IMPACT OF FEMALE GENITAL MUTILATION ON EDUCATION OF GIRLS WITH HEARING IMPAIRMENT IN GUCHA COUNTY-KENYA

BY

KIMONGE BOCHERE MUMA HILDA
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JUNE 2011
DECLARATION

This thesis is my original work and has not been presented for a degree in any other University.

Signature ……………………… Date …………………

Kmonge Bochere Muma Hilda
E55/12890/05

Supervisors Approval:

This thesis has been submitted with our approval as university supervisors:

Signature…………………… Date………………

Name: Dr. Rachel W. Kamau -Kang’ethe
Department of Early Childhood Studies

Signature…………………… Date………………

Name: Dr. Alice Ondigi
Department of Hospitality & Tourism Management
DEDICATION

My dedication goes to my late father Kimonge who prioritized education as key to life and to my husband Muma and our children: Grace, Teresa Hellen, Rodah and Dad for their moral and material support.
ACKNOWLEDGEMENT

Writing this research was not an easy task. I therefore take this chance to recognize the following as the key persons who assisted me to produce my thesis. First, I would like to extend my recognition to Dr John Aluko Orodho, Senior Lecturer in the Bureau of Educational Research at Kenyatta University for his simple and clear guidance on thesis writing. I also recognize Dr Rachael W. Kamau-Kang’ethe from the Department of Early Childhood Studies, Kenyatta University for her fast and keen approach in correcting the drafts of my work. I further thank Dr Alice Ondigi from the Department of Hospitality and Tourism Management, Kenyatta University for her good efforts in working together with the first supervisor in correcting drafts presented. I am also grateful to Dr John Mugo of the Department of Special Needs Education, Kenyatta University for his wise advice on how to go about with literature review. I also thank Prof. Gathogo Mukuria for his word of encouragement and wise advice on thesis writing. Finally, I extend my appreciation to my family for their support and encouragement during the entire duration I was undertaking my studies at Kenyatta University.
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<table>
<thead>
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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ROK</td>
<td>Republic of Kenya</td>
</tr>
<tr>
<td>FC</td>
<td>Female Circumcision</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>FPAK</td>
<td>Family Planning Association of Kenya</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>PATH</td>
<td>Programme for Appropriate Technology in Health</td>
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<tr>
<td>KDHS</td>
<td>Kenya Demographic and Health Survey</td>
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<tr>
<td>MYWO</td>
<td>Maendeleo ya Wanawake Organisation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>KSDC</td>
<td>Kenya Society for the Deaf Children</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children Education Fund</td>
</tr>
<tr>
<td>ARP</td>
<td>Alternative Rite of Passage</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>WHO</td>
<td>World Health Organization</td>
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The aim of this research was to find out the impact of Female Genital Mutilation (FGM) on education of girls with hearing impairment in Gucha County which is in Kenya. FGM is the partial or total removal of the female external genitalia (WHO, 1995). It results in immediate Physical Problems, for example, intense pain and/or hemorrhage that can lead to shock during and after the procedure, hemorrhage can also lead to anemia, wound infection, including tetanus, damage to adjoining organs from the use of blunt instruments by unskilled operators and urine retention from swelling and/or blockage of the urethra (Koso-Thomas, 1987). According to Rushwan, H. (1996) it also leads to long term complications like Painful or blocked menses, recurrent urinary tract infections, dermoid cysts, and keloid scars(hardening of the scars), infertility and increases the risk of HIV infection. It is against this background that the researcher set to find out the impact of FGM on education for girls with hearing impairments. According to Adoyo P.O (2002) children with hearing impairment have continued to lag behind their hearing counterparts in all academic achievements. This has resulted from the broad regular curriculum which is extensive and demanding and is not adapted to meet the special needs of these children. The effects of FGM outlined above equally affect hearing impaired girls who undergo the process. The objectives of the research were to find out the impact of FGM on: Class attendance, discipline, academic performance, transition to the next level of education after FGM in girls with hearing impairment, and if there are administrative or educational arrangements to assist the students after undergoing FGM to advance their studies. The study used survey design to collect data by using questionnaires on literate girls and teachers and interview schedules on illiterate girls and the headteachers who preferred the method because of administrative commitments of lacking time to fill the questionnaires. Thus, the survey design emphasizes frequency or number of answers to the same question by different people (Orodho, 2005). The target population included all girls with hearing impairment and their teachers who were 40 in number in all the following 5 units: Nduru, Nyakembene, Bombaba, Magena and Nyaigesa in Gucha county. The sample size constituted of 23 girls and 7 teachers, making a total of 30 respondents. The research used simple random sampling which is a procedure in which all individuals in the defined population have an equal independent chance of being selected as a member of the sample (Orodho, 2005). The researcher used purposive sampling method for selecting all girls from upper classes(4-8) only. To achieve the objectives outlined above a T –test was conducted out to determine the significance of the predictor variables. This choice was taken because the sample size was small. A coefficient of the predictor variable was considered significant if it had a value greater or equal to 2.58 at 95% significant level. The impact was found to be significant as 67% of the predictor variables had values above 2.58. The research recommended that Alternative Rite of Passage should be used instead of the procedure as a means of eradicating FGM. Also low reinforcers should apprehend and prosecute any parent or guardian who practices FGM.
CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

FGM occurs throughout the world. WHO estimates that between 100 million and 140 million girls and women alive today have experienced some form of the practice. It is further estimated that up to 3 million girls in sub-Saharan Africa, Egypt and Sudan are at risk of genital mutilation annually in Kenya FGM is practised only among certain ethnic groups and prevalence rates are intermediate. FGM prevalence countrywide is nearly universal among women of the Somali (97 per cent), Kisii (96 per cent) and Masai (93 per cent) groups, and significantly lower among Kikuyu (34 per cent) and Kamba (27 per cent). (UNICEF, 2005).

