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LECTURE

The normal and the aberrant in female genital cutting

Shifting paradigms

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In this lecture I consider preliminary results of continuing fieldwork in Sudan while revisiting my earlier observations on female genital cutting there in light of the growing practice of "female cosmetic genital surgery" (FGCS) in the West. Despite remarkable similarities in their aesthetic rationales, FGCS is becoming increasingly common in the West while Sudanese "traditional" FGC remains subject to censure and international abolition campaigns. At least one FGCS procedure, "The Barbie," results in genitalia that resemble those produced by traditional FGC. Several Sudanese families with whom I conduct research no longer practice FGC of any sort. I parse the reasons for this along with those indicated for the rise of FCGS in the West, and explore the web of ironies that link the two contexts.

Keywords: female genital cutting, labiaplasty, cultural aesthetics, normalization

Before traveling to rural northern Sudan for ethnographic research in 1976, I knew that female genital cutting (FGC) was prevalent there, though I was naïve about its context and significance. It was easy, from a distance, to consider the practice an extreme form of gender violence and, in the 1970s and early 1980s, to frame it in sex-hierarchical terms: as men controlling women's sexuality. But the longer I stayed in the village and the more I learned, the more simplistic this explanation seemed. Certainly, no woman or adolescent girl I met had escaped being cut, but none had wanted to. For them, the practice of FGC was normal, taken for granted, seldom even discussed among themselves. Though acknowledged to be very painful, the experience was looked forward to, while the prospect of not being cut was horrifying.

It is often suggested that, given more knowledge and freedom, women would eschew their conditioning and elect not to undergo the practice. Yet the attribution

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of false consciousness to my friends' understandings would be both patronizing and uninformed, demanding no direct engagement on the analyst's part with women who were cut. Claims of dominated consciousness are insufficient to grasp the intricacies of power relations and their continuous reproduction and transformation. For the issue has far less to do with how men oppress women than with how a system of gender-asymmetric values and constraints is internalized by both, with their active participation, and thus becomes self-sustaining, naturalized, indeed unselfconsciously 'real'. Although I had not gone to Sudan to study FGC, the tacit meanings with which villagers imbued it ultimately made this an important area of my research. I found myself drawn to discover as much as I could about the practice and its rationale in the village on the Sudanese Nile that I call Hofriyat.

In this talk I revisit three phases of my research in Sudan, while weaving throughout some remarks on genital cutting as practiced in the West. The procedure in Sudan is currently known as female circumcision (*khitān al-banāt*), more controversially, female genital mutilation or FGM, and recently FGM/C, female genital mutilation/cutting, the term adopted by the World Health Organization when researchers as well as activists in practicing populations objected to the condemnatory tone of FGM.[1] First I sketch how I came to understand what Hofriyati women were doing when they arranged for their prepubescent daughters[2] to be cut and for themselves to be opened and resewn with every birth.[3] Next I describe archival research into attempts by British colonial agents, officials, and parliamentarians to stop or at least modify the most severe of these practices between the 1920s and 1940s. Finally, I say something about my current research with families I first worked with in the 1970s, some of whom have given up female genital cutting altogether. In that the practice had been crucial to women's self-definition and gender performance in the past, their decision to stop deserves exploration, in part because parsing one context in which abandonment makes sense may cast light on the process elsewhere.

Indeed, it now appears that support for FGC has dropped significantly in several countries where it was deeply entrenched in the past (York 2010). In Sudan, for instance, UNICEF research shows that popular endorsement of FGC fell from 79 percent in 1989–90 to 51 percent in 2006, despite a prevalence rate of 89 percent that year (UNICEF 2010: 40). More recent figures suggest the decline to be

1. My own preference is for FGC or FGS (female genital surgery), as these are arguably more value-neutral terms.

2. The operation was usually performed on girls between the ages of five and ten.

3. Depending on her scar, an infibulated woman giving birth may require an anterior cut to release the child. Following delivery, local midwives usually stitch together the separated tissue, a procedure referred to as a circumcision repair or reinfibulation. Canadian obstetricians working with infibulated women are cautioned that "performing or assisting with the practice of FGC/M [*sic*] in Canada is a criminal offence" and that "requests" for reinfibulation must be declined (Perron and Senikas 2013; Blake 2014). They may, however, offer "reconstructive" procedures to prevent the cut labial membrane from readhering (Perron et al. 2013: e9). The subject of reinfibulation is a matter of some controversy in Canada (e.g., Kotaska and Avery 2014), and although I have not yet systematically researched it, I imagine this may also be the case elsewhere.

real: whereas some 98 percent of Sudanese girls below age fourteen underwent the procedure in the 1970s, between 2010 and 2015 prevalence in that age group fell to 32 percent—a massive drop at least among adolescents (UNICEF 2016).[4] Public education campaigns involving respected religious and professional figures have brought the practice into the open, denaturalizing it and prompting salutary community debate. Yet this is an incomplete explanation for the shift. The growing rejection of female circumcision in northern Sudan is, I think, part of a broader social transformation that is creating new opportunities, imposing new constraints, and altering gender dynamics in important ways. I return to these issues later on.

There is, of course, an odd and disquieting twist to the trajectory I've described. For just as African women are rethinking the need to alter the genitals with which they were born, more and more women in Europe, the Americas, New Zealand, and Australia—places that led the campaign against FGM—are discovering their genitals to be "abnormal": disproportioned, messy, lacking symmetry.[5] Their labia minora are too long, their vaginas too slack, their outer labia either too obtrusive or not plump enough. The remedies include labiaplasty, "vaginal rejuvenation" (vaginoplasty), clitoral "de-roofing," and lipo-injection. A widespread cultural denial of aging, or even becoming adult, may well underlie the tremendous increase in these practices, in that the desired outcome is for genitals resembling those of a prepubescent girl, reflecting a "clean-slit aesthetic . . . of absence and smoothness, with no external structures visible" (McDougall 2013: 776; see also Braun and Wilkinson 2001; Kobrin 2004; Manderson 2004; Boraei, Clark, and Frith 2008; Liao and Creighton 2007; Berer 2010a; Dalal 2014; Motakef et al. 2015). The now common practice of genital depilation (think Brazilian) is contributing to the trend, making visible physical structures that were previously covered up. Also implicated is the upsurge of easily accessible Internet pornography, viewed by both sexes from an early age. Soft-core films and magazines typically feature women whose hairless genitals have been either surgically reduced or digitally altered, "healed to a single crease" in industry terms. "Think of it as 'digital labiaplasty,'" writes Kirsten Drysdale (2010; see also Freeman, 2010; Devlin 2014; McBride 2016). Publication standards require that female genitals be invisible; in Australia, censorship laws deem that showing genital "detail" such as inner labia is obscene (Bramwell 2002; Drysdale 2010). Plastic surgeons and "cosmetic gynecologists" (a new, if unofficial, specialty) report that women arrive at their clinics armed with pictures of "ideal"

4. It is still possible that some of the girls who remained uncut at age fourteen could undergo the procedure later on. Salafist organizations in Sudan encourage women and girls to have a '*sunna*' procedure and have funded clinics for that purpose, much to the chagrin of Sudanese feminists. The decline in FGC is marked throughout the continent: UNICEF data suggest that by 2016 rates had dropped by a third in Kenya and Tanzania and by half in CAR, Liberia, and Nigeria (UNICEF, February 26, 2016: http://www.unicef.org/protection/57929_58002.html, accessed September 26, 2016). However, an overview of the data by Shell-Duncan and Naik (2016) suggests that Sudan has seen little change.

