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## **Women in Transition: Resisting Female Genital Cutting (FGC) in Egypt**

In the past, women were expected to undergo Female Genital Cutting (FGC) because they weren't educated. But now, I, for example, didn't perform FGC on my daughter because I knew from a very early age in primary school that it is not good for a girl. People tried pressuring me to perform FGC on my daughter but I knew better.

*A mother from rural Sohag*

In the past, girls would get cut by a *daya* (traditional birth attendant). And they would tame the wound by placing oven dust over it. Now, the procedure is safer and less painful as it is done by a doctor. They use aesthetics so the girl doesn't feel a thing.

*A young women from urban Al Gharbeya*

## **Background**

Female genital cutting (FGC) continues to be a widespread practice in Egypt. FGC is defined by the World Health Organization (WHO, 2008) as “all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons”. The practice is known to lead to negative health consequences including severe pain, shock, excessive bleeding, urination problems, psychological consequences, and, in some instances, death. Although FGC among girls 17 years of age and younger decreased by 10 percentage points between 2005 and 2014 (El-Zanaty & Way 2006; MoHP, et al., 2015a), its prevalence remains at 92 percent among ever-married women ages 15 to 49 (Ministry of Health and Population, El-Zanaty and Associates, & ICF International, 2015a). Moreover, the proportion of ever-married women who support FGC decreased by only four percentage points between 2008 to 2014 (MoHP, et al., 2015a). Alarming, data from the 2014 Survey of Young People in Egypt (SYPE) indicate that seven out of 10 young people ages 15 to 29 years planned on having their daughters undergo FGC in the future (Roushdy and Sieverding, 2014).

Data have also shown that FGC is increasingly being performed by medical practitioners (e.g. physicians and nurses), highlighting the medicalization of a cultural practice that has traditionally been performed by traditional birth attendants and lay women in the community. Medicalization is “a situation in which FGC is practiced by any category of health-care provider, whether in a public or private clinic, at home, or elsewhere” (WHO, 2010). The rates of Egyptian girls and young women (ages 19 years and younger) who underwent FGC by a doctor or a nurse rose from 55 percent in 1995 to 81.9 percent in 2014 (MoPH et al 2015b), making Egypt the country with the highest prevalence rate of FGC being performed by medical practitioners (El-Zanaty et al 1996; UNICEF 2013). This increase could be attributed to a 1994 medical decree issued by the Ministry of Health and Population (MoHP) that allowed FGC to be performed only by physicians in designated facilities (mainly public hospitals) at fixed times and cost (Shell-Duncan 2001). The decree was initially issued with the intention of reducing FGC complications and, eventually, ending the practice. However, this did not take place and civil society and international actors pressured the Ministry to reissue a ban on the practice in all hospitals a year after (Barsoum et al 2011). Subsequently, deaths of girls who underwent FGC in hospitals led to the criminalization of the practice in 2008 and the toughening of the law in 2016 (Amin, Moety & Sabry 2017).

Campaigns to abandon FGC in Egypt in the 1990s primarily highlighted the immediate health harms of the practice and may have partly contributed to the rising medicalization of FGC. A qualitative study highlighted that the main reason for mothers’ decision to seek medical FGC for



their daughters was that medical professionals had better training and knowledge about performing FGC and, consequently, girls faced lower risks of health complications (Modrek & Sieverding 2016). The medicalization of the practice has contributed to portraying it as a modern and safe practice as long as it is performed by a medical practitioner. This situation lends itself to an analysis of FGC medicalization through a modernization theory lens. Modernisation theory predicts that as a society modernizes (by improved education, and increased wealth, urbanity, and access to modern media), harmful traditional practices like FGC would be gradually abandoned. We examine whether the “modernization” of FGC through medicalization constitutes a form of gendered resistance. Alternatively, we pose the question whether “modernizing” FGC as a procedure that is performed by medical professionals allows it to persist and weakens gendered resistance against it.

### **Study Objectives**

Utilizing mixed quantitative data (EDHS) and qualitative data gathered as part of a Population Council study on social marketing approaches pertaining to FGC in Egypt, we explore women’s FGC practices – abandonment altogether versus medicalization – through a modernization theory lens, analyzing how practices and perceptions contribute to variations in forms of gendered resistance. By gendered resistance we mean the measured and subversive solutions devised by women to emancipate themselves one way or another from prevalent gender norms. We operationalize modernisation through three proxy indicators: education, wealth, and urban place of residence. In the following sections, we describe the conceptual framework guiding our analysis, the methodology of the study, and the results of analysis of quantitative and qualitative data.

