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Article

Interpreting Signs of Female Genital Mutilation Within a Risky Legal Framework

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ABSTRACT

The Norwegian law against female genital mutilation/cutting (FGM/C) was strengthened in 2004 through the addition of a duty to avert that requires extra vigilance from employees in the welfare system, including social workers, nurses and teachers, to protect girls from being subjected to FGM/C. The law against discrimination forbids discrimination based on ethnic background. These two laws may come into conflict and spill over into communicative situations in which the interpretation of the signs of potential future crimes takes place. This article particularly explores the challenges and risks for nurses, teachers and welfare officers in interpreting the early signs of an imminent FGM/C procedure in their attempts to communicate during efforts to avert female genital mutilation. The data is based on the documentation of one particular case, following it through the welfare and legal systems and including a secondary data source of interviews of official employees as well individuals of African descent who live in Norway.

I. INTRODUCTION

Female genital mutilation/cutting (FGM/C)[1] is a widespread practice in many African countries. One hundred and forty million girls and women are living with its consequences and 3.3 million girls are at risk every year (WHO, 2012; Yoder et al., 2013). Female genital mutilation (FGM), also called female circumcision and female genital cutting (FGC), consists of four types: (i) clitoridectomy, which involves partial or total removal of the clitoris and/or the prepuce; (ii) excision, which involves partial or total removal of the labia minora and/or the labia majora; (3) infibulation, which involves narrowing the vaginal opening through the creation of a covering seal, with or without the removal of the clitoris; (4) other types, which involve other harmful procedures to the female genitalia for nonmedical purposes (Berg et al., 2010).

Through migration, the practice has spread to European countries. Documents from the European Parliament suggest that half a million women and girls inside the European Union have undergone or are at risk of the procedure (European Parliament, 2010). The practice, recognized as a violation of human rights and the rights of the child, is usually carried out between infancy and 15 years of age and is embedded in a social and cultural context of meaning (Schultz and Lien, 2013). New knowledge often needs to be deeply internalized in order for a shift of attitude to occur (Lien and Schultz, 2013). In most affected African countries, there are laws banning FGM/C that seem to have a deterrent effect (Shell-Duncan et al., 2013). In addition, there are campaigns for its abolition in most countries (Berg and Denison, 2013; Shell-Duncan and Hernlund, 2006; UNICEF, 2013).

European countries have banned the procedure either by employing previously existing criminal laws or by introducing new ones. Four countries have a duty to report suspected cases, but it seems that only Sweden and Norway have created a duty to avert it whereby those who wilfully fail to try to prevent it will be liable to fines or imprisonment. In addition to laws, information campaigns, training of health workers, voluntary genital examinations, free hotlines, international cooperation programmes, etc., have been introduced (Jonassen and Saur, 2011; Lien, Schultz and Borgen, 2012; Leye et al., 2007; Turillazzi and Fineschi, 2007). The UK was the first European country to pass laws expressly criminalizing the practice,[2] but according to Guiné and Fuentes (2007) and Bindel (2014), seems to have allowed FGM practices to continue within this legal framework. Guiné and Fuentes (2007) argue that the French approach, which has been to prosecute cases in the courts, has had a positive effect on deterring FGM. The best approach to combat the practice, the authors suggest, is a combination of British community sensitivity and French universalistic principles and strict laws.

A UK report from the New Culture Forum (Bindel, 2014) argues that FGM has been given low priority in the UK as female genital mutilation has been taken less seriously than other forms of violence. France is presented as a model of best practice, having brought 29 cases before the criminal courts between 1979 and 2004. The report suggests a multi-agency approach, using prosecution, medical examinations and reporting as ways of combatting the practice and that not reporting suspected FGM should be made a crime (Bindel, 2014: 30), leading to professionals being more proactive when dealing with the problem. In Europe, too, there have been very few cases brought to court because of the transnational character of the problem as the people concerned are usually in the migrant community who travel out of the country to get the procedure done. Other factors are the secrecy of the communities and the reluctance of professionals to properly investigate complaints and concerns about FGM. Leye et al. (2007) have described how factors like the fear of racism and discrimination, as well as relativism and cultural sensitivity, have led to cases of FGM going unreported. In a study of 15 European countries, she and her colleagues found the same pattern in most countries.

According to Boyle and Preves (2000), the ruling elites of many countries have been receptive to the problem and have played to the larger global community as much as to a local audience in passing laws against FGM, implying that national laws are developed to change rather than reflect local attitudes. States copy each

other's laws; the passage of these laws reflects external international forces and creates a top-down strategy for change rather than the development of policies in response to bottom-up pressure based on locally-anchored political demands. The laws passed are intended to provide an 'enabling environment' for the abandonment of FGM, but there has been little research on the process and type of legislative reforms or their effects and levels of acceptance (Shell-Duncan et al., 2013; UNICEF, 2010: 3).