5. This is especially the case for Brazil, which leads the world in per capita consumption of cosmetic surgeries, and where the incidence of labiaplasty is increasing (Dorneles de Andrade 2010).

but often photoshopped vulvas taken from porn magazines or the Internet, asking doctors to make them look "like that," "normal," "tidy," and "neat" (Drysdale 2010; Davis 2011; McDougall 2013; O'Regan 2013; Coughlin 2016; McBride 2016). The aesthetic standards of medical professionals are also, of course, shaped by such cultural ideals (see Braun and Wilkinson 2001), let alone that most procedures are performed in the private sector for substantial fees. Supplementing the trend are ubiquitous music videos with scantily clad performers (Buchanan 2013), the current fashion for tight-fitting clothes, and the proliferation of fitness clubs that provide occasion for self and peer appraisal. Increasing numbers of Western women and girls are distressed to learn that their genitals do not match the ostensible norm.

All this begs us to consider the aesthetics of female genitals and female genital cutting in both Africa and the West. It further invites the question of why some nonmedically necessary operations are vilified in the West, even criminalized, while others are available, advertised, and touted as life-enhancing options for those who can afford to have them done. In 1985, the year that Britain's Parliament passed its first dedicated law prohibiting FGM, labiaplasty was seldom performed on British women, and of those who had it done the majority were sex workers, lingerie models, or pornography stars (Kobrin 2004; Johnsdotter and Essén 2010). The British law as first proposed declared FGC illegal except when necessary for a woman's physical health. Under intense pressure from the Health Department and the Royal College of Obstetricians and Gynaecologists, a clause was added to justify female genital surgery on the grounds of mental health, mainly for genetic and congenital abnormalities. Its illegality for reasons of "custom or ritual" was, however, upheld (Sochart 1988; Guiné and Moreno Fuentes 2007: 493).

In 2003 the act was amended in light of rising immigration from regions where FGC is traditionally practiced.[6] The revised law specifies that, except for medically necessary operations performed by registered medical professionals on grounds of physical or mental health, or, in the case of childbirth, by registered midwives or medical trainees, the excision, infibulation, or other mutilation of a woman's genitals by a UK national is illegal, whether performed within or outside the United Kingdom. It is also an offense to assist a girl or woman to mutilate her own genitals. Moreover, the law declares that, "for the purpose of determining whether an operation is necessary for the mental health of the girl it is immaterial whether she or any other person believes the operation is required as a matter of custom or ritual."[7]

What do the terms "custom" or "ritual" mean in this text? In popular parlance such words are typically used to describe the behaviors of "Others," of people whose practices differ from those of the dominant group that constitutes the self-evident norm. But clearly norms are not stable, and social conventions change. It's important to remember that "'female circumcision' was practised by the European and American medical professions in the 19th century as a cure for a wide variety of conditions including insomnia, sterility, unhappy marriage, and psychological disorders" (Conroy 2006: 106), and the idea that such procedures

6. In Scotland revisions were made in 2005.

7. Act of Parliament, Chapter 31, Female Genital Mutilation Act, October 30, 2003.

are sexually repressive may have been conditioned by their historical use (Conroy 2006; cf. Green 2005; Rodriquez 2014). Moreover, the line between idealized, "customary," and "normalizing" is remarkably blurred. Surely, performing an operation to modify healthy female genitals that appear abnormal only under increasingly restrictive cultural definitions of physical normality, and to address mental health issues that such ostensibly adverse appearance entails, verges on "convention," much like so-called "traditional" forms of FGC. Similar observations compelled one writer to ask, "When does a fashion become part of culture or a custom or ritual? Only when you come from Africa?" (Berer 2010a: 108).

It seems clear that we are witnessing a sea-change in the way human bodies are imagined in the West, as expanding opportunities to sculpt one's appearance coincide with a narrowing of aesthetic ideals and more constrained descriptions of what is normal, natural, and acceptable. Medical attitudes have changed. While in 2007 the American Congress of Obstetricians and Gynecologists advised against such procedures in the absence of data supporting their safety and efficacy (Lee 2011a), by 2012 the International Federation of Gynecologists and Obstetricians (FIGO) included an extended presentation on "cosmetic gynecology" at its annual meeting in Rome (O'Regan 2013).

Statistics of actual labiaplasties are elusive and, when available, likely underestimated as most procedures are done in the largely unregulated private sector, absent professional oversight or credentialing.[8] Though currently not as popular as liposuction or breast augmentation,[9] the demand is climbing year by year. One UK doctor reported that the number of women requesting labiaplasty had increased fivefold between 2008 and 2014; and that two thousand procedures are annually performed under the National Health (Devlin 2014). The *Guardian* noted that a Harley Street medical practice logged over five thousand inquiries in 2010 (Lee 2011b). In 2014, the American Society for Aesthetic Plastic Surgery (ASAPS) reported that the number of labiaplasties had risen dramatically and the number of cosmetic surgeons doing them had "increased from 21% to 29% in the past year alone" (ASAPS 2014). As I write in September 2016, 1595 plastic surgery clinics in the United States are marketed on the website whatclinic.com, and if the figure the ASAPS reports is true, some 463 of those perform labiaplasties.[10] The same website advertises 80 private labiaplasty clinics in the United Kingdom, 80 in Australia, 48 in Canada, 71 in France, 95 in Germany, 60 in Poland, 40 in Italy, and 150 in Brazil, plus 152 in Turkey, 50 in Mexico, and 108 in India that encourage medical tourism.[11] Cosmetic labiaplasty clinics listed on that site number 756 worldwide,

8. R. Davis (2011); Lee (2011b); Berliet (2012).

9. ASAPS-Stats2015.pdf, downloaded from http://www.surgery.org/media/statistics, accessed September 26, 2016.

10. http://www.whatclinic.com/cosmetic-plastic-surgery/us, accessed September 26, 2016. Interestingly, in contrast to other countries, only twenty-seven US labiaplasty clinics advertise themselves as such on that site.

11. http://www.whatclinic.com/cosmetic-plastic-surgery/Worldwide/labiaplasty, accessed September 26, 2016

including nine in Egypt and one Ghana, where "traditional" FGC is also performed.[12] This is clearly a global trend.

It is also an elite trend, since the nonmedically necessary operations are relatively expensive and, with few exceptions, not compensated by government or private health insurance.[13] "Perfect" genitals are not free to any and all. But acquiring them is permissible (to some) as long as a client can pay. Modifying one's body through biomedicine to align it with prevailing aesthetic conventions is acceptable, even encouraged, for well-off women "of" the West, even as African women "in" the West are routinely denied restitching of their lacerated circumcision wounds after giving birth (Perron and Senikas 2013; Blake 2014; cf. Kotaska and Avery 2014). Here the concatenation of class and race rings clear, despite the potential dangers to health for both.

A study of current labiaplasty procedures (Motakef et al. 2015) lists seven different techniques, some of which, such as "direct excision," may lead to visible scar formation, loss of sensation, and compromised neurovascular supply. Such surgeries are not without risk, and the long-term consequences of cosmetic labiaplasty for sexual function, pregnancy, and birth remain unknown (Green 2005; Berer 2010a, 2010b; Lee 2011b; Zar 2013; Motakef et al. 2015; Plastic Surgery Practice 2015).[14]

The World Health Organization (WHO) defines "female genital mutilation" as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO 2008, 2013).[15] The 2008 text continues:

> The guiding principles for considering genital practices as female genital mutilation should be those of human rights, including the right to health, the rights of children and the right to nondiscrimination on the basis of sex. Some practices, such as genital cosmetic surgery and hymen repair, which are legally accepted in many countries and not generally

12. Ibid. Other than those just described, countries advertising labiaplasty clinics include Albania, Argentina, Belgium, the Canary Islands, China and Hong Kong, Colombia, Costa Rica, Croatia, Cyprus, the Czech Republic, the Dominican Republic, Finland, Greece, Guatemala, Ireland, Indonesia, Japan, Jordan, Latvia, Lebanon, Lithuania, Malaysia, Malta, Mauritius, the Netherlands, New Zealand, Norway, Pakistan, Peru, the Philippines, Portugal, Qatar, Romania, Russia, Saudi Arabia, Singapore, Slovakia, Slovenia, South Africa, Spain, South Korea, Sweden, Switzerland, Taiwan, Thailand, Tunisia, the UAE, Ukraine, and Vietnam. Some of those in the Pacific Rim are part of a global cosmetic surgery chain headquartered in Australia.