### **Conceptual Framework: Modernization, Development and Gender Equality**

The classical theory of Modernization was developed by American social scientists to study problems and find solutions for underdeveloped countries in the post-war period. The theory was first created in the 1950s as an explanation of how the industrial societies of North America and Western Europe developed and how the underdeveloped should exhibit the same pattern towards development (So, 1990). Development under the modernization theory is viewed as the reliance of the “Third World” on external loans and aid to transform traditional institutions (Levy 1967). In other words, it is defined as the process of a nation’s transformation from a traditional society to a modern one and has its roots in the ideas of linear progress whereby societies develop in fairly predictable stages from simplicity to complexity and from homogeneity to heterogeneity. In this sense, the “traditionality” which the “underdeveloped” world holds acts as an impediment to

progress and thus, modernity is the desirable model to remove all the barriers to development and growth (Raj 2014). Naturally, modernization has been critiqued as reflecting a colonial and presumptive superiority (Phillips 2018).

Modernization theory draws a clear distinction between what is “traditional,” which is always to the disadvantage of Western ideals, and what is “modern” that underdeveloped nations ought to follow (Chakrabarty 2000). Less fully rehearsed is how gender figures into the modernization paradigm, which is clearly not gender-neutral (Hooper 1999). With its focus on individualism, the theory suggests that individuals are given the autonomy to take decisions based on equal communication and establish mutual respect. It, thus, indicates that a trickle-down effect<sup>1</sup> will take place for women, where by they will attain power and independence through employment and such individualism eventually will help promote gender equality and eradicate violence against women (Giddens 1990; 1991; 1999; Ahlberg, Roman & Duncan 2007).

Modernization has been critiqued by feminists as reinforcing masculinity by highlighting the dualist existence of reality and creating dichotomies between modern versus traditional; public versus private; and rational versus conservative. The theory, thus, relates masculine traits to the public sphere where individualism, independence and impersonality are best displayed. On the other hand, feminine traits are more linked to the private sphere as it portrays “traditional”, dependent and personal traits. In other words, masculine traits are valued and feminine ones devalued under the modernization theory (Hooper 1999).

The two main indicators of modernisation are education and employment (Inglehart & Norris, 2003), although wealth, age, gender, religiosity, use of modern media, and urban/rural place of residence (Martinez & Khalil 2012; Stockemer & Sundstrom 2014).

### **Modernity and the Medicalization of Reproductive Healthcare**

Women’s reproductive lives became increasingly medicalised during the twentieth century in the Western world (Greil 1991) where medicine expanded to encompass outcomes related to the body which were not defined previously as medical issues, such as menstruation, child birth, and, in this case, FGC. Women are currently embracing modern technology in various forms of reproductive health, particularly in childbirth where caesarean section birth (c-section) has become the most common medical intervention. Assistive technology is said to provide women with a sense of safety Kohler Riessman (1983) and Illich (1976), and is portrayed in the medical profession as effective

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<sup>1</sup> Women will gradually experience gender equality as a result of the increasing individualism amongst men.



and valuable. Based on this, women rely on the medical profession to avoid “risks” and achieve safety during the process of giving birth (Giddens 1991).

On the surface, the rise of medicalisation in reproductive health care is generally perceived as giving women a higher sense of control. According to two studies that examined c-section births in the USA and Turkey, middle-class women believed that c-sections gave them control and empowerment. Yet, feminist writing have vehemently criticized the medicalization of the birth experience as causing women’s loss of authority and autonomy over their bodies (Floyd 1994; Cindoglu & Sayan-Cengiz 2010). Moreover, feminist writers highlighted that the shift to medicalisation is for women’s bodies to be controlled and subjected to a patriarchal medical profession. According to Levy (1992), women’s medical treatment is highly connected to ideas around the inferiority of women’s bodies: "Women enter the medical system as patients, defined as ill and in need of care, no matter how normal their conditions are" (p. 93). Therefore, pregnancy is being defined as an abnormality which reflects that women are victims of their own reproductive system and, thus, constantly need medical intervention.

Medicalization has also been described as dehumanizing. Levy (1992) highlights, “it objectifies people by treating them as machines in need of repair. The mind and spirit are separated from the body by an institution that is only interested in physiological processes. Through specialization, medicine focuses on increasingly smaller areas of the body, thus fragmenting care”. With such fragmentation, an increased sense of alienation from one’s body is experienced. Williams and Calnan (1996) explored this matter in their paper where women’s experience of childbirth was described as alienating given that they were coerced into using obstetric techniques without fully understanding what risks they are mitigating by using them or why they are using them in general. This creates a sense of estrangement between women and their bodies/ reproductive lives.

The question we raise here is whether women who actively seek medical intervention in the case of FGC become empowered or disempowered as they intend to reduce the medical risks of this practice but do not abandon it altogether. There have been accounts that reveal the reliance of Egyptian women on medical practitioners to decide whether a daughter is in need of FGC or not, which lends itself to the rhetoric of subordination and deformity (Modrek & Sieverding 2016). Another study carried out by Nina Van Eekert, Els Leye and Sarah Van de Velde (2015) where being more educated and a member of a wealthier household increases the likelihood of a mother opting for a medical practitioner to perform FGC on her daughter.

