

**PSYCHOSOCIAL EFFECTS OF FISTULA ON ADOLESCENT GIRLS:
IMPLICATIONS ON THEIR EDUCATION AND THE ROLE OF GUIDING
AND COUNSELLING.**

BY

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DECLARATION

Declaration by the Candidate:

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DEDICATION

I dedicate this thesis to my dear mama, Susan Ondiso (RIP). You made me who I am today. I cherish the values and ethos you taught me. Mama-you will always be my hero and pillar of strength. Dad, Mr. Michael E. Otondo. My love, Aekoz-you have always been there for me giving me moral support. Mr. and Mrs. Hillary Mabeya; and the entire fraternity of fistula stakeholders, fistula patients and survivors whom we share experience.

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ABSTRACT

The purpose of this study was to investigate the psychosocial effects of fistula on the education of adolescent girls affected with fistula and the role of guidance and counseling. The main objective of this study was to investigate the psychosocial stressors of fistula among adolescent girls in learning institutions in order to establish how their education is affected by fistula and the role of guidance and counseling in helping them to adjust in school. This study was guided by self-determination theory. It adopted the qualitative approach and phenomenological design. Purposive sampling was used to select adolescent girls who have suffered from fistula. The target population included adolescent girls in learning institutions with their ages ranging from thirteen to twenty three years old. Data was analyzed by use of thematic and content analysis. A biographical form was used to obtain personal data from the adolescent girls affected with fistula. Fifteen adolescent girls were interviewed. Majority of fistulas resulted from obstructed labor. Most of the participants were in primary school when they developed fistula which led to them dropping out of school. The adolescent girls were out of school for at least a year before they were facilitated to resume school. The study found out that psychosocial stressors such as loneliness, resentment, and isolation among others affected the education of the adolescent girls. Guidance and counseling is an important service in reintegrating the adolescent girls back to school and creating their self-esteem. The study recommends addressing teenage pregnancy to prevent occurrence of fistulas among adolescents. It also recommends empowering the adolescent girls who have been affected with fistula through education so as to reduce the stigma associated with fistula.

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ACRONYMS

HRO	Human Rights Organization
HRW	Human Rights Watch
KNH	Kenyatta National Hospital
MOH	Ministry of Health
NGO	Non-governmental organization
OF	Obstetric Fistula
PTSD	Post-Traumatic Stress Disorder
RVF	Recto-Vaginal Fistula
SDT	Self-Determination Theory
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Funds
VVF	Vesco-Vaginal Fistula
WHO	World Health Organization.

CHAPTER ONE

INTRODUCTION

1.0 Overview

In this chapter the following are discussed; the background of the study, statement of the problem, purpose of the study, research objectives and questions, significance and justification of the study. It also presents the limitations, assumptions, scope, the theoretical and conceptual frameworks and the operational definitions of terms.

1.1 Background to the Study

Result Education Fund (2009) established that education is a basic human right and a significant factor in the development of children, communities, and countries. Opening classroom doors to all children, especially girls, will help break the intergenerational chains of poverty because education is intrinsically linked to all development goals such as supporting gender empowerment, improving child health and maternal health, reducing hunger, fighting the spread of HIV and diseases of poverty, spurring economic growth, and building peace. Result Education Fund (2009) also established that particularly for women and adolescent girls, the economic and personal empowerment that education provides allows them to make healthier choices for themselves and their families. Benefits of girls education include not only reducing the impact of HIV/AIDS, but reduction of poverty, improvement of the health of women and their children, delay of marriage, reduction of female genital cutting, and increase in self-confidence and decision-making. On average, for a girl in a poor country, each additional year of education beyond grades three or four will lead to 20% higher wages and a 10% decrease in the risk of her own children dying of preventable causes (Result Education Fund, 2009) like maternal morbidity.

While education is important, poor health may prevent children from attending school and from learning. The equivalent of more than 200 million school years is lost each year in low income countries as a result of ill-health. The impact on learning and cognition is equivalent to a deficit of more than 630 million IQ points (Partnership for Child Development, 2015). Recent research has shown that poor health among children reduces their time in school and their learning during that time (Glewwe & Miguel, 2008), yet hundreds of millions of children in less developed countries suffer from poor health (Befekadu, 2000).

According to Thui, Creanga and Ahmed (2007) most women affected with obstetric fistula are from rural areas where health services are poor or non-existence; road conditions make travel difficult, and the cost of transportation and medical care are too high. These women, usually poor and illiterate, are married and have their first pregnancy at a young age (Thui, et al, 2007). They are exposed to early and frequent sexual relations and to repeated pregnancies and childbirth before they are physically mature and psychologically ready. This increases the risk of developing Obstetric Fistula, a devastating consequence affecting over two million girls and young women (Human Rights Organization (HRO), 2014).

Fistula is a health issue that qualifies as a traumatic event leading to the development of post-traumatic stress disorder (PTSD) or post-traumatic stress (WHO, 2006; Ahmed & Holtz, 2007). This is evident in a prospective observational study to screen women in Bangladesh and Ethiopia with fistula for mental health dysfunction. In this study, out of 68 women with fistula, 66 were at risk for mental dysfunction as measured by the General Health Questionnaire (GHQ-28) (WHO 2006; Ahmed & Holtz 2007). Another study by United Nations Population Fund (UNFPA), (2004)

indicates that women with obstetric fistula face a myriad of psychological problems which include mental health dysfunctions, PTSD, loss of body control, and loss of dignity and self-worth. As a result of their health condition, women with obstetric fistula may lose their jobs or will not be able to carry out economic tasks they used to do (Mutambara, Maunganidze, & Muchichwa, 2013). Reliable evidence shows that ill health affect access, participation, completion and achievement (Pridmore, 2007).

Fistula also predisposes women to high levels of depression as researched by Khisa, Mutiso and Mwangi (2011) on 70 women who consented and attended a fistula camp at Kenyatta National Hospital (KNH). Among them, 2(2.9%) and 12(17.1%) reported a history of psychiatric illness and suicidal ideations respectively while depression was present in 51(72.9%) patients with 18(25.7%) meeting criteria for severe depression. The social consequences of fistula are very severe according to Wall (2006). They include a continuous and uncontrollable stream of urine or feces or both coming out of her vagina which is both a physical and social catastrophe. Wall says “No escape is possible from the constant trickle of urine, the constant ooze of stool. 24 hours a day, these women become physically and morally offensive to their husbands, their families, their friends and their neighbor’s. Indelibly stigmatized by their condition, they are forced to the margins of society.”

According to Wall, Arrowsmith, Briggs, Browning and Lassey (2005) as quoted “unaccounted hundreds of thousands of young mothers annually suffer childbirth injuries; injuries which reduce them to ultimate state of human wretchedness. These young women belonging generally to the age group of 15-23 years and at the very beginning of their reproductive lives, they are more to be pitied. They are constantly in pain, incontinent of urine or feces, and bearing a heavy burden of sadness in

discovering their child is stillborn. They are ashamed, abandoned by their husbands, outcasts of society, unemployable except in the fields they live. They exist, without friends and without hope because their injuries are prudential, affecting those parts of the body which must be hidden from view and which a woman may not in modesty easily speak about. They endure their injuries in silent shame.” Tan (2004) further argues as quoted “once married, young girls will no longer be able to stay in school. They tend to be socially isolated, sequestered at home to raise another generation of children where daughters are again deprived of opportunities to break out the intergenerational cycles of early marriage and poverty. Ultimately, it is the society which pays for this. The young brides, as well as their children, face greater risks for illness and death.” The young brides also represent “wasted human capital”, reduced to becoming “baby-makers” yet vulnerable to suffering child birth injury including fistula” (Tan, 2004)

One major contemporary social problem confronting most countries in the world is teenage pregnancy (Gyan, 2013) and child or early marriage. As indicated by UNICEF (2014), worldwide, more than 700 million women alive today were married before their 18th birthday. More than one in three (about 250 million) entered into marriage union before age 15. This means that the adolescent girls education ended, thus closing their academic prowess and participation in development yet creating an illiterate society and placing them to a vulnerable position of suffering a fistula. WHO (2006) indicates that over 14 million girls give birth each year, among them 12.8 million from developing countries with Africa having the highest level of adolescent pregnancies. In Kenya, 20% - 30% of adolescent girls have babies before the age of 18 (WHO, 2006)

Kalembo and Zgambo (2012) estimate that more than 2 million young women live with untreated Obstetric Fistula which has remained a hidden condition because it affects some of the most marginalized members of the population; poor, young, often illiterate girls and women in remote regions of the world. According to WHO (2006) fistula is a health issue that affects adolescent girls. Poor health prevents them from attending school and learning (Partnership for Child Development, 2015). Health related problems play a major role in limiting the ability to learn through sensory participation, cognitions, connectedness and engagement with school leading to absenteeism and dropping out of school. This is the basis of this study, to investigate the psychosocial effects of fistula on adolescent girls and its implications on their education and the role of guidance and counseling in adjustment of the adolescent girls.

1.2 Statement of the Problem

According to Bloom, (2007), “good health means that children can attend school more frequently and pay attention in class. Good attendance enabled by good health, is more likely to lead to higher attainment through secondary and post-secondary education and in adulthood.” Health has effects on cognitive development and school participation in both the short and the long-term. In the short-term, poor health can lead to poor participation, irregular attendance and high rates of drop-out. In the long-term, poor health can lead to a decrease in wages earned and productivity (Sridher, 2008). Fistula is a health issue which qualifies as a post-traumatic stress disorder (WHO, 2006; Ahmed & Holtz, 2007). Adolescent girls affected with fistula suffer psychological problems and those who have experienced rape or other sexual violence often suffer additional social stigma, (MacDonald & Stanton, 2007).

According to Ding and Lehrer (2007) the academic performance of female students is strongly and negatively affected by poor physical and mental health conditions. The young people's health influences their ability to learn and to complete school because health and education are closely related (Tate, 2013). Research shows that an individual's health status measured by the probability of sickness significantly affects academic success. Experiencing sickness before the age of 21 decreases education on average by 1.4 years (Suhrccke & De Paz Nieves, 2011).

Many women have been living with fistulas for years or even decades, and because of their incontinence, they are viewed by their families and communities as disabled and defective. This results in missed opportunities for schooling especially for the adolescent girls yet fistula is preventable, treatable and manageable, but the public does not understand due to lack of knowledge about fistula (UNFPA, 2004). Fistula is a problem that affects many adolescent girls as indicated in the report on Kenya country situation presented at the 2nd meeting of the working group in Addis Ababa Ethiopia in 2002. The number of vesico-vaginal fistula (VVF) operations done annually during the ten years between 1992 and 2001 increased steadily from a low of 36 cases to a high of 479 cases (MOH & UNFPA, 2004). Therefore, there is need to understand the problem of fistula so as to help reintegrate the affected into the society. The adolescent girls need a continuum of care which include; self-care, antenatal care, care during birth and care after birth. Several studies cited in Kipkulei, Chepchieng, Chepchieng, & Boitt, (2012) have shown that female education worldwide provides benefits to the family and the society at large. Therefore there is a continuous need to study the factors that negatively affect girls' participation in education so as to make education accessible to them which will enable them to contribute meaningfully to their communities and nations development. Therefore fistula being a health issue,

there is need to investigate its effects on the adolescent girls education and how guiding and counseling can help build their resilience.

1.3 Purpose of the Study

The purpose of this study was to investigate the psychosocial effects of fistula on the education of adolescent girls and the role of guidance and counseling in helping the adolescent girls back to school.

1.4 Research Objectives

This study was guided by the following objectives:-

1. To establish the influence of psychosocial effects of fistula on adolescent girls education in learning institutions.
2. To investigate the psychosocial stressors of fistula among adolescent girls in learning institutions.
3. To find out the role of guidance and counseling in helping adolescent girls affected with fistula to adjust in learning institutions.

1.5 Research Questions

The following research questions which were derived from the research objectives were answered in this study:

1. What is the influence of psychosocial effects of fistula on adolescent girl's education in learning institutions?
2. What are the psychosocial stressors of fistula on adolescent girls in learning institutions?
3. What is the role of guidance and counseling in adjustment of adolescent girls affected with fistula in learning institutions?

1.6 Significance of the Study

Most people are unaware that fistula is a preventable and treatable condition. Many have suffered with it for decades. For instance, a study in Kenya by UNFPA (2014), estimates that 3000 new cases develop each year and only 7.5% are able to access treatment. There is therefore the need to study the psychosocial effects of fistula. This study seeks to assess the psychosocial effects of fistula on adolescent girls in Kenya and its implications to their education so as to help the adolescent girls affected with fistula to be reintegrated especially at school for better academic performance.

If the root problem of fistula is not addressed the adolescent girls will continue to face more psychosocial challenges causing anxiety, depression, school-dropout, inferiority complex, a low self-esteem, early pregnancies and above all poor education and subsequent poor academic performance. Helping adolescent girls affected with fistula to cope and reconnect with the society can only be done by exploring what they experience and their dilemmas. This research also aims to suggest ways of closing the gap between adolescent girls affected by fistula and those not affected in respect to their education. This is necessary because to achieve universal education; the government spends a lot of money in education after the introduction of free primary education in 2002. This will be attained by suggesting sound education policies, measures and solutions to minimize the consequences of fistula on the academic performance of adolescent girls in Kenya because closing the gender equality gap is essential to the achievement of better health which enables children to learn.

1.7 Justification of the Study

Much investigation on fistula focuses on the treatment and physical repairs with little if any on social and psychological impacts. This study therefore embarked on

investigating the psychosocial impact of fistula and its implication to the education of adolescent girls in Kenya. This is a neglected component and yet an aspect of re-integration to benefit these adolescent girls and the society as a whole. This would enable the adolescent girls to go back to school and to be accepted into the society. The government will then attain two of the millennium goals which include attaining universal primary education and promoting gender equality and empowering women. This would also be useful information for service providers especially teachers; adolescent girls themselves and the stakeholders in the fistula world including the government in its endeavor to attain vision 2030 of empowering women and eradicating poverty and ensuring universal primary education.