13. In Britain a woman can expect to pay £3000 and up; in Canada and the United States, the cost is a comparable $5000–$10,000, depending on the type of labiaplasty performed.

14. Claims about the harmfulness of FGM/C have been a mainstay of the abandonment initiative. Yet here too the evidence is scarce, and when provided, its interpretation has been questionable (see Obermeyer 1999; Shweder 2005, 2016; Public Policy Advisory Network on Female Genital Surgeries in Africa 2012).

15. The fact sheet has since been updated (February 2016), and reference to Western cosmetic female genital cutting has been removed (accessed again, September 26, 2016). The passage remains, however, in the 2008 WHO interagency publication *Eliminating female genital mutilation.*

> considered to constitute female genital mutilation, actually fall under the definition used here. It has been considered important, however, to maintain a broad definition of female genital mutilation in order to avoid loopholes that might allow *the* practice to continue. (WHO 2008: 28, my emphasis)

While the seeming inclusiveness in this passage is admirable, it betrays itself at the end. For *the* practice can only refer to operations performed on African girls and young women, ostensibly against their wills. The phrasing rehearses a well-worn "African women are victims, Western women have free choice" scenario. I realize that I am being provocative here, but I am hardly the first to make these links. A burgeoning literature has sprung up around the obvious policy contradictions, making visible what the discourse of choice and free will elides.[16] Labiaplasty with or without "clitoral de-roofing" fits well within WHO classifications of FGM/C as Type IIa, "removal of the labia minor only," and Type IIb, "partial or total removal of the clitoris and the labia minora." Though less commonly practiced, Type IIc, "partial or total removal of the clitoris, the labia minora, and the labia majora," is also performed as FGCS, the acronym for "female genital cosmetic surgery" now used industry-wide.[17] When these contradictions were brought to government attention in the United Kingdom in 2015, the home affairs select committee called for a tightening of the 2003 FGM law to cover all such "procedures which have no medical purpose" (Topping 2015). Regardless, women flock to surgeons, countless of whom advertise their techniques on the web. It is, after all, women's "choice."[18]

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16. This includes academic articles and journalistic reports. See, for instance, S.W. Davis (2002); Manderson (2004); Green (2005); Liao and Creighton (2007); Sullivan (2007); Kennedy (2009); Berer (2010a, 2010b); Braun (2010); Dustin (2010); Johnsdotter and Essén (2010); Whitcomb (2011); Ashong and Batta (2013); Baker 2013; Badham (2015); Holloway (2015); Topping (2015). Braun (2009) tackles the issue of choice head on; Conroy (2006) is a particularly useful intervention from a medical professional. See also Shweder (2016).

17. Dribben (2015) describes a labiaplasty in the United States that involved trimming the labia majora and the clitoral hood. For a recent summary of information about FGM/C (which does not include FGCS), see Shell-Duncan and Naik (2016).

18. The law in Canada places FGC under the criminal code (December 14, 2011) as aggravated assault, specifying that the terms "wounds" or "maims" include:

> to excise, infibulate or mutilate, in whole or in part, the labia majora, labia minora or clitoris of a person, except where (a) a surgical procedure is performed, by a person duly qualified by provincial law to practice medicine, for the benefit of the physical health of the person or for the purpose of that person having normal reproductive functions or normal sexual appearance or function, or (b) the person is at least eighteen years of age and there is no resulting bodily harm.

Key words here are the contingent "normal" and "resulting bodily harm." In the city where I live, cosmetic surgeons and cosmetic gynecologists routinely perform the "Toronto Trim."

It is crucial, I think, to ask, in any social context—where the desirable, the reasonable, and the thinkable are contingent on history, accepted practice, and pressures of family, peers, and the encompassing social milieu—what is entirely free about choice or will? Some may object that the operations referred to as FGM are performed on girls too young to protest, and I concede the point. Yet we must remember that our schooling as cultural beings starts at birth. I have recently viewed several (for me disturbing) web postings from very young American and Canadian teens telling of how they had begged their mothers to let them have a labiaplasty, and how thrilled they were with the results.[19] They no longer feel self-conscious or embarrassed; they feel "normal," just like other girls. The headline of a recent article in the Internet magazine *Vocative* reads, "Doctors warn that teen labiaplasty is on the rise" (Clark-Flory 2016). Biomedical labiaplasty has been performed on girls as young as ten, long before their genitals have fully matured (Liao and Creighton 2007; cf. Frauenhoffer 2015). Said one prominent surgeon to a writer with the online magazine *Guernica*, "I get a lot of young women brought to me by their moms. . . . It's always the moms who bring them in" (O'Regan 2013).

In late-twentieth-century Hofriyat, female normality was defined by a particular genital configuration produced by surgically reducing the labia minora, with or without reducing the clitoris, and shaping the labia majora so that they partially adhered. Girls underwent the procedure, locally known as *ṭahūr* or purification, at a young age, but always before pubescence. Medical midwives did the cutting and stitching, and typically performed the "modified" or "intermediate" (*mitwasiṭ*) procedure introduced in the 1920s by British instructors as an improvement on the more extreme "pharaonic circumcisions" commonly done at that time. Pharaonic circumcision (prevalent until the 1960s in Hofriyat) entailed excision of the inner labia and often the protruding clitoris, reduction of the outer labia, and infibulation, or all but complete closure of the vaginal orifice. It had shocked British officials, who were sure that it accounted for low birth rates in Sudan, hence a diminished pool of available "free labor," workers who were neither slaves nor former slaves but an incipient "free" proletariat (Boddy 2007). As more British professional women became involved in the colonial project, they undertook efforts to stop all but the least intrusive form of FGC (what cosmetic surgeons call clitoral "de-roofing" and some Muslim groups refer to as *sunna*) through education and legislation. Their efforts ultimately failed, yet the midwifery school's modified operation took hold. Entailing partial closure, it satisfied women's desire to have their genital area covered and the inner labia not protrude. When I began research in the rural north, women told me they underwent the procedure so as to make their bodies clean, smooth, and pure.

19. The ASAPS reports that in 2015, 4.6 percent of labiaplasties performed in the United States were on girls under age eighteen (ASAPS-Stats2015.pdf, p. 16). That figure represents an increase over 2014, at 2.9 percent (2014-Stats.pdf, p. 15). (Both downloaded from http://www.surgery.org/media/statistics, accessed September 26, 2016.) See also Conroy (2006); Boraei, Clark, and Frith (2008); Dorneles de Andrade (2010); O'Regan (2013); Dribben (2015); Clark-Flory (2016).