According to the Global Women project (2007), many girls in the Tharaka region, Kenya quit school as soon as they undergo FGM which is still widely practiced in that region and other parts of Africa. In this region, the practice involves a ceremony to perform the cutting, followed by a month long seclusion for the wounds to heal during which the girls are often beaten and then a big family and community celebration after the seclusion ends where abusive songs are often sung. Because of the harmful physical and psychological effects FGM prevents most girls who undergo it from finishing their education

Education for the hearing impaired remains a big challenge in Kenya. Integration programmes instituted by the Government of Kenya to enable such children learn like other children without disabilities have not met the expectations (Adoyo, 2004). There are difficulties including lack of proper policy structures/guidelines, poor
implementation, inadequate itinerant teachers for peripatetic services and above all negative attitudes towards the programme by the stakeholders. In a further attempt to bring pupils with special needs on board and at par with their hearing counterparts, the Kenyan education policy is currently advocating for inclusive approach. There are few learning institutions for the hearing impaired in the country. Kenya has 29 schools for the hearing impaired, five of which are secondary schools. These Special institutions in Kenya follow the regular curriculum, which is extensive and demanding, centrally designed and rigid, leaving little flexibility for adaptations for teachers to try out new approaches. The timing for the completion of the curriculum is also unrealistic for the deaf students as the teaching and learning processes are slowed down due to the processes involved. According to UNESCO (2005) inclusive method is the way forward for the hearing impaired. This is the inclusion of deaf children in mainstream schools. The basic problems faced when deaf and hearing students are educated together according to Antia and Stinson (1999) are lack of mutual access to communication.

The hearing impaired face great challenges in their strive to attain the academic goals. FGM compounds the problems further as it does not discriminate against them where it is practised. This study will focus on the impact of FGM on the education of girls with hearing impairment. The impact will be measured in terms of Class attendance, discipline, academic performance, transition to the next level of education and if there are administrative arrangements to assist girls continue with their studies.
1.2 Statement of the Problem

Studies conducted by Family Planning Association of Kenya (FPAK, 1996), Maendeleo ya Wanawake Organisation (MYWO, 1998), Oloyinka (1997), and Toibia (1995), indicate that the cultural practice of FGM is a process of transition for an individual from childhood to adulthood. They also observe that FGM aims to curb masturbation, insanity, epilepsy and bestows honour to the initiate. However, there are negative effects such as indiscipline, poor academic performance, repetition of classes and school drop outs (Global Women Project, 2007) that are associated with FGM in school age going girls.

In Africa, WHO estimates that 91.5 million women and girls above 9 years old are currently living with the consequences of FGM, and that 32 percent of all women aged 15-49 in Kenya have undergone the practice. This proportion includes the hearing impaired.

There has been no specific study on the impact of FGM on education for girls with hearing impairments. It is against this background that this research was conducted to determine whether there is any relationship between FGM and the education of the hearing impaired.

1.3 The Purpose of the Study

The purpose of the study was to find out the impact of Female Genital Mutilation on education of girls with hearing impairment in Gucha County.
1.4 Objectives of the Study

The study objectives were:

i) To find out the school attendance of girls with hearing impairments after FGM.

ii) To establish the types of indiscipline in girls with hearing impairments after FGM.

iii) To analyze the academic performance of girls with hearing impairments after FGM.

iv) To find out the transition rates of girls with hearing impairments’ to the next level of classes.

v) To find out if there are administrative or educational arrangements to assist the students after undergoing FGM to advance their studies.

1.5 Research Questions

The following were the research questions: -

i) What are the school attendance patterns of girl children with hearing impairment after FGM?

ii) What are the types of indiscipline cases among girls with hearing impairment after FGM?

iii) How is the academic performance of girls with hearing impairment after FGM?

iv) How is the transition rate of girls with hearing impairment to the next level of education after FGM?

v) What are the administrative or educational arrangements to assist the girls with hearing impairment to advance their studies after FGM?
1.6 **Significance of the Study**

The findings of this study will contribute to advancement of knowledge about the impact of FGM on education of girls with hearing impairment. It will also improve strategies for managing education for girls with hearing impairment before or after undergoing FGM. This information will also be used as a basis for campaigning against FGM in Gucha County and others may use this study as a basis for further research on this subject.

1.7 **Delimitation and Limitations of the Study**

The study delimited itself to all 5 units for girls with hearing impairment in Gucha County where there are rampant cases of FGM. It involved girls with hearing impairment in upper classes (4-8) only. Girls in upper classes were assumed to be of good age to understand FGM. The researcher would have involved other districts in Kenya for more conclusive results, however, this was not possible due to the limited time and resources, both human and finances. There were also limitations of other factors like un-cooperation from headteachers in providing statistical references.

1.8 **Assumptions of the Study**

The following assumptions were made during the research:

i) The selected respondents were aware of FGM tradition among the Gusii people.

ii) FGM targeted all girls in the school going age bracket in the Gusii community.

iii) FGM has a negative impact on education of girls with hearing impairments.
1.9 Theoretical Framework

A theory is defined as a set of interrelated concepts, assumptions and generalizations that systematically describes and explains behavior (Ndurumo, 2007). Therefore, a theory attempts to fit relevant facts into a logical explanation and also serves as a framework for collecting more information. This research study based its findings on Social Learning Theory of Albert Bandura, an American Psychologist. Bandura indicates that a child observes his parents, teachers, siblings and peers and copy desirable or undesirable behaviours irrespective of the consequences. However, the child has ability to select and control his behaviour. The Theory also touches on motivation and reproduction. For example, a learner will continue to enact an acquired behaviour if he/she is motivated. This theory is found relevant to this study because FGM is a social value. Young girls observe what their grandmothers, mothers, aunts, sisters and peers practise. By observing the cultural ceremonies, young girls understand that they have an obligation to do in their lives. Later, they themselves practise FGM irrespective of the negative consequences on their education which include absenteeism, indiscipline, poor academic performance and even dropping out of school. Like what Bandura suggests the girls have the ability to select and control their behaviours by empowering girls with Alternative Rite of Passage as a motivation, the practise of FGM will slowly be phased out.