In analysing trust and risk in child protection in England, Ferguson (2005) argues that, during the past 30 years, there has been a reorganization of child protection because a powerful blame culture has emerged based on the perception that professionals fail to protect children. It is no longer only abusive families that are at risk of becoming the focus of blaming systems, but also social workers, who, according to Ferguson, are subjected to purity and pollution rituals by the community, by being publicly exposed in the media, by being humiliated and by being dismissed from their jobs. For the individual social worker, these new risks have led to fears that they will be held publicly responsible for the death and suffering of children.

Other countries have also developed policies to deal with scandals that are shaming the system (Lull and Hinerman, 1997; Reder and Duncan, 1999). The development of new legislation and the expansion of the roles of employees by the introduction of new duties, as well as fines and punishments for employees, can be seen as a response to the new risks involved not only in caring for the children of the majority, but also for children whose parents have a minority background. It is also a way of increasing the accountability of employees.

Korbin (2002) argues that the relationship of cultures to child maltreatment needs to be unpacked. She sees cultural competence as important in the area of child abuse. Brophy (2008: 78) argues that social scientists have explored the cultural contexts of parenting in different cultural settings, but that this knowledge has been missing within the legal framework. Green (1982) argues that when assessing cases of child abuse, both cultural and ethnic competence are important. Ethnicity can be relevant as a frame through which the signs of child abuse can be interpreted, but this frame of interpretation can also lead to stigmatization, resulting in decisions that may be considered discriminatory.

In this article, we will focus on expert systems, interpretation within cultural contexts and the law in order to analyse what is at stake for employees who are trying to avert FGM and protect children. The following issues will be explored: Is imposing a penalty on employers the best way to remove the obstacles that have been created by the fear of being accused of racism and discrimination? What happens to the role of the expert caregiver when accountability is enforced in this way? How do new laws and regulations spill over into 'professional encounters', or relevant 'communicative situations', that is, situations in which FGM becomes a relevant issue to be explored by the staff of the welfare system? What are the legal and moral dilemmas and challenges for professionals in interpreting the signs of FGM? Using Norway as an example, we will concentrate our discussion on two conflicting laws: the law against discrimination and the law against female genital mutilation, and particularly, the duty to avert FGM, which is contained in paragraph 2 of that law.[3]

II. THE LEGAL FRAMEWORK

In Norway, all forms of genital mutilation of girls and women are punishable pursuant to section 1 of the Act of 1996 relating to female genital mutilation. The penal provisions encompass all those who perform genital mutilation, including health personnel. However, the girl or the woman involved (the victim) will not be liable to punishment, as it is not illegal to be circumcised. In 2004 the FGM law was strengthened with a duty to avert. By establishing a punishment of up to one year in prison or a fine, the duty to avert is meant to motivate professionals to act on their suspicions of an imminent FGM procedure. The law thereby provides additional pressure by instigating fear in the minds of the personnel if they do not try to avert FGM, thereby making them accountable.

The background documents[4] proposing the implementation of a duty to avert FGM make references to national security and its military secrets. In that context people can be punished if they are aware of dangers and do nothing to avert them. The duty to avert FGM seeks to predict a crime that has not yet taken place and to prevent it from happening. It is forward-looking and relies on a person's subjective guesses about an incident that may occur in the future. The duty to avert is activated whenever someone believes that it is more likely that a girl will be genitally mutilated than that she will not. This applies irrespective of the type of FGM and the scope of the operation. There is no requirement for positive evidence of a planned act of genital mutilation. The knowledge requirement for the duty to avert ('more likely') indicates a higher threshold than the knowledge requirement for an existing duty to report child abuse ('reason to believe', 'justified concern'). As stated in the government's information circular, '[t]he threshold for the duty to avert should, however, not be placed so high as to undermine the intention of the Act, which is to prevent FGM from taking place.' (The Ministry of Children Equality and Social Inclusion and the Ministry of Health, 2008:19, our translation.)

To satisfy the duty to avert, a report of concern should be given either to the Child Welfare Services or to the Police who would then examine the case. It is not recommended that professionals try to avert FGM by investigating and acting on their own accord; rather, they are advised to refer the case to the Child Welfare Services (Ministry of Children and Family and the Ministry of Health, 2008). It is not regarded a crime to be genitally mutilated if the procedure is done before moving to Norway. If a girl has younger sisters at risk of FGM, her case could be reported in order to prevent them from being mutilated, otherwise the duty of confidentiality will apply. If a girl suffers from health consequences due to FGM and is not given proper help and care by her parents, her case could be reported to the Child Welfare Services as child abuse. While the intention behind the duty to avert is commendable, it has introduced something new in the operation of the welfare services: threats of punishments for employees for not acting on their subjective guesses about the risk of a potential future crime. This law has not been openly discussed in the media or among experts, and was passed without much public discussion.

To help health workers, teachers and doctors to interpret the signs indicating a possible FGM, bureaucrats have written guidelines listing signs of potential concern. These include: that the girl's mother and/or other female relatives have been genitally mutilated; that the girl has been subject to serious abuse; that the family is

planning to visit the home country; that the parents are intending to extend her school holiday; that one of the parents wishes to take the girl abroad without informing the other parent; that friends or the girl herself provide information indicating that she might be subject to FGM; and that the parents have limited resources to resist pressure from relatives or others.[5] In addition, the parents of children originating from countries where 30 per cent of the population practice FGM are supposed to be invited by health personnel to voluntary talks on FGM (Lien et al., 2012).