The motivation behind this research is that fistula is a problem as indicated in a study by Khisa, Mutiso and Mwangi (2011) which shows that of the patients admitted at KNH ranging between 13-76 years; nearly half who were 25 years and below had lived with the condition for an average of 6 years. This shows that many women and adolescent girls, particularly the poor, illiterate, and rural are not fully enjoying the benefits which the Kenyan government has put in place to reduce maternal mortality and morbidity by introducing free maternal care; and to foster education by free education as indicated in the Millennium Development Goals, (HRW, 2010). Many adolescent girls face higher risk of developing fistula and dropping-out of school. This consequently would lead to health issues which may lead to psychosocial problems that might impact on the educational performance of the adolescent girls.

The findings of this study may help to reduce the psychosocial effects of fistula on adolescent girls by addressing them. They will also help to reintegrate the adolescent

girls back to school so as to empower them academically and to build their self-esteem through guidance and counselling.

1.8 Scope of the Study

This study was carried out in Kenya and participants drawn from the *Beyond Fistula* Non-Governmental Organization program situated in Eldoret town. This program empowers women who have suffered from fistula by sending them back to school or to vocational training after receiving them from different parts of Kenya. The study participants were adolescent girls who have received fistula treatment and aged between 13 to 23 years old and in learning institutions. This study addressed the psychosocial stressors of fistula on the adolescent girls and its implications on their education in learning institutions. The researcher also established the role of guidance and counseling in helping the adolescent girls affected with fistula especially in their inclusion in education.

1.9 Limitations of the Study

This study considered data from adolescent girls in school drawn from the *Beyond Fistula* NGO program only which may not be a representative of all adolescent girls affected with fistula. This means that only their views were given because it was difficult to locate other adolescent girls affected with fistula from the community and yet research indicates that there are many adolescent girls suffering from fistula. However this data set represents a broad sample of adolescent girls from a range of counties despite the fact that fistula is a hidden occurrence and it may be difficult to obtain a national representative of women who have this condition. But to my knowledge this research represents the first research description of experiences of adolescent girls affected with fistula and its effect on their education in Kenya. To

ensure concrete data, thick description was used and data collected till point of saturation.

This study also used unstructured interview with participants. This poses a likelihood of bias responses due to the presence of the researcher and inherent inaccuracies and reporting biases. This research used biographical forms and in-depth interview questions to allow better understanding of nuances of adolescent girl's experiences with fistula. Confidentiality was assured and rapport created to encourage genuine responses.

1.10 Assumptions of the Study

This study assumed that the respondents who are adolescent girls shared their experiences honestly and accurately as they are familiar with the researcher after creating a rapport with them.

It also assumed that the adolescent girls were in a position to talk about their condition despite their life having been affected with fistula.

1.11. Theoretical Framework

This study was based on Self-Determination Theory (SDT) developed by Edward L. Deci and Richard M. Ryan 1980. This theory deals with human motivation, personality and optimal functioning (Tran, 2014). The theory focuses on volitional or self-determined behavior and the social and cultural conditions that promote it. SDT also postulates a set of basic and universal psychological needs of autonomy, competence and relatedness, which are apparent in every culture and in all developmental phases of life (Deci & Ryan, 2000), the fulfillment of which is

considered necessary and essential to vital, healthy human functioning regardless of culture or stage of development (Ryan 2009).

Autonomy is defined as being in control and able to express one's preferences (Deci & Ryan, 2000) and the need to control the course of one's life (Tran, 2014). Autonomy is high when individuals feel they are engaging in exercise because they choose to do so, not because they feel pressured by other people or external factors. Ideally, exercisers will engage in exercise because they enjoy the experience.

Walsh, (2011) defines Competence as, a perceived self-belief in one's ability to perform well in an activity. Feedback is a great tool for influencing clients' competence.

According to Ryan, (2009), Relatedness is defined by a feeling of connection to an environment and/or other human beings, being helpful to others and being helped by others. It is a sense of shared experience. Motivation can improve in clients if they feel there is a warm, accepting atmosphere (Walsh, 2011).

According to Pius, (2010), SDT has been found to predict how a person will develop their interests and passions. SDT supports the hypothesis that all individuals have ordinary, instinctive, and beneficial inclinations to improve themselves. SDT provides a foundation to understand how to motivate people in different domains. It is a framework that was designed to explain the motivation behind a person's growth and development as a human being. It proposes that individuals have an innate tendency to understand, explore, and impact their worlds. SDT suggests that this self-determined or autonomous motivation emanates from the individual and leads to optimal persistence and performance. SDT has been used to forecast a large collection of psychological and developmental outcomes, as well as to examine the social and

cultural circumstances that enhance or diminish people's natural interests and passions (Deci & Ryan, 2000).

Educational progress will be profoundly limited if adolescent girls affected with fistula are not motivated and able to learn. Health-related problems play a major role in limiting the motivation and ability to learn. Educationally relevant health disparities including fistula impede motivation and ability to learn through sensory perceptions; cognitions; connectedness and engagement with school; absenteeism; and dropping out (Basch, 2010). The adolescent girls' interests and passion to education are diminished and thus need to reexamine them by SDT.

Fistula leaves women leaking urine and or feces which lead to most of them to be ostracized, rejected, abandoned and described as dead women walking (HRO, 2014). Their relatedness, autonomy and competence are thwarted due to feelings of having no close affectionate relationship with others. They lack the control of their life especially that they cannot control their bowel movement; which makes them suffer from pain and shame and so isolate themselves. Therefore intervention is necessary to help the adolescent girls to develop resilience, regain their normal life and reignite their interest and passions especially in education.

Due to the young age of the adolescent girls, the probability that they have acquired critical skills and developed their personal capacity to manage adverse situations that may affect their overall welfare and economic wellbeing is almost none. Thus the SDT argues that developing a sense of autonomy and competence are critical to the process of internalization and integration, through which the adolescent girls will come to self-regulate and sustain behaviors conducive to health and being (Ryan, Patrick, Deci & Williams, 2008)

If the social, emotional and cognitive needs of adolescent girls are met then they will function and grow optimally. Therefore to actualize the adolescent girls inherent potential, the social environment needs to nurture them so as to promote their interest in learning, valuing themselves and building a confidence in their own capacities and attributes so as to foster resilience.

Fistula leaves a woman physically, emotionally, financially and socially traumatized, with no formal education, no money for petty trading, no gainful employment, no vocational training, and no tangible means of livelihood. The adolescent girls, despite the healing, they join the group of destitute in the society and begin a long journey into pain, sadness, humiliation and total rejection. SDT suggests that, it is necessary for the adolescent girls' psychological needs to be satisfied for their growth and success. The need for autonomy, competence and relatedness suggests that the adolescent girls should be in "control" of their own lives, to interact effectively with their environment and form connections and relationships.

1.12 Conceptual Framework

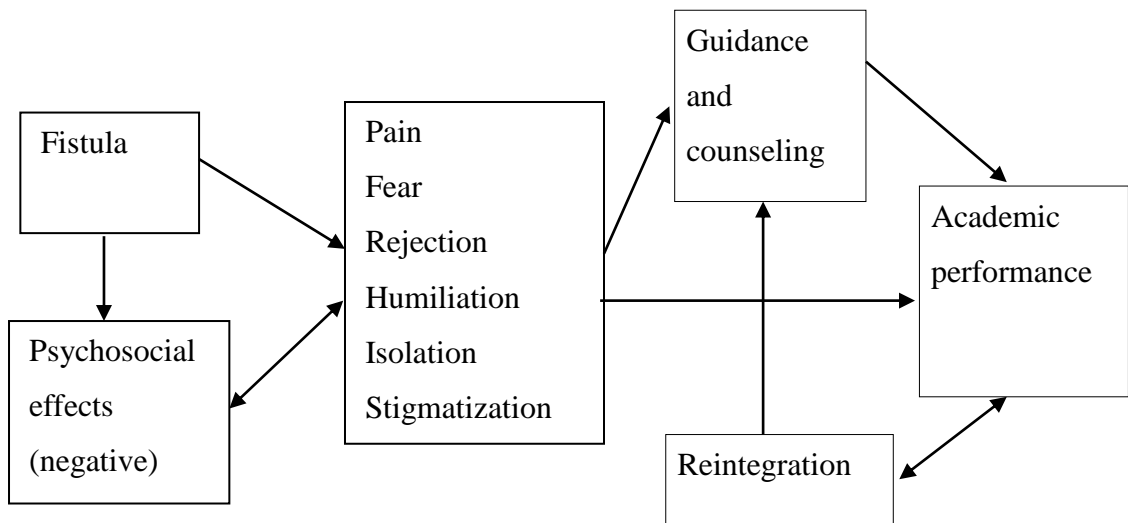


Figure 1.1 Conceptual Framework

The adolescent girl having suffered from fistula, a health issue, suffer psychosocial effects that cause pain, fear, rejection, isolation and humiliation due to constant leakage of urine and feces which together affect their Education as manifest in academic performance. But with availability of guidance and counseling they can be reintegrated back into the society and be included into education.

1.13 Operational Definition of Terms

Adolescent girls-this has been used to mean female persons of between ages 13 to 23 years who have suffered from fistula.

Counseling- professional service designed to help an individual analyze herself and learn more about self and use such understanding to enable the person to become an effective member of the society.

Education-it is a process of teaching, training and learning especially in schools or colleges, to improve knowledge and develop skills. In this study the term education has been used to mean a developmental process provided by a school or other institution for acquisition of knowledge, skills and attitudes.

Academic performance- This refers to how the young women attain and retain knowledge, skills and attitudes acquired from school or other institutions that offer knowledge and skills as will be seen in their performance reports, school ranking and self-reporting.

Fistula- it has been used to mean a hole between the bladder and birth canal or between the rectum and birth canal that leaves woman leaking urine and or feces.

Guidance- it is the help or advice given to somebody to help them in deciding where they want to go, what they want to do and how to solve problems arising in their lives.

Implications-this has been used in this study to mean the outcome in the involvement in education. It will be determined by use of self-report and school report cards.

Psychosocial effects-an effect is a result or a consequence of having fistula while psychosocial is relating to interrelation of social factors and individual thought and behavior. This has been used in this study to refer to cognitive, emotional and social outcomes. It focuses on the living environment, relationships and support systems and their impact on the education of adolescent girls.

In measuring the cognitive effects this study focused on the motivation and thinking of adolescent girls. In measuring emotional effects, this study focused on the feelings and support systems (the self-regulate) for the adolescent girls. And in measuring the social effects, the focus was on relationships and the economic status.

CHAPTER TWO

LITERATURE REVIEW

2.0 Overview

This section contains review of literature related to the psychosocial effects of fistula on the academic performance of adolescent girls. The chapter discusses the definition and causes of fistula, the physical symptoms and effects of fistula, the socio-economic status and early marriage. It also focuses on fistula demographics in Kenya and the educational implications of fistula.

2.1 Definition of Fistula

Fistula is an abnormal or surgically made passage between a hollow or tubular organ and the body surface or between hollow tubular organs (Fistula Foundation, 2014). Obstetric fistula is an abnormal connection between the vagina, rectum and/or bladder which may develop after prolonged and obstructed labour and lead to continuous urinary or faecal incontinence. A hole between the urinary bladder and the vagina is regarded as vesico-vaginal fistula whereas a hole between the rectum and the vagina is known as rectovaginal fistula (Tunçalp 2015).

Obstetric fistula is an indicator of the health system failing to provide accessible, timely and appropriate intrapartum care (Tunçalp 2015). Obstructed labour is one of the leading causes of maternal mortality in developing countries and with it, comes other morbidities, the most devastating being obstetric fistula. It is estimated that for every maternal death, 20-30 women develop serious obstetric complications including fistula. These women, apart from surviving the ordeal of obstructed labour, face the physical and psychosocial challenges of living with obstetric fistula (Ahmed 2015).

2.2 Causes of Fistula

This study focused on the fistula between the bladder and the birth canal or between the rectum and the birth canal. There are several causes of fistula which include:

2.2.1 Obstructed labour

Obstetric fistula is a maternal morbidity that occurs from prolonged and obstructed labor especially due to cephalo-pelvic disposition. The obstruction usually occurs because the pelvis is too narrow or small to allow for the passage of the head of the baby during labor. This causes an obstruction which without timely intervention of a trained physician to relieve, it the resultant effect is that the baby's head compresses against the bladder and the pelvic bone anteriorly or against the rectum and the pelvic bone posteriorly. Tissue necrosis thus, occurs if the pressure is not relieved in time. Incontinence arises when the dead tissue slough off and the patient who survives ends up with either a Vesico-vaginal fistula (VVF) or Recto-vaginal fistula (RVF) (WHO, 2001, in Baba 2013). According to Kimani, (2013), a study conducted in West Pokot by Mabeya in 2003 found that prolonged labor was a major causative factor of obstetric fistula.

Once the adolescent girls develop fistula due to obstructed labor leading to leakage of urine or feces; they will suffer psychological problems (MacDonald & Stanton, 2007). This in turn will negatively affect their physical and mental conditions and in consequence affect their ability to learn and to complete school because health and education are related closely (Tate, 2013). According to WHO (2006) over 14 million girls give birth each year and in Kenya 20-30% of adolescent girls have babies before the age of 18. This means that the adolescent girl's education is affected since female students are strongly and negatively affected by poor physical and mental health

conditions. Experiencing sickness before the age of 21 decreases education on average of 1.4 years (Suhrcke & De Paz Nieves 2011) hence the need to investigate how fistula a health issue affects the education of adolescent girls and in consequence their academic performance.

2.2.2 Teenage pregnancy and early marriage

According to UNICEF (2014) child marriage is a global problem with an estimated 14 million girls given out in marriage before they turn 18, some as young as 9. Evidence shows that, 14 of the 20 countries with the highest rate of child marriage are in Africa (Fookes, 2013). In Ethiopia, the rate of child marriage is three times higher in the Northern region of Amhara (75%) than in the capital city of Addis Ababa (26%) (UNICEF, 2014).