## **FGC and Modernity**

According to the modernization paradigm, one would presume that there is a linear link between modernity (assessed through social status measures) and FGC abandonment. However, women's decisions related to FGC can follow different pathways, one of which is medicalization rather than abandonment. Given that Egyptian women are located in communal rather than an individualistic context makes the adaptation of modernity challenging. Therefore, improvements in social status (i.e. education and employment) and attitudes (intention to abandon) may be insufficient as decisions cannot be made in isolation from one's social environment (family, peers, and society).

Therefore, the decision-making process is believed to be more complex and does not only involve the mother alone but other family members as well (father, grandmother, etc.). The extent to which a women's opinion weigh in on the decision regarding FGC is unknown as it may indeed depend on her social status but also depends on her position within the family and the community. A mother may oppose having her daughters undergo FGC, but given her limited "power" within the family may neither be willing nor able to influence this decision.

## **Methodology**

This is a mixed methods study comprising of (1) analysis of quantitative nationally representative data (Egyptian Demographic Health Surveys, EDHS); (2) analysis of primary qualitative data gathered in Cairo, urban and rural Gharbeya (a Lower Egypt Governorate) and urban and rural Sohag (an Upper Egypt Governorate). The qualitative component of the study relied on mothers' and young women's perceptions of FGC, utilizing data from five focus group discussions (FGDs) with mothers of girls at the age of FGC (10-14 years old) and five FGDs with female youth aged 18 to 24 years. This study was initially designed by the Population Council in 2016 to explore people's perceptions of FGC abandonment campaigns and the extracted data was reanalyzed to explore the objectives of this paper.

For the quantitative component of the study, we analysed secondary data from the 2005, 2008, and 2014 EDHS. The EDHS is a nationally representative survey of health and welfare indicators pertaining to ever-married women ages 15 to 49 years and their households. The number of women in each dataset is: 19,474 in 2005, 16,527 in 2008, and 21,762 in 2014. We specifically assessed the practices of mothers of girls ages 15-24 (performed FGC and whether medicalized or traditional)



and intentions of ever-married young women (ages 18-24) (to perform FGC on their daughters or not). The data was analyzed for the purpose of this study using STATA.

The original qualitative study organized two types of FGDs in Cairo, Gharbeya, and Sohag, 10 FGDs with mothers of girls ages 10 to 14 years and 10 FGDs with female youth (18-25 years of age). Ethical permission to conduct the study was provided by the Population Council's Institutional Review Board (IRB) and a local IRB in Egypt. The FGDs with mothers included eight to ten participants per group. In Sohag and Gharbeya governorates, FGDs recruited an almost equal number of participants between rural and urban areas. The study was limited to women with at least some elementary schooling who were exposed to at least one FGC abandonment communication campaign.

## **Findings**

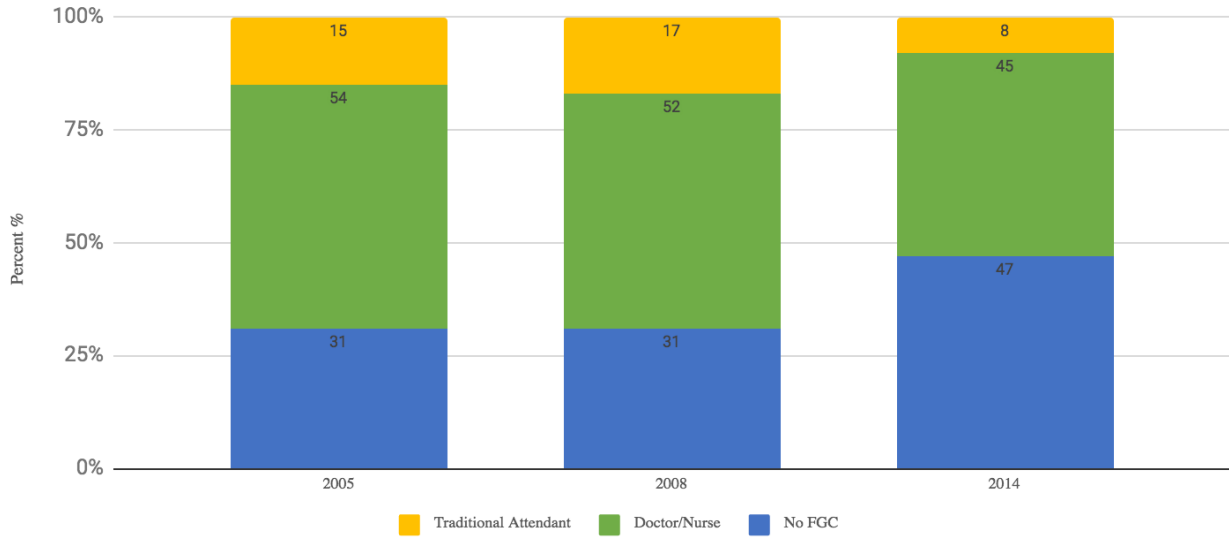
### **Quantitative Findings: Modernity, FGC Abandonment and Medicalization**