The Swedish social anthropologist Johnsdotter (2009a) has formulated the following dilemma: '…nobody really knows where to draw the line between, on the one hand, the duty to report suspicion of FGM/C and, on the other hand, not to act in a way that violates the Discrimination Act.' The Norwegian law against discrimination forbids 'direct and indirect discrimination on the basis of ethnicity, national origin, descent, skin colour, language, religion or belief…. "Direct discrimination" means that the purpose or effect of an act or omission is such that persons or enterprises are treated less favourably than others are, have been or would have been treated in a corresponding situation on such grounds as are mentioned in the first paragraph'.[6] The fact that the incidence of FGM is unequally distributed among different ethnic groups may lead the government to assign less attention to some ethnic groups and more attention to others in order to provide children with diverse backgrounds equal protection against violence and child abuse. Faced with this dilemma i.e. *inequality of problems* leading to *inequality of measures in order to achieve equality of protection*, both the majority population as well as minorities could object to the way the law against discrimination is understood and implemented in practice.

The organization against official discrimination (OMOD) sent several letters to the Ministry of Children, Equality and Social Inclusion expressing concern about 'racial profiling', that is, that ethnicity and race become indicators when targeting, controlling and averting FGM. The Association of Somali women and children, together with the Male network on FGM, also sent letters complaining that they were discriminated against by the exercise of the duty to avert resulting in genital examinations of African children that proved unfounded. They argued that in 2009 42 girls had been genitally examined by doctors at Oslo University Hospital due to suspicion on FGM, but only two had been mutilated.

'Somalis and Africans in general experience that as a group we are exposed to public contempt because of FGM. Also, individual concerns about who we are and what kind of life experience we have are not taken into account. As a group we experience that it is discriminatory that only children of African background are exposed to genital examinations. Even though these examinations are done as a preventive measure against FGM, they give a strong impression of suspicion on the basis of ethnicity and race.'[7]

Johnsdotter (2009a,b) has analysed encounters between welfare staff and the diaspora communities in Sweden and highlighted the danger of stigmatization and discrimination against ethnic groups seen from the perspectives of those communities. In this article, we will discuss the dilemmas with reference to the Norwegian context. We have adopted a somewhat different perspective: that of the expert caregivers. Our aim is to examine the risks and challenges that employees in the welfare system face when they interpret signs and try to fulfil the intentions of

both the FGM law and the law against discrimination in their professional encounters.

III. METHOD AND ANALYSIS

This article is based on data provided by one particular case reported to the Social Welfare Services, the Ombudsman of Discrimination and the Norwegian Equality Tribunal.[8] The analysed documents involve letters of concern, laws, appeals and protocols. This particular case works as an apt illustration (Gluckman, 1961) that demonstrates the dilemmas related to the law against FGM and particularly the duty to avert. In addition, 71 informants working within the welfare system, consisting of social workers, teachers, nurses, doctors and bureaucrats, were interviewed about the challenges in their encounters with families when they suspected circumcision was imminent or had already happened. These interviews dealt with the challenges related to communication, and served as a *secondary data source*. We also interviewed members from the diaspora communities in Norway (48 informants from Somali, Gambian, Eritrean and Kenyan backgrounds). Frame analysis (Goffman, 1974) is used as a way to address interactional practices by identifying strips of activities, like cases, to be analysed processually in order to see how people perceive the frame and present themselves within it. A communicative frame provides a context for interpretation. This context is framed both by the persons present, their professional roles, their relations and habits, laws, norms and regulations, as well as the knowledge and culture that people carry with them into these communicative frames (Goffman, 1959, 1961; Scheff, 1994; Smith, 2006). Within these frames, interpretation takes place when signs are perceived that also point to activities outside the contextual frame. The aim of this article is to analyse the interpretation of signs within the legal frames that we have presented.

According to Gregory Bateson (1972: 414), the concept of redundancy is important in the interpretation of signs. Redundancy requires guessing when information is missing. 'As I see it', Bateson argues, 'if the receiver can guess at missing parts of the message, then those parts which are received must in fact carry a meaning which refers to the missing parts and is information about those parts.' Bateson is particularly concerned with the role context plays in discovering meaning. He exemplifies redundancy using the following metaphor: 'If I see the top part of a tree standing up, I can predict – with better than random success – that the tree has roots in the ground. The perception of the tree top is redundant with (i.e. contains 'information' about) parts of the system which I cannot perceive owing to the slash provided by the opacity of the ground' (Bateson, 1972: 414). The idea of redundancy is that we can make qualified guesses about future events if we have enough contextual information; in the same way, we can assume, more or less, that an FGM procedure will take place soon, or that a child may be a victim of abuse, if we have some information, even though crucial information is missing. This means that we, according to Bateson, must attain meaning from signs as they speak to us from within their contexts, whereby they tell us something about what is both present and missing.