One major contemporary social problem confronting most countries in the world is teenage pregnancy (Gyan, 2013). Besides, child or early marriage among girls is most common in South Asia and sub-Saharan Africa as indicated by UNICEF (2014). Worldwide more than 700 million women alive today were married before their 18th birthday. More than one in three (about 250 million) entered into union before age 15 (UNICEF, 2014). This means that the adolescent girl's education ended, thus closing their academic prowess and participation in development yet creating an illiterate society vulnerable to fistulas. School dropout is seen as a cause as well as a consequence of teenage pregnancy. It was clear from the study by Gyan (2013) which found out that some of the respondents dropped out of school due to the pregnancy while others became pregnant because they dropped out of school. Thus most pregnant girls drop out of school to deliver and after delivery they feel shy and do not return to school thereby serving as a baseline for other girls with similar problems to

imitate. Gyan again revealed that teenage pregnancy reduces the study hours of the respondents. It was clear that before the pregnancy, the respondents could study averagely for three (3) to four (4) hours but this reduced to an average of one (1) to two (2) hours.

According to Fookes (2013) the toxic combination of a young girl having sex, getting pregnant and going through childbirth when her body is not developed enough accounts for at least 25% of known fistula cases. These consequences are largely due to girls' physical immaturity where the pelvis and birth canal are not fully developed. Teen pregnancy, particularly below age 15, increases risk of developing OF, because their small pelvises make them prone to obstructed labor. Obstetric fistula can also be caused by the sexual relations associated with child marriage, which takes place even before menarche. Married teenage girls with low levels of education suffer greater risk of social isolation, domestic violence and sexual violence (HRO 2014).

There is a "road to OF" that begins when young girls grow up in nutritionally marginal circumstances, are married around the age of menarche, become pregnant while still adolescents, and labor at home either alone or under the care of untrained birth attendants for prolonged periods of time and without adequate access to emergency obstetric care (Wall et. al 2005). Early marriages may be a consequence of poverty, because the parents did not have the financial ability to pay the girl child's school fees (Kudzai, 2013).

Women who are afflicted with obstetric fistula today are not much different from women with obstetric fistula prior to the 1900s. They are young, primiparous, poor, uneducated and with virtually no access to obstetric care. Child marriage remains common in resource-poor nations, putting these girls at high risk for premature child

bearing and cephalo-pelvic disposition, which can cause obstructed labor. A very high percentage of girls in Ethiopia 25%, Uganda 42%, and Mali 45% are married and give birth by the age of 18. Their risk of fistula development is as high as 88%, (Semere & Nour, 2008) and yet according to Nour, (2006) girls' ages 10-15 years are especially vulnerable because their pelvic bones are not ready for child bearing and delivery.

In Kenya, research shows that the majority of fistulas in West Pokot were seen to occur in women aged 20 years and below. These were also women who had no formal education or had attained primary education at the lowest level and had no specific occupation. In Ethiopia and Nigeria over 25% of fistula patients had become pregnant before the age of 15 and over 50% had become pregnant before the age of 18 (UNFPA, 2002, in Kimani, 2013). From the above statistics, it can be said that adolescent girls of ages 20 and below, who get pregnant are at a higher risk of getting a fistula and suffering psychosocial effects of the same which impact their education.

A study according to Tan (2014) indicates that once the adolescent girls are married, they will no longer be able to stay or attend school. Instead they remain at home to raise another generation of children where daughters are again deprived of education yet vulnerable to child birth injuries including fistula. So this study wishes to establish psychosocial effects of fistula and their implication to the adolescent girl's education so as to help empower the adolescent girls by ensuring their inclusion back to education.

2.2.3. Gynaecological trauma

Traumatic fistula is a result of direct gynecological trauma, usually from violent rape, mass rape and or forced insertion of objects into a woman's vagina. Brutal rape can result in genital injury and the formation of a rapture, or fistula between a woman's

vagina, her bladder, rectum or both. Traumatic fistula compounds the psychosocial trauma, fear, and stigma that accompany rape. Cases of traumatic fistula have been reported in several countries such as Ethiopia, Kenya, Tanzania, Sudan, (Pinel & Bosire, 2010)

According to committee 18, (2008) a study by Kalume et, al. revealed that 17 of the 100 female victims of sexual violence developed a fistula as a result of their injuries; while at the maternity hospital in Kindu, 36 of the 2010 female victims of sexual violence developed a fistula as a result of sexual assault. In Ethiopia, Muleta et. al., reported 91 girls and women with fistulas resulting from sexual violence. A study in Kenya, Nduati and Muita identified cases of fistula among 21 sexually abused children.

According to Ahmed and Holtz, (2007) fistula is a health issue that qualifies as a post-traumatic stress. This is evident in a prospective observational study to screen women in Bangladesh and Ethiopia with fistula for mental health dysfunction as measured by General Health Questionnaire (GQH-28) in which out of 68 women with fistula, 66 were at risk of mental dysfunction. Another study by UNFPA (2004) indicated that women with OF face a myriad of psychological problems. This include mental health dysfunction, PTSD, loss of body control, loss of dignity and self-worth which result in them losing their jobs or not being able to carry out economic tasks they used to do (Mutambara et. al 2013). This may include not being able to attend school and not being able to learn while there because reliable evidence shows that ill health affects access, participation, completion and achievement (Pridmore, 2007). This study seeks to establish the role of Guidance and counseling in the adjustment of adolescent girls affected with traumatic fistula in school. As noted by MacDonald and Stanton (2007),

those who have experienced rape or other sexual violence often suffer additional social stigma.

2.2.4. Accidents

Fistula may also be caused by accidents such as penetrating injuries to the vagina and bladder involving cattle horns, or impalements of falling on a stick, infection (particularly lymph-granuloma venereum. It may also be caused by diphtheria, measles, schistosomiasis, tuberculosis and infected centipede bites.), foreign bodies (Arikan et. al, 2000; Fourie & Ramphal 2001 in Wall, Arrowsmith, Briggs, Browning & Anyetei, 2005), bladder calculi (Piercy, Gregory et. al, 1998 in Wall et. al, 2005), mishaps during masturbation (Ramaia & Kumar 1998 in Wall et. al,2005) and cervical cancer.

Fistula may also occur congenitally, or from surgical, radiation, malignant, and other causes such as unskilled abortion (Hilton, 2003 in Cook, Dickens & Syed, 2006). This leads to development of RVF and VVF which leaves adolescent girls stigmatized. This affects the adolescent girl's health. According to Ding and Lehrer, (2007), the adolescent girls are strongly and negatively affected by poor physical and mental health condition and therefore this study seeks to establish how fistula psychosocially affects adolescent girl's performance in education.

2.2.5 Traditional cultural practices

In some parts of the world, harmful traditional practices are also responsible for fistula formation. For example, in northern Nigeria, a harmful traditional practice called gishiri-cutting is responsible for fistula formation in 2-13% of cases (Tahzib 1983; Tahzib 1985; Wall 1988; Ampofa, Out et. al, 1990; Wall, Karshima et. al, 2004 in Wall et. al, 2005). Gishiri is the Hausa word for salt. The belief is that an imbalance

of salty and sweet food stuffs can cause a 'film' to grow over the woman's vagina, causing a variety of gynecological complaints, the most important of these being difficulty in labor (Wall, 1998 in Wall et. al, 2005). When this diagnosis is made, surgical treatment is often undertaken. A midwife or barber is summoned. A sharp object such as a knife, razor blade, or piece of broken glass is inserted into the vagina, and a series of random cuts is made to alleviate the postulated obstruction and "open the way" for the baby to come out. Serious infections, life threatening hemorrhage and fistulas frequently result from this practice. The gishiri fistula typically presents as a direct longitudinal slit in the bladder neck and urethra, occasionally presenting as a similar posterior injury affecting the rectum (Wall et. al, 2005). Another traditional practice that has been reported to produce fistula is the insertion of caustic substances into the vagina, either as part of a traditional herbal remedy for a gynecologic condition (Lawson 1968 in Wall et. al, 2005), or as part of traditional puerperal practices to "help" the vagina return to its nulliparous state (Wall et. al, 2005)

In my point of view, traditional practices are causing a lot of harm to the adolescent girls especially in causing the development of fistulas. Therefore if the root cause of fistula is not addressed- specifically the traditional practices, adolescent girls will continue to face psychosocial challenges causing school drop-out, low self-esteem and poor educational performance. This is why this study focuses on investigating psychosocial stressors of fistula on adolescent girls and its impact on their education.

2.2.6 Poverty

According to Mohammad (2007) low socio-economic status has been identified as the major cause of OFs. Complications during pregnancy and birth are worsened in poor countries (HRO, 2014). Most women affected with OF are from rural areas where

health services are poor or non-existent, road conditions make travelling difficult, and the cost of transportation and medical care is too high (Thui et. al. 2007).

Poor women die more frequently, they get fistulas, and the poorer the woman the greater her likelihood of dying or suffering a catastrophic obstetric complication. Poor women do not have adequate, prompt access to emergency obstetric care. Indeed, it is commonly said that OF result from a combination of “obstructed labor and obstructed transportation” (Thaddeus & Maine 1994 in Wall et. al, 2005). Wall articulated the concept of three “stages of delay” that result in maternal mortality: delay in deciding to seek care, delay in arriving at a health care facility, and delay in receiving adequate care once a woman arrives at such facility. All of these factors are present in the development of OF (Wall et. al, 2005)

The prevalence of OFs, the lack of provision for their timely repair, the suffering of untreated women and the stigmatization of both untreated and sometimes treated women represent gross violation of human dignity, and of the legally recognized human rights that serve to protect women’s dignity (Cook et. al, 2006)

According to Kudzai (2013), because of the high prevalence of poverty, many young girls from the ages of 11 to 16 years engage in risky behavior which makes them vulnerable. Poor girl children are also at a greater risk of several negative outcomes, such as poor academic achievement, school drop-out, abuse, neglect, behavioral and socio-emotional problems, physical health problems, and developmental delays (Kent, 2006:96; Moore, et. al, 2009; Chilton, et. al, 2007:40-44 in Kudzai 2013).

A study by Kalembo and Zgambo (2012) estimates more than 2 million young women live with untreated OF which has remained a hidden condition because it affects some

of the most marginalized members of the population namely the; poor, young, often illiterate girls and women from remote regions of the world.

Due to poverty many girls are married or marry early predisposing them to the development of fistula; when they develop fistula they suffer in silence due to shame, they isolate themselves, they are stigmatized by their condition and forced to the margins of the society due to the constant trickle of urine constant ooze of stool (Wall, 2006). This is why this study seeks to investigate the psychosocial effects of fistula on adolescent girls and its implication on their education.

2.3 Physical Symptoms of Fistula

Research shows that young women with fistula have the following physical symptoms (Mabeya, 2004)

1. Incontinence or constant uncontrollable leaking of urine and or stool.
2. Frequent bladder infections.
3. Painful genital ulcerations from the constant wetness-ammoniac dermatitis
4. Infertility-amenorrhea, uterine damage
5. Foul odor
6. Often associated with nerve damage to legs-common perianal

The social consequences of fistula are very severe. According to Wall, (2006) they include a continuous and uncontrollable stream of urine or feces or both coming out of her vagina. This is both a physical and social catastrophe. Therefore this study seeks to be able to identify the psychosocial stressors and effects of fistula on the adolescent girl's educational attainment.

2.4 Effects of Fistula

A meta-analysis conducted by Ahmed and Holtz (2007), showed that an average of 85% of the women suffering from OF experience fetal loss. To make matters worse, while they feel mentally tormented and devastated, they typically find themselves violently thrashed into an intense environment where they are not given the chance to mourn. Instead, their main priority becomes their ongoing fight to live and fight for social position and value in society. They are sometimes described as ‘poor little girls,’ “the wretched of the earth,” and “women who cannot even be successful prostitutes.”

Fistula leaves its victims with urine or fecal incontinence that causes lifelong complications with infection, pain, and smell, (HRO, 2014). Fistula is a devastating condition, causing suffering to women who are ostracized, rejected, abandoned and described as dead women walking. Due to these the women suffering from fistula suffer shame and so isolate themselves which really means that adolescent girls with fistula are most likely to miss school, drop out of school or lose concentration while at school since they might not be able to stand the rejection. In conclusion, Sadig, as quoted in Baba (2013) says, “if anyone had seen the sad eyes of these girls, really children, embarrassed and ashamed of themselves, they will never forget the torment and despair.” This is why the issue of fistula captures attention and compels people to feel pity for women with fistula and to condemn the stigma they face (Ryan, 2014). The younger the age at the time of marriage, the lower the probability that girls will have acquired critical skills and develop their personal capacity to manage adverse situations that may affect their overall welfare and economic well-being (FMRWG 2003 in Emirie 2005).

Muleta and Williams (1999 in Mutambara et. al, 2013) pointed out that leaking urine and feces can lead to other medical complications like genital sores, ulcerations, dehydration, frequent infection and kidney disease. The woman might therefore have difficulties even when walking which would then result in unemployment due to severe nerve damage that often affects women ability to walk (Ijaiya & Aboyeji, 2004).

According to WHEC (2009), feelings of insecurity, anger, apathy, dependence, guilty, indignity, feeling of abandonment, shame, embarrassment, depression and denial are common. Women feel loss of self-confidence and self-esteem. Lack of personal hygiene makes the situation worse.

Research has shown that the socio-economic consequences of fistulas on the lives of the women and their families were found to be dramatic. Because of the odor and stigma associated with the condition, women with fistulas often isolate themselves from their families and communities or are abandoned by their husbands. The social and physical effects often render women unable to work or participate in community life. This can cause them anxiety, depression and other adverse psychosocial effects (Velez, Ramsey & Tell, 2007) like low self-esteem, rejection, isolation and shame, financial issues and other stressors within the adolescent girls' social and family environment, medical issues, concerns about health and concerns about missing education or attaining achievement due to their condition.

In summary, fistula leaves victims with uncontrollable incontinence, severe infections; ostracism due to odor, inability to work hence increased poverty, depression that may lead to suicide thoughts or even death. They may also isolate themselves from the public due to rejection. They are stigmatized, ashamed and

embarrassed which makes them have poor self-perception and lack self-esteem. For the adolescent girls in school, this might mean missing school or dropping out of school. There is therefore need to investigate the psychosocial effects of fistula on the education of adolescent girls in Kenya and the role of guidance and counseling in building their resilience especially back to school.

2.5 Fistula Demographics in Kenya

A research by Wall (2006) shows that cases of RVF and or VVF are rare in developed countries while in developing countries, it is a common complication of childbirth resulting from prolonged obstructed labor. Estimates suggest that at least 3 million women in poor countries have unrepaired fistulas and 30,000 to 130,000 new cases develop each year in Africa alone. The general public and the world of medical community remain largely unaware of this problem.