We assessed the association between FGC practices (abandonment versus medicalized or traditional FGC) and socio-economic factors (education, wealth, and urban/rural residence as proxy measures for modernization) across 2005, 2008 and 2014. Cross-tabulation analyses were carried out on samples of two sets of women: 1) mothers of daughters ages 15-24 and 2) ever-married young women ages 18-24. The age range of the daughters was chosen as such given that the average age of FGC is 8 to 14 years and would mean that the possibility of undergoing the practice at that age is minimal. For the young women, they were assessed based on their intentions of performing FGC on their daughters in the future.

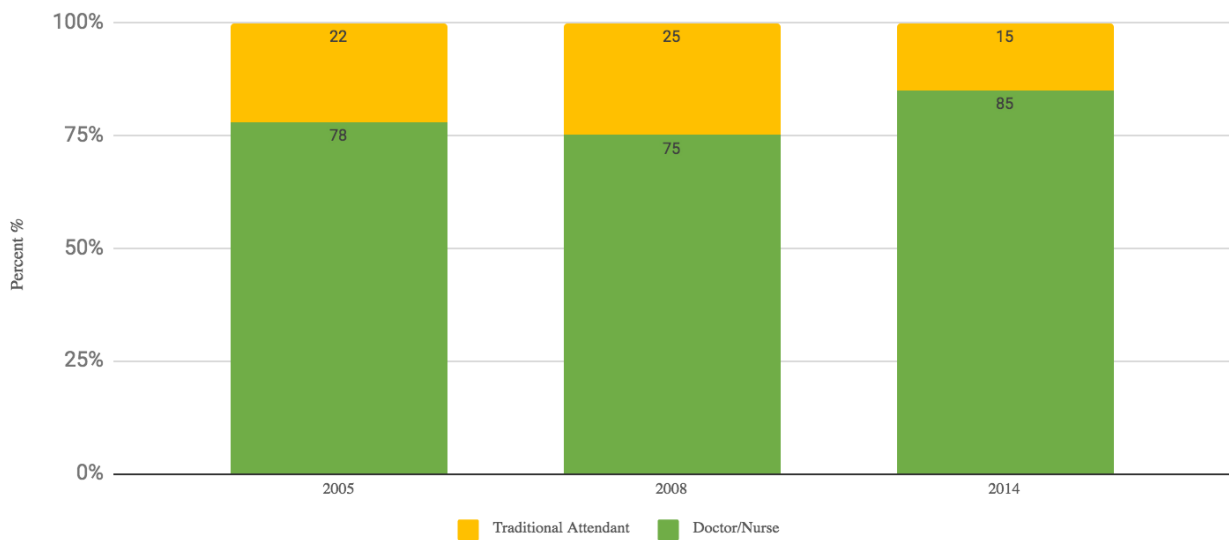
Graph 1 presents, for 2005, 2008, and 2014, the proportion of mothers who did not perform FGC on their daughters (FGC abandonment), those who performed it with the aid of a doctor/nurse (medicalized FGC), and those who performed it with the aid of a *daya*/traditional attendant (traditional FGC). Overall FGC abandonment increased from 31% in 2005 and 2008 to 47% in 2014. Looking further into the mothers who performed FGC on their daughters, Graph 2 shows that medicalized FGC increased from 78% and 75% in 2005 and 2008, respectively, to 85% in 2014. As such, the increase in FGC abandonment in 2014 was coupled with a 10 percentage point increase in medicalized FGC (and an equal decrease in traditional FGC) among those who did not abandon the practice. Regarding young women (ages 18-24), their intentions to abandon the practice increased

steadily over the years. Approximately a 12% increase took place between 2005 and 2014 (See Graph 3).