1.9.1 Conceptual Framework

The researcher developed the conceptual framework by employing two perceptions. The first being reasons given by various societies for supporting FGM. These are shown in figure 1.9.2. below as path A. They include traditional values like social identity, transition from childhood to adulthood, prevention of promiscuity,
acceptance by the society, possibility of marriage, health born babies. Each value above leads to the other. The second perception is shown as path B. These are negative consequences after FGM. They include; school indiscipline, absenteeism, poor academic performance, fighting, repetition of classes, school dropout and early marriage. All these negative effects on education need investigation. Both perceptions, point to FGM, as an independent variable. The following figure shows the positive and negative values of FGM:

**Figure 1.9.2: Conceptual Framework of positive and negative values of FGM**
1.10 Operational Definition of Terms

Female Genital Mutilation (FGM) - refers to female circumcision or the cutting of a woman’s/girl’s genitalia. It is in three forms:

- **Clitoridectomy** – This involves the removing of clitoral hood with or without removing, part or entire of the clitoris
- **Excision** – Involves the removing of clitoris together with part of all labia minora. This is the commonest form of FGM, comprising 80% of all cases in the world
- **Infibulations** - Involves the removing of part or all external genitalia, labia minora and stitching or narrowing the vaginal opening, leaving a small hole for urine and menstruation. This is the most severe form of FGM.

Health risks - refer to dangers caused to the life of an initiate after circumcision

Traditional values – refer to cultural beliefs that are valued highly.

Operation – refers to actual procedure of Female Genital Mutilation.

Promiscuity – Having many sexual partners.

Hearing Impairment: It is a general term indicating a hearing disability that may vary in severity from mild to profound. This is categorised as follows:

- **Deaf**: Are those whose hearing loss is so severe that they cannot hear and understand speech even if the sounds are made louder for them through a hearing aid.
- **Hard of Hearing**: These are people who despite the hearing loss, have enough useful hearing left (residual hearing). This hearing ability can enable them to hear speech and acquire spoken language normally.
CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The literature review sought to make a survey of the studies which have been undertaken with regard to FGM. It focused on origin of FGM, reasons for undertaking FGM, effects of FGM, and education for the hearing impaired in Kenya.

2.2 Origin of FGM

Oloyinka (1997), reports that female circumcision evolved from early times in primitive communities’ desire of establishing control over sexual behaviours of women. In some Western countries like United States of America (USA) and England, genital surgery of clitoridectomy was performed to curb masturbation, nymphomania, hysteria, depression, epilepsy and insanity (Toubia, 1995).

FGM was practised in all the continents of the world including Australia but most people discarded it on seeing that it served no purpose and was harmful to the health of the girl child. For example, FGM was practised by Phoenicians, Hittites, Egyptians and Ethiopians by 5th Century B.C (Toubia, 1995).

In Africa, 28 countries have been practising female circumcision as one of the rites of passage that prepares young girls for womanhood and marriage. Hosken (1993), estimates 80 to 115 million African girls have undergone some form of FGM. Somali is leading with a prevalence rate of 98% and the last country being the Democratic Republic of Congo with the prevalence rate of 5%.
Female Genital Mutilation (FGM) constitutes all procedures which involve the partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reasons (WHO, 1995). Prior to the adoption of the term FGM, the practices were referred to as “female circumcision”.

According to Hosken, F. (1993) there are Four Types of FGM:

*Type 1:* Excision (removal) of the clitoral hood with or without removal of part or all of the clitoris.

*Type 2:* Removal of the clitoris together with part or all of the labia minora.

*Type 3 (infibulations):* Removal of part or all of the external genitalia (clitoris, labia minora, and labia majora) and stitching and/or narrowing of the vaginal opening leaving a small hole for urine and menstrual flow.

*Type 4 (unclassified):* including: pricking, piercing, stretching, or incision of the clitoris and/or labia; cauterization by burning the clitoris and surrounding tissues; incisions to the vaginal wall; scraping or cutting of the vagina and surrounding tissues; and introduction of corrosive substances or herbs into the vagina.

Kenya is among the countries in Sub-Saharan Africa that accounts for 50% of the three types of FGM. These types include: clitoridectomy, excision, and infibulations. According to KDHS (1998) the females who are circumcised between age 15 and 49 are as follows: Kisii (97%), Maasai (89%), Kalenjin (62%), Taita Taveta (59%), Embu Meru (54%), Kikuyu 43%), Kamba (33%) and Mijikenda/Swahili (12%). The above statistical representation indicates that the Gusii community has the highest FGM prevalence rate with 97% and the Mijikenda are the lowest with 12%. This
observation points out that the FGM is most severe in the Gusii community. This formed the basis to investigate the impact this ritual has on the attitudes of girls with hearing impairment towards education.

The controversy towards female circumcision in Kenya goes back to colonial times when the missionaries of Scotland Church in Central Province and the government of the day condemned the act as immoral and unhygienic. Thiongo (1965), reports that female circumcision was also condemned on medical grounds. In 1921, some missionary churches in Guthumo, Kijabe and Kambui urged their followers to stop carrying out female circumcision. This made the government of the day to take a positive stand against FGM. In 1924, Kikuyu Central Association (KCA) was formed and took a firm stand in supporting the colonial government in condemning and regulating FGM. This led to some areas adapting to less severe form of FGM which was clitoridectomy. But Meru and Embu communities still continued with infibulations.

In 1945, the colonial government set up a parliamentary inquiry on FGM and it affirmed that FGM constituted a medical and health problem. It therefore, recommended the government to adapt a policy on a slow but a careful education, enlightening the natives about the customs and traditions which served no purpose. From 1926 to 1956, the colonial government enacted various legislations seeking to change FGM by reducing the severity of the act, defining age of circumcision and endorsing parental consent before the procedure could take place. In 1957, the Local Native Council passed a ban on all forms of FGM but the locals did not respect the ban as they took it to be colonial oriented. Ensuing opposition and related political
outcomes continued by the natives, made the government to revoke all resolutions about FGM in 1958, on the ground that FGM was a deeply rooted and accepted custom. In 1977, the Retired Anglican Bishop David Gitari of Mt. Kenya Diocese condemned FGM as medically dangerous. He also appealed to Christians to shun customs and traditions which were no longer necessary.

