a slow but steady rise in sexual liberalism around the ideals of female sexuality, desire and pleasure (2, 3, 4, 5, 6), the pressure to remain virginal manifests itself through a potent nexus of markets and moral economies of gender and intimacy. Drawing on interviews with physicians specializing in female genital aesthetic surgeries in Indian cities of Delhi, Ahmedabad and Bangalore, I show how restorative surgeries on the healthy body are proffered through the language of sexual “rights” and the (neoliberal) market. I reflect on how the questions of respectability, marriage anxieties and notions of desirable modernity shape this discourse by inviting young women in their own production of ideal patriarchal subjects. Ultimately, the larger question that I pose through these interrogations is how are we to make sense of sexual freedoms of women in the age of “moral consumption”(7, 8), a condition where the paradigms of tradition and modernity have been harmoniously fused. Subsequently, how does the standard models of sexual and reproductive health (SRH) research respond to these shifting realities of the global south? Notwithstanding the recent calls and the revived thinking (9,10) to address the “unfinished agenda for sexual and reproductive health in the Sustainable Development Goal (SDG) era” (11) and the need to go beyond the traditional parameters of family planning and HIV prevention[[1]](#footnote-1), it is surprising that the often uneasy alliance of technology and markets with young peoples sexual lives still remain outside the ambit of these renewed discussions. Given that young people in the global south will increasingly form the consumer-base for medical products and services, this neglect is problematic.

Family sociologists and anthropologists working on India have often noted a shift in how modern intimacies are interpreted through the idioms of choice, companionship and emotional compatibility (12, 13). Despite these putative changes, scholars have reminded how the centrality of the “moral economy” (14) of the family remains lodged in governing premarital and conjugal intimate practices of young Indians (5, 6). For example, in Bhandari’s ethnographic study on professional young adults in premarital relationships in Delhi showed how young women experienced higher expectations of social surveillance and self-control of their sexual selves than their male partners in similar relationships. The author noted how despite the modern self-making achieved through an individuated erotic love in these premarital relationships, the Hindu ritual of *kanyadaan* (gift of a virgin) governed the suitability and prospect of young females in marriage decisions. Similar sentiments were echoed in Twamley & Sidharth’s work on young women in a Mumbai slum and in the small town of Baroda (in the western state of Gujarat) where women in premarital relationships routinely engaged in self-surveillance ‘strategies’ through appropriate dressing, ‘respectable’ outings with their male partners and keeping outdoor socializing times in-line with their parents’ expectations. Significantly, the authors note that these ‘strategies’ of young women cut across class and caste boundaries pointing to the hegemonic cultural significance of feminine respectability. Not surprisingly, this pressure to remain sexually respectable defines conjugal intimacies as Puri (2) notes from her interviews with urban married women whose accounts of sexual enjoyment and pleasure are woven around the ideals of wifely duty for the ‘understanding’ husband; aptly so, Puri labels this as the ‘marital romanticization of sex’ (p. 119). Taken together, in these ‘modern’ articulations of intimacy the notion of sexual respectability is firmly lodged and is understood through woman’s sexual comportment and her virginity or as Phadke (15) puts it sharply “sexy, but respectable” in her description of middle class sexuality in neo-capitalist India. Building on this scholarship, I contend that the feminist engagement with desire and sexuality can be rendered more fruitful if one engages with the “market” and as I show using the case of aesthetic procedures, simultaneously enabling (female) sexual autonomy while reinforcing asymmetries of socialization, gender relations and sexual experience.