Few studies on fistula have been done in Kenya, and the few done are mainly on the treatment especially of OF which is a big problem in Kenya, although the actual prevalence is unknown. According to the report on the Kenya country situation presented at the 2nd meeting of the working group of the prevention and treatment of OF in Addis Ababa, Ethiopia in October-November 2002, the number of VVF operations done annually during the ten years between 1992 and the year 2001 increased steadily from a low of 36 cases to a high of 479 cases in 2001 (MOH & UNFPA, 2004).

Orwenya (1994 as cited in MOH & UNFPA, 2004), found that in Kenyatta National Hospital; 36.6% of the patients were primigravidas and they constituted the single largest group of patients who developed OF. In west Pokot, a study by Mabeya (2004) shows that primigravidas constituted 62.7%. All the 66 women studied in West Pokot

were married and a majority 66.4% was below 20 years and also primigravidas. The youngest patient at the onset of fistula in this study was 14 years and the ages ranged from 14 to 38 years with a mean of 20.5 years (MOH & UNFPA 2004).

Another study in Kenya by Khisa, Mutiso and Mwangi (2011) indicate that ages of women admitted at Kenyatta National Hospital ranged between 13 and 76 years. Nearly half were 25 years and below. Patients had lived with the condition for an average of six years with the largest duration recorded at 37 years. A recent hospital based study in Kenya by UNFPA (2014) estimated that there are 3000 new cases each year with approximately one to two fistula cases per 1000 deliveries and only about 7.5% of the women are able to access treatment. A meta-analysis study by Maheu-Giroux et al (2015) estimates that Kenya is one of the countries in Africa that has the largest number of women of reproductive age (15-49 years) who have experienced vaginal fistula symptoms estimated between 69,400 and 113,700. This indicates that fistula is a problem especially in Kenya affecting adolescent girls that needs thorough investigation not only about treatment but its effects like psychosocial effects which this study seeks to fill in concerning the education of the adolescent girls who are vulnerable.

2.6 Educational Implication of Poverty and Early Marriage: Predisposes of Fistula

Education is an important social determinant of health. People's opportunities for health are strongly influenced by the social and economic conditions in which they live (Higgins, Lavin & Metcalfe, 2008). Children's access to education and to learning is affected by the availability and quality of schooling and by family characteristics such as socio-economic status and parental attitude to schooling.

Access can also be influenced by child characteristics such as aptitude, motivation and behavior. This can however be negatively affected by poor health and nutritional status. It is therefore of concern that a quarter of all children eligible to be in school are malnourished (Galal et al., 2005 in Pridmore, 2007) and that children in developing countries frequently carry an additional burden of infectious diseases (Pridmore, 2007).

Child marriage is a manifestation of gender inequality, reflecting social norms that perpetuate discrimination against girls. Girls who marry are denied their childhood. They are often socially isolated, cut off from family and friends and other sources of support with limited opportunities for education and employment. Households typically make decisions about girls' schooling and marriage jointly, not sequentially and Education tends to lose out. Accordingly, lower levels of education are found among women who are married in childhood. In Malawi, for instance, nearly two thirds of women with no formal education were child brides compared to 5 percent of women who attended secondary school or higher levels of education (UNICEF 2014).

Teenage pregnancy is one of the social ills that affect society. The existence of teenage pregnancy does not auger well for the development of the girl-child. This is attributable to the girl's age and the absence of any consistent means of support to care for the children and themselves when they should be in school. It is alleged that teenage pregnancy and its associate motherhood are characterized with shame, disgrace, school drop-out, and sometimes end of the individual's dreams of achieving higher pursuits (Gyan, 2013).

Cunning and Boulton, (1996 in Gyan 2013), asserted that teenage pregnancy has a lot of social consequences which include school drop-out, or interrupted schooling, falling

prey to criminal activity, abortion, ostracism, child neglect, school adjustment difficulties for their children, adoption, lack of social security, poverty, repeated pregnancy and negative effects on domestic life. Girls who are married early are often denied access to education or pulled out of school, diminishing the opportunity to acquire critical life skills, which will enable them to escape poverty related conditions. Some parents even fear that formal education of girls' will increase their bride price (FMRWG 2000 in Emirie 2005) and so be a deterrent to prospective husbands. For a number of poor families, the potential rewards of educating daughters are too off and therefore their education is not recognized as an investment. Families perceive that a girl's education will only benefit her husband's household, and not her parents. Prevailing gender norms on the roles of girls focus mainly on marriage, and as such it becomes acceptable to remove girls from school for marriage. In some cases, girls are not even allowed to go to school at all, because an education is perceived as unnecessary for becoming wives and mothers (FMRWG 2003:12 in Emirie 2005).

According to Adebola, Anyachebelu and Madu (2012 as quoted in Kipkulei, Chepchieng, Chepchieng & Boitt, 2012) the higher the level of girls' education status, the more developed a nation is. However, even with this knowledge about women education, inequality in female participation in education is still glaring despite commitments by various governments to the attainment of the Millennium Development goal of 8th of September, 2000 that by the year 2015 all children worldwide of both genders would have equal access to all levels of education. This witnessed inequality is attributed to a myriad of factors; specifically, socio-economic, socio-cultural and school-based factors. Early marriage is a socio-cultural factor that denies a girl-child the opportunity to attend school. In some rural Arid and Semi-arid

areas of Kenya, parents still arrange some marriages for their children. When this is done, it is usual for the girl-child as young as 12 years to quit school thus the level of education and marrying age parents expect of their daughters is coherent.

In Kenya, girls who become pregnant usually face a lot of ridicule from their fellow pupils to the extent that it would be difficult for them to return to school after giving birth. Though the government and Non-Governmental organizations have been very supportive to such girls and even give them a leeway to join schools of their choice to recover from the pregnancy stigma, this has born little fruit, an indication that it is a serious stigma that require psychological interventions. (Kipkulei, et. Al., 2012).

Poverty and early marriage are the major causes that predispose adolescent girls to the vulnerability of getting a fistula and thus affecting their education. Several research shows that girls who marry young and or get pregnant early are at a higher risk of developing a fistula (Nour, 2006: Mabeya, 2004: Fookes, 2013: Baba, 2013: HRO, 2014).

According to Wall et. al, (2005), fistula affects those parts of the body which must be hidden from view and which a woman may not speak out and therefore endure their injuries in silent shame. Tan (2004) says that the young brides represents wasted human capital and they are reduced to baby makers yet vulnerable to developing a fistula which is a child birth injury. This is why this study fills the gap of finding out the psychosocial stressors of fistula and its effects on the academic performance of adolescent girls in learning institutions in Kenya.

2.7 Education an Empowerment for Adolescent Girls

Education has a crucial preventive and rehabilitative part to play in fulfilling the needs and rights of women. Education also serves a broader function. It gives shape

and structure to children lives and can instill community values, promote justice and respect for human rights and enhance peace, stability and inter-dependence. It is important to carry on educating young people no matter how difficulty the circumstances. Education promotes psychosocial and physical well-being while teachers can recognize signs of stress in children as well as impart vital survival information on issues such as personal safety and health (UNESCO, 2002).

The importance of educating girls is entering public consciousness globally. The education of girls is a stimulus for societal change and human development. Studies consistently document that girls' education enhances the welfare of the population and increases the country's economic productivity. Hence, investing in girls' education provides the highest returns, both economically and socially (UNESCO 2002). Which is the reason why this study intended to find out the role of guidance and counseling in helping the adolescent girls affected with fistula to adjust in learning institutions because giving them an education is one way of reintegrating them back into the society empowered with skills. According to a research by Befekadu (2000) it is evident that education is a backbone for social and economic advancement; that provision of primary education is instrumental to increase the adolescent girl's participation in development.

2.8 Summary of Literature Review

According to human rights watch (HRW), (2010), women and girls need access to information to make informed choices about their sexual and reproductive lives. They also need information about access to services. All these are lacking among many of the women and girls and even among some health providers. For example, according to HRW, (2010), a 20 year old Kwamboka W. became pregnant at age 13 while in

primary school, developed a fistula and lived with it for seven years before hearing on the radio about a UNFPA funded fistula repair camp offering free surgeries.

In spite of some government efforts to introduce sexuality education in upper primary and secondary schools, Kenya has not made it part of the official syllabus and as a result there is no time allocated within school hour to teach it. Due to lack of information, there is high rate of pregnancies and hence vulnerability to fistulas of adolescent girls. There is therefore need to understand that fistula as a health issue, has psychosocial effects which may include denial, shock, rejection, isolation, stigma, blame, loneliness, shame, anxiety, depression, hate, desperation, low self-esteem, poor self-perception, guilt among others. This means that apart from treatment, the psychosocial effects of fistula need to be studied so as to help re-integrate the affected adolescent girls back into the society and particularly their inclusion into learning institutions. Adolescent girls who have or are suffering from fistula may have increased negative educational, psychological, sociological and emotional outcomes compared to the general population. They may therefore need unique educational and psychosocial support needs in order to thrive. Thus understanding these particular vulnerabilities is crucial to implementing an effective response that focuses on specific needs of this affected population especially in the inclusion in education and the role of guidance and counseling.

A research by Befekadu, (2000) indicates that particularly for adolescent girls, the economic and personal empowerment that education provides allows them to make healthier choices for themselves and their families. This includes reduction of HIV/AIDS, reduction of poverty, improvement of their health and that of their children, delay in marriage, reduction of female genital cutting and increase in self-

confidence and decision making. In conclusion there is therefore need to investigate the psychosocial effects of fistula on adolescent girls and its implication to their academic performance so as to help them get empowered and gain skills to participate in development.

In conclusion, fistula has social and physical effects which render adolescent girls with fistula unable to work and or participate in the community. They become anxious which causes depression and other adverse psychosocial effects (Velez, Ramsey & Tell, 2007). This affects the adolescent girl's health and since there is evidence that ill-health affect access, participation, completion and achievement (Pridmore, 2007) then fistula being a health issue affects adolescent girls psychosocially and in consequence, their academic performance. There is therefore need to study how fistula affects the adolescent girls and the role of guidance and counseling so as to bring them back to education and social inclusion which is why this study seeks to investigate and establish the psychosocial effects of fistula on adolescent girls and its implication to their education and the role of guidance and counseling.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.0 Overview

This chapter describes the methods applied in carrying out the research. It is organized in the following subsections: research design, geographical location, research methodology, target population, sampling procedure, data collection procedures, data collection instruments, data analysis and presentation, trustworthiness and ethical considerations.

3.1 Research design

This study used Phenomenological design which is a strategy of inquiry in which the researcher identifies the essence of human experience about a phenomenon as described by participants. It aims at understanding lived experiences and involves studying a small number of subjects through extensive and prolonged engagement to develop patterns and relationships of meaning (Moustakes, 1994, in Creswell, 2009).

According to Patton (2002) phenomenological approach focus on exploring how human beings make sense of experience and transform experience into consciousness both individually and as a shared meaning. This requires methodologically, carefully, and thoroughly capturing and describing how people experience some phenomenon-how they perceive it, describe it, feel about it, judge it, remember it, make sense of it and talk about it with others.

Phenomenological design has been used to describe the adolescent girls' experiences of fistula and the psychosocial effects of fistula and the implication on their education. The study focused on the lived experience of the adolescent girls in Kenya and

described what all participants have experienced due to fistula and what meaning they ascribe to it (Creswell, 2007) and in consequence how this affects their education.

According to Creswell, (2007), the phenomenological research entails a descriptive study of how individuals experience a specific phenomenon. It is appropriate to this study because the research aimed at gaining access to the adolescent girls' to identify their experience with fistula so as to describe the effects and their perceptions of fistula so as to understand their lived experience and how their education has been affected by the same.

3.2 The Geographical Location of the Study

This study focused on participants drawn from *Beyond Fistula* NGO located in Eldoret Town of Uasin Gishu County (re:appendix E). Eldoret is the largest city in Uasin Gishu County with a population of 289,380 according to Kenya Information Guide (2015). Eldoret is situated some 330km Northwest of Nairobi. It is the administrative capital of Uasin Gishu. It is set on a plateau south of Cheranganyi hills. It has a high altitude making it suitable center for athletics training. It is also an important education center and a crucial transport corridor linking Kenya and Uganda and South Sudan. Boosted by agribusiness and sports tourism, thanks to its renowned world runners, the city enjoys a robust economy and a vibrant day and night life (Kenya Information Guide, 2015). Eldoret is preferred because it is where the *Beyond Fistula* NGO is situated.

This NGO has been purposively chosen because it receives adolescent girls affected with fistula from different parts of Kenya and it is concerned with empowering them and reintegrating them back into the society. These women are either healed or awaiting another surgery to repair the fistula. As a researcher I sought permission

from the management of the NGO to do research and having been a volunteer in the same organization is an added advantage of creating a rapport with the adolescent girls.

3.3 Research Methodology

This study used Qualitative methodology. According to Kothari (2008) Qualitative research is concerned with qualitative phenomenon relating to or involving quality or kind. It aims at discovering the underlying motives and desires using in-depth interviews. It is designed to find out how people feel or what they think about a particular subject or institution. This has been appropriate in this study since data was gathered using in-depth interviews with adolescent girls who have directly experienced the phenomenon of fistula in their lives. A qualitative approach has been used to conduct a complex, detailed understanding of the issue of psychosocial effects of fistula on adolescent girls in Kenya and its implication on their education which can only be established by talking directly with the adolescent girls, going to them, listening to their stories and hearing their voices (Creswell, 2007).

3.4 Target Population

The target population in this study comprised of 15 adolescent girls affected with fistula and who are either healed or undergoing treatment. They were of ages 13 to 23 and in learning institutions under the sponsorship of the *Beyond Fistula* NGO situated at Eldoret. This NGO receives the adolescent girls affected with fistula from different parts of Kenya and helps to empower them by taking them back to school or to vocational training. The affected adolescent girls in school were chosen because they would give adequate information about their academic performance which is the focus of this study.