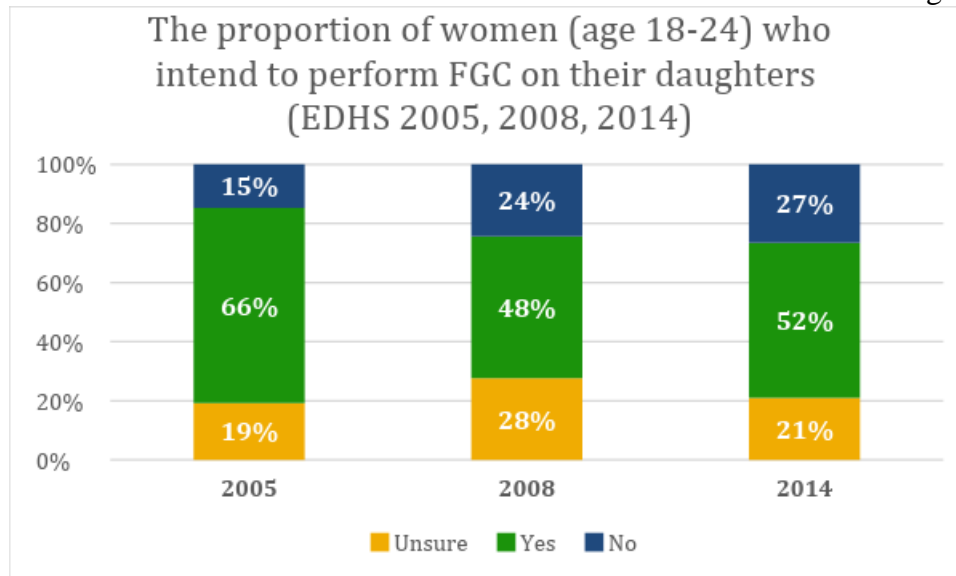
Graph 1: Proportion FGC abandonment, medicalization, and traditional practice (EDHS 2005, 2008, 2014)



Graph 2: Proportion FGC medicalization versus traditional practice (EDHS 2005, 2008, 2014)