In 1982, the Retired President of Kenya, H.E. President Daniel arap Moi condemned FGM in Baringo District and warned that any person found performing the act on girls would be prosecuted. The former president also condemned FGM in Meru District in 1989. From early 1990s, there have been a series of campaigns towards FGM eradication by various groups, institutions, the government and individuals. There have been also Conventions and Universal Declarations on Human Rights which Kenya has put its signature to defend the plight of the girl child, FGM included. For example, Maendeleo ya Wanawake Organization (MYWO) initiated the Alternative Rite of Passage (ARP) in 1991, which was implemented in 1996 and 30 girls graduated. Girls are trained on positive customs without necessarily undergoing physical pain (genital cut). The four pilot project districts for Alternative Rite of Passage to replace FGM were Gusii, Meru, Samburu and Narok.

Between 1995 and 1999, the Alternative Rite of Passage was conducted in Gucha, Meru North, Meru South, Narok and Samburu districts by MYWO and Programme for Appropriate Technology in Health (PATH) whereby 1600 girls went through the process. MYWO and PATH (1999) showed that by April 2001, 3000 girls from the above four pilot districts had gone through the alternative rite of passage.
There are a variety of reasons why female genital mutilation was and is still being practiced. These are discussed in subsections below:

2.2.1 Socio-Cultural Reasons

Some communities believe that unless a girl’s clitoris is removed, she will not become a mature woman, or even a full member of the human race. She will have no right to associate with others of her age group, or her ancestors. Female genital mutilation is believed to ensure a girl’s virginity until she is married.

In some communities, FGM is the rite of passage into womanhood and is accompanied by ceremonies to mark the occasion when the girl becomes a mature woman. In communities girls are subjected to powerful social pressure from their peers and family members to undergo the procedure. They may be rejected by the group or family if they do not follow tradition.

2.2.2 Hygienic and Aesthetic Reasons:

In FGM practicing communities, it is believed that a woman’s external genitalia are ugly and dirty and will continue to grow ever bigger if they are not cut away. Removing these structures makes a girl hygienically clean. FGM is believed to make a girl beautiful.

2.2.3 Spiritual and Religious Reasons:

Some communities believe that removing the external genitalia is necessary to make a girl spiritually clean and is therefore required by religion.
2.2.4 Psycho Sexual Reasons:
A girl who has not gone through FGM is believed to have an overactive and uncontrollable sex drive so that she is likely to lose her virginity prematurely, disgrace her family, damage her chances of marriage, become a menace to all men and her community as a whole. The belief is that the uncut clitoris will grow big and pressure on this organ and arouse intense desire.

2.3 Effects of FGM

2.3.1 Effect of FGM on Education
Studies conducted by Women's Global (2007) a non-governmental organization, found that many girls in the Tharaka region quit school as soon as they undergo female genital mutilation (FGM), which is still widely practiced in that region and other parts of Africa. Sometimes FGM is performed on girls as young as 12 or 13 years old, who most often then drop out of school to marry and start a family. In this region of Kenya, the practice involves a ceremony to perform the cutting, followed by a month-long seclusion for the wounds to heal, during which the girls are often beaten and then a big family and community celebration is performed. Because of the harmful physical and psychological effects of the practice it prevents most girls, who undergo it from finishing their education. According to the World Health Organization (1995) the complications after FGM are common and can lead to death. They include the following:

2.3.2 The Immediate Physical Effects
These include severe pain due to the operation being performed with crude instruments and without anesthesia. The range of complications associated with FGM
is wide. In medical settings where local anesthetic is available, it is difficult to administer an anesthesia as the clitoris is a highly vascular organ with a dense concentration of nerve endings. Multiple painful injections are required to anaesthetize the area completely.

The second effect is the injury to the adjacent tissue of urethra, vagina perineum and rectum which can result from the use of crude instruments, or because the operator is ignorant of the anatomy and physiology of the female external genitalia, has poor eyesight or a careless technique, or may be operating in poor light. Such injury is especially likely if the girl is struggling because of pain and fear. Damage to the urethra can result in incontinence.

Hemorrhage is another problem. Excision of the clitoris involves cutting the clitoral artery which has a strong flow and high pressure. Packing, tying or stitching to stop bleeding may not be effective and this can lead to hemorrhage. Secondary hemorrhage may occur after the first week as a result of sloughing of the clot over the artery due to infection. Cutting of the labia causes further damage to blood vessels.

Shock is another effect. Immediately after the procedure, the girl may go into shock as a result of the sudden loss of blood (haemorrhagic shock) and experience severe pain and trauma which can be fatal. Another problem is urine retention. This can result from swelling and inflammation around the wound, the girl’s fear of the pain of passing urine on the raw wound, or injury to the urethra. Retention is common; it may last for hours or days, but is usually reversible. This condition often leads to urinary tract infection.
Fracture or dislocation is another effect. Fractures of the clavicle, femur or humerus or dislocation of the hip joint can occur if heavy pressure is applied to restrain the struggling girl during the operation. It is common for several adults to hold a girl down during the mutilation.

Infection is another problem which is common as a result of unhygienic conditions; use of unsterilized instruments, the application of substances such as herbs or ashes to the wound, which provide an excellent growth medium for bacteria, binding of the legs following type III female genital mutilation (infibulations), which prevents wound drainage, or contamination of the wound with urine and/or faeces. Infections may prevent the wound from healing and may result in an abscess, fever, ascending urinary tract infection, pelvic infection, tetanus, gangrene or septicaemia. Severe infections can be fatal. Group mutilations in which the same unclean instruments are used on each girl successively may pose a risk of transmission of blood borne diseases such as HIV and hepatitis B, although, there have been no confirmed cases of such transmission to date.

Failure to heal is another physical effect. The wounds may fail to heal quickly because of infection, irritation from urine or rubbing when walking, or an underlying condition such as anaemia or malnutrition. This can lead to a purulent, weeping wound or to a chronic infected ulcer.