3.5 Sample Size and Sampling Procedure

Participants were selected via purposive sampling and the sample size of fifteen adolescent girls was determined by appoint of saturation when no more new information was being presented. The eligibility criteria included;

1. Having suffered from fistula.
2. Being a member of Beyond Fistula program.
3. Of age 13 to 23 years old.
4. In a learning institution.
5. Willingness to participate in the research.
6. A Kenyan citizen because it's the focus country in this research.

Purposive sampling is a technique widely used in qualitative research for the identification and selection of information-rich cases for the most effective use of limited resources. It was used because there was need for emphasis of in-depth understanding therefore selecting information rich case for study which offers useful manifestations of the phenomenon, (Patton, 2002). This study used purposive sampling so as to get a deeper understanding of what fistula is and its psychosocial impact on adolescent girls affected and its implication on their academic performance.

3.6 Data Collection Instruments

This study used unstructured interviews which is an oral administration of questions involving face to face interaction. Kothari (2008) observes that interview schedules are particularly suitable for intensive investigation. Advantage was that the researcher obtained more information in greater depth. Also personal information as well as supplementary information about the participant's personal characteristics was easy to get through a face to face interview.

This study used unstructured interview per participant which was conducted with the adolescent girls. Participants were asked to describe experiences; challenges, perceptions of themselves and other people and the meaning they provide for their experience so as to gain an in-depth understanding of the phenomena of fistula in their lives and its implications to their education. Probing questions were used to get in-depth information, realistic information and required data concerning the psychosocial effects of fistula from the adolescent girls affected with fistula and how this in turn affected their academic performance. This was important because the interview helped to obtain required data to meet the specific objectives of the study and they were more flexible for the interviewer and interviewee (Kothari, 2008). The interview probe questions focused on the following domains;

1. Experiences with fistula as an individual in relation with others.
2. Self-perception due to fistula and its effect on education.
3. Role of Guidance and Counseling in relation to adjustment in education.

This study also used biographical form to obtain personal information about the adolescent girls affected with fistula which backed up the interview to get more information about each participant. The participant's report cards were also used to help rate their performance in learning institutions and they were requested to comment on their general performance in learning institutions.

3.7 Trustworthiness of the Study.

According to Polit and Beck, (2004), trustworthiness encompasses several different dimensions namely; credibility, dependability, transferability and conformability.

According to Lincoln and Guba, (2000 in Morrow 2005), credibility refers to the idea of internal consistency, where the core issue is "how we ensure rigor in the research

process and how we communicate to others that we have done so”. It is achieved to the extent that the research methods engender confidence in the truth of the data. In this study the use of in-depth interviews coupled with intensive note taking was used to achieve credibility.

Dependability refers to the evidence that is consistent and stable (Polit & Beck, 2004). It deals with the core issue that “the way in which a study is conducted should be consistent across time, researchers, and analysis techniques” (Gasson 2004, in Marrow 2005). This was accomplished in this study through careful tracking of research design and keeping of the audit trail-a detailed chronology of the research interviews of one on one and outcomes of their school performance from report cards and also the biographical form.

Transferability is the extent to which qualitative research findings can be transferred to other settings. It is promoted by the amount of information provided. In this study, this was ensured by provision of thick description-a rich and thorough description of research settings and process. The researcher did thorough probing of interview questions to gain all necessary information and ensure that thorough note-taking and video taping of the proceedings is done with the awareness and permission of the participants.

Conformability is similar to objectivity; it is the degree to which study results are derived from characteristics of participants and the study context, not from the researchers biases (Polit & Beck, 2004). It is a measure of how well the inquiry’s findings are supported by the data collected (Lincoln & Guba, 1985 in Morrow 2005). In this study, this was achieved by conducting an in-depth interview per participant together with the use of open ended questions.

3.8 Ethical Considerations

Ethical approval letter was obtained from Moi University which was then presented to NACOSTI to obtain a research permit. Permission was then granted by the Beyond Fistula NGO to carry out research from participants in their organization after presenting the research permit. The study participants also gave their consent by agreeing to sign the consent letter. This was after being informed of their rights in relation to the study after a detailed information regarding the nature and purpose of the study was made available to them. This enabled the participants to make informed choices to participate or not to participate. The participants were also informed on the voluntary nature of participation. The participants were assured of the confidentiality and anonymity of the information they gave to the researcher. The participants were assured of protection from any psychological harm by ensuring safe circumstances like involving counselors who are available in the NGO to give psychological help.

3.9 Data Analysis

Qualitative data was analysed thematically based on emerging themes and content. The in-depth interviews were transcribed and audio taped. Data was analyzed using thematic and content analysis concurrently through initial reading of the transcripts and listening to the audio tapes to identify categories and themes.

Thematic analysis involved categorization of related themes. Thus, in this study, after data was collected, it was transcribed and then categorized into important themes depending on the particular statements made by the participants and then it was interpreted. Tables and graphs were also used to present data and tabulate the different themes from the adolescent girl's responses from interviews on how fistula has affected their educational performance.

Content analysis is more rigorous and it improves reliability. It examines the intensity with which certain words, points of view and emotionally laden words are used (Orodho, 2009). The frequency with which a symbol or idea appears was interpreted as a measure of importance, attention or emphasis; the relative balance of favorable attributions regarding a symbol or an idea was interpreted as a measure of direction or bias; the kinds of qualifications and associations made with respect to a symbol or idea was interpreted as a measure of intensity of belief (Krippendorf, 1980 in Orodho 2009).

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION, PRESENTATION AND DISCUSSION.

4.0 Overview

This chapter presents the study findings which have been analyzed based on the study objectives and findings of the data collected.

4.1 Data Collection

This study comprised of 15 adolescent girls in learning institutions under the sponsorship of *Beyond Fistula* NGO program situated at Eldoret in Uasin Gishu County. A sample size of 15 adolescent girls was necessary because it was the point of data saturation. All participants' names are omitted to ensure anonymity.

The adolescent girls were scheduled to complete a biographical form to obtain basic demographic information and after which an interview was done using interview probe questions. An in-depth interview with the participants was done using English and or Kiswahili depending on whichever the participants were comfortable with. The interviews were recorded by hand and also videotaped; those in Kiswahili were translated into English.

4.2 Psychosocial Effects of Fistula on Adolescent Girl's Education.

A sample size at the point of data saturation of 15 adolescent girls in learning institutions and members of *Beyond Fistula* NGO filled a biographical form. The adolescent girls presented the following characteristics and descriptions;

4.2.1 County of origin

The study sought to find out from which county the participants came from. Table 4.1 below indicates that 3 (20.0%) were from Homabay county, 2 (13.3%) were from Bungoma county and the rest were from diverse counties. The participants came from 12 different counties. This shows that the fistula is indeed a problem which cuts

across Kenya and so it needs to be addressed to ensure the adolescent girls are not affected by the same especially in their education.

Table 4.1 County of origin

	Frequency	Percentage
Baringo	1	6.7
Bungoma	2	13.3
Busia	1	6.7
Elgeyo marakwet	1	6.7
Homabay	3	20.0
Kakamega	1	6.7
Kericho	1	6.7
Kilifi	1	6.7
West-pokot	1	6.7
Samburu	1	6.7
Uasin Gishu	1	6.7
Vihiga	1	6.7
Total	15	100.0

4.2.2 Age of participants

The study sought to find out the age of the participants: Table 4.2 below shows that of the participants, 1(6.7%) was between 13-15 years, 8(53.3%) were between 16-18 years, 4(26.7%) were between 19-21 years and 2(13.3%) were between 22-23 years. Majority of the participants were in the bracket of 16-18 years. This means that the majority of the participants were in their teen years and therefore qualify as adolescent girls whom this study seeks to find out how fistula affects their education and the role of guidance and counseling in their adjustment.

Table 4.2 Age of participants

	Frequency	Percentage
13-15 years	1	6.7
16-18 years	8	53.3
19-21 years	4	26.7
22-23 years	2	13.3
Total	15	100.0

4.2.3 Age when the participants developed fistula

The participants were asked at what age they developed fistula: 4(26.7%) stated they had it since they were born, 3 (20.0%) said when they were 14 years, 2 (13.3%) stated they were 13 years while the rest 1(6.7%) stated at 10, 15, 16, 18, 21 and 23 years. Most of the participants were teenagers or in adolescence age when they developed fistula. It also means that they were school going age.

4.2.4 Causes leading to Fistula development

The study sought to find out what causes led to the participants developing fistula. In figure 4.1 below shows that 10(66.7%) were due to obstructed labor, 4(26.7%) were born with it and 1(6.7%) was a rape victim. The study found that majority of the participants developed fistula because of obstructed labor.

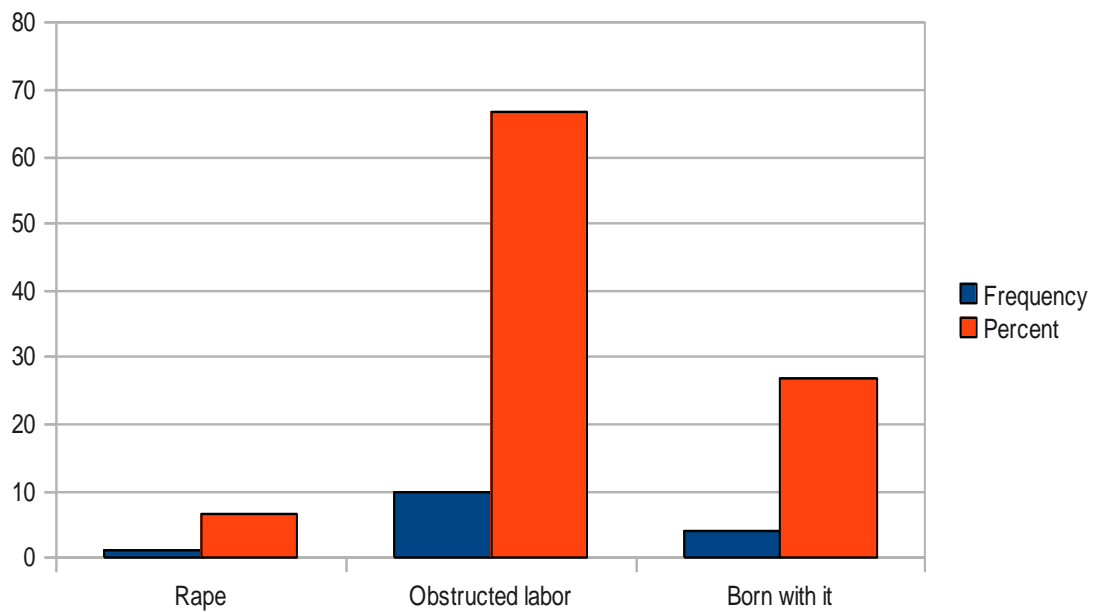


Figure 4.1 Causes leading to Fistula development

4.2.5 Duration with Fistula

The study sought to find out for how long the participants had been suffering from fistula: 6(40.0%) stated they had suffered from fistula for over 4 years, 8(53.3%) stated for 1 year and 1(6.7%) said for 2 years as shown in figure 4.2 below. This implies that the adolescent girls suffered fistula for at least over a year and since fistula is a health issue; and health affects participation and learning, then chances are high that the adolescent girls education was affected with fistula.

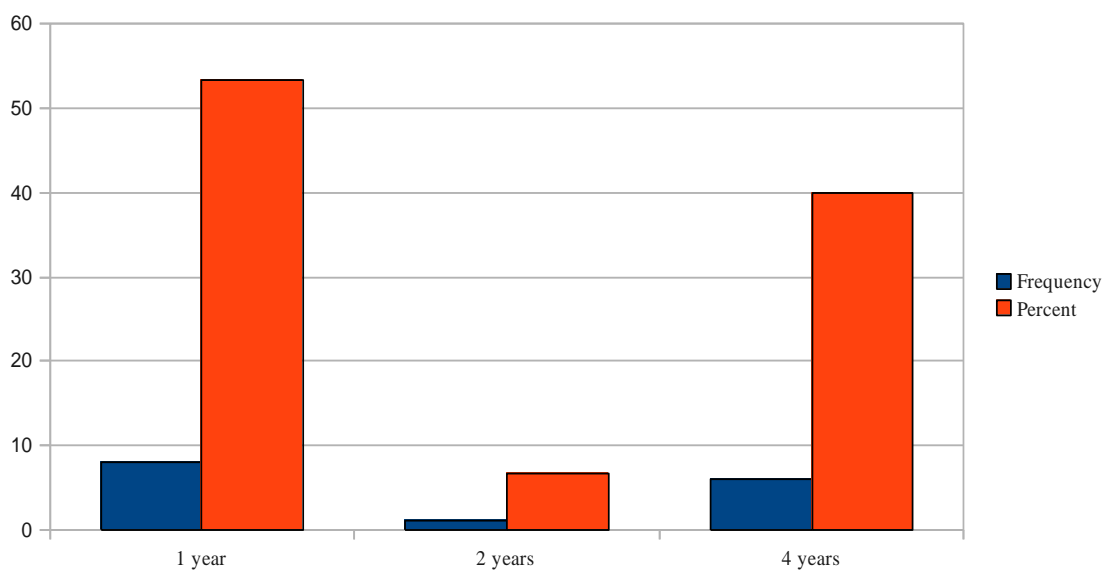


Figure 4.2 Duration with Fistula

4.2.6. Education Level when fistula occurred

The study sought to find out the education level of the participants when fistula occurred that 8(53.3%) were in primary school, 3(20.0%) were in secondary school and 4(26.7%) were not in school. Most suffered from fistula when they were in primary school. This is an indication that the adolescent girls suffered ill health due to fistula: a PTSD which could have an effect on their education.

4.2.7 Continuation of School after fistula occurred

The study also sought to find out if the participants continued with their education after fistula occurred and the responses indicated that 11(73.3%) dropped out of school and 3(20.0%) stated yes they joined and continued with their schooling but with frequent absenteeism while 1(6.7%) never joined school until much later after accessing treatment. This is an indication that fistula affects the education of adolescent girls.

4.2.8 Time dropped out of school due to fistula

The study further sought to find out how long the adolescent girls stayed out of school due to fistula: 7 (46.7%) stated 1 year, 2 (13.3%) stated two years and 1(6.7%) stated 3 years with another 1(6.7%) who stated over 3 years. This is an indication that fistula disrupted the adolescent girl's education and especially participation and learning while at school.