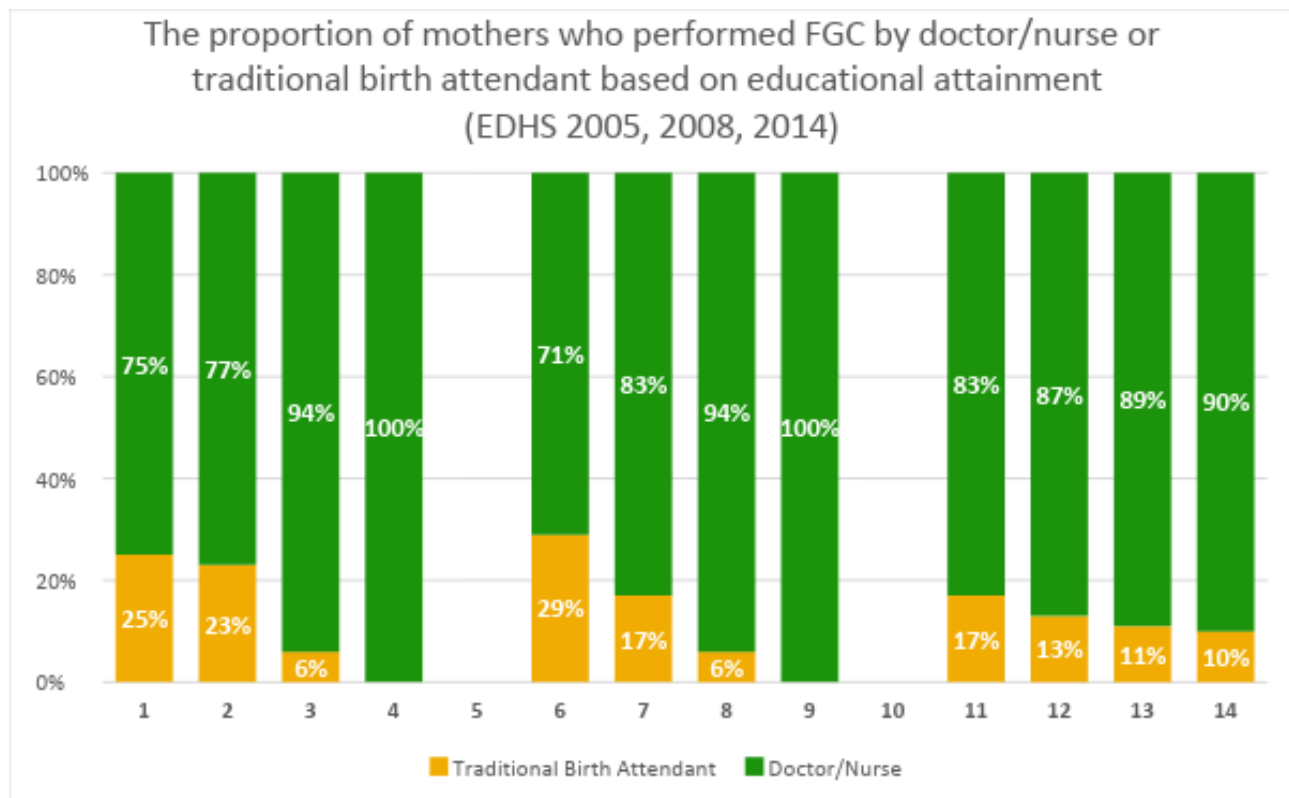




Graph 3

To form a better understanding of modernity's influence on the medicalization of FGC, we examined the association between mother's level of education, wealth, and urban/rural residence, and whether FGC was performed by a doctor/nurse or a *daya*/traditional attendant. Graph 4 presents the proportion of mothers who performed medicalized FGC on their daughters by education across 2005, 2008, and 2014. For education, mothers who were more educated tended to perform FGC on their daughters by a doctor or a nurse. Mothers with primary and secondary education have seen the highest increase of medicalization between 2005 and 2014 (8% and 10%). Also, the rates of mothers having performed FGC on their daughters by traditional birth attendants have surprisingly increased among those with secondary and higher education (7% and 10% respectively). Therefore, the gap in practice across education levels has been closing over time. The results for wealth (not shown) follow a similar trend. A higher proportion of wealthier mothers opt for medicalized FGC, although medicalized FGC increased over time among the poor. Finally, mothers in urban areas were more likely than their counterparts in rural areas to rely on FGC medicalization. Daughters in all regions generally did not witness a shift of any kind in FGC over the years except those who belonged to rural Upper and Lower Egypt where the likelihood of daughters undergoing FGC by medical practitioners increased significantly (16% and 8% respectively between 2005 and 2014).

Graph 4:



Even though the abandonment of the practice, as shown in the previous graphs, has been rising steadily over the years, the obvious prevalence of medicalization drives the question around whether modernization, taking the form of medicalization in this context, is a contributor or a challenge to gendered resistance. Will this shift from traditionality to modernization, pave the way further for gendered resistance and full abandonment of the practice? The following qualitative section will be unpacking this matter more in-depth.

### **Qualitative Findings:**

Although young women and mothers who were interviewed in the Population Council study seemed to be well-informed about the harms and health consequences associated with FGC, they indicated that they lacked appropriate medical information on why FGC is wrong or harmful. The vast majority mentioned that FGC can cause bleeding, sexual coldness, psychological problems, complications during delivery and death. Some mothers particularly stated that sexual dissatisfaction led many men to have extramarital affairs or to divorce their wives. A few mentioned that FGC can cause weak joints, ovarian inflammation, uterine complications, infertility and menstrual delay or complications. Some noted that although they underwent FGC, they did not suffer from any of these complications and found it difficult to understand why FGC is harmful.



The conflicting information received on the topic made most of them believe that they need to consult a physician.

Some mothers who were supportive of or ambivalent about FGC stated that women who did not undergo FGC may suffer from infertility, high arousal, and sexual disorientation. Some of these women thought that performing FGC on girls at a younger age would prevent psychological problems because girls would be less likely to remember the experience and the trauma of undergoing FGC. Additionally, some women believed that FGC can help the girl grow and build up her body. Some mothers also mentioned that it is done for beautification/cosmetic purposes.

### **FGC Abandonment:**

With such practice being upheld as a strong social/cultural norm, abandoning it is a form of resisting tradition. Looking closely at the women who decided to abandon the practice, the majority of them appeared to be younger, more educated, and raised in urban areas. With the perception that FGC is on the decline, respondents believe that these characteristics are the main contributing factors to abandonment. These factors lead to awareness-raising, recognition of health consequences, seeking reassurances for abandonment and inflicting a sense of fear.

The majority of young women and mothers believe that education and awareness is a strong contributor. The higher your education level is, the less likely you are to perform FGC on your daughter. A girl from urban AlGharbeya says, “I can’t forget when our school teacher talked to us about FGC. It was the first time to know that FGC was wrong. It was also the first time I talk about it with anyone. I still remember clearly the information she gave us that day.”

Another mother from rural Sohag expressed that if she had known earlier that FGC is not good for a woman’s health, she wouldn’t have performed FGC on her daughter in the first place.

### Awareness Raising on FGC Abandonment

There is a general perception that people started abandoning the practice especially with the increased exposure to information on FGC abandonment either from community sessions and traditional media or from personal experience. Abandoning the practice based on being exposed to information on abandonment in the media or during lectures/community sessions slightly appeared during the discussions. A mother from urban AlGharebya highlights,

“I honestly didn’t perform FGC on my daughter on the basis that the past is not like the present, everything is progressing. In the past, women could undergo FGC normally but

now everything is different. I have decided to abandon the practice after listening to what is said on TV.”

### Seeking Reassurances for Abandonment

A constant theme across all the focus group discussions that appeared was the fact that women decided to abandon the practice only after consulting a medical practitioner. Illustrating this point, a mother from urban AlGharbeya mentions,

“Since FGC is important in our family, I took my daughter to a doctor and the doctor examined her and told me that she doesn’t need to undergo FGC. I talked with my mother afterwards to get her advice on the matter and she was supportive since my sister was not cut as well (based on a doctor’s advice) and she got married and everything is normal.”