Juxtapose these observations to the following quote culled from a web blog posted in May 2013 by Alana Nuñez, a writer for the American magazine *Shape*:

> One procedure women keep requesting is the "Barbie," which can be performed two ways. One involves cutting a "wedge"-shaped piece of tissue from the central section of each inner lip and then stitching the two lips together for smaller inner labia. The second technique is trimming or amputating the entire labia minora. The end result is a smooth, unlined "clamshell"-type genital area in which the outer labia appear sealed together with no labia minora protruding. (Nuñez 2013)

The procedure was invented by Red Alinsod, a cosmetic surgeon in Laguna Beach, California, and refers, of course, to Mattel Co.'s ever-popular Barbie Doll™, whose plastic genital area is smooth and "clean," lacking even a slit or a tuft of pubic hair.[20]

> "Many of my patients want to achieve a clean, smooth look as they would with their face and underarms," explains Christine Hamori, MD, an ASAPS member [and colleague of Dr. Alinsod]. (ASAPS 2014)

The irony of the comparison is clear. But it is hardly fortuitous, in that a smooth, clean (and hairless) prepubescent look is, or at least was, idealized in both Sudan and the West.

Clean, smooth, and pure

Let me delve a little more deeply into the moral aesthetics of female circumcision in Hofriyat, which superficially at least resembles the Barbie aesthetic just described. Before I do, it is worth recalling that, as feminist theory teaches us, aesthetic conventions are never neutral, they are political. They are also strongly normalizing. As anthropologists well realize, power in all societies works, as it were, "from below," as selves are formed and bodies shaped in dynamic everyday relations among human agents, social institutions, cultural meanings, conventions, and constraints; in interactions between subjects and their humanly constructed environment of objects, spaces, and others: through practical engagement with the world (Bourdieu 1977, 1990; Foucault 1990). The "modern" disciplines and techniques of power identified by Foucault (1979, 1990) have nonbureaucratic parallels in quotidian social life, suffused as it is with what Comaroff and Comaroff call "power in the nonagentive mode." Nonagentive power "proliferates outside the realm of institutional politics, saturating such things as aesthetics and ethics, built form and bodily representation, medical knowledge and mundane usage" (Comaroff and Comaroff 1992:22).[21] Thus, as I have argued elsewhere (Boddy 1989, 1998), it makes better

20. "The Barbie" is an aggressive form of labiaplasty that results in "very tiny 'tucked-in' labia"; as Alinsod describes his technique, "I can remove all or almost all of the labia minora to be below the level of the majora and I call that a Barbie or Smooth Look." Alinsod at https://www.realself.com/question/seattle-wa-alinsod-technique, November 15, 2015, accessed September 26, 2016.

21. See also Giddens (1984) on "structuration," the intersection of structure and agency.

ethnographic sense to view FGC in Sudan as nonagentively embedded in everyday life than imposed by coercive agentive restraint. In the process of acquiring culturally appropriate aesthetic sensibilities, the social order is internalized "by the hidden persuasion of an implicit pedagogy" (Bourdieu 1990: 69), and power is embodied, made self. There are implications here for exploring the upsurge in demand for cosmetic surgeries in the West (Rodrigues 2012).

In what follows I contextualize the Hofriyati practice by mapping its cultural logic as I learned it the 1970s and 1980s, when consensual notions of propriety—purity, cleanliness, integrity, "closure"—governed behavior and ideals of physical form, architecture, foods, odors, and the objects of daily life. Tracing images of propriety through these disparate domains led to a horizon of intelligibility where ideological, practical, and sensory realms converged (Boddy 1989).

In villages and towns along the main Nile, girls and boys underwent genital operations at roughly the same age, in prepubescence, usually before age ten. The procedures respectively oriented children to their incompletely shared social world, establishing differences in their sensibilities and adult perspectives. A girl's body was feminized by the removal of boyish outer flesh, then enclosed by infibulation and the courtyard walls behind which the now mature female should remain. Her body was made clean and smooth (depilation and exfoliation by smoke bath completed the process when she became a bride); her womb was protected, unexposed. The boy's body was masculinized, uncovered, opened to confront the world. Each sex was made visibly distinct and socially complete by its respective operation. As with labiaplasty in the West, FGC in Sudan enforced strong heteronormative ideals. The Hofriyati female body, however, also became both metonym and icon for village society, guarded against external threat by her own scar tissue, household walls, and the defensive efforts of local men.

Indeed, infibulated wombs were analogous to houses in function and form. The men's door to the courtyard is called the *khashm al-bayt*, "the mouth of the house," a term that also refers to a man's descendants; a woman's vaginal opening is *akh-khashm al-bayt al-wilāda*, "the mouth of the house of childbirth." The front of the courtyard is the men's area and place where guests—strangers—are entertained; like the vagina, it is the part of the house (body) that is penetrable under controlled conditions from without. The house's protected inner part, its "belly" (*buṭon*), by implication its "womb,"[22] is women's domain, a private space where kin and close friends gather. The honor and integrity of the family were preserved when women stayed within courtyard walls and outside forces were kept at bay. Likewise, the in-marrying village, logical extension of the house, was safe, protected.

Infibulation, by enclosing the womb, contained and safeguarded uterine blood, the source of a woman's fertility and her village's wellbeing. Local concepts of procreation stipulated that a child's bones and sinew (hard body parts) are formed from the semen or "seed" of its father, while its flesh and blood (soft parts) are formed from its mother's blood. Such contributions were thought complementary, if differently weighted: flesh and blood are, after all, ephemeral, and bones relatively

22. Although the technical term for womb or uterus is *riḥm*, and has connotations of mercy (as in one of the names of ʿAllah, *Al rahman al rahīm*, The Most Merciful), in everyday parlance the more encompassing term *buṭon* (belly, stomach) is often used instead.

enduring even after death. Like the skeleton that structures the body, patrilineal descent structures human relations in a lasting way. While preferred marriages are patrilineally endogamous (to cousins within the father's line), in practice marriages traced through maternal kin are highly valued, even should prospective spouses belong to different local lineages. Indeed, relationships traced through flesh and blood, that is, through women, bind the village's skeletal (and inherently centrifugal) descent groups, providing connective tissue that will eventually succumb to entropy and decay unless renewed by successive intermarriages. The social body—the endogamous village—was thus also homologous with the physical one; both are virtuous entities.

Moving from the esoterically social to the practical and mundane, wombs shared qualities with jars used for mixing bread, *kisra*, the wafery sorghum pancake that is the staple in northern Sudan. *Kisra* in turn is analogous in composition to the body of a child. Just as a child is made in the womb from male seed joined with female blood, *kisra* dough is made by combining grain produced by male labor with water that women fetch from wells or the Nile. The vessel used for mixing *kisra*, a narrow-necked pot called a *gūlla*, often substituted for by a lidded enamel bowl (*korīya*), must be impervious, such that the contents cannot seep out when the batter is left to prove. In these features, and in its shape, women said, the *kisra* container resembled an infibulated pregnant womb.

It is a short step from these images to others involving food. Foods that are encased, such as eggs, tinned fish, and tomato paste, and fruits surrounded by rinds or peels are prized as "clean" and "neat" (*naḍīf*), for their enveloping layer conserves moisture and protects the contents from dirt. The adage "a Sudanese girl is like a watermelon because there is no way in" works on several levels at once: the enclosing rind guards both the seeds and the moist red flesh inside. Consuming clean foods such as these is said to "bring blood," thereby capacitating female fertility. Color is significant: Orange Pekoe tea, referred to as "doctor's blood," is highly recommended for pregnant women. Foods that are white are also regarded as clean and said to increase the body's blood; those that are both white and enclosed (such as eggs) are considered especially beneficial to women who wish to conceive.