4.2.9 Current Level of Education

The participants were asked their current level of education as shown in table 4.5: 11(73.3%) stated secondary, 3(20.0%) stated primary and 1(6.7%) stated college. Most of the participants were in secondary school at the time of interview. This is an indication that fistula is not the end in itself, the adolescent girls affected can be given a chance to continue their education.

4.2.10 Relationship with Peers and participation in activities

The study sought to find out the relationship of the participants with their peers before treatment. The responses indicated that for 13(86.7%) it was bad, 2(13.3%) it was fair; whereas on their relationship with their peers after treatment, 12(80.0%) stated it was good and 3(20.0%) stated it was bad. On participation in school activities before treatment, 13(86.7%) said it was bad while 2(13.3%) said it was fair. On participation in school activities after treatment 13(86.7%) said it was good and 1(6.7%) said it was fair while 1(6.7%) didn't see any difference. This shows that the participant's relationship with their peers before treatment was bad but improved to good after treatment. This means that the leaking affected the adolescent girls but once it stopped then they returned to normalcy.

4.2.11 Effect of fistula on academic performance of adolescent girls

The participants were asked if fistula had affected their education at school and 10(66.7%) stated it has affected them a lot, 4(26.7%) stated somewhat and 1(6.7%) stated not at all. This shows that majority of the participant's education had been affected by fistula. When probed further to give a self-report, majority said they do not perform the way they used to perform in school academics before fistula. This was majorly attributed to absence from school. This was also confirmed by their report cards.

4.3 Objective analysis

Transcripts were analyzed using thematic and content analysis concurrently, a qualitative method used for 'identifying, analyzing and reporting patterns (themes) within data' (Braun & Clarke, 2006). On analysis of each of the interviews, a coding framework was devised. This study section was structured in terms of the main themes which emerged from the interviews. The following sections outline the main themes and sub themes emerging from analysis of the interview transcripts in line with the objectives of this study.

4.3.1 Psychosocial stressors of fistula

Loneliness-Lack of friends and family support

All the adolescent girls expressed lack of friends when they had fistula. This they attributed to the odor they produced which caused their friends to run away from them as quoted;

"I was lonely, friends took off from me, they ran away and nobody helped me"

More concerns of the adolescent girls was not being accepted and or supported by family members and relatives. Most of the adolescent girls expressed that a family member either chased them away or insulted them or did not provide for them their basic needs as indicated by a 17 year old adolescent girl:

"You do not have friends, people do not want you. For instance me when my parents died, we went to my grandmothers but after her death, everybody decided to take my siblings except me claiming that I will make their house dirty and produce a bad smell in their house. My friends and age mates ran away from me saying I'm smelling. I used to sleep in a sack in the kitchen with domestic animals."

While another adolescent girl 20 years of age who faced rejection from a family member also says:

"My sister chased me away from her home because I was smelling and told me to go back home and at home I had a step mother who was not happy with me, I was uncomfortable."

Poor relationship with peers at school

The adolescent girls were also asked about their relationship with peers while at school when they had fistula. Almost all the adolescent girls expressed unsupportive relationship with peers at school. Their peers at school either laughed at them or did not socialize with them. Majority of fellow students including teachers did not understand what was happening to them as another adolescent girl narrates:

"In class you are alone and desperate because nobody wants to associate with you. They keep saying somebody is smelling. You have to wait for everybody to go out of the classroom before you do."

The adolescent girls were also affected with the gossip of fellow students at school about their condition as indicated in the following quote:

"Due to the gossip of my peers I felt I'm not part of them. I felt I'm in my own world and not worthy. Some even came to ask me what was happening to me to make me smell and this made me feel totally embarrassed."

While the other adolescent girls who had congenital fistula (had it since birth) expressed that in nursery school and part of class one, living with fistula was not a problem to them. This was because either they did not realize they were leaking or most of the other kids were wetting themselves so it was a normal thing, but after class one onwards, they realized they were different and that they were the only ones leaking. This uniqueness of continued leakage after lower classes became a concern to them as quoted by one:

"In nursery many pupils used to urinate in their clothes and wet themselves so it did not matter but in class one onwards, I was alone and it affected me. I used to ask my mum why I was the only one wetting but no answer."

Abandonment

From the in depth interview schedules most participants felt they were abandoned or forced to separate from the society especially withdrawal from school. While some students supported the participants and were sympathetic to their plight, the majority ostracized them and at times mocked them. A participant described her relationship with her classmates this way:

"During break time, I was afraid to go out and leave the chair because the other children would laugh at me if I had leaked and my clothes were dirty."

Another participant commented that her classmates left her alone and did not want to associate with her. She narrated this bit of her ordeal:

"They largely ignored me and never wanted anything to do with me as they said that I smelled and they were embarrassed being with me."

Self-isolation

Some participants decided to isolate themselves from the community. This removed the interaction they had with their peers before and any social support during their

illness. It also contributed to their being ostracized as it confirmed to the community that they are not normal human beings. They felt lonely. One participant put it this way;

“Not that my family or people feared me. I was the one who feared people more than they feared me. I was thinking about what they thought about how I smelled. It was bad.”

Helplessness

Other participants felt helpless as they could not do anything about their problems and condition. With their physical health compromised and their social status lost, the participants' lives are often left to fate. Often, the participants find themselves with a disease which they do not know the cure nor understand. They are traumatized and cannot intervene in their own situation. This participant's comment about her situation captured her helplessness:

“If now one backbites me, what can I do? The urine is flowing and there is nothing I can do about it. Let them continue! It is not my wish.”

Another survivor expressed similar feelings of helplessness during their illness. One particularly was resigned to her fate as seen in her words:

“I didn't feel anything. Even when I pity myself what shall I do?”

Stigmatized

Most of the adolescent girls stated being despised by the society, family and friends due to having fistula. This was an overwhelming situation to them as indicated in the words of one of the participants:

‘I was despised, by people. They talked bad things about me. I was worried because people kept talking about my condition and sometimes when I passed where some people are they would spit saliva saying that I'm stinking. So I feared to take a walk and I would just sit at home’

Fear

When the adolescent girls were asked about how they perceived their life. All the adolescent girls expressed a life of fear especially while at school due to fear of the smell, odor and wetting themselves in the presence of others who did not even understand them. They too did not understand themselves as expressed by one of them, 13 years old:

"Imagine sitting in class only to realize that you are wet or standing up and the entire of your cloth is wet and you are smelling urine or stool. It is hard, you cannot be comfortable, you are always worried and live with fear, and you cannot go to school, visit or even go to church because of fear."

Resentment

Majority of the adolescent girls expressed their hatred for life and of being different especially with the fact that they did not understand what was happening to them. The 4(26.7%) who had congenital fistulas expressed more hatred and bitterness of being born different from the rest of humanity while those that developed fistula in their teen ages 11(73.3%) felt despair, hating themselves and thinking that it was a punishment they had received.

"People thought that my condition was contagious. When they saw me they would run away. I felt bad, I wished I should be no more. Worse of I didn't even understand myself."

4.3.2 Effects of fistula on adolescent girls academic performance

Drop out of school

The study sought to find out if the participants continued with their education when they developed fistula. 11(73.3%) stated that they dropped out of school and 3(20.0%) stated that they continued with their schooling but with frequent absenteeism from school, while 1(6.7%) never joined school due to fistula till later after accessing

treatment. Those who developed fistula while in school dropped out and they did not continue with schooling until after treatment when they were facilitated back to school while those who were not in school managed to join and continued learning but on irregular basis.

Academic performance

At the time of interview all the adolescent girls were back in school but majority expressed poor or average performance. They were asked to comment on their academic performance generally before and after having fistula. All said that they are not performing the way they used to perform before fistula. Those who got it while in school 11(73.3%) indicated that dropping out affected their performance; and 4(26.7%) who had congenital fistula indicated that frequent absenteeism from school affected their academic performance a great deal.

Those who were in school 11(73.3%) before fistula occurred, 1(9.1%) stated that her performance was excellent, 3(27.2%) performance was very good, 5(45.5%) performance was good and 2(18.2%) performance was average. This reveals that the adolescent girls were academically good before they developed fistula.

After the adolescent girls developed fistula it is revealed that all of them dropped in their academic performance with 2(13.3%) performance being very good, 2(13.3%) performance being good, 6(40.0%) performance being average and 5(33.4%) performance being below average. This is an indication that fistula affects adolescent girls performance in education.

The participants were further asked the ways in which fistula affected their academic performance and they responded as follows:

1. The 11(73.3%) indicated that it creates a gap in the course of learning due to dropping out of school.
2. The 3(20.0%) indicated that it reduces the concentration rate due to fear of wetting oneself while in class.
3. The 1(6.7%) indicated that it reduces the study time not being able to start school on time.

Lost hope for education

When asked about their hopes of going back to school when they had fistula, the 11(73.3%) indicated that they had lost hope completely since they never expected to be healed or get finances to go on with their education. Hope was lost because they came from marginalized areas and from poor socio-economic backgrounds. This made them to completely forget everything about school and going back meant starting afresh which to them was quite an uphill task.

"I never thought I would ever go back to school again because I did not know I will ever get well again, I felt I was useless, I am sick, I will never get well again"

4.3.3 Role of guidance and counselling in adjustment of adolescent girls affected with fistula.

The study sought to find out if the adolescent girls had ever received guidance and counseling. All the 15(100%) said they had been guided and counseled. They also indicated having received pre and post-surgery guidance and counseling while at the hospital facility by trained counselors in the facility. On the nature of counseling done

all the participants agreed to have received both individual and group counseling. The adolescent girls also indicated to be involved in peer counseling on going at the facility especially during school holidays. When further asked how guidance and counseling had impacted their lives. They answered that guidance and counseling has enabled them to gain;

Hope for life

The study sought to find out how the participants feel about their future. Nearly all the participants 14(93.3%) stated they felt very hopeful due to having received guidance and counseling. This implies that the participants became optimistic about their future after receiving guidance and counseling.

Build their self-esteem.

All the adolescent girls mentioned gaining self-esteem and confidence after guidance and counseling sessions especially the group counseling and the peer counseling sessions. This has made them to realize that they are not alone and there is hope of getting better and returning to normal life as they continue to work together and with the counselors.

Influenced their decision to go back to school

The adolescent girls also indicated that it was guidance and counseling that enabled them make a decision to go back to school. When asked how guidance and counseling had impacted their performance and interactions at school. All the adolescent girls indicated that going back to school in itself was such a relief after all hope was lost. They further indicated that guidance and counseling:

1. Had enabled them to have good relationship with peers at school by avoiding resentment.

2. They were also assured of no more absenteeism after treatment.
3. They were also assured of school fees through the NGO.
4. It was a sign of future life through educational empowerment.

The study sought to know if the educational life of the participants had improved as a result of guidance and counseling. 14(93.3%) said it has improved a great deal and only 1(6.7%) stated that it has improved a little.

Helped them to develop knowledge about fistula

All the adolescent girls also indicated that guidance and counseling had helped them to develop knowledge about fistula. They said that initially they did not understand what their condition was but during the sessions they learned more about it. They realized it was a curable and also preventable condition. They also indicated that they were determined to share with others and advise those with the same to seek medical care as quoted from one:

"I will tell the society that fistula is real but people should not fear because it is both preventable and treatable. I will also encourage my peers to help in the fight against fistula and at the same time make those who are suffering to be women of substance in the society. Those who have I will tell them to seek treatment."

It enhanced their mental health.

Majority of the adolescent girls, especially those that were healed completely, indicated that during both individual and group counseling sessions, they felt free from the burden of fistula. They mentioned feeling relieved from the concerns about stigma, isolation and resentment. They shared a positive outlook to life coupled with hope for future and improved happiness due to feeling of relief from worries and fear of wetting themselves. One said:

"Guidance and counseling has helped me to forget the past and to focus on the future"

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Overview

This chapter is a synthesis of the entire thesis. It presents the summary of findings, conclusions, recommendations and suggestions for future research.

5.1 Summary of Findings

The study participants filled a biographical form to obtain basic demographic information. This was followed by a face to face interview per participant to obtain information regarding three main research questions as follows:-

1. What are the psychosocial stressors of fistula on adolescent girls in learning institutions
2. What is the influence of psychosocial effects of fistula on adolescent girls academic performance in learning institutions
3. What is the role of G/C in adjustment of adolescent girls affected with fistula in learning institutions

5.1.1 Psychosocial effects of fistula on adolescent girls education

The study found out that the majority of the participants that is 8 were between 16-18 years of age. This conforms to a study by Maheu-Giroux et al (2015) which is a meta-analysis of national household survey on prevalence of symptoms of vaginal fistula in 19 sub-Saharan African countries. This study showed that Kenya is one of the African countries with the largest number of women of reproductive age (15-49 years) who have experienced vaginal symptoms estimated between 69,400 and 113,700 (Maheu-Giroux et al, 2015). Another study by Landry et al (2013) in five countries of

Bangladesh, Guinea, Niger, Nigeria and Uganda indicates that at the time of admission the fistula clients had little education and for many it occurred after the first pregnancy with the median age being 20.0 years. These studies conform to this study which found out that the adolescent girls when asked at what age they develop fistula, 4 stated they had it since they were born and 11 had developed fistula in their teen years qualifying to be adolescents.

The study found the causes that led to the participants developing fistula. 10 said due to obstructed labor while 4 had it since birth (congenital fistula) and 1 was caused by rape. This study shows that most adolescent girls developed fistula due to obstructed labor which is a major cause of fistulas as indicated in a study in West Pokot by Mabeya (2004) which found that prolonged labor was a major causative factor of obstetric fistula. It also agrees with a study by Fookes, (2013) which indicated that the toxic combination of a young girl having sex, getting pregnant and going through childbirth when her body is not developed enough accounts for at least 25% of known fistula cases. These consequences are largely due to girl's physical immaturity where the pelvis and birth canal are not fully developed. Teen pregnancy, particularly those below age 15, increases risk of developing OF, since their small pelvises make them prone to obstructed labor. Obstetric fistula can also be caused by the sexual relations associated with child marriage, which takes place even before menarche (HRO 2014). The findings of this research also conforms to a study by Maheu-Giroux et al (2015) which found that fistulas are mostly often pregnancy related (90.4%) followed by pelvic operations related at (5.3%) and then sexual assault related at (4.3%). These studies indicate that there is need for the government and other stakeholders in the education sector including families to sensitize the youths on the effect of early pregnancies so as to avoid occurrences of fistulas and consequent school drop-out.