There was very few accounts of women individually deciding to abandon the practice solely on the basis of knowledge or awareness. Abandonment, however, was a collective decision within the family and was heavily reliant on a doctor’s opinion. Such reliance reflects strong hesitancy and sense of inferiority as to what women are in control of, if not their bodies. It placed the medical practitioner as the judge, not on the basis of knowledge and scientific achievements since they do not study such a practice during medical school but rather on the basis of prevalent traditions and ultimately, patriarchy. It, thus, creates a dichotomy between the “female” body and the “male” medicine and instills further unequal ideals into a “modernized” world.

The vast majority of young women and mothers believe FGC is still widely practiced because there is still lack of awareness. They believed some parents are afraid that their daughters may be infertile or incapable of giving birth when they get married if they had not undergone the practice. Most women and mothers, however, added that FGC was on the decline among new generations. Some stated that a few families do not disclose if they have performed FGC on their daughters because of fear of legal ramifications. Illustrating this point, a mother from urban Sohag noted, “A lot of people stopped the practice after hearing that there is a fine and they may be subjected to imprisonment.” When it comes to their personal views on the practice, most of the young women and mothers were ambivalent about it, with some expressing that they have fully abandoned it. They were aware that FGC is harmful and may cause many short and long-term physical and psychological complications. However, they still believed that it was necessary to consult primarily physicians and then sheikhs to be fully convinced with abandonment.



### **FGC Medicalization:**

With the inclusion of medical personnel into the equation, this raises the question of whether modernization empowers women to resist traditional forms of gender-based violence or introduces new coping strategies that does not require a confrontation with tradition. Even though modernization, in terms of characteristics, is evident amongst the rising generations of Egyptian women, who are achieving higher levels of education, the communal nature of the Egyptian society, that defies the idea of individualism expressed in modernization, does not allow for a trickle-down effect to take place as forms of resistance against gender-based violence. More precisely, FGC abandonment does not usually rise organically or on an individual basis. The prevailing social norm and the lack of unified messaging act as very strong impediments to abandonment, eventually creating hesitancy and paving the way for a modernized form of FGCs that is medicalization. Some women expressed that it is highly difficult to resist social pressure even if they are aware of the consequences and convinced that FGC is harmful. Some women expressed ambivalence during focus group discussions given the potential social sanctions that are attributed to not undergoing FGC such as divorce or reducing the prospects of marriageability:

“I obtained information against the practice of FGC through community sessions, TV programs and campaign pamphlets. Though I don’t want to perform FGC on my daughter, customs and traditions oblige me to circumcise her. I am very confused as I need to follow the norm in this village yet I’m worried of the consequences and how I would hurt my daughter”. A mother from rural Sohag.

“A lot of people till now say if the girl doesn’t undergo FGC and she gets married, her husband will divorce her when he finds out.” A mother from urban Sohag

This sense of ambivalence was driven further, as indicated by the majority of women, by contradictory media messages pertaining to the practice. As a result, many did not fully accept the benefits of abandonment and, instead, needed to hear it from a medical professional. For example, although some young women noted that they were in favor of FGC abandonment, they still noted that they would first consult a physician before deciding on the practice. Others believed that the messages held in advertisements and on-the-ground initiatives shed FGC medicalization in a positive light and intentionally promote it. A mother from rural Sohag said, “The information made available now drives the people to perform the practice by a doctor but not to abandon FGC.” A girl from urban Sohag also mentioned, “People have become more aware ever since the “No to FGC”

advertisement. People now take their daughters to doctors instead of traditional birth attendants.” This signifies that in some instances, the campaigns that have been calling for the abandonment of the practice, may have contributed to women’s move from traditional to medicalized FGC rather than abandonment due to their extreme and sole focus on the harms of FGC. This, thus, glorified the role of the doctor in the practice.

Given that many were ambivalent regarding the topic, potential solutions and what is believed to be “balanced” suggestions started to arise. FGC medicalization was strongly highlighted in the findings and portrayed as an educated decision that is derived from awareness-raising. For example, a young woman in urban Sohag said: “I attended a lecture on FGC that showed how modernized the practice has become. Doctors first examine the girl and then decide whether [a girl] needs FGC or not.” A mother from rural Sohag also mentioned, “In the past, you would find people sending their girls to the *daya*/traditional attendant. However, nowadays, given we have become more aware, people started going to doctors to perform the procedure instead.”