According to Pierce's (1955) theory of signs, the signs exist in the mind of the interpreter and not outside of the interpreter. Nothing is a sign unless it is interpreted

as a sign. There are three major classes of signs according to this theory: icon, index and symbol. An icon stands directly for something, like a photo. An index uses part of something to stand for the whole, like Bateson's treetop, which stands for the whole tree, as well as the roots of the tree. A sign using an arbitrary connection between a present and an absent component is a symbol. The ability to read signs is rooted in practice and embodied in the knowledge resident in the practice and is located in the mind of the interpreter. The ability to read indexical signs – such as a girl's circumcision or upcoming circumcision, when nothing has been seen or expressed – rests upon the knowledge that the interpretant has about FGM and the signs of FGM within the cultural context of the tradition. This is what Pierce calls habit and what Jensen (2005) has described as 'interpretation repertoires'.

Jensen analyses how primary care givers, mostly mothers, interpret signs indicating that their children have been victims of sexual abuse. She shows the difficulties in sign interpretation, especially in cases in which there is no obvious connection between the sign and the abuse. Jensen distinguishes between six interpretive repertoires that relate to age, personality, agency, socialisation, parental conflict and parental deficiency. An example in which two repertoires are involved in a case of sexual abuse is when a child does not want to visit daddy. This can be interpreted as a sign that something is happening at dad's, as a parental deficiency, or it can be interpreted in an age repertoire, indicating that the child wants more autonomy as he is growing up. It can indicate other factors as well, such as those linked to personality and socialization. Accordingly, signs can have multiple and contradictory meanings (Jensen, 2005: 476) and can be interpreted within different repertoires that make different conclusions relevant. Caregivers must use the knowledge they have; it seems that parents draw from a wide range of knowledge of both the cultural context and the child's personality. Interpretation is still difficult: '(…) there is a constant tension between interpreting too much or too little; too fast or too slow; too normal or too deviant' (Jensen, 2005: 493).

According to Innis (2005: 500), the interpretation of child abuse will start with a person being perplexed about a 'problematic situation'. Something needs to be resolved, like the conduct of a child who is behaving strangely. An indexical sign has an energetic effect and introduces action. We do not only 'grasp signs', we can be grasped by them, even against our will (Innis, 2005: 500). Innis argues that the context is important not only when trying to 'grasp' situations, but also skills: 'The ability to read signs is, then, a skill, and skills are rooted in practices and the types of embodied knowledge resident in these practices' (Innis, 2005: 504). As an expert, the caregiver will belong to an interpretive tradition and will come to a problematic situation with a configured set of fore-structures that will be of a different standard or character from say, those of a mother. There is much more at stake for a mother in a family situation than there is for an expert caregiver, a social worker or a teacher, which makes the expert caregiver less biased. 'It is the trained social worker who has the interpretation skills to disambiguate the situation and to help the caregiver to become adept at reading the signs' (Innis, 2005: 504). However, with the intent of heightening the accountability of experts, the government has passed various laws that may have influenced this position of neutrality when it comes to interpreting an imminent FGM procedure. The duty to avert may have created more personal risks

and may have changed the interpretative framework and the role of the caregiver. The expert caregivers' personal interests may have been influenced by both the duty to avert and the discrimination law.

IV. CASE ANALYSIS

In August 2008, a teacher at a Norwegian primary school realised that he had a duty to avert what he feared would be an impending FGM operation after having observed one of his new students, a Somali girl, for some months. He alerted the child welfare service by writing a letter explaining the reasons for his concern.

> She [the Somali girl] soon made me worry and the worry was later strengthened. It is seldom that we have students with such aggressive behaviour, especially when it comes to girls. The behaviour must be said to be very deviant and she is very disobedient and acts towards the teachers in a very aggressive way. Her concentration when it comes to tasks and reading lasts only five minutes. She can hardly read (…) her eyes ought to be checked. She leaves her seat without permission, goes out of the classroom, does whatever she likes and she will not listen if corrected. This behaviour is not compatible with teaching. If she is ignored, she quietens down (…). I am very worried about her (…) that she is exposed to sexual abuse/physical punishment, or that she has had a traumatic experience in connection with FGM/C or perhaps other traumas. Her family is from Somalia and since most girls from there have been circumcised or there is a danger that this will happen, I hope that you will check on these circumstances so that she can be saved (hopefully, it has not happened yet). Her rebellious behaviour and lack of concentration also makes me worried that she could have a neurological dysfunction, i.e., ADHD. There could, however, be a possible explanation that the parents probably have more problems with her than with her sister, and maybe the girl is punished more severely and for this reason tries to keep a low profile at home (…).
>
> You may contact me if there are things that are unclear to you, but I think I have said most of what can be relevant for you to check up on her, so that the girl's home situation can become as good as possible, and that you can prevent her from being exposed to any form of abuse, including FGM, and perhaps so that the family can get further help with bringing her up without physical punishment."[9]