The study sought to find out for how long the participants had been suffering from fistula. 6 stated they had suffered from fistula for over 4 years, 8 stated for 1 year and 1 said for 2 years. Majority of the adolescent girls had suffered for a period of 1 year which is contrary to the findings of Khisa, Mutiso, and Mwangi (2011) which show that the 70 patients in Kenyatta National Hospital had lived with fistula for an average period of 6 years with the longest duration recorded at 37 years. This could be due to the current efforts of the government to sensitize the public and provide treatment for fistula coupled with the efforts of NGOs.

The study sought to find out if the adolescent girls were in school when fistula occurred, 11 stated yes and 4 stated no. The study also established the education level the participants were when they developed fistula. 8 stated they were in primary school, 3 stated they were in secondary school and 4 were not in school. Most of the adolescent girls suffered from fistula when they were in primary school. These findings tally with the findings of Kenya National Bureau of Statistics, MOH, National Aids Control Council, Kenya Medical Research Institute and National Council for Population and Development (2015) research on Kenyan demographic and health survey 2014. They show that of those affected with fistula 1,015(1.1%) had no education, 3,793(0.6%) had not completed primary, 3,543(1.4%) had completed primary and 6,274(1.1) were in secondary schools and above. In another study by Khisa, Mutiso and Mwangi (2011) on demographics of fistula patients in Kenyatta National Hospital on 70 women, 19(27.2%) had no education, 42(60.0%) had primary education and 9(12.8%) had secondary education and above. Thus the majority of those who develop fistula have primary school education. The government therefore needs to create education systems like special schools to help the affected adolescent

girls to finish school. There is also need to sensitize the public on sex education and preventive measures of fistula so as to avoid more occurrences.

The study sought to find out if the participants continued with their education when they developed fistula. 12 stated that they dropped out of school and 3 stated that they continued with their schooling but with frequent absenteeism from school. Those who developed fistula while in school dropped out and did not continue with schooling until after treatment when they were facilitated back, while those who were not in school managed to join and continued learning though on irregular basis. Research shows that Fistula is a health issue that qualifies as a traumatic event leading to the development of post-traumatic stress disorder (PTSD) or post-traumatic stress (WHO, 2006; Ahmed & Holtz, 2007). This means that the adolescent girls education is affected since female students are strongly and negatively affected by poor physical and mental health conditions and experiencing sickness before the age of 21 decreases their education on average of 1.4 years (Suhrccke & De Paz Nieves 2011).

The study sought to find out the relationship of the participants with their peers before treatment. 13 stated it was bad, 2 stated it was fair. Whereas on their relationship with their peers after treatment, 12 stated it was good and 3 stated it was bad. The participants also responded about their participation in school activities before treatment. 13 said it was bad while 1 said it was fair. On participation in school activities after treatment, 13 said it was good and 1 said it was fair. This shows that the participant's relationship with their peers before treatment was bad but it improved and became good after treatment. This finding is in line with a study done by Landry, et al (2013) of 1354 women from five different countries who participated in a prospective cohort study conducted between 2007 and 2010 at the time of admission,

discharge and at 3 month follow up visit. Laundry et al found out that women experienced isolation perhaps because of the reactions of others or their own discomfort with their condition. Many women were unable to eat with others or attend a community or religious function. At follow up, most women reported that many aspects of their lives had improved while there were differences between women who were dry and those who were not dry, even women who were not dry reported improvements in many parts of their lives. This indicates that fistula treatment is a major factor in changing the lives of those affected with fistula because it improves happiness coupled with relief from worries of wetting themselves. Once healed the adolescent girls related well with others. This could be because they felt free from the fistula burden and concerns of stigmatization, abandonment, isolation, hatred and resentment.

5.1.2 Psychosocial stressors of fistula on adolescent girls in learning institutions

Interviewing the adolescent girls elicited various psychosocial stressors of fistula which affected the adolescent girl's education. The adolescent girls identified experiences which included lack of friends, lack of family support, resentment, fear, abandonment, stigmatization, and embarrassment, loneliness and hopelessness which affected their education. Despite the small sample size, this study resonates with characteristics documented in other similar studies. For instance by Mutambara, et al (2013) conducted in Zimbabwe found that women with OF faced various psychological problems which include; helplessness, sadness, suicidal thoughts, Stigma, blame, feelings of worthlessness, fear, shame and social withdrawal. In another study by Habiba, Kabunga and Thananga (2016) on psychological effects of OF on young mothers in western Kenya, among them 35% were stigmatized, 29% felt social worthlessness and 20% were isolated. Another study by UNFPA (2012) in

Kaptembwa-Nakuru Kenya concluded that the foul odor emanating from the affected women leads to humiliation and severe social cultural stigmatization and isolation. Another study by Diallo (2009) in Guinea shows that women who develop OF often suffer stigma, abandonment, loss of self-esteem and social isolation. This study therefore concludes that fistula has major psychosocial consequences which can dearly affect the education of the adolescent girls. The adolescent girls should therefore be reintegrated to return to normalcy through interventions such as guidance and counseling as they restart their journey in education.

5.1.3 Effects of fistula on adolescent girls education

Dropping out of school

The study sought to find out if the participants continued with their education when they developed fistula. 11 stated that they dropped out of school and 3 stated that they continued with their schooling but with frequent absenteeism from school while 1 never joined school due to fistula till later after accessing treatment. The study also sought to find out how long did they stay out of school due to fistula. 7 stated 1 year, 2 stated two years and 1 stated 3 years with another 1 who stated over 3 years. Those who developed fistula while in school dropped out and they did not continue with schooling while those who were not in school managed to join and continued learning though on irregular basis. This could be attributed to the smell of the leakages of the adolescent girls. They were unable to play with their fellow students at school and they were often isolated. The fear of stigma was so strong and many of them, 11 adolescent girls avoided their peers and isolated themselves by going to greater lengths of dropping out of school as one says:

"I stopped going to school when I had fistula because I felt isolated. I wondered how I would stay at school leaking, so I decided to stay away from school."

The findings of this study conform to the findings of Landry et al on 1354 women from five different countries which indicated that women experience isolation perhaps because of the reactions of others or their own discomfort with the fistula condition. This makes them unable to eat with others or even attend community or religious events (Landry et al, 2013). This confirms why the adolescent girls could not continue with school but instead opted to drop out or attend school irregularly.

Academic performance.

At the time of interview all the adolescent girls were back in school but they all expressed poor or average performance. They were asked to comment on their academic performance generally and all said that they are not performing the way they used to perform before fistula. The 11 who got it while in school attributed it to the gap when they dropped out of school and the 4 who had congenital fistula indicated that the frequent absenteeism from school affected their academic performance a great deal. Therefore fistula had affected their educational ability a lot as indicated by 10, among them 6 said that fistula had affected their education negatively.

When asked the ways in which fistula caused poor performance? They attributed it to creating the gap in the course of learning due to the drop out. On average the adolescent girls were out of school for 2½ years or frequent absenteeism. Other factors attributed to poor performance included reduction in the concentration rate and reduction in the study time. This could be due to frequent absenteeism and or worries of wetting themselves as indicated in other researches. For instance by Schwarz and Lui (2000) which found that poor health can affect school performance in many ways including absenteeism, affecting concentration level in the classroom, and affecting students abilities to participate in the extra co-curricular activities. Another survey by

American Academy of Pediatrics, health care and child's ability to learn (1992 in Schwarz & Lui, 2000) nearly unanimously agreed that a child's overall health and fitness are very important to his or her performance in school.

This finding indicates that all those who were in school dropped out of school and stayed for at-least 1 year thus creating a gap in the course of learning which 11 attributed to poor performance when they resumed their education after fistula repair. Fistula is a health issue that predisposes women to high levels of depression as researched by Khisa, Mutiso and Mwangi (2011) on 70 women who consented at KNH and reported that 2(2.9%) had a history of psychiatric illness, 12(17.1%) had suicidal ideations while 51(72.9%) presented depression with 18(25.7%) meeting criteria for severe depression. Evidence shows that ill health and malnutrition affect access, participation, completion and achievement (Pridmore, 2007). Therefore this study conforms to previous studies which prove that education attainment is affected by ill health. Schraml, Perski, Grossi and Makower (2012) investigated if chronic stress has implications for adolescent academic achievement. Of 270 high school students who answered a questionnaire on stress symptoms on two occasions at the beginning and at the end of high school, those who perceived severe stress symptoms at both time points finished high school with significantly worse final grades than those who reported experiencing stress at only one or none of the time points. Another study by Wolfe found out that absenteeism due to chronic illness is related to even lower school achievement than the general high absence (Wolfe, 1985 in Carolyn & Lui, 2000). The gap during school drop-out and frequent absenteeism could be the reason why the adolescent girls affected with fistula are performing poorly.

When asked about their hopes of going back to school, the 11 who had dropped out indicated that they had lost hope completely. They mentioned that hope was lost because they never expected to be healed nor get finances to go on with their education since they came from marginalized areas and from poor socio-economic background. This made them to completely forget everything about school and going back meant starting afresh which to them was quite an uphill task. These findings are consistent with a study by Gyan (2013) exploring the effects of teenage pregnancy on the educational attainment of teenage mothers which indicated the respondents' view on whether there was the possibility for them to go back to school after delivery. Majority of the respondents 47(94%) believed that there was no possibility of going back to school after they had delivered while interestingly only 3 (6%) of the respondents stated that it was possible for them to go back to school after delivery. This implies that most of the teenage pregnant girls and mothers were not aware of the fact that after delivery they could still go to school. The findings revealed that most of the teenage mothers had dropped out of school, that is 86%.(Gyan, 2013), as is the case with the adolescent girls affected with fistula who had dropped out of school and had lost hopes of ever going back. In my opinion if the *Beyond Fistula* NGO would not reintegrate them back to school most if not all of them would have lost it all.

5.1.4 Role of G/C in adjustment of adolescent girls affected with fistula in learning institutions

This study sought to find out if the adolescent girls had received guidance and counseling. They all agreed to have received both individual and group counseling before and after surgery. They also indicated that they received frequent guidance and counseling by trained counselors at the NGO. The study established that guidance and

counseling had impacted the lives of adolescent girls by giving them hope for life, building their self-esteem, influencing their decision to go back to school and improving their knowledge on fistula. This is in line with a research done in Eritrea which established that one on one counseling of fistula patients with a trained individual addresses perceptions and misconceptions and makes a difference in women's self-esteem, enhanced their mental health and helped them have positive behavioral intentions (Johnson, Turan, Hailemariam, Mengsteab, Jena, & Polan, 2010). Another study by Khisa 2015, established the need for psychological and moral support as essential to the reintegration of women following surgery hence the need for counseling services.

G/C helped the adolescent girls to feel hopeful about their future as indicated in their report that it improved their happiness due to feelings of relief from worries and influenced their decision to go back to school. G/C done before surgery also made them have a positive outlook on life free from the burden of fistula and its concerns of stigma, isolation, resentment and hatred for life. This is not unique to a study by Johnson et al, 2010, which established that the participants felt better about themselves and their futures following treatment and counseling. That before guidance and counseling, only 15.2% of women strongly agreed that they were a person of worth but after counseling this percentage increased to 71.4% (Johnson et al, 2010). This shows that treatment of fistulas is not enough but counseling completes the healing and helps fistula survivors return to normal life.

This study also established that all the adolescent girls who got fistula while in school dropped out due to fear, shame, resentment, isolation and stigmatization. But after pre and post surgery counseling they all went back to school through the sponsorship of

the NGO. The adolescent girls also indicated that through guidance and counseling offered frequently at the NGO, their relationship with peers at school had improved a great deal. This enabled them to feel relaxed at school and interact freely. This conforms to a study by Johnson et al. (2010) in which initially 71.4% of women strongly believed that they were not worthy of being around others because of their fistulas; this number decreased to 28.3% following counseling. This indicates that reintegration is often a social process that requires a supportive social environment and if it lacks women will find it difficult to settle back (Khisa, 2015). This is also similar to a study done in Lilongwe, Malawi in which 20 women were interviewed. It established that repair had resolved the women's concerns and improved their quality of life at individual level including feelings of freedom, confidence and personal growth. It also improved their interpersonal quality of life in terms of their relationships with family and friends, reduced stigma and increased participation with their communities (Drew, Wilkinson, Nundwe, Moyo, Mataya, Mwale, & Tang, 2016).

This finding significantly indicates that guidance and counseling services are very necessary for the adolescent girls and that it has really helped them to improve generally. The adolescent girls noted that a chance to reintegrate them back to school contributed positively to their self-esteem. This is also demonstrated in a study by Khisa, (2015) which confirms the vitality of counseling given the psychological burden fistula places on women and the social stigma associated with it. They are then likely to benefit from counseling that focuses on return to normalcy or dealing with permanent loss. In another study by Johnson et al. 2010, there was a statistical significant increase in women's self-esteem scores from an average score of 13.6 out of 30 before pre-operative counseling to 27.9 after post operative counseling.

A study done in Eritrea by Johnson et. al, (2010) demonstrated a significant and positive impact of a formal counseling program on fistula patients which aimed to evaluate the short term impact of pre and post surgery counseling by trained counselors and which established that counseling improved patients knowledge on fistula, self-esteem, enhanced their mental health and helped them to have positive behavioral intentions. This confirms to the findings of this study which established that the adolescent girls' knowledge on fistula was increased after pre and post surgery group counseling. The group counseling helped them to realize that they are not alone which contributed to building their self-esteem. This study therefore encourages continued G/C services to the adolescent girls affected with fistula as it helps them to reintegrate back into the society and gain normalcy. Guidance and counseling is an integral part of comprehensive fistula care services for the adolescent girls to address their treatment and social reintegration (Khisa, 2015)

5.2 Conclusions

Adolescent girls who developed fistula in school and eventually dropped out due to the same and stayed away from school for a certain period of time before going back reported average or below average academic achievement attributed to the gap created during drop out. Those who had congenital fistula and went to school reported poor concentration due to incontinence and reduction of study time caused by the effects of fistula on their education and they performed averagely and or below average in their academics.