2.3.3 Long-term Complications

Physical complications may include difficulty in passing urine which can occur as a result of damage to the urethral and recurrent of urinary tract infection. This is
particularly common following type III mutilation, when the normal flow of urine is deflected and the perineum remains constantly wet and susceptible to bacterial growth. Both types of infection can spread to the uterus and kidneys. If not treated, kidney stones and other kidney damage may result.

Pelvic infections are also common in infibulated women. They are painful and may be accompanied by a discharge. Infections may spread to the uterus, fallopian tubes and ovaries, and may become chronic, leading to infertility due to pelvic infections which cause irreparable damage to the reproductive organs. Keloid scar is another problem. Slow and incomplete healing of the wound and post operative infection can lead to the production of excess connective tissue in the scar (keloids). This may obstruct the vaginal orifice, leading to painful menstrual period. Following infibulations, scarring can be so extensive that it prevents penile penetration and may cause sexual and psychological problems.

Abscess and cysts are also discussed as long term effects. Deep infection resulting from faulty healing or an embedded stitch can cause an abscess which may require surgical incision. Cysts and abscesses on the vulva are the commonest complications of infibulations. They vary in size and occasionally become infected. They are extremely painful and inhibit sexual intercourse.

Clitoral neuroma is another effect. A painful neuroma can develop as a result of the clitoral nerve being trapped in a stitch, or in the scar tissue of the healed wound, leading to hypersensitivity and dyspareunia. Difficulties in menstruation can occur as a result of partial or total occlusion of the vaginal opening. Such difficulties include
accumulation of menstrual blood in the vagina. Haematocolpos may appear as a bluish bulging membrane in the vaginal orifice and can prevent penetrative sexual intercourse. It can also cause distension of the abdomen which, together with the lack of menstrual flow, may give rise to suspicions of pregnancy with potentially serious social implications.

Calculus formation in the vagina is another problem caused by FGM. This can occur as a result of the accumulation of menstrual debris and urinary deposits in the vagina or in the space behind the bridge of scar tissue formed after infibulations. Fistulae (holes or false passages) between the bladder and the vagina or between the rectum and vagina, can develop as a result of injury to the soft tissues during mutilation, opening up infibulations or re-suturing infibulations, sexual intercourse or obstructed labour. Incontinence of urine and feces can be lifelong and have serious social consequences. Problems in childbirth are also common, particularly following severe forms of mutilation, because the tough scar tissue that forms causes partial or total occlusion of the vaginal opening. Difficulties in performing an examination during labour can lead to incorrect monitoring of the stage of labour and fetal presentation. Prolonged and obstructed labour can lead to tearing of the perineum, hemorrhage, fistula formation, and uterine inertia. These complications can cause harm to the neonate (including stillbirth) and maternal death. In the event of miscarriage, the fetus may be retained in the uterus or birth canal.

2.3.4 Psychosocial Complications of FGM

Genital mutilation is commonly performed when girls are young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by
parents, relatives and friends that the girl has trusted. Girls are generally conscious when the painful operation is undertaken as no anesthetic or other medication is used. They have to be physically restrained because they struggle. In some instances they are forced to watch the mutilation of other girls. This can lead to psychosocial problems. Some women suffer pain during sexual intercourse and menstruation that is almost as bad as the initial experience of genital mutilation. Some girls and women are ready to express the humiliation, inhibition and fear that have become part of their lives as a result of enduring genital mutilation. Others find it difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain.

Girls may suffer feelings of betrayal, bitterness and anger at being subjected to such an ordeal, even if they receive support from their families immediately following the procedure. This may cause a crisis of confidence and trust in family and friends that may have long term implications. It may affect the relationship between the girl and her parents, and may also affect her ability to form intimate relationships in the future. For some girls and women, the experience of genital mutilation and its effect on them are comparable to that of rape. The experience of genital mutilation has been associated with a range of mental and Psychosomatic disorders. For example, girls have reported disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentration and learning, and other symptoms of post-traumatic stress. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic or even psychotic disorders. Girls who have not been excised
may be socially stigmatized, rejected by their communities, and unable to marry locally, which may also cause psychological trauma.

2.3.5 Sexual Complications of FGM

Sexual problems as a result of FGM can affect both partners in a marriage, from fear of the first sexual intercourse onwards, and create great anxiety. Excised women may suffer painful sexual intercourse (dyspareunia) because of scarring, narrow vaginal opening, or obstruction of the vagina due to elongation of labia minora, and complications such as infection. Vaginal penetration for women with a tight introitus may be difficult or even impossible without tearing or re-cutting the scar. Inhibition of coitus because of fear of pain may damage the marital relationship and even lead to divorce.

2.4 Education of the Hearing Impairment in Kenya

Education for the hearing impaired in Kenya falls under the ministry of education, special education division. This section of the ministry deals with the administration of education of persons with special needs, education for the deaf being one of them. History of education for the deaf in Kenya dates back to the founding of Kenya Society for Deaf Children (KSDC) in 1958 and the subsequent establishment of the first two schools for the deaf, Nyangoma and Mumias primary schools in western Kenya in 1961. Later, Vocational, Technical and academic secondary schools for the deaf girls and boys were set up.

The hearing impaired children sit for a national examination, Kenya Certificate for Primary Education (KCPE) together with their hearing counterparts in regular
schools. The only rebate offered is an extra 30 minutes during the examination period. There are few academic secondary schools for the deaf, to accommodate those who qualify to proceed for secondary education. The universities in Kenya have no interpreting services for the deaf. Integration programmes have been established so that the hearing impaired are taught in regular schools. In a further attempt to bring pupils with special needs on board and at par with their hearing counterparts, the inclusive approach was initiated.

According to UNESCO (2005), the term refers to the diversity of needs of all learners through increased curriculum content, approaches, structures and strategies, with a common vision which covers all children of the appropriate age range and a conviction that it is the responsibility of the regular system to educate all children. It is a process of reforming schools and attitudes which ensures that every child receives quality and appropriate education within the regular schools. In this way, inclusion is more complex than mere physical placement of children with special needs in the regular classroom.