These associations ramified: a fetus miscarried during the second trimester would be wrapped and placed inside a *gūlla*, like the unfinished *kisra* it resembled, then buried within the courtyard. The unmarked grave was typically dug near the kitchen, the women's area in the interior, or belly, of the house. Methods for handling other failed pregnancies are intelligible by this logic. A stillborn was wrapped as a corpse and buried along the outer wall of the compound just to one side of the men's entrance or "mouth of the house." As the infant's body had emerged from the metaphoric house fully formed (formed by the womb's internal heat much as *kisra* is baked by the heat of a woman's griddle in the belly of the house), it was laid to rest near the wall of the house/maternal body next to the orifice through which it had passed and its father (formally, legitimately) comes and goes. The path of the stillborn was arrested in the womb; s/he fell short of entering the world of other families, descent lines, and houses, for that requires breath, the obvious presence of a soul. Infants who breathe then die are buried like any other person, in the cemetery on the fringe of the desert beyond cultivated and humanly occupied space.

Such features of everyday logic—a logic of enclosure personified by the socially mature female body—situated infibulation in a cultural and historical order that made the practice thinkable, indeed doable. They suggested a world where meaning resides in qualities that bodies and objects share, where images do not reduce or condense to underlying truths but are themselves truths—self-referential, recursive, nonreductive. Here bodies and objects were iterative, inherently relational, implicating other bodies, objects, and humanly constructed space in an unremitting cycle of significance.

Undergoing infibulation viscerally oriented a girl to this specific "universe of probabilities" and significances (Bourdieu 1990). Through exposure to the connections immanent in the practical acts and objects of quotidian life, the meaning of her reshaped body was gradually built up and continuously revived. The routine tasks of fetching water or baking bread that girls assumed as they grew up, their everyday movements across thresholds, into a room or out of it, all reverberated with tacit meanings. They coalesced to identify her self with her fertility, the need to bear children in morally appropriate ways. They were practical metaphors by which subjective reality, anchored in pain and embedded in bodily memory, was periodically renewed. Women were asked to relive their traumatic experiences as they matured: actually, when their bodies were opened and reclosed with each delivery; vicariously, when they witnessed others' circumcisions and births; and symbolically, as they performed their daily routines. When social conventions are affixed to bodily sensibilities, the former—and the gendered power relations they imply—are rendered natural and unquestionably real. The very walls of a family compound, its layout, with women's quarters in the back, men's in the front, spoke to the woman of her body/self, for she was housed within her own "body" when she was bodily present in the house (Boddy 1998: 102). The congruity and interwovenness of ideas that identified infibulation with procreation and social wellbeing made them especially powerful, compelling, and politically effective. When I began doing research in Sudan, FGC was deeply rooted in villagers' world, as it had been when colonial officials first encountered it and began to work for change.

Colonial efforts

Seen ethnographically, female circumcision was not an obsolete or isolable "trait" that colonizers or their foreign successors could extract from its matrix like a rotten tooth or expect women to discard as "evil" on outsiders' advice. Nor was it separable from male circumcision, for the practices defined the genders in complementary ways. Yet to Europeans arguing from a scientific view of human anatomy presumed to be ideologically neutral and historically transcendent—unmediated, culture-free—the practices were wholly incommensurable. Male circumcision was seen as a minor procedure. That there was little outcry about unhygienic operations performed on Sudanese boys suggests that colonial interests lay less in the altruistic betterment of native health than with economic growth, discussed below—and since male circumcision is religiously required in Islam, with avoiding incendiary affronts to that faith.

The story of colonial attempts to convince Sudanese to quit FGC is complex (see Boddy 2007), and here I can address only a couple of points. The practice came to official (male) attention in the 1920s, when, as intimated above, a shortage of suitable labor to fuel economic development was attributed to low birth rates, and these in turn were blamed on near universal pharaonic circumcision in the Arabic-speaking north. While the belief that infibulation limits population growth has been shown to lack basis,[23] it seemed plausible at the time, as the practice can negatively affect a woman's reproductive health. Following the devastating loss of life in World War I and the influenza pandemic that ensued, international concern was everywhere focused on female reproduction, the politics of the womb. Comparatively little concern was raised regarding female sexuality, human rights, or the maintenance of bodily integrity, issues that became prominent in campaigns to end FGC from the 1980s on. This indicates why in 1920s colonial Sudan, infibulation was condemned as barbaric, but not so-called "simple clitoridectomy," the acceptability of which was eventually enshrined in law (Boddy 2007).

So repulsed were the British by infibulation that its meanings were hardly explored. Sudanese women were not consulted; its significance was gleaned from Sudanese men or merely assumed. The practice seemed utterly irrational: in all but closing the wombs of prepubescent girls, older women and men inflicted untold suffering on their daughters so as to control their sexuality and maintain family honor, while in fact compromising the very thing—fertility—they sought to protect.

Ina Beasley, Controller of Girls' Education in Sudan from the late 1930s through the 1940s, confessed "the difficulty" she and her colleagues had experienced "in trying to understand the mentality of people who could practice this human cruelty and yet be first-rate individuals in other ways" (Beasley 1992: 401). She repeatedly taught her pupils that "such operations are useless as a means of promoting chastity," a commonly invoked rationale, because virtue "can only be implanted by proper moral education and maintained by the individual's own conscious effort."[24]

23. While FGC may well contribute to individual fertility problems, Sudan has about the same infertility rates as other countries and a healthy growth rate, estimated in 2015 at between 1.7 and 2.2 percent, reflecting the segment of the population currently in their reproductive years (CIA World Factbook: Sudan, 2015: https://www.cia.gov/library/publications/the-world-factbook/geos/su.html, accessed September 26, 2016; World Bank: http://data.worldbank.org/indicator/SP.POP.GROW, accessed September 26, 2016). On average a Sudanese woman bears five to six children in her lifetime, according to the latest (2008) census records (UNFPA: Population Dynamics of Sudan, n.d., http://countryoffice.unfpa.org/, accessed September 26, 2016; World Factbook: Sudan, filemanager/files/sudan/facts/population_fact_sheet_final1-1.pdf, accessed September 26, 2016). For a counterargument suggesting that women who have undergone FGM/C are considerably more likely to experience difficulty and have poorer outcomes giving birth, see the WHO study authored by Banks et al., published in *The Lancet* in 2006. However, other scholars dispute the statistical significance of that study and regard its claims to be overblown (Public Policy Advisory Network on Female Genital Surgeries in Africa 2012)

24. "Female circumcision in the Anglo-Egyptian Sudan". E. D. Pridie, et al., Khartoum, 1 Mar., 1945, Sudan Archive, Durham University (hereinafter SAD) 658/9, p. 6, and Beasley's marginal notes in same.

Liberal notions of agency such as Beasley's were based on assumptions that human nature is inherently presocial; an individual can transcend her historical context and social training through an act of will. They acknowledged that selfhood is mediated by social relations, but not that these very relations, along with the humanly fashioned environment in which and through which they occur, actually produce the knowing self and the virtuous subject, if not in a self-conscious way. In other words, it was not within their purview to recognize that people, as Mahmood (2004) puts it, come to "inhabit" socially inculcated dispositions and values, and thereby produce themselves as subjects within the context of their own possibility. Given the individualistic stance of colonial officials, and their strong belief that British gender relations were "natural" and "normal" while those of Sudanese were anything but, it seems clear why early abolition efforts met little success.