Fistula leaves adolescent girls physically, emotionally, and socially, traumatized. Lack of support from their families, peers and society is the hardest consequence to bear psychosocially. These adolescent girls are confronted with isolation, separation, kept

from touching other individuals' belongings, despised, humiliated, drop out of school and lose concentration while in school which affects their education.

Guidance and counseling is an important aspect in helping the adolescent girls to adjust in their education and to return to normalcy so as to avoid the immediate consequences on adolescent girl's education and well-being. Because of its implications on education, it can have significant negative repercussions on the adolescent girls' future chances of being accepted into a quality line of education.

5.3 Recommendations

Based on the findings of this study the researcher recommends the following:

1. Fistula affects the educational attainment of adolescent girls. Given the multiple levels of predisposing factors of the same, single intervention strategies by single sectors will not solve these effects and the problem of fistula as a whole. What is required therefore is a comprehensive approach that incorporates the home, the school, the community, the healthcare setting as well as change at the structural level.
2. Adolescent girls affected with fistula need a combination of support from their peers, school and family to avoid the psychosocial stressors of it especially in their inclusion back to education.
3. Adolescent girls affected with fistula should be given continuous guidance and counseling services to facilitate them to return to normalcy and to their personal empowerment by giving them opportunities in education.
4. Obstructed labor was one major problem revealed by the study as a cause of fistula among adolescent girls. To address it, the government should

strengthen hospitals, families and schools to be able to provide the necessary care, support and sex education of their members including adolescent girls.

5.4 Suggestions for Future Research

1. The findings of this research study are based on a small sample from the Beyond Fistula NGO alone. Future research should incorporate research using a bigger sample size to enable generalizability of the findings.
2. This study only focused on the effects of fistula on the academic performance of the adolescent girls and discovered that it has a negative effect. Future research should therefore focus on the solutions to the psychosocial effects of fistula on the education of the adolescent girls.
3. Moreover, future research should incorporate evaluations of school settings, students and teachers to help in the reintegration of the adolescent girls affected with fistula back to school. This study only involved self-reports and biographical data of the adolescent girls.

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APPENDICES

Appendix A: Research Consent Letter

I am a postgraduate student at Moi University, pursuing M. Phil. Degree in Guidance and Counseling in the department of Educational Psychology. I'm currently carrying out my thesis research on the **psychosocial effects of fistula on adolescent girls and its implications on education.**

I kindly request you to participate honestly and accurately in this study as one of the participants to be interviewed? Your responses and the findings in general will be kept confidential and will not be used for any other purpose except for this study.

If you accept to participate, I'm pleased to inform you that you may request the researcher to inform you about the findings of this study.

Kindly sign in the space provided on this letter if you accept to participate in the study. Thanking you very much for participating in the study.

Yours faithfully

Norah A. Otondo

Participant Signature.....

Date

Appendix B: Introduction Letter

Moi University,
Department of Educational Psychology,
P.O Box 3900,
Eldoret

Dear participant/informant,

I am a master of philosophy student in guidance and counseling at Moi University Department of Educational Psychology undertaking educational research on the topic *Psychosocial Effects of Fistula on Adolescent Girls and Its Implication to Their Education*. The ultimate goal of this study is to provide an insight into the psychosocial issues of fistula on adolescent girls and how this impacts on their education which in turn might affect the entire society.

Kindly participate in the interview sessions with the best of your ability. All the information given will be treated with ultimate confidentiality and will be purposely used for this research. Thanking you in anticipation.

Yours faithfully

Norah Amisi Otondo
0721863752

b) If no, how long did you stay out of school due to fistula?

1 year-----

2 years-----

3 years-----

Other-----

8. What level of education are you now?

Primary class-----

Secondary form-----

College -----

9. How was your relationship with your peers before treatment?

Good () fair () poor ()

10. How is your relationship with your peers after treatment?

Good () fair () poor ()

11. How was your participation in school activities before treatment?

Good () fair () poor ()

12. How is your participation in school activities after treatment?

Good () fair () poor ()

13. How do you feel about your future

Very hopeful () somewhat hopeful () not hopeful ()

14. a) Have you received any guidance and counseling support?

Yes () No. ()

b) If yes, how has guidance and counseling impacted your academic performance?

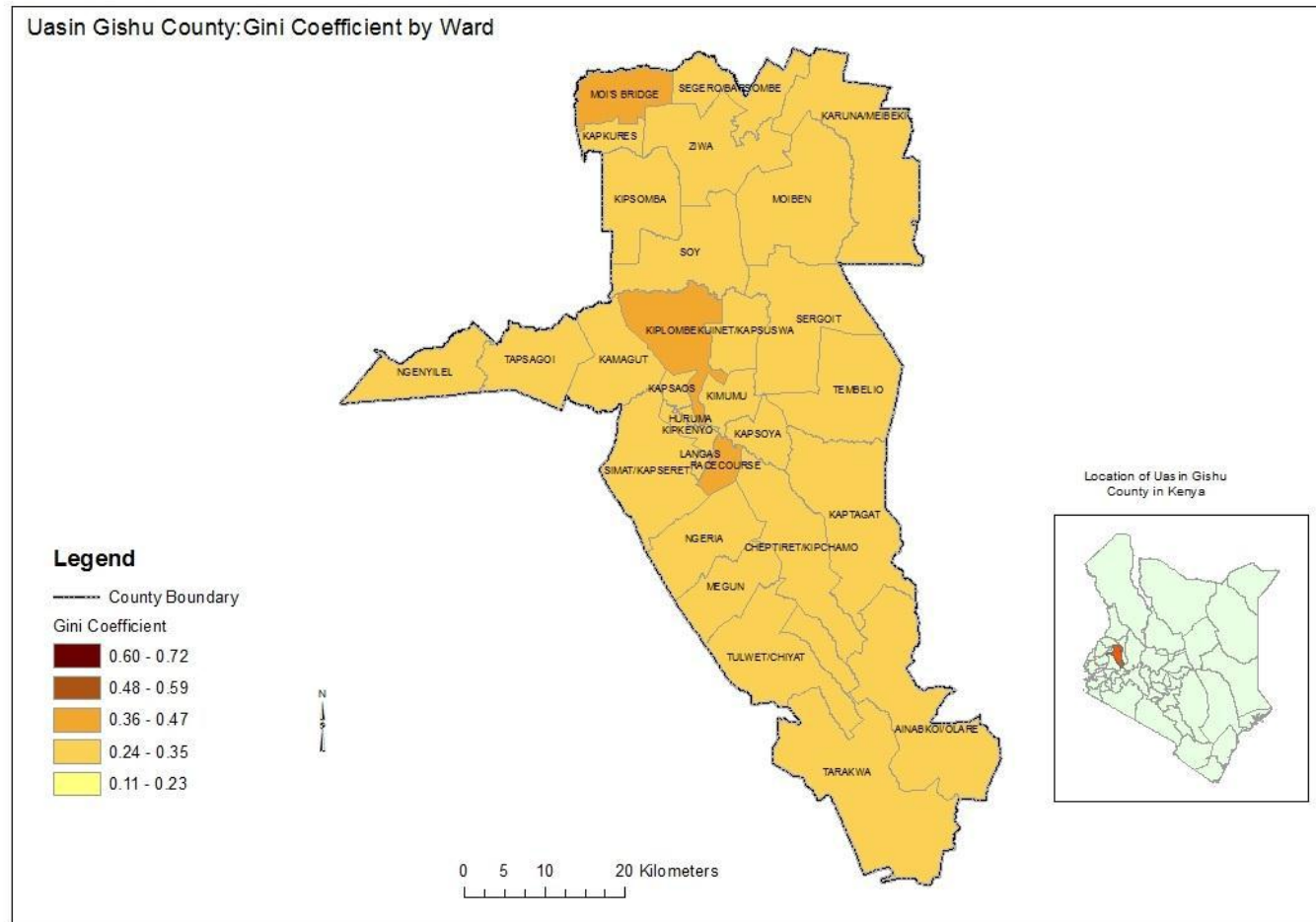
Not improved () Improved a little ()

Improved a great deal ()

Appendix D: Interview Probe Questions

1. Would you share the experiences you are/went through due to having a fistula?
2. How has fistula affected your relationship with other peers especially at school?
3. How has fistula affected you as a person?
4. How has fistula affected your relationship with your peers at school?
5. How would you rate your academic performance at school?
6. In what way do you think fistula has affected your academic performance?
7. What is your opinion about your general academic performance from your school reports? (kindly would you show me your reports)
8. Have you ever received guidance and counseling?
9. Would you describe how guidance and counseling has impacted your school life?
10. What would you wish to share with your friends and the society concerning fistula experience?


Appendix E: Map of Uasin Gishu County





Appendix F: Research Permit

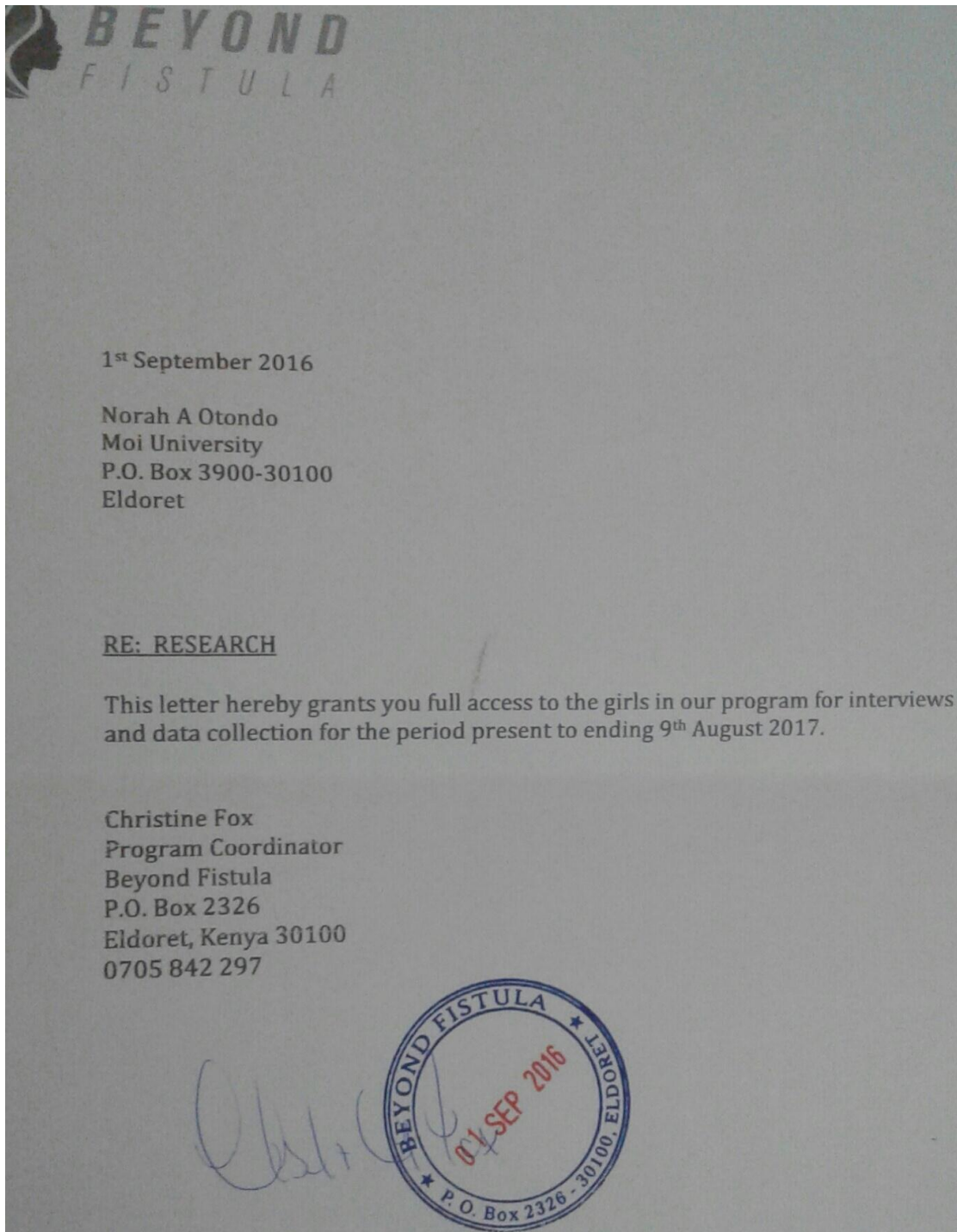
THIS IS TO CERTIFY THAT:
MISS. NORAH AMISI OTONDO
of **MOI UNIVERSITY ELDORET, 0-40105**
maseno, has been permitted to conduct
research in **Uasin-Gishu County**
on the topic: **PSYCHOSOCIAL EFFECTS**
OF FISTULA ON ADOLESCENT GIRLS IN
KENYA: IMPLICATIONS ON THEIR
EDUCATION
for the period ending:
9th August, 2017

Permit No : NACOSTI/P/16/93809/12925
Date Of Issue : 19th August, 2016
Fee Received :Ksh 1000




.....
Applicant's Signature


.....
Director General
National Commission for Science,
Technology & Innovation

Appendix G: Permit From Beyond Fistula NGO

Appendix H: Research Work Plan and Timeframe

ACTIVITY	DURATION
Writing of research proposal	November 2014-March 2015
Presentation of the research proposal	June 2015
Correction of research errors	July 2015
Data collection	January to April 2016
Data analysis	September 2016
Report writing and handing in	October 2016
First draft	October 2016
Defending thesis	October 2018

Appendix I: The Research Budget

Budget item	Ksh.
Production of Research Instrument	
Typing and printing-10 pages research instrument (40*10)	400
-Research report(first draft)120 pages*50	6000
-correction first draft	2400
-final printing	1200
Binding 10 copies of thesis @500 (10*500)	5000
Photocopy of the final research report (120*10*3)	3600
Computer services	3000
Transport and substance	
Public transport to the field for 30days(1000*30)	30000
Lunch in the field @200 per day (200*30)	6000
Accommodation for researcher and assistant	80000
Incidental costs	
Stationery, pens, pencils, folders, files	15000
Honorarium	30000
Hire venues during data collections	30000
TOTALS	212600