The teacher observes certain signs that he interprets. Pursuant to the requirements implied by the duty to avert, he must report to the child welfare service in order to fulfil this duty. In this case, he is not absolutely certain what the girl's problem is. However, he observes something that he, from the background of his professional competence, views as alarming. Unruly behaviour, aggression, restlessness, and Somali descent were the obvious signs that needed to be interpreted. He concludes that female genital mutilation, or the fear that it could happen, could be a cause for the girl's behaviour. The child welfare services, on receiving the letter, investigated the case and interviewed the parents. The mother, a Somali, who herself had been circumcised, told the authorities that she was against FGM because she had suffered a terrible experience with the procedure. The girl's father said that the girl had not been circumcised and that they had no intention of having her circumcised. The child welfare service wanted the girl to be examined by a doctor to confirm the

parents' story and to investigate the concern expressed in the letter. The parents protested at first, but subsequently agreed. The girl was then examined by a female doctor in the presence of the mother. The doctor found that the girl had not undergone FGM. After this examination and interviews with family members, the service decided that the girl was not a victim of child abuse. Family relations were deemed to be positive and harmonious. There was no reason to think that the girl was at risk of FGM in the future, so the welfare services closed the case at that point.

Complaint to the Ombudsman against Discrimination

The father, however, was not satisfied with the way the family had been treated; he filed a complaint with the Ombudsman against Discrimination, arguing that the family had been subject to discrimination by the child welfare service, which had examined the girl's genitalia purely because the girl is Somali. He maintained that the service had thereby violated the discrimination act.

The Ombudsman against Discrimination, together with the Discrimination and Equality Tribunal, has the responsibility to process complaints alleging discrimination. The Ombudsman can bring a case to the Norwegian Discrimination and Equality Tribunal. An appeal of a case can also be sent to the Tribunal, which can impose fines and provide a formal and public statement on a dispute or give instructions aimed at improving the conditions that have caused discrimination. The Ombudsman and the Tribunal are responsible to the Government, and can, if necessary, initiate proceedings before the courts. In the present case, the Ombudsman, after having examined the father's allegations, found in his favour. The law against discrimination had indeed been violated by the child welfare services. The whole case, the Ombudsman argued, was built solely on the basis of the girl's Somali background. 'It is undoubtedly because of the girls Somali background that the Child Welfare Services decided to do a genital examination.'[10] Therefore, the authorities had violated the anti-discrimination law.

Appeal to the Discrimination and Equality Tribunal

The child welfare service appealed the decision to the Discrimination and Equality Tribunal. It wrote to the Tribunal explaining the factors on which it had determined its legal obligation. It argued that the letter of concern from the girl's teacher had been enough for them to start an investigation. A medical examination is the only way to find out if a girl has been circumcised. Indeed, they would be liable to punishment if they did not try to avert the procedure. They had talked with the parents, who had convinced them that the girl was not a victim of general child abuse; however, the meeting had strengthened their suspicions regarding FGM, particularly when the parents were initially unwilling to allow their daughter be medically examined. There was a series of signs that supported their suspicion, and led to the genital examination, which, according to the father, was a traumatic experience for the girl and the family.

The Discrimination and Equality Tribunal was unable to reach an unanimous conclusion. The majority considered that the medical examination was based on discrimination, but found for the agency on the ground that it had not violated the

anti-discrimination law as it had built a case on the merits of the report and interviews with the parents. The minority could not find that the girl's family had been subject to discrimination at all. A medical examination, they said, was the only way to clarify the facts of the case. Taking into account a new series of signs provided by the parents' resistance to a medical examination and the father's questions about what would happen if they refused an examination and if they took the children out of the country, the agency was justified in harbouring suspicions of an impending FGM operation. In the view of the minority, if the investigation by the agency and the medical examination had not taken place, the Somali girl could have been in a much worse situation than ethnic Norwegian children with regard to physical and sexual abuse. That would unquestionably amount to discrimination.

V. DISCUSSION AND ANALYSIS

1. The Ethnicity and FGM Interpretation Repertoires

This case consisted in several stages. In the first, it was the teacher who interpreted and read the signs that had created the 'problematic situation' which *moved* him to write a letter of concern to the child welfare services. Later the child welfare services had to reinterpret and check out the signs that were reported and reach a final conclusion. The case could have stopped here, but it moved further to the Ombudsman and later to the Tribunal and they interpreted the signs again. Different conclusions were reached throughout the process, and these again were reported back to the school and the teacher. The signs that were interpreted first and reported by the teacher were: (1) deviant conduct, (2) aggression, (3) lack of reading skills and (4) disobedience. These signs were read within an *ethnic (Somali) interpretation repertoire* with an attached *FGM repertoire*. As argued the letter argued: 'Her family is from Somalia, and since most of the girls there have been circumcised or are at risk, I hope the services will check out these circumstances.' Ethnicity then became the overall and dominant sign in the light of which the other signs were interpreted and given meaning.