Political efforts may have been stymied, too, by how British midwifery instructors taught the human body in ways that implicitly, if unintentionally, affirmed the value of infibulation. The women who founded Sudan's first midwifery school were sisters, Mabel and Gertrude Wolff. Knowing that native birth attendants also performed female circumcisions, the Wolffs took a pragmatic stance. They did not support a peremptory ban on the procedure but, controversially, taught a less damaging operation using sterile implements, local anesthetics, and antiseptic solutions. In this way they hoped to "reduce harm," and gradually bring about abandonment of genital cutting as Sudanese became better educated. Because few midwifery trainees were literate, the sisters elected to work with rather than against local knowledge, taking heed of pupils' experiences and invoking their embodied memories. They used images that first summoned, then attempted to revise women's cultural dispositions. They taught in Arabic, incorporating words from "women's vocabulary."[25] They built discursive bridges between local understandings and their own by creating scientific analogies to the objects and acts of Sudanese daily life with which women's bodies are metonymously linked, though whether they grasped that relation is not clear from the evidence at hand. By these means they devised an ingenious and powerful synthesis of biomedical and lay techniques that bent to local practice even as they strove to undermine it. The strategy of linking lessons to women's daily lives was hardly novel or unique, but may have complicated the sisters' aims. For instance, in a report about her first year's work, Mabel Wolff wrote,

> I illustrate by local colour all their lectures as I find they understand and assimilate them better,—viz. in giving them an anatomy and physiology lesson I compare the body to a house and the organs [to] the furniture—the functions of the lungs as windows that air the house etc. etc.[26]

She lectured, "the body resembles a furnished house and all the contents have a special use."[27]

25. "Elementary practical lessons for midwives of the Sudan," n.d., SAD 581/5/5.

26. M. E. Wolff, Speech to the Committee of the Guild of Service, 1922, SAD 579/3/29.

27. "Elementary practical lessons for midwives of the Sudan," n.d., SAD 581/5/8.

Did her students feel a surge of recognition? Clearly these were analogies they could understand, a native "house" being homologous not just with the human body in local thought, but with an infibulated female body at that. The Wolffs did not invent this association but, unwittingly perhaps, invoked it. Student midwives may well have gleaned from classroom images that their much maligned "commonsense" was more scientific, hence less barbaric, than they'd been told. But to the Wolffs any resonance between local ideas and biomedical constructs was heuristic, not sincere. Their mission remained uncompromised: to substitute rational science for harmful cultural practice and fallacious belief (Boddy 2003, 2007).[28]

The Wolffs' lesson book advised, "Should a midwife do circumcisions . . . she must perform the operation with all cleanliness just as she would a labour case, and attend the case daily for seven days, or more if necessary, in order to avoid infection of the wound."[29] Though clearly beneficial, such counsel insinuated biomedicine into local practice, thereby wrapping "tradition" in biomedical mystique, lending it new authorizations (though it needed none), and fostering syncretisms that seemed likely to ensure the custom's resilience.

Recall the practical logic of enclosure that informed infibulation in Hofriyat while reading the following passage from the Wolffs' lesson book:

> Most illnesses are caused by the entrance into the body by way of the mouth [*khashm*], the eyes, the nostrils, through the skin or a wound (or ulcer) of minute living things which cannot be seen except under a microscope. Just as there are a great variety of insects and seeds, so there are microbes. . . . There are microbes that will turn milk sour and meat putrid and food poisonous, but if food is sterilized and *kept in sealed tins*, the microbes cannot penetrate and the contents such as tomato sauce, milk, sardines and numerous other foodstuffs, will keep good for long periods but as soon as the tin is opened microbes get on the food and it will soon be poisoned and unfit to eat.
>
> If our bodies are healthy and strong like the sealed tins, the microbes cannot harm us, but if microbes get a hold of us, they may give us some illness according to what microbe has infected us.[30] (My emphasis)

Such analogies made perfect vernacular sense.

Khartoum

Let me now shift to my recent research with several Hofriyati families who have relocated to Khartoum. Again it's a complicated story, and I have not yet finished the work, but some prominent issues have emerged. Several urban Hofriyati families have elected not to have their daughters cut, or even to have them undergo the milder "*sunna*" intervention of removing the clitoral hood. There appear to be several reasons for this, important among them a greater awareness that genital

28. See also Bell (1998) on the Wolff sisters and their methods.

29. "Elementary practical lessons" for Midwives of the Sudan, SAD 581/5/13.

30. Ibid., SAD 581/5/16.

cutting is not unanimously sanctioned by Islamic scholars. But that is not the whole of their rationale, and to explore it further requires us to consider implications of the current political economy for gender relations and health.

Beginning in the late 1990s with the discovery of oil reserves, Sudan's economy began to improve after years of decline. By 2003, negotiations with the International Monetary Fund had produced a reformed banking system, restructured taxes and tariffs, and privatized social services, including and especially healthcare. The stage was set for oil revenues to flow when the decades-long civil war between the Islamist government in Khartoum and the secularist/Christian south was brought to an end. In 2005, the Comprehensive Peace Agreement was signed, allowing international access to oilfields at least until July 2011, when the independence of South Sudan was declared. Between those years, when north–south power-sharing accords were in force, rising fortunes tempered the state's Islamic zeal and lightened the atmosphere in the urban and rural north. Women could go bareheaded in public without fear of official censure, though most Muslim women still modestly covered their hair.

Oil exports sent the economy soaring in 2006, 2007, and the first part of 2008, with GDP growth at almost 10 percent per year.[31] During the monetary crisis of 2008, growth declined but did not stall, hovering around 5 percent per year. Though Sudan fell into recession after the split with South Sudan, it is now beginning to recover lost ground. In 2015, GDP was estimated to have grown by 3.5 percent.[32]

During the oil boom, roads were laid to connect once remote parts of the country, and a new mega-dam was built on the main Nile to provide hydroelectric power to the north. Private capital, imported foods, electronic equipment, and all manner of Chinese goods rushed in. Universities were built or extended in most major towns. Automobiles, once closely regulated, were suddenly widely available for purchase by bank loan, with interest. So too were cell phones and satellite-fed TVs. Peace, growing prosperity, and the relaxation of government controls led to greater possibilities for some, but increased precariousness for many, in part because of shifting consumption patterns and new ideas about what constitutes a normal life.

For decades, Hofriyati and other Arab Sudanese have placed a high value on educating girls. This concern waned after 1989 during the first years of Islamist rule, but as state restrictions on women's deportment relaxed, it revived. Economic growth helped produce an emergent bimodal attendance rate at high schools and universities (Sudan Government 2010; CRIN 2011), that is echoed in other parts of the world. These days, more young women than men are enrolled in post-secondary

31. EconomyWatch: http://www.economywatch.com/economic-statistics/country/Sudan/, based on sources from the IMF, World Bank, UN, OECD, and CIA World Factbook, retrieved September 16, 2015; CIA World Factbook, Sudan: https://www.cia.gov/library/publications/the-world-factbook/geos/su.html, updated August 24, 2016, accessed September 26, 2016.

32. CIA World Factbook, Sudan (as note 31).

institutions, and it's rare for a Hofriyati family not to have a daughter who is studying at a college or university or has recently graduated from one.[33]

The cell phone is a contributing factor here: with it, parents and brothers feel they can monitor a young woman and ensure she is safe when outside the home, even when attending a coeducational school (Boddy 2016, and in press). Moreover, so few men now enroll in university that coeducation has become a moot point. If the graduation ceremony I attended in January 2010 at the Sudan University of Science and Technology is any indication, less than a fifth of university students today are male, a figure anecdotally confirmed by students at the University of Khartoum in 2015.

I was repeatedly told that that fewer young men continue to "read" because they need to work for pay, so as to contribute to their parents' household expenses, subsidize their sisters' educations,[34] and accumulate savings toward their own future marriages. Some young men take on several jobs in order to make ends meet. Thus more twenty-something Hofriyati daughters than sons have university educations, but few of either are married or permanently employed. An increasing number remain with their natal families and participate in the grey economy through which goods and services are distributed via domestic extensions of the market, among family and friends. This situation has been contributing to some intriguing shifts in the realm of marriage and family life (Boddy 2013, 2016, in press).