**The Virginity Industry: Gender, Body and Technology**

The neoliberal restructuring of the Indian economy that started in the 1990s has ushered a shift from public sector to creating conditions for healthcare as a site of corporate profitmaking. Writing about the growth of biotechnologies that are predicated on “the political economy of hope” (16; cited in 17), authors have shown how the biomedical market capitalizes on social anxieties to forge a successful industry around the bodies of healthy people (18). While there has been some writings (19, 20) on the new reproductive technologies and its increased social and medical surveillance on women’s bodies, aesthetic surgeries have often remained outside the analytical framework of feminist analysis. Rodrigues’ (21) call for a serious engagement with the biopolitics of human genitalia is noteworthy. She adopts a Foucauldian (22) framework to argue how aesthetic surgeries around the vagina (in particular, vaginoplasty and labiaplasty) marks a redeployment of biopower in the creation of what she calls, an “optimal” vagina- one that is expected to be receptive both to reproduction and heteronormative erotica. Her critique however should be understood from the popular Western discourse of aesthetic ‘enhancement/function’ where vulval utility and appearance constitute idealized visions of femininity. She shows how in the West, the cosmetic genital industry defines women’s bodies in terms of ‘excesses’ (‘excess’ tissue and skin in the cases of vagioplasty and labioplasty respectively whereas ‘excess’ blood in the discourse of menstrual hygiene) that needs corrective mechanisms to manage and regulate them in order to make them ‘acceptable’. This process, she argues ultimately ‘intensifies power relations by disciplining desire, producing subjects for desire as well as desiring subjects’ (21, p. 789). Unsurprisingly, this clinical gaze dominates the narrative around women’s genitalia globally. Writing from Brazil, Dornales de Andrade (23) notes how body-modification by cosmetic surgeries (that include breast augmentation/reduction, liposuction, tummy tuck, rhinopalasty and genital cosmetic surgeries) has been on the rise where women in her research sample self- selected themselves for corrective ‘improvement’ procedures after reportedly being in long periods of discontentment about their bodies. The author concluded that these women used body-modification as a means of expression and viewed cosmetic surgery as “psychotherapy by scalpel” (23, p. 78). In fact, this paradox of women’s autonomy and rights about their own bodies versus the pathology or sexual disutility associated with perceived body/genital ‘abnormality’ is echoed in several other studies. Wild and colleagues’ (24) pilot study on the ethically controversial hymen reconstruction surgery from Tunisia exemplifies this dilemma. They found that in a deeply entrenched patriarchal system that maintains an automatic correspondence between hymen, virginity and blood on bed sheets[[2]](#footnote-2) (a requirement for arranged marriages), women used technology (such as the hymen reconstruction surgery) pragmatically to realize their personal aims which were either to marry or become mothers or to overcome past violent sexual experiences. According to the authors these women were “both victims and agents: they cannot realistically hope to be completely free of coercive patriarchal attempts to control their bodies, but they may resist such attempts by seeking hymen reconstruction” (24, p. 60).

The view that hymen reconstruction surgery or hymenoplasty (as it is more commonly known) is a pragmatic form of resistance is steadily gaining ground in the literature that comes from the Middle East. For example, anthropologists working on Iran (see 25, 26) have shown how women have manipulated the virginity industry by inadvertently blurring the anatomical markers between original and ‘fake’ virginity (one that is recreated through surgery) thereby potentially transforming the narrative through a re-signification of gendered constructs. Whether hymenoplasty is a covert resistance tactic through which women unwittingly challenge hegemonic discourses mandating female premarital virginity or a process of reinforcing patriarchal expectations remains inconclusive, what is clear from the preceding review is the persistent medical and cultural pathologization of women’s genitalia and sexuality (27). How does the aforementioned paradox play out for both women and physicians involved in this production of desirable subjects? I attempt to examine this question through a qualitative interview-based pilot study conducted across three cities of India.

**The Pilot Study: Data and Method**  
Although originally intended to capture the “voices” of the clients (female patients who have either undergone or contemplating to undergo the procedure), this study could only gain access to interviewing the aesthetic surgeons (more commonly known as plastic surgeons in India) across the cities of Ahmedabad, Delhi and Bangalore. My interest in interviewing the patients was readily turned down by the physicians who emphasized the secret ‘pact’ that they shared with their patients where out-patient records for both consultation and procedures were not kept in file to “respect” patient confidentiality. Although this may seem to be a very unusual medical practice, previous studies (23) have similarly noted how the doctors had emerged as “an emphatic companion, as a friend, psychologist and therapist, in a way” (p. 81)- a relationship built on a secret that is socially abhorrent. I chose these cities due to their thriving aesthetic industries, up-market middle class consumer practices and relative anonymity that big city life offers. Given the extreme clandestine nature of these ‘treatments’, it was important to choose sites carefully. I interviewed three aesthetic surgeons in Delhi and the National Capital Region (NCR), two in the north-west Indian city of Ahmedabad and two in the south Indian city of Bangalore. Funding to conduct this pilot study came from the Population Foundation of India (New Delhi: <https://www.populationfoundation.in/>), a national non-governmental organization that works on research and advocacy of gender-based health interventions/programs. The ethical approval for the study was obtained from the Institutional Ethics Committee of the Indian Institute of Technology, Gandhinagar.