There was also the claim that due to the old ways and severity of FGC, girls were driven to be sexually cold and were exposed to a lot of harms. However, with medicalizing FGC and reducing its severity, women can still adhere to traditions and reduce potential harms associated with the practice. This refers to the safety factor within medicalization highlighted by Giddens as women embrace technology to mitigate risks. Illustrating this point, a mother from Sohag mentioned,

“I talked with my husband that I don’t want to perform FGC on my daughter but he asked why since there are new forms of FGC that just involve a little pricking, nothing more. I didn’t know how to respond to him back then.”

Another mother from rural Sohag also highlights, “There is a new trend of people saying we perform a simple FGC procedure on our daughters. The modern way. So it is not severe.”

Reducing the experience of pain appeared to be a significant reason for the shift towards medicalization. With the use of sterile medical equipment and anesthetics, some women believed that FGC medicalization is, thus, pain-free. A young woman from rural Sohag illustrates this point by saying, “A doctor performed FGC on me and gave me anesthetics right before the procedure. I did not feel a thing.”

Also, the safety factor in the context of medicalization included the usage of and reliance on blood tests and medical analyses before the procedure which gave mothers further justification that their daughters are in safe hands. A mother from rural Sohag illustrates this by saying, “A doctor must



ask for medical analyses before he practices FGC on the girl so that they could indicate if the girl is anemic or at risk of blood thinners. This was told to us by a doctor during a community session to reach a final decision whether a girl needs to undergo FGC or not.”

The choice factor that was previously mentioned in the conceptual framework also appeared in the findings. It was indicated that women go through a rigorous process of choosing a qualified doctor who is capable of ensuring that the FGC procedure is carried out safely. On the other hand, such choice is faulty if the girl was to be harmed. Supporters of FGC medicalization believe that if a girl dies during or after the procedure, the doctor is to be blamed, not the procedure itself. Illustrating this point, a girl from Cairo says “A girl may die during the procedure at the hands of the doctor. Yet, people would still practice FGC and just blame the doctor for the death. They would say it’s the girl’s destiny.” This implies that a social norm such as FGC is a necessity that is inviolable even in light of modernization/medicalization and in the event of extreme repercussion such as death. People, on the other hand, are looking for alterations that would still allow them to practice harmful traditions without subjecting themselves to social sanctions.

### **FGM as Cosmetic Surgery:**

FGC arose strongly in the findings as a beautification procedure that ensures that the labia minora is of “normal size” (is not protruding or abnormal), that the vagina is “clean” and that it is generally perceived as beautiful, especially for marriage purposes. Such rhetoric on FGC being a cosmetic surgery is rarely documented in literature regarding FGC medicalization. This could be linked to the factor pertaining to social status within medicalization as women look better and become more marriageable by “beautifying” the genitalia. A mother from urban AlGharbeya says, “a doctor told me that my daughter's labia (*shafreteen*) doesn’t look nice and she needs to undergo a beautification procedure.” Another young woman from urban Sohag mentions, “My mother-in-law says a girl needs to undergo FGC so that her clitoris wouldn’t look like that of a boy (referring to the penis).” With such justification being used, it becomes strongly linked to the feminist critique of medicalization as women’s bodies here are depicted as deformed and require medical intervention to be beautified. It, thus, instills the sense of weakness and subordination of women’s bodies. It also defies the rhetoric around gendered resistance and allows for more justifications to uphold the practice which undeniably not lead to any form of FGC abandonment.

Beautification is also depicted as a different procedure that cannot be compared to FGC as it serves a different purpose. A mother from rural Sohag illustrates this by saying, “A mother took her girl to

undergo a beautification procedure by a cosmetic surgeon because she is convinced that FGC is wrong and is a different practice. So she looked for a good cosmetic surgeon who would know what to do unlike a *daya*.” Another mother from urban AlGharbeya highlighted, “This is beautification not FGC. Some girls need it because their vagina looks ugly, the extra skin hurts them and they wouldn’t look nice for their husbands. This is different from FGC.” Such justifications illustrate the means by which modernization can further intensify and instill long prevailing harmful practices that defeats the concept of gendered resistance. This ultimately unpacks the loopholes within the modernization theory.

## **Conclusion**

With such pressure, women are at crossroads where they are expected to balance between their ‘traditional’ domestic responsibilities and their public ‘modern’ self that provides for the family. There is, however, an emerging subversion culture within which women seek to improve their bargaining position. Within the context of FGC, this paper shows that women are caught between tradition and modernity, where some have publicly abandoned the practice while others are performing medicalization as a form of refuge against the strict adherence to the traditional feminine spheres. It also shows that the rhetoric around modernisation being a path for resistance and abandonment of FGC can be partially misleading as new adaptations (i.e. medicalization/beautification) may arise which are purportedly a modern process yet reinforce a traditional practice.

\* An Arabic version of this paper was published in the “[Gendered Resistance Publication](#)”

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