Typically, men must work for many years before they can afford to marry. The price of a modern wedding is high: unless a prospective couple are very close kin, the groom's parents are wealthy, or the bride-to-be is particularly religious and agrees to modest proceedings, it can cost tens of thousands of Sudanese pounds. The expense is all but fully borne by the groom and his kin.[35] The typical age gap between bride and groom has thus widened, with men typically marrying between their mid- to late thirties and early fifties, and many women between their late twenties and early forties.[36] As more consumer goods become available, expectations rise as to what a proper wedding should entail and the time it takes to col-

33. On female-to-male enrollment ratios, see http://www.uis.unesco.org/DataCentre/Pages/country-profile.aspx?code=SDN, accessed September 26, 2016. For a somewhat less rosy picture that nonetheless shows higher female university attendance than male, see Nour (2011).

34. This is in part so that their sisters can attract well-educated husbands, and elevate the family's status.

35. Singerman (2007) notes that in Egypt, where comparable conditions prevail, a man's wedding may cost the equivalent of his entire earnings *and* those of his father for a period of five to seven years (see also Malmstrom 2015; Schielke 2015). Yet in Cairo the bride's family can be expected to pay about a third of the wedding costs (Singerman 2007), far more than is the norm among Hofriyati in Khartoum.

36. There are exceptions to this trend, which may constitute a backlash against the precariousness and costs of the marriage system. Recently some farming families in the village of Hofriyat have married their daughters and sons before either had competed high school. In the last five years, some urban Hofriyati parents have agreed to polygynous first marriages for their teenaged daughters, fearing that if they waited for an ideal

lect the needed funds is increased. Young men generally seek work abroad, where wages, although perhaps low, are nonetheless paid in foreign currency, providing a hedge against the unstable Sudanese pound as well as domestic inflation rates that currently hover around 16.5 percent.[37] Those who cannot leave the country see the buying power of their earnings diminish year by year. This too is contributing to ever-later marriage. Moreover, while marriages in the past were almost always arranged by a couple's parents, today single women seek companionate spouses of their choice; several have successfully eluded "good" matches arranged by kin (Boddy in press).

Ubiquitous satellite TV has fueled local aspirations on this front: characters in American films and serials from Egypt and Turkey have become role models for Hofriyati girls. New terms, such as "love story" and *djikies*, from the English slang word "chicks," have entered everyday speech, referring to romantic heterosexual relationships based on mutual attraction and care. As state morality monitoring eased, one began to see couples walking side by side in city streets or sitting together in cafés—acts formerly punishable by imprisonment or the lash. While waning surveillance and the flood of foreign images have helped ease cross-sex relations, the protocols of television viewing have contributed as well.

Satellite TV has reshaped domestic space. Televisions are communal objects; only better-off Hofriyati households boast more than one set. Women and men of all generations now watch together, in the same room, even if they are not immediate kin. Exposure to standard broadcast Arabic streamed throughout the Middle East has been eroding formerly marked distinctions between men's and women's speech while drawing together male and female worlds. But if TV engenders communal experience, the effects of cell phones are less clear.

Mobile phones are individual means of communication, plentiful and relatively cheap, and in constant use by women and men regardless of age. Although Internet videos and Facebook posts may be widely shared among family and friends, cell phones have also fostered new sensibilities of intimacy, privacy, and secrecy, especially among younger Sudanese. Courtyard walls are no longer obstacles to cross-sex communication. So as to maintain personal space should a parent find a phone unattended, Hofriyati daughters regularly delete records of incoming and outgoing calls and use the phonebook function solely for family-approved contacts (Boddy 2016). Combine this with greater opportunities for youth to meet, and it is hardly surprising to learn that unwed pregnancies are on the rise.

A pregnant girl has few options: abortions are illegal and risky to procure. It may be possible to disguise her condition under loose-fitting clothes, and kin may be willing to help until the birth. But the appearance of a newborn in the family may be difficult to explain, and infants are being abandoned on public buses, beside busy roads, and on the steps of mosques in ever higher numbers, averaging 110–20 per month in Khartoum alone (Goddard 2007; UNICEF Sudan 2007;

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match their daughters might never wed. See Boddy (in press) for more on contemporary marriage and age issues in Sudan.

37. For the latest 2016 inflation rates, see http://www.tradingeconomics.com/sudan/inflation-cpi, accessed September 26, 2016.

WUNRN 2007; Al Jazeera 2009). In February 2016, Maygoma, Khartoum's foundling orphanage, had to close its doors as it had no more room. Needless to say, the situation is one of grave public concern (Boddy in press).

On the other hand, since so many people are formally marrying later in life, more couples are failing to conceive within the expected first year of marriage.[38] In vitro fertilization offers a remedy permitted under Islam (Inhorn 2004, 2006) and several IVF clinics have sprung up in Khartoum over the last half-decade. But the costs, again, are high—at least US $5000 per attempt—and few couples can afford it. Faced with these compound pressures, the government declared that foundling adoption is an honorable and charitable act and smoothed the way for prospective foster parents to receive a child (Goddard 2007; Polgreen 2008; Sudan Government 2010; Boddy in press). Still, Islamic modesty and inheritance protocols, together with a strong social stigma attached to adopting nonkin, let alone those of illicit liaisons, prevent this from being an ideal remedy for childlessness (Boddy 2013, in press; see also Bargach 2002; Inhorn 2004; Mattson 2008). As Marcia Inhorn (2006: 95) notes, Islam "privileges—even mandates—biological descent and inheritance. Preserving the 'origins' of each child, meaning his or her relationships to a known biological mother and father, is considered not only ideal in Islam, but a moral imperative."

The economic exigencies of late marriage and problematic fertility, together with the demand for biological offspring, are shaping the context in which the practice of FGC is being rethought, and at least some Hofriyati no longer allow it to be done. The explicit reason for stopping, they say, is that FGC causes health problems. This knowledge is not new: Hofriyati said as much to me in the 1980s, yet insisted that because *ṭahūr* created aesthetically and morally proper female bodies, they would continue to practice it despite the negative effects that might ensue. Indeed, infibulation was considered to promote health by hastening maturation in a sickly girl. So what has changed? For one thing, biomedicine has become the first and most acceptable resort for people seeking solutions to health concerns of all sorts. In the past, women having fertility problems or domestic difficulties might suspect themselves possessed by *zayran*, *zār* spirits, and consult a ritual specialist in an effort to obtain relief (Boddy 1989, 2013). But Islamist suppression of the *zār* as a heretical cult appears to have borne fruit. It is certainly possible that the displacement of *zār* as a remedy for fertility trouble has increased women's dependence on biomedicine. The rise of IVF clinics is a case in point, though I know that some women undergoing fertility treatment also consult popular Islamic healers who appeal to *zayran*. Still, the current ambiance of "rationality" and anti-"superstition" in Sudan has been influential in persuading some Hofriyati to abandon FGC.