Surgeons were recruited through an online search of media reporting, advertisements and promotional materials around female genital procedures in India. In some cases, I had also approached the treatment facility through their social media profiles. Although cosmetic procedures are also offered in government hospitals in India, the private clinics are the ones that dominate the scene (28; *Times of India*, September 6, 2016[[3]](#footnote-3)). Hence, all my interviews were with physicians who practiced either in large private hospitals or in their own private clinics. These were the surgeons who also offered other cosmetic procedures including liposuction, abdominoplasty, breast reduction/augmentation and a range of female genital aesthetic surgeries such as vaginal tightening, vaginal rejuvenation and labiaplasty. Interviews with physicians were conducted in their own professional spaces (clinics/hospitals) using a combination of Hindi and English over a period of 5 weeks in January-February 2019. A signed (by the author) consent form that provided a description of the study was administered to all physicians before the start of the interviews. My semi-structured interview instrument included open-ended questions on patient-type and their motivations to undergo these procedures, questions on parental approvals (since as discussed in the opening section, parental approvals are pivotal in obtaining social legitimacy of a romantic union, especially in arranged marriages) and finally perceptions of physicians, their policies on post-operative care and medical ethics around these procedures. The physicians reported that those seeking hymenoplasty (they were unable to provide a ballpark number of reconstructive surgeries performed annually, since no patient records were maintained to ensure confidentiality) typically come either with their mothers or with another adult female companion. In most clinics where I interviewed, the cost of hymenoplasty ranged anywhere between 30,000-50,000 Indian Rupees (approximately, US$432-US$720).

Given the short duration of the pilot study and the extremely secret nature of the procedures, I was able to interview physicians who were all men. Female plastic surgeons (although rare) were not prepared to talk to me about their experiences once they found out that my interviews would be organized around hymenoplasty and other female aesthetic surgeries. This was surprising since I had anticipated some degree of suspicion (26) and resistance from male doctors than female doctors given my status as a female researcher in a sexually restrained culture where discussions around body and sexuality are unbecoming of women. I interpret the reluctance on part of the female surgeons as being fraught with a *more* morally ambivalent position that ultimately reproduces repressive norms around women’s sexual rights. These limitations, notwithstanding, the interviews with physicians offered insights that motivate sociological interrogation of a very secretive and highly under-studied topic. In what follows, I build on the sociological scholarship of the middle class in India to argue how the intersecting logics of the market and consumption have come to dominate sexual cultures around body and sexuality. Additionally, I reflect on the bio-moral role of the physicians in offering the controversial procedure of hymenoplasty and conclude by calling for more research to understand the social and public health implications of the burgeoning cosmetic industry.

**Findings:**   
***The ‘Good Life’: Bodies in the making***  
While driving down the highways of any big Indian city, it is perhaps not surprising to find flashy billboards inviting women (and men) to tauten, enhance and modify their body parts almost akin to a multi-cuisine restaurant offering a delectable menu of choices. Amidst the cheerful models with tautened bodies are the marketing taglines of “*Cosmetic artistry for the beautiful you*” or “*Beautifying personality, Enhancing confidence…we make beautiful people*”, advocating an easy association between a beautiful body (one that is free of excesses) and professional success. Unsurprisingly, media reports on these new lifestyle choices are abound[[4]](#footnote-4). Meanwhile, websites of certain private clinics offering aesthetic surgeries have now carefully curated images and testimonials that almost make body-modification practices a foundational experience of cosmopolitan lifestyle. The clinics that I visited had walls adorned with physician accolades and patient testimonials evoking enormous optimism in surgical procedures that help realize cosmopolitan aspirations. Glossy brochures were typically handed out by an English-speaking receptionist who would kindly guide me to waiting rooms with modern décor, soothing, meditative music and smells akin to relaxing lounges or spas. Clearly, the focus is on “feeling and looking good” (as the marketing tagline of one brochure proudly announced) where the pathology of labs/clinics has been appropriately removed turning them into ideal spaces for luxury consumption. Further, the frequent use of English language by clinic staff and the physicians themselves offers interesting sociological fodder. In interviews that largely progressed in Hindi, physicians would suddenly use socially non-threatening English metaphors (for sex or sexual intercourse) such as “thrill” or “union” with a studied attempt to perhaps avoid discussing taboo topics with a female researcher. Psychoanalyst Sudhir Kakar’s (29) influential work on Indian sexuality or Puri’s (2) analysis of women and desire in postcolonial India, remind us how English as an *international* language (as opposed to an *Indian* language) allowed educated Indians to discuss forbidden matters, although as Kakar notes, these “euphemisms carry strong affective charge” (p. 20). Puri (2) complicates this complex process of negotiating the politics of sexuality by noting our inability to “name the discourse of sexuality in Hindi*….[while, on the other hand]* English eases the narratives on sexuality but also constrains them” (parentheses added; p. 131). This cultural authority of English language which normalizes as well as restricts the narratives on sex and sexuality, was apparent in the interviews with the physicians.