As ethnicity is an imperative status (Barth, 1969:17), the Somali background easily becomes an overriding and hierarchical sign that dominates over the interpretation of other signs. Stereotypical and generalized knowledge associated with ethnicity easily enters the mind in spite of the fact that it can be interpreted as illegitimate and incomplete. Ethnicity may connect different types of knowledge in the following way: Somali – FGM – infibulation – illegal – avert – report –child abuse. This way of thinking is described by Lakoff and Johnson (1999: 33) as following a source-path-goal-schema. It has a special logic and built-in inferences. Within this path, 'Somali' can become the organizing source.

With regard to the teacher's reasoning, we can imagine that both ethnicity and statistical prevalence are relevant as organizing sources. Somalia has an FGM prevalence of 98% (UNICEF, 2013). This fact, in combination with ethnicity, may act as a sign and may be placed within the *ethnic interpretation repertoire* together with other indicators that the teacher interpreted in the class situation. Framed by *the ethnic interpretation repertoire,* and *the FGM repertoire*, the teacher operated with two

theories that involved FGM: (1) the girl had already been subjected to FGM and (2) the operation was impending.

The case shows that expert caregivers and teachers operate in a multicultural setting in which the packet of six interpretational repertoires described by Jensen (2005) have become insufficient. In addition, due to migration, there are other signs that call for specific interpretation repertoires to be comprehended in reasonable ways. *The FGM repertoire* represents packages of knowledge involving types of FGM, distribution, health consequences, age when the cutting is performed and different behaviour signals, as presented in the guidelines. In addition, *the ethnicity repertoire* consists of knowledge of country background, ethnic groups who practice the procedure, statistical prevalence, clothing, rituals and other issues pertaining to different ethnic groups. Different laws also enter into the two repertoires according to their relevance. These repertoires may be thick or thin (Geertz, 1973), depending upon the expert's knowledge. The repertoires could also be described as schemas (D'Andrade and Strauss, 1992; Strauss and Quinn, 1997) or packages of knowledge (Strauss, 1992).

The teacher, however, did not only apply *the ethnicity* and *FGM repertoire*, but *the personality repertoire* as well, which involves attention deficit hyperactivity disorder (ADHD), poor eyesight or neurological dysfunction. *The personality repertoire* (Jensen, 2005) is a more general repertoire applicable to all, irrespective of ethnicity and country of origin. Another more general repertoire that was relevant to the teacher's interpretation of signs is the *parental deficiency repertoire*, which warns against general child abuse and sexual abuse. In the teacher's letter of concern, sexual abuse was mentioned as a possible interpretation of the signs observed.

At stage two of the case, the welfare services interpreted the signs that the teacher had reported in the letter and it also brought in more information that it interpreted. The father's initial resistance to a medical examination of the girl's genitalia was interpreted as suspicious and read within a *repertoire of deficiency of parents*. The father's question about the potential consequences if the girl was sent out of the country was also read within the suspicious repertoires of FGM and deficiency of parents. The sum of several signs enforced suspicion that ultimately led to the genital examination of the girl.

The interpretation of signs can however be difficult and frequently arbitrary. The signs listed in the Government's circular are insufficient, and informants have told us that there are several other signs that they read as creating suspicion that a FGM procedure has been performed. Several of the Somali women we interviewed said that if a girl spends fifteen minutes in the toilet she may have undergone FGM. This time-consuming urination is due to the narrowing of the vaginal opening caused by infibulation. A Norwegian Somali nurse added: 'If a girl looks depressed and low, it can indicate that she is afraid and is going to be cut soon, or it can indicate that she has been traumatised by a circumcision already carried out in her country of origin.' This means that the psychological mood of a girl is perceived as a sign that FGM has taken place, or a sign that the girl is worried that it will take place. Our informants also said that body movements can also be a sign. If the girl moves in a certain way and no longer wants to go to the gym, it can indicate that FGM is restricting her. This is knowledge of an informal character that circulates in the diaspora, but now

also among care experts, health workers and teachers who were interviewed. But signs embedded in one ethnic context cannot necessarily be transferred to another. A Gambian woman argued that in Gambia you can see whether a girl has been circumcised because she displays a new sense of pride. She looks happier, more content, and feels superior to minors. She may start abusing those who are not circumcised. This implies that there can be a variety of signs in a professional encounter that could influence a teacher or a professional care expert to take a decision to act. In addition laws, regulations and policies may have a motivational influence on the person who is supposed to interpret signs.

Nevertheless, there is an expectation that an expert caregiver, particularly, will have sufficient competence to make knowledge-based assessments and interpretations of child abuse and FGM. However, the fact seems to be that ideal thick ethnic and FGM interpretational repertoires do not really exist in the minds of most expert caregivers. Their repertoires are often thin, and therefore, their competence is generally weak with regard to knowledge about FGM and ethnicity in spite of the fact that the Government has strenuously endeavoured to provide knowledge through guidelines, circulars, and seminars. It is easy to make superficial and generalized conclusions based on 'common sense' assumptions. Another challenge for an expert caregiver is that a mother and father may try to conceal information or distort signs in order to protect themselves from the suspicion of FGM, which thereby makes interpretation even more difficult.