According to Antia and Stinson (1999), the hearing impaired girls face several challenges such as lack of mutual access to communication. Because of the special communicative consequences of deafness, deaf people risk being isolated if they are put together with hearing pupils who do not know how to sign and that a deaf individual has no chance of real participation if he is surrounded by people who do not know how to sign.
Studies conducted by Liu, Saur & Long (1996) have reported deaf children in inclusive settings experiencing a number of problems some of which include; rapid rate at which tasks in the classroom are discussed, abrupt and quick turn taking in the discussions, rapid change of the conversational theme or topic, the high numbers of speakers involved in a group discussion. These may create difficulties in the control of the communication cop and may result in the deaf not benefiting from the group discussion.

Antia & Stinson (1999) have empirically documented that the outcomes of the academic and social integration are not satisfactory. It has been pointed out that there are some difficulties that are inherent in inclusive practices such as the regular classroom teachers who possess negative attitude towards inclusion.

From the above studies it is evident that the hearing impaired face enormous challenges in their pursuit of academic excellence. FGM compounds the problems because the hearing impaired girls are not spared the rite in the communities which practice it. There are no studies which have been undertaken on the effect of FGM on the education of the hearing impaired, hence, need for this research.
CHAPTER THREE

METHODOLOGY

3.1 Research Design

Survey research design deals with incidences, distribution and interrelations of educational variables. Thus, the survey design emphasizes frequency or number of answers to the same questions by different people (Orodho, 2005). Mugenda and Mugenda (2003) further observe that a survey is an attempt to collect data from members of a population in respect to one or more variables. The research also obtained both qualitative and quantitative data which made it possible to investigate the impact of FGM on education of girls with hearing impairment. Figure 3.1.1. below shows the design model, nature of data which was both quantitative and qualitative, types of instruments which included questionnaires for literate girls and teachers, interview schedule for semi literate girls and the headteachers who had preferred the method.
3.2 Study Variables

A variable is any characteristic which shows variability or variation (Orodho, 2005). Independent variable is the one which the researcher usually controls while dependent variable is the one controlled by independent variable.
**Independent variable: FGM:** This refers to female circumcision or the cutting of a woman’s or girl’s genitalia. An independent variable is usually controlled by an investigator.

**Dependent variables:** These variables are controlled by independent variable. They included: absenteeism, indiscipline, poor academic performance, repetition of classes and school dropout.

### 3.3 The Locale of the Study

The study took place in Gucha County, Kenya. The county has five (5) units for learners with hearing impairment. These units include: Nduru, Nyaigesa, Magena, Nyakembene and Bombaba. These units are located 38, 35, 43, 34, 39 kilometers from Kisii town centre respectively. Nduru unit was where the pilot study was conducted. Gucha County was selected because of its rampant cases of FGM. It is also known as a region with fertile soils where cash crops like tea and coffee are grown besides, food crops like maize, sugarcane and bananas. The people there also practise dairy farming.

### 3.4 The Target Population

The study population included all girls (31) with hearing impairment and their teachers (9), in all the five units in Gucha County, making a total of 40 participants.

### 3.5 Sampling Techniques and Sample Size

#### 3.5.1 Sampling Techniques

This research study used simple random sampling which is a procedure in which all
individuals in the defined population have an equal independent chance of being selected as a member of the sample (Orodho, 2005). Under this method the researcher used purposive sampling in selecting all girls with hearing impairment in upper classes (4-8) only and their teachers. Girls in upper classes were selected because of their age in understanding cultural practices like FGM.

3.5.2 Sample Size

The study sample involved 23 girls and 7 teachers making a total of 30 participants. This excluded those who had participated (8 girls and 2 teachers) at Nuru Pilot Study.

3.6 The Research Instruments

The basic research instruments that were used for this study were questionnaires and interview schedules. The questionnaires had open and closed ended questions. The open ended questions provided an opportunity for the respondents who were literate girls and teachers to reveal the impact of FGM on education of girls with hearing impairment while the closed ended ones were intended to limit the participants so that they would provide specific information. Face to Face Interview was conducted among semi literate and head teachers who had preferred that method because of the commitments they have with administrative work and therefore lacked enough time to concentrate in filling the given questionnaires. All the responses were recorded by the investigator and her assistant.

3.7 Pilot Study
Before the actual study, there was a pilot study which was conducted at Nduru Unit with 8 girls and 2 teachers to test validity and reliability of the questionnaires and interview schedule.

### 3.7.1 Validity

Validity is the extent to which an instrument actually is designed to measure. To ascertain validity of the questions and the interview schedule, the researcher consulted her supervisors from Kenyatta University. The pilot exercise gave a basis for rectifying any mistakes in the questionnaires.

### 3.7.2 Reliability

Reliability refers to the degree of consistency between two measures of the same thing. Fraenkel & Wallen (2009) advanced that a measuring instrument is reliable if it provides consistent information after several tests. It must have the capacity to consistently yield similar results when repeated measurements are taken under the same conditions. The test-retest method was used during the pilot study to test the reliability of the instrument. After administering the 1st test, the researcher waited for 2 weeks before administering the 2nd one with the same questions but written on papers of a different colour. The responses provided during the second test were the same as those given in the first one. The researcher therefore, concluded that the questionnaires and interview schedule were reliable.

### 3.8 Data Collection Techniques

The researcher used both quantitative and qualitative methods because both approaches were found useful. For quantitative data, bar graphs, tables and
percentages were used. To analyze qualitative data the researcher recorded in descriptive manner all the responses provided by semi literate girls and the head teachers. T-test was then used to show the relationship between FGM and its impact on education of girls with hearing impairment.

3.9 Logistical and Ethical Considerations

A letter was sought from the Dean, School of Graduate Studies, Kenyatta University which enabled the researcher to get a permit from the Ministry of Education Science and Technology. The permit together with the letter of authorization from National Council for Science And Technology were presented to the District Commissioner, District Education Officer, Medical Officer of Health, Assistant Education Officers and all the five Head teachers of the five Units for the Hearing Impaired in Gucha County. The researcher then was allowed to conduct the research in the respective units for the hearing impaired girls. The respondents were assured of confidentiality of responses provided. They were also not supposed to disclose their names when answering the questionnaires or when they were being interviewed. The participants were also explained the importance of that research in learning process. Any respondent had a right to withdraw from participating if he or she considered doing so and that decision could remain binding.
CHAPTER FOUR
DATA ANALYSIS, RESULTS AND DISCUSSION

4.0 Introduction

This study sought to establish whether FGM affects the education of hearing impaired girls. The impact was assessed in terms of school attendance, academic performance, type of indiscipline, and transition rates to the next level of classes.