Authors writing on India’s new middle class and tracing the process of cultural globalization ( (30) have previously noted how the slogan of the ‘feel good factor’ (31) consolidated the national sentiment of a growing (affluent) middle class engaged in the production of a distinctive consumerist lifestyle. Interestingly, many metaphors such as- ‘world-class’, ‘(Indian) dream’, ‘unbound’-that have been often used to define the new vision of India following economic liberalization were invoked in glossy brochures of aesthetic surgeries inviting clients to a range of unrestricted opportunities in body modification and genital aesthetic surgeries. Significant in the language used in these brochures is the emphasis on the autonomous selfhood and choice exercised by the client-patient. In an insightful analysis of bridal magazines (particularly, the *Bride & Home*) in post-liberalized India, sociologist Patricia Uberoi (12) similarly notes how these niche magazines offered tips on bride’s self-presentation, make-up, diet, bridal shopping, skin care, exercise and weight loss regimen in ‘staging of a socially notable wedding’ (p. 235). She adds how the “editorial [of *B&H*] is explicitly framed in the neoliberal vocabulary of *choice*” (p. 240) in which the ‘modern’ notions of freedom to *choose* from a range of consumer lifestyles is fused with the self-conscious choice of being ‘traditional’ where patrivirilocality remains unchallenged and the bride’s ‘adjustment’ to her new home and in-laws is prized. Likewise, the construction of women as purportedly autonomous agents in *choosing* to undergo hymenoplasty and other genital aesthetic procedures is abound in promotional brochures, clinic websites as well as in physicians’ narratives (discussed more in the last section of this paper).

***Markets and Moral Consumption***   
Significantly, social anthropologists (8, 31, 32) examining *change* through the lens of urban lifestyles and spaces have noted how the consumer market is a potent site where pleasures, anxieties and fears find sociologically rich articulations. Srivastava’s (7, 8) use of the term “moral consumption” is a useful entry point to understand the tension between social norms and the seductive promise of consumerism-led modernity. In his discussion of new urban leisure spaces such as upper middle class gated residential enclaves and Hindu temple complexes[[5]](#footnote-5) that combine hyper-consumerism, norms and religiosity, Srivastava (7) describes the making of moral consumption (or a moral middle class) “where the active participation in consumerism is accompanied by an anxiety about it and its relationship to ‘Indianness’” (7, p. 134). In these new forms of (upper) middle class consumption, Srivastava adds, “women can be both the guardian of tradition *and* take part in the sexualized presentations of the self, rather than having to choose between the two” (emphasis added; p. 135). This observation finds resonance with the female client-patients who are reportedly choosing to self-surveillance and self-diagnose their non-virginal states as a ‘problem’ that needs to be managed by cosmetic surgeries. Social-moral anxiety around the hymen (or the vagina) is paramount to the success and growth of female genital aesthetic surgeries. Similar to Srivastava’s (8) analysis of moral consumerism wherein women take active part in consumerism but “can return home to ‘tradition’ when required’ (p.136), I argue, women’s cosmetic-surgery induced (putative) freedoms makes them loyal ‘glocal’(33) consumers who are self-consciously both ‘modern’ and traditional. It ultimately makes pleasure, as Rodrigues (21) forcefully argues a “biopolitical burden” and the cosmetic industry, a regulatory vehicle, disciplining female sexuality by means of male codes of honor. Noteworthy in these interpretations of middle class consumption is William Mazzarella’s (32) notion of “progress through pleasure” where he argues the potential of aspirational consumption to transform vice into virtue (using the example of the advertising and marketing of a premium brand of condoms in India called the Kama Sutra). In this understanding, consumption becomes a morally loaded act where its goal “-as pleasure is connected to a noble charitable cause, bound by values and good intentions” (31, p. 262). Young women’s motivation to liberate themselves from the ‘vice’ of premarital coitus and present themselves as ‘virtuous’, respectable (hymen-intact) subjects to desirable suitors turns pleasure as a (wifely) moral duty. Significantly, consumption becomes the trope that connects the notion of pleasure as being both privilege and duty. Brosius’s (32) pointed reminder of the basic market rule for a commodity (in this case, virginity) to remain valuable, is significant: both the producer and the buyer should know how to weave it into the larger performative social scripts; only then, she asserts “can a commodity become a status-marker and –maker” (32, p. 264). In the concluding section, I evaluate how healthcare professionals (as producers or suppliers of the virginity industry) *justify* these controversial surgical procedures in the age of consumption, distinction and morality.