Ethnicity easily creates redundancy, as explained by Bateson. It defines the context in which the signs are interpreted. Ethnicity frames the situation and makes other signs relevant – the age of the girl, the unruliness of the girl, a mother subjected to FGM, a father indicating a plan for a home visit – and it puts the duty to avert into a central position as a relevant topic to consider within the repertoire. In the case of ethnic Norwegian girls, a teacher or a social worker would hardly think of FGM as something to be taken into consideration when interpreting cases of unruly behaviour or 'going home for vacation'. Rather, FGM would be considered as a rather silly issue to have in mind and would be excluded as a relevant topic to consider. As a sign, ethnicity may exclude some issues from being considered and may include others, leading to an organisation of knowledge in which bits of information follow a certain model and structure (D'Andrade and Strauss, 1992). Within this structure of knowledge, relevant laws can be taken into consideration and will enter into the repertoire as elements in a chain of connected bits of information.

2. Laws and Professional Roles

The duty to avert, the Child Welfare Act and the Anti-FGM Act are legal frames surrounding and fuelling the interpretational repertoires of the care experts who observe signs of potential child abuse and FGM. The interpretation of signs can lead to a choice about which law to follow, based on the person's values and principles, as well as competence. When the competence to interpret signs is weak because of the lack of specific contextual knowledge, there may be too many risks involved for the employee within the system. This can be one of the reasons why the authorities instruct employees, like teachers, to refer the case to the child welfare services and

not to investigate it themselves. The duty to avert is fulfilled immediately the teacher passes it on to a higher level. This could lead to cases being reported too early, on a weak basis. A weak case can escalate and become more serious when treated unnecessarily at a higher level. When a case takes off, as it did in this instance, and works its way through the system, it may produce an unpleasant feedback effect for those who first interpreted the signs and acted on them. It is shameful to be accused of discrimination, both for a teacher who reports a case, a school, and the welfare services who deal with it. The particular case, described in this article, was represented in the media as discrimination. In a radio interview commenting on the case, a teacher complained that 'from now on it will be very difficult for us to avert FGM'.

The duty to avert is creating pressure to refer concerns to a higher level. The pressure can result in a hyper-vigilant attitude towards the prevention of FGM, creating false alarms, and escalations of cases. Learning from false alarms through feedback to the lower levels can result in a reaction that is opposite to what the duty to avert intended. It can result in risk-aversion, denial and turning a blind eye to signs that something is seriously amiss, in order to avoid unnecessary trouble. The Discrimination Law can also lead to risk-aversion behaviour, and the two laws together can generate a movement towards keeping silent and disregarding relevant information and signs. As a result of the personal costs added by the imposition of the duty to avert, the expert caregiver may no longer be sufficiently neutral, but unbalanced because of the threats of punishment. The objectivity that was described by Innis (2005) as something that is more characteristic of experts than of primary caregivers may have been reduced as a result.

3. Repertoires and Suspicion

Handelman (1983) found that cases of child abuse develop in stages and have a particular micro-structure. In the first stage, social workers or health workers decide whether or not they are dealing with a case of child abuse, i.e. they are met with the 'problematic situation' and through interpretation, make a decision to act. This implies that the case becomes framed so that what happens next is interpreted and understood with reference to the interpretations and attitudes established in the first phase.

While social/health workers conceive a case as linear, Handelman argues, it can develop into a closed micro-system of meaning and become self-governing. The suspicion and interpretation on which the case is built can be confirmed by the parents' behaviour. Parents of girls who are at risk may fear this development and it may be one of the reasons why some of them avoid or ignore letters from a nurse to attend a meeting, as was reported among our informants. It might also explain why parents feel that they must declare their position very early on ('we do not do it') to avoid activating the duty to avert and to reduce suspicion. Some expert care givers have expressed a feeling of being uncomfortable in their role. One social worker in our study said: 'Often parents dismiss the issue and declare that FGM is something that was practised in the old days. Then it is difficult to continue discussing FGM. And you leave the topic'. Another said: 'Shall we remove their pride immediately? Being integrated is difficult enough. FGM is a terrible tradition, but they have so many

other problems as well, and we do not want to insult them more than necessary'. When parents with African backgrounds declare that they consider it stigmatizing to pursue a discussion on FGM, it will make a conversation about the issue difficult and also reduce the relevance of the ethnicity and the FGM repertoires as frames for interpretation. Hyper-vigilance and over-eagerness resulting from the duty to avert can make parents and children feel that they are persecuted by the law and condemned regardless of the facts. It can lead to a withdrawal from health care, a reaction reported by several health personnel.