4.1 Methods of Data Analysis

Data was analyzed using frequencies, bar graphs, percentages and tables. T-test was used to ascertain the level of significance of the impact of FGM on education of the hearing impaired as shown in the following bar graphs:

Figure 4 1.1 Showing the age of circumcision
The graph depicts that a large proportion of the girls undergo the rite between six and ten years. This is a tender age where they have begun their schooling. At this age they do not understand FGM and why they have to go through it. The pain experienced during the exercise affects them physically such that they are not able to attend school for at least 20 days during the healing process. The girls are also affected psychologically in the long run.

As a result their education will be affected and they will not perform like their counterparts who do not undergo the rite.

**Figure 4.1.2 Common reasons for circumcising girls in Gusii community**

As indicated in the graph above, girls are circumcised for various reasons. The most dominant reason for circumcision among the girls is to prevent immorality at a rate of 65%. This is followed by a sign of maturity into adulthood (5%), to gain respect among girls (2%) and for identity with the community.
The figure shows that after FGM girls undergo behavioral changes some of which are undesirable. A majority of the girls engage in fights (35%) with other girls especially those who have not undergone that rite of passage and are known as *ebisagane* in Ekegusii language. Lack of respect for teachers also takes a proportion of 26%, lateness (22%) and use of vulgar language at a rate of 17%. Such behaviors results in distractions such that the girls cannot fully focus on their studies. Also lack of respect for their teachers implies that they will not be very keen in class when they are being taught by the same teachers. The overall effect will be poor performance in class.

**Table1. Showing T-test for the individual factors**
Average number of days attended in a term before and after the FGM

<table>
<thead>
<tr>
<th>Factors</th>
<th>T – test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days attended</td>
<td>5.375</td>
</tr>
<tr>
<td>Academic performance</td>
<td>3.17</td>
</tr>
<tr>
<td>Transition rates</td>
<td>1.0</td>
</tr>
</tbody>
</table>
The T-value is significant where the test statistic is greater than 2.58 at 95% significant level. The significant coefficients imply that the FGM affects the education of the hearing impaired. A coefficient of less than 2.58 indicates that FGM has no impact on the education of the hearing impaired with respect to the predictor variable. From the table 1 above only two predictor variables that is number of days attended and academic performance have a t-value of more than 2.58. This implies that FGM affects the number of days attended by the girls and also their academic performance. These factors have an overall impact on the education level of the affected girls.

The transition rates are not affected as the t-value is less than 2.58. This shows that FGM does not affect the transition rates significantly.

The study therefore advocates that FGM has an impact on the level of education for the hearing impaired girls. According to the t-test, this is supported by 67% of the predictor variables. The transition rates could be affected by other factors besides FGM as there is no significant relationship.

The level of indiscipline cases after FGM, the age of circumcision and the reasons for undertaking FGM do not support the education for hearing impaired girl child. It is therefore evident that FGM impacts negatively on the education of the girl child.
CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATION

5.0 Introduction
This section of the study ties up the observations made in the field study with the objectives set at the beginning of the study. The chapter further touches on summary, the implication of the study findings, conclusion, recommendations and further research.

5.1 Summary
The objective of this study was to find out the impact of FGM on education of girls with hearing impairments in Gucha County, Nyanza Province. The study found that FGM has an impact on the level of education for the hearing impaired girls. According to the t-test this is supported by 67% of the predictor variables.

5.2 Implications of the Findings
It was observed that a large proportion of the girls undergo the rite between six and ten years. This is a tender age where they have begun their schooling. The pain experienced during the exercise affects them physically such that they are not able to attend school for at least 20 days during the healing process. The girls are also affected psychologically in the long run. As a result their education is affected and do not perform like their counterparts who do not undergo the rite.

Girls are circumcised to prevent immorality as a sign of maturity into adulthood, to gain respect among girls and for identity with the community. The reasons raised
were non academic. The exercise therefore does not consider its effects on education of the girls.

Girls undergo behavioral changes after FGM, some of which are undesirable. They engage in supremacy fights with other girls especially those who have not undergone the ritual. They also lack respect for their teachers, such behaviors results in distractions such that the girls cannot fully focus on their studies. Also lack of respect for their teachers implies that they will not be very keen in class when they are being taught by the same teachers. The overall effect will be poor performance in class.

The study therefore, concludes that FGM has an impact on the level of education for the hearing impaired girls. According to the t-test this is supported by 67% of the predictor variables. The transition rates could be affected by other factors besides FGM as there is no significant relationship.

5.3 Conclusion

The study has shown that FGM has a negative impact on the education of girls with hearing impairment. As a result more emphasis should be placed on the alternative rites of passage. For example, in the Tharaka Nithi county of Kenya, new festivals have been organized for the months of August and December, when circumcision is usually performed. The local group calls itself, "Ntanira na Mugambo" which loosely translates as "circumcision through words". With support from their local community the women have devised a new approach to initiation into womanhood that includes song, education, celebration, and a week of seclusion. During a week of seclusion, girls in the alternative program are educated on a wide range of subjects, including
personal hygiene, relationships, dating, courtship, and marriage. The program also covers topics such as peer pressure, male and female reproductive anatomy, menstruation, conception, prevention of pregnancy, the consequences of teen pregnancy, sexually transmitted diseases including; HIV and AIDS, and ways to prevent exposure. Positive aspects of tribal culture are also taught, such as self esteem, decision making, and respect for elders.