**Conclusion*:* Negotiating *Dharma* and Desire**

I have borrowed the title of this section-Dharma and Desire-from noted sociologist Uberoi’s (14) work on family and popular culture in India. While Uberoi used this to examine the tensions embedded in preserving the “moral economy” of the joint family in India, I find its two conceptual oppositions, *dharma* (a normative Hindu meaning of social duty) and desire, useful to summarize the contradictions in the modern romantic love complex. As discussed earlier, allegiance to social duty or *dharma* (in presenting oneself as virginal or improving erotic utility for heterosexual conjugality) governs much of the anxiety around hymenoplasty and other female genital aesthetic surgeries. In contrast, desire, on the surface, offers a free-fall, uninhibited space which ultimately produces gendered ‘deviant’ bodies that need to be regulated. In other words, *dharma* disciplines desire. The trope of *dharma* (as in medical duty)was invoked by the physicians to explain their morally ambivalent position. In a culture of deep-rooted patriarchal norms and no clear medical guidelines or regulatory framework governing the cosmetic industry, aesthetic surgeons’ response to these controversial procedures remained ambivalent at best. During my interviews, I was particularly curious to understand how cosmetic surgeons viewed these procedures or whether they were reflective of their social roles while accepting requests of performing female genital aesthetic procedures on otherwise healthy bodies of young women. What emerged fairly consistently was how these surgeons espoused the language of “medical duty” and “patient rights” to reconcile with this moral unease. All surgeons that I interviewed indicated the compulsive need to prove themselves as empathetic medical companions for their patient-clients from the perspective of “medical duty” and their inability to refuse treatment. The recourse to “medical duty”, while comforting, seemed contrived since it is not uncommon for those same clinics to offer “special packages” (may include discounted treatment cost and a two-night hotel stay for the patient) to young women before the wedding “season” commences in October every year. Similarly, social media pages of certain private clinics routinely offer special discounted rates for body-modification and genital surgeries (targeting both women and men) before the arrival of highly commercialized annual socio-religious (Hindu) festivals such as *Diwali, Navratri* and *Karva Chauth*. Clearly, Dornales de Andrade’s (23) assertion of how medical ethics becoming more “bendable” to the logic of the market finds resonance in this study as well. It is worth noting that physicians justified their medical duty to perform these controversial procedures as a means to respect patient autonomy, freedom and empowerment. While this gender politics is immediately appealing, what it hides is its simultaneous process of delimiting female sexual expressions. This superficial co-optation of feminist language of choice and rights has been noted in studies that report physician responses (21,34). Ultimately, in this neoliberal framing of a modern, autonomous woman, proffered through the language of duty, market and ‘care of the self, bodies are appropriately controlled or as Brosius (32) puts it, “fetishized for a more private gaze (of the husband)” (p. 321). In Mazzarella’s (31) sense, the (female) consumer in this new economy of pleasure has travelled a full circle where pleasure dominates sacrifice as self-fulfilment (p. 101)- the making of a virtuous self through technology and market.

So, how do we make sense and address this tacit complicity of physicians under the all-encompassing garb of medical duty in the age of neoliberal consumerism? Wild and colleagues’ (24) recommendation is straightforward but pointed. They argue that the “medical duty” should *also* include physicians providing (1) appropriate medical information to patients about sexual and reproductive health so that they are able to recognize that “cultural beliefs about virginity are biologically false and misleading” (p. 60), and (2) a counselling based empowerment approach that educates women about their options. The authors are however cautious in their recommendations since in many cases and cultural contexts where the virginity “certificate” or “rule” persists, women use hymenoplasty as a temporary resource (35, cf 24) under violent forms of social disapprovals for premarital coitus.