VI. CONCLUSION AND RECOMMENDATIONS

The difficulties of interpreting signs to make a qualified interpretation regarding FGM have been analysed and discussed. It is unrealistic to expect that teachers, nurses and social workers have sufficient diverse and contextual knowledge to grasp signs indicating the likelihood of a future FGM-related crime. The cultural and interpretational competence regarding FGM is unclear and leads to superficial, stereotypical, generalized and often wrong conclusions in the interpretation of signs. We have shown that a list of six interpretational repertoires for the interpretation of signs is insufficient within a multicultural setting like Norway. FGM, early marriage and forced marriage have become issues that the authorities must address with the help of experts. There is therefore a need for new interpretational repertoires. The *ethnic interpretational repertoire* is often based on insufficient knowledge and can be assessed as both immoral and illegal. In spite of its incomplete character, it enters cases of child abuse, often as a necessity, in an effort to understand unfamiliar customs and to evaluate issues. Expert caregivers have a heavy burden in trying to avert FGM and they risk personal punishment and blame if it is not averted. And they risk being accused of discrimination if their worries were unfounded. The list of signs prepared by the government is a form of formalized knowledge that creates the illusion that a reliable and qualified interpretation can be made based on the list alone. As we have seen, information derives not only from verbal communication, but also from non-verbal signals, such as the body movements or the psychological mood of a child. Interpretational knowledge from one ethnic repertoire is not necessarily transferable to another. The problem with the duty to avert is that it demands too much of an employee's ability to make a qualified interpretation about a crime not yet committed, thereby putting expert caregivers at personal risk of punishment by the state; consequently, it eliminates some of their neutrality and objectivity.

There are two opposing strategies that may be developed by an expert in an effort to meet the demands of the law. One strategy is to develop a paradigm of suspicion and to become hyper-vigilant in order to satisfy the duty to avert and to be sure that an FGM procedure is averted, thereby potentially creating a false alarm – as in the case we have described here. This strategy also may lead to the persecution of members of the diaspora community. Informants with Gambian and Somali backgrounds within this study have been worried about persecution and discrimination because of FGM. An opposite strategy that may be adopted is to turn a blind eye to signs of FGM as a matter of self-protection, thereby creating silence and secrecy. The reasons underlying this last strategy can be found both in the act against discrimination and the duty to avert: hyper-vigilance can create not only false alarms and stress in the

community, but also lead to a series of accusations of discrimination and blame against the expert caregivers when making mistakes in trying to avert FGM.

The law against discrimination has a knock-on effect on the way a case will be built and may cause employees to be more careful than necessary, thereby creating obstacles to efforts to protect the rights of children. These obstacles have been observed in many European countries (Leye et al., 2007). The dilemma created by the fact that problems are not experienced equally throughout society, so that, in order to achieve equality of protection, protective measures must be applied unequally, implies that there is a need to be aware that the law against discrimination must work at different levels; the group level and the individual level. The aim of the law is to create equality and prevent discrimination. Unfortunately, in some cases, the protection of the rights at the group level may contradict the aim of equality at the individual level. An exaggerated focus on the protection of the reputation (the honour) of a group in order to avoid stigmatization, may lead to individuals within the group being less well protected if their problems are ignored when they are victims of human rights violations caused by members within the group. The law against discrimination should be interpreted and practised in a way that protects individuals within the group, and particularly those who are the most vulnerable, like women and children. This requires that the law against discrimination should not be applied superficially as if protecting a group's honour, but reach down to protect individuals.

As for the duty to avert, the principle of threatening employees with punishment for not trying to avert a crime not yet committed but believed to be likely to happen, should be discussed more thoroughly. We argue that this law is questionable, both in principle and in practice. Solutions aimed at overcoming some of the negative consequences of the duty to avert can be (1) reducing the extra pressure on employees by removing the threat of punishment and fines; and/or (2) providing more cultural and contextual knowledge to give expert caregivers a wider, more in-depth and more relevant interpretational repertoire to enable them to make better interpretations and assessments. Rather than replicating a duty to avert in all European countries, a stronger commitment and focus on the protection of children's and women's rights at an individual level would perhaps be the best way to remove the obstructive factors that can make it difficult to protect girls from FGM. In any event, interpretation will continue to be quite difficult and risky.

NOTES

1. The formulation 'female genital mutilation' (FGM) is most often used in legal documents and when discussing legal documents. 'Female genital cutting' is often used by researchers as it is thought to be a neutral formulation and less stigmatizing than the former. 'Circumcision' is assumed to be a more experience-near concept relating to the assessments of the practice for those who practise the tradition. In this article, in general, we will use FGM as we discuss a legal case and refer to laws and legal documents, but we will also use the words 'circumcision' and 'cutting' when we describe cases described by employees and members within the diaspora communities that use these formulations.
2. Prohibition of Female Circumcision Act 1985; Female Genital Mutilation Act 2003 (for England, Wales and Northern Ireland) and Prohibition of Female Genital Mutilation (Scotland) Act 2005 (for Scotland).

3. The Norwegian Directorate of Health. The Law prohibiting FGM, 2004.
4. Ot.prp. nr. 21, 2003–2004.
5. Ministry of Children and Family and the Ministry of Health (2008: 21).
6. Discrimination Act, Section 4, paragraphs 1 and 2.
7. Letter dated 17 July 2009, our translation.
8. Case no 49/2011.
9. (The Norwegian Discrimination and Equality Tribunal Case no. 49/2011, our translation)
10. The Ombudsman Case, 49/2011: 4.

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