MYWO has found an alternative rite of passage to be working well. Girls are put in a class of their own, secluded and thoroughly educated on matters relating to adulthood and maturity. When they are ready, the girls graduate and are considered adults. This points to the fact that the problem can be tackled if society is thoroughly educated and sensitized on the subject. Once the society as a whole understands and accepts the problem and the benefits of available alternatives, no one will have to go through circumcision or Female Genital Mutilation (FGM).

Tanzania adapted a program for initiation without mutilation in 1998. Girls aged 10 to 13 receive instruction in domestic chores, midwifery, hygiene, sex and pregnancy over a two-week period. For the initiation ritual, the girls are beautifully dressed and participate in a ceremony where they demonstrate their readiness to receive instructions in womanhood. The whole village joins in drumming, singing, dancing and feasting to celebrate the new phase of the girls' development. The Inter-African Committee has urged all African countries to develop initiation without mutilation.
5.4 Recommendations

There should be severe penalties to the parents who force their children to undergo FGM and also law enforcement agencies should ensure all the culprits are apprehended. Also alternatively Rite of Passage should be emphasized and advocated for by all stakeholders of education. Centres like the ones run by World Vision in West Pokot and other areas in Kenya should be supported so as provide shelter for girls who have run away from home because of FGM. Structural adjustments should be undertaken on the integration programme so that the outcomes are satisfactory (Antia & Stinson 1999). For example, replacement of the regular classroom teachers who show negative attitude towards inclusion should be done.

5.5 Further Research

The study has made various recommendations in regards to the impact of FGM on the education of girl child with hearing impairment. The recommendations reflect the scope of the measures that would be applicable at the society level. However there are other areas that need further research since this study did not exhaust them. The first key area of further research is to find out the social dynamics that lead to bullying which was observed as the most common indiscipline case in girls with hearing impairments.

The second area to be researched in future includes that of comparison of academic performance of girls with hearing impairment who have gone through FGM and that of those who have not.
REFERENCES


Carr, D. (1997). *Female Genital Cutting Findings from Demographic and Health Survey*. Macro International Calverton. Maryland, USA.


APPENDICES

Appendix 1: Research Authorisation

NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Telegram: "SCIENCETECH", Nairobi
Telephone: 254-020-461340, 2218249
254-020-310571, 2213123
Fax: 254-020-2213125, 218245, 218249
When replying please quote
Ref: NCST/5/002/R/765/5

Our Ref:

Kimonge Bochere Muma Hilda,
Kenyatta University,
Po Box 43844,
NAIROBI

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on “Impact of female genital mutilation on education of girls with hearing impairment in Gucha District, Kenya” I am pleased to inform you that you have been authorized to undertake your research in Gucha District for a period ending 30th June 2010.

You are advised to report to The District Commissioner and The District Education Officer and The Medical Officer of Health, Gucha District before embarking on your research project.

Upon completion of your research project, you are expected to submit two copies of your research report/thesis to our office.

[Signature]
PROF. S. A. ABDULRAZAK Ph.D, MBS
SECRETARY

Copy to:
The District Commissioner
Gucha District

The District Education Officer
Gucha District
Appendix 2: Questionnaire for Girl Pupils in Upper Classes Only

Girls’ Questionnaire about the impact of Female Genital Mutilation on their education. This information will be treated as confidential. Do not write your name on the Questionnaire:

Please tick or write the answer.

1. Age:
   i) Below 10 years old
   ii) 10 – 20 years

2. Have you ever participated in circumcision ceremonies as an initiate?
   (i) Yes (ii) No

3. At what age are girls in Gusii community circumcised?
   i) Below 5 years old
   ii) 6 - 10 years old
   iii) 11 – 15 years old
   iv) 16 – 20 years
   v) Above 20 years old

4. Choose the most common reason for circumcising girls in Gusii community.
   i) Respect among the peers
   ii) Maturity into adulthood
   iii) Identity with the community
   iv) To prevent immorality

5. i) Do you know of any of your classmates who did not continue with schooling after FGM?
   ii) If yes, how many? ..........................................................
 iii) Where did those classmates proceed to after FGM?

.................................................................................................................................

6. Briefly explain the behavioural changes in girl students after undergoing changes in girl students after undergoing FGM?

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.................................................................................................................................

7. Are you aware of any indiscipline cases among girl students after the FGM? If yes, what are the examples?

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8. Are there any arrangements to assist girl students with hearing impairments to continue with their education after FGM?

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.................................................................................................................................

9. i) What are the alternative rites of passage available in Gucha District for girl children with impairment?

ii) Do you think there are beneficial to the education of girl children with impairment and if so why?

Thank you for your time to answer my questions
Appendix 3: Questionnaire For Head Teachers And Teachers

Teachers’ Questionnaire about the impact of FGM on education of girls with hearing impairment in Gucha district.

Please tick or write the answer. Everything written is treated as confidential.

1. Age:
   i 18 – 20 years old
   ii 20 – 30 years old
   iii 30 – 40 years old
   iv Above 40 years old

2. Gender:
   I Female
   ii Male

3. At what age are girls in Gusii community circumcised?
   i Below 5 years old
   ii 6 - 10 years old
   iii 11 – 15 years old
   iv 16 – 20 years
   Above 20 years old

4. Choose the most common reason for circumcising girls in Gusii community.
   i) Respect among the peers
   ii) Maturity into adulthood
   iii) Identity with the community
   iv) To prevent immorality

   Any other (Specify) ..................................................
5. How is the transition of girl students with hearing impairment to the next level of classes after FGM? (Kindly provide relevant statistical records)

........................................................................................................................................
........................................................................................................................................

6. What is the most common type of incidence among girl students after FGM in your school?
   i) Absenteeism
   ii) Lack of respect
   iii) Poor academic performance
   iv) Repetition of classes
   v) Dropping out of School

7. What is the academic performance trends of girl students with hearing impairments after undergoing FGM? (Kindly provide relevant statistical records) .........................................................................................................................
........................................................................................................................................
........................................................................................................................................

8. What are the administrative or educational arrangements to assist the girls with hearing impairment to advance their studies before and after FGM in Gucha District?
........................................................................................................................................
........................................................................................................................................

Thank you so much for your time to answer my questions