Finally, returning to the question of how this intellectual inquiry shapes the sexual and reproductive health of young people is important. I have, throughout this paper, shown the dangers of a growing private, profit-making cosmetic (beauty) industry that draws its success from making bodies as sites of capitalist consumption. With an understanding that this new form of corporeal capitalism will only persists and grow, how do we make this industry safer for women and men? Thankfully, a few authors have shown us the way: Marge Berer’s (34) forceful call in her editorial piece for *Reproductive Health Matters* to shift our intellectual gaze from theorizing to more policy-driven questions is refreshing. She directs our attention to what happens *after* these surgeries have been performed and wonders about post-operative care, (altered?) self-perception of body-image and a range of psychological effects on client-patients. Similar sentiments are echoed by other authors (23, 24). And while more research to best understand the motivations and needs of both the physicians and patients is always desirable to have effective policies around sexual health (36), incorporating reproductive and sexual health education as part of school curriculum and public health communications (that breaks myths around body and educates young people about the risks of medically unnecessary surgeries) can go a long way in rupturing the certainty of coercively patriarchal environments.

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1. See the Guttmacher-Lancet Report for a detailed discussion on the definitional advances and a renewed vision for SRHR interventions in the Global South, Starrs AM, Ezeh, AC, Barker, G. et al (2018). Accelerate progress-sexual and reproductive health and rights for all-Report of the Guttmacher-*Lancet* Commission. Lancet. doi.org/10.1016/ S0140-6736(18)30293-9 [↑](#footnote-ref-1)
2. This culture of presenting oneself as virginal on the wedding night persists, despite the fact that hymen is not a reliable indicator of past sexual experience; studies have shown that some women may lack a hymen at birth or the hymen can be torn for reasons other than coital behaviour such as athletic activities and an injurious fall (36). Still other studies have noted the shifting cultural definitions of virginity and that vaginal sexual penetration cannot be medically or informally ascertained with certainty (24) [↑](#footnote-ref-2)
3. India is steadily becoming home to reconstructive surgeries attracting both domestic and foreign clients. See *Times of India* (September 6, 2016) “India ranks 4th on list of plastic surgery hotspots” or *Business Standard* (Jan 21, 2013) “Plastic Surgery: India ranks 4 in world, attracts foreigners”. While government hospitals and medical schools have accredited and trained reconstructive surgeons, cosmetic or aesthetic surgeries are primarily carried out in private hospitals or as Bhattacharya (28) sarcastically note how government institutions that have well-trained and experienced practioners think of these enhancement procedures to be “too frivolous a thing to indulge in, as much more noble deeds like treating burns and congenital abnormalities are always beckoning us” (p. 431) [↑](#footnote-ref-3)
4. See for example media reporting on designer vaginas in Quartz, India (January 3, 2017) “In sex-shy India, more women now want designer vaginas”, or “Women going under knife to restore virginity” (Times of India, 2010) or a leading English-language news magazine, *India Today*, dedicated its cover story to this rage “What’s on the Menu? Who’s going under the knife and why” (*India Today*: April 30, 2012). Furthermore, in the year 2012, a product called “18 Again” was launched as a ‘woman’s empowerment product’ aimed at ‘rejuvenating and tightening’ the vagina (<http://www.18again.com/>). The video ad featuring a married woman and her male partner were shown prancing around in the patio of what it seemed to be a joint-family household with a pair of bemused elderly onlookers (probably, the in-laws) sending reassuring signals to the ad viewers- marital sexual conjugality has been appropriately domesticated. [↑](#footnote-ref-4)
5. Srivastava’s (8) analysis of new urbanism in India and its consolidation through a consumer society is organized around the cultural examination of Akshardham Temple complex in Delhi, owned by the Hindu Swaminarayan sect (a dominant transnational Hindu community), resembling, as Srivastava suggests, a “religious theme park” whose design draws inspiration from the North American theme parks of Disneyland and Universal Studios. He adds how women visitors “move seamlessly between playing consumers and devoutly religious persons precisely because the same space provides opportunities for both consumerism and religiosity” (7, cf 8, p. 135) [↑](#footnote-ref-5)