Medical education programs on Sudanese TV have spread the message that FGC is harmful to women's health. Such shows are popular with Hofriyati women, who bear primary responsibility for the reproductive success of their marriages

38. During an interview in February 2016, doctors at a prominent fertility clinic in Khartoum told me that male infertility is increasing. They attributed this to age, occupation (especially driving a three-wheeled taxi or an *amjad*, a small van also used as a taxi, as in both vehicles the driver sits atop the engine), and exposure to pesticides (the use of which has grown dramatically in Sudan over the past two decades).

and for family wellbeing. Women tune in to learn about treatments for common complaints such as "lazy colon," hemorrhoids, diabetes, or hypertension, and are hearing about FGC in this context. Yet the practice has long been medicalized; in the 1920s, recall, the Wolff sisters introduced biotherapeutic methods to the traditional cutting, suturing, and aftercare of girls. Women are therefore accustomed to think about the procedure in medical terms, just as they also regard pregnancy and birth as needing medical intercession. Although information on FGC's harmfulness aired on radio in the past and is widely taught in schools, I suspect that the visual immediacy of respected male doctors discussing the practice on communally watched TV is having a greater effect in getting women and men to discuss it.[39] While the WHO has long advocated against (further) medicalizing FGC lest embedding it in a biomedical context ensure the custom's persistence, ironically, and contra to WHO expectations, colonial era medicalization may be contributing to its present demise. Hofriyati now view the practice in terms of women's health, biomedically defined, and are increasingly prepared to rethink their gender aesthetics, or, perhaps, to link these strands.

In light of all this, a key factor convincing families to heed medical counsel against the practice has been the state's partial withdrawal from the medical arena. Under structural adjustment initiatives, as well as continuing high levels of military spending, public funding for healthcare has been slashed. In the 1980s medicine was fully socialized, with private consultations available after-hours. But today few services are funded solely by the state, most are privatized, and even government-supported hospitals and clinics require fees for use. The majority of pensioners and the formally employed have private health insurance that provides family coverage, yet even those lucky enough to have such plans complain that they pay less than half the expense of a hospital stay, operation, or course of prescription drugs. Accidents, catastrophic illnesses, and chronic ailments such as the ubiquitous diabetes and hypertension put inordinate strains on meager budgets and require contributions from the broadest networks of kin. Indeed, the emergency medical demands of kin often stymie or postpone young men's marriage plans. If practicing FGC causes problems for the health of girls and women that could drain family resources, it now makes economic sense to stop. While not the only reason for the decision, financial worries are a contributing factor given the escalating costs of living, making a family, and enabling social continuity. FGC is slipping out from under the aegis of morality, just as, perhaps, the once "enchanted" female body is falling increasingly under biomedical purview (Boddy 2013). Absurdly, of course, this is happening just as the enchantedness of biomedicine is revealing itself in the expansion of nonmedically necessary cosmetic procedures such as labiaplasty in the West and beyond.

39. By comparison, the human rights approach to abolishing FGC has not gained traction among Hofriyati, its presumption of radical individualism making little sense to the women with whom I work. It is true, however, that young women who regularly watched Oprah Winfrey on TV have been exposed to Western condemnation of FGC, and many now refer to it as "FGM" (though whether they comprehend what the acronym stands for, I can't say).

The upshot

The recent and growing popularity of labiaplasty and other procedures under the rubric of FGCS vividly exposes the similarities between "us" and African "Others," however much hegemonic discourse obfuscates such correlations and physicians flat-out deny them (Dalal 2014). Respecting contextual differences, practices that bring the female body to accord with an elusive ideal of womanhood in Hofriyat formally parallel the normalizing disciplines of Western, indeed global, femininity. Both derive from a presumption that female bodies are in need of improvement and continuous monitoring; both enlist women as agents of their self-modification and enjoin them to self-surveillance and restraint; both work to instill in women a desire to conform, to become who and what they "ought" to be (Boddy 1998; cf. Bordo 1993). My aim here is not to trivialize FGM/C, but to detrivialize and expose as equally political—equally subordinating and, in Foucault's sense, productive; equally worthy of critique—practices of Western femininity such as FGCS. If Western women and men resist placing their cultural practices in the same light as those of Sudanese and other African groups, and insist on seeing in the latter a form of violence absent from their own, this is because Africa remains for them a locus of the aberrant and exotic, in terms of which they are oppositionally defined. Hofriyati gender constructions are distanced from "us" in abstract time and space (Fabian 1983) in ways that our own are not, and perhaps, because they are taken for granted, can never be (cf. Bordo 1993: 50; see Gunning 1992; Hale 1994).

Yet it's clear in the hard light of day that the notional gap between "us" and "them" can no longer be sustained. Here is why. First, the Internet knows few bounds. Spicy music videos and pornography created in the West circulate globally and are now commonly seen in Sudan, where porn DVDs can be rented from tobacco kiosks, or films watched online for as little as one SDG per day—about sixteen US cents at official rates of exchange, far less at black market rates. According to instructors at Ahfad University for Women in Omdurman and several independent scholars in Khartoum, Western porn is commonly watched by both women and men, alone or in sex-exclusive gatherings. In 2014 I attended a lecture at a public elementary school in a poor neighborhood of Omdurman warning children against watching *aflam sex* (sex films) on the net. One must therefore presume that Sudanese are exposed to the same images of hairless, surgically reduced, or photoshopped female genitalia that are compelling young Western women to question their normality.[40]

Second, and in troubling consequence, though fewer young Sudanese women have undergone "traditional" FGC than ever before, gossip and rumors abound of husbands sending their uncut brides home to their mothers, asking for them to be fixed because their bodies don't look right. This, presumably, is because Sudanese men's experience of women's naked bodies and their notions of normality, like those of Western women seeking labiaplasties and of their husbands and boyfriends who encourage them to go, have been shaped by the biomedically or digitally altered "closed" and "smooth" ideal.

40. See also Malmstrom (2015) and Schielke (2015) on the circulation of pornography in Egypt, where it is also viewed by both women and men.

Whether or how often this actually happens in Sudan seems irrelevant: the message is there. Western-led international efforts to convince Sudanese, Somali, and other African women and men of the propriety of the "natural," uncut vulva so as to reduce women's suffering and perhaps save lives comes to naught in a world where hegemonic images of idealized altered women's bodies circulate unimpeded. How long before these "new" cosmetic surgeries are widely available in Africa? They are already on offer in Ghana, Egypt, and South Africa, after all.

The anthropologist in me savors the tidy exposure of biomedicine's cultural construction in this case, and decries the hypocritical narrative of African barbarity that persists in the righteous West. My feminist side is not too surprised by the strong similarities between idealized women's bodies in late-twentieth-century Sudan and the early-twenty-first century West, even down to the words—clean, smooth, modest, invisible, closed—used to describe them. The politics of aesthetics are subtle and hard to withstand. Yet there is something even more troubling about the convergences and contradictions outlined here. For they expose the multiple ways that techniques and concepts of the gendered body linked to global neoliberalism saturate the most intimate levels of human life in the twenty-first century, no matter who we are or where we live.

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Le normal et l'aberrant au sujet de l'excision féminine: Paradigmes changeants

Résumé : Dans ce cours, je présente les résultats préliminaires de mes travaux en cours au Soudan, tout en revenant sur une de mes observations dans le passé au sujet de l'ablation génitale féminine au Soudan à la lumière de la pratique de plus en plus fréquente de la chirurgie esthétique génitale féminine en Occident. En dépit de similarités frappantes au niveau de leurs rationalisations esthétiques, cette pratique se repend en Occident tandis que les pratiques d'excision Soudanaises "traditionnelles" demeurent un sujet de censure et de campagne internationale d'abolition. Au moins l'une des procédures, la "Barbie," résulte au même résultat excision traditionnelle. Plusieurs familles Soudanaises avec qui j'ai mené des recherches ne pratiquent plus l'excision féminine. J'examine les raisons de ce choix en parallèle avec les raisons justifiant la chirurgie esthétique génitale en Occident, et l'ironie du sort qui associe ces deux contextes.

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