DECLARATION

I, Eyotaru Lillian Awizia, hereby declare that the work presented in this dissertation is my work unless otherwise acknowledged, and that it has not been presented in any Institution for any Academic award or any other purpose.

Signature……..

Reg. No: **13/MMSPPM/32/027**

Date……..

APPROVAL

This is to certify that this dissertation entitled "SOCIAL REINTERGRATION AND WELL-BEING OF WOMEN AND GIRLS AFFECTED BY FISTULA IN SOROTI DISTRICT UGANDA has been submitted in fulfillment of the requirements for the award of the degree of Masters in Management Studies (Project Planning and Management) of Uganda Management Institute with our approval as Institute supervisors, respectively.

Supervisor: Dr. ROSE NAMARA, PhD

Signature: …… Date: ……..

Supervisor: Mr. JAMES KAMUKAMA

Signature: **……** Date: **…….**

DEDICATION

I dedicate this research work to my beloved mum Palma Eyogawizia who stood up for the Education of the girl child and has been there for me in all ways. Also to my beloved husband George Bhoka who inspired me a lot in life and to my beloved son Samuel Godwin A. Bhoka who not only missed mum's love and care but remained understanding to mum's academic struggle. Lastly to my Lt. Dad, Modest Eyogawizia and Lt. Rev. Fr. Stephen Ojobile who laid the foundation to my education.

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ACCRONYMS

RRH	Regional Referral Hospital
DHO	District Health Officer
ANC	Antenatal Care
CS	Cesarean Section
EmOC	Emergency Obstetric Care
UBOS	Uganda Bureau of Statistics
HSSP	Health Sector Strategic Plan
NOFS	National Obstetric Fistula Strategy
MDG's	Millennium Development Goals
SDG	Sustainable Development Goals
NUSAF	Northern Uganda Social Action Fund
NAADS	National Agricultural Advisory Services
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
PNC	Post Natal Care
UDHS	Uganda Demographic and Health Survey
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
EH	Engender Health
WHO	World Health Organization
ICPD	International Conference on Population and Development

TERREWODE	The Association for Rehabilitation and Re-orientation of Women for Development
NGO	Non-Governmental Organization
RVF	Recto Virginal Fistula
SPSS	Statistical Package for Social Scientists
VVF	Vesco Virginal Fistula
WDP	Women's Dignity Project
UNHS	Uganda National Housing Survey
SR	Social Reintegration
OFAAN	Obstetric Fistula Advocacy and Awareness Network
FS	Fistula Survivor
OFSP	Obstetric Fistula Strategic Plan
BOD	Board of Directors
UMI	Uganda Management Institute
AMREF	African Medical and Research Foundation
USAID	United States Agency for International Development

ABSTRACT

The study examined the relationship between Social reintegration and the well-being of women and girls affected by Obstetric Fistula in Soroti District Uganda, while using TERREWODE interventions as a case study. The following objectives guided the study: To examine the relationship between Counseling support and Socio-economic well-being of the women and girls affected by Fistula in Soroti District; To investigate the relationship between skill empowerment support and socio-economic well-being of the women and girls affected by Fistula in Soroti District and lastly; To explore the relationship between social empowerment and socio-economic well-being of women and girls affected by fistula in Soroti District. The study used both qualitative and quantitative methods to collect and analyze data. The sample size was 74respondents. Simple random sampling and purposive sampling techniques were employed in selecting respondents. The study used both Primary and Secondary data. Analysis was done using statistical package for social scientists (SPSS. Findings revealed a strong positive relationship r=0.940 between counseling support and emotional well-being of women affected by fistula. This implies that anything affecting counselling greatly impacts on well-being of fistula victims. Counselling support was found to be in adequate. There was a strong positive relationship r=0.887 existing between skill empowerment support and socio-economic well-being of women and girls affected by fistula where by more quality skill empowerment provided was related to more socio-economic well-being of the women and vice-versa. There was a strong positive relationship r=0.849 between social empowerment and well-being of women affected by fistula where by more social empowerment was related to more well-being of the women and vice-versa, although other social empowerment aspects such as involvement of public

institutions, male involvement are not yet implemented. Thus, the study concluded that psychosocial support through counseling; skill empowerment and social empowerment have close relationship with physical, social and economic well-being of women affected by fistula. It is recommended that at policy level, for better well-being of women to be achieved, Government and other funding agencies should increase on funding allocation to social reintegration intervention. The study also recommends, policy reviews, cultural reforms, clear structures by Government and NGOs to implement social policies. The study further recommends that the Government of Uganda should design policies, strategies that will not only be helpful to the Government and local NGOs but rather to the external stakeholders who may wish to partner with the Government in the fight against fistula. At community level, the study recommends involvement of the affected women in planning and programming by Local Governments and NGOs. Engage media to capture and document women's experiences before, during and after fistula. Lastly, Government should step up poverty alleviation programs that should benefit the survivors of fistula for better well-being of the women.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

The battle against fistula is a just cause. Social Reintegration is the poor relation of this war, meaning it is not taken seriously yet this component must receive very special attention, and innovating and promising strategies can help make a difference (Marrakech, 2010). This further implies that, Social reintegration is one of the innovative and promising strategies used to combat effects of obstetric fistula. A study was conducted using a case of interventions by The Association for Rehabilitation and Re-orientation of Women for Development (TERREWODE) in Soroti District Uganda. This study considered social reintegration with dimensions of counseling support, skills and social empowerment as independent variable (IV), while well-being was considered as dependent variable (DV). This chapter presents the background to the study, the statement of the problem, the general objective of the study (purpose) and the specific objectives of the study, the research questions, and the hypothesis, the scope of the study, the significance and justification of the study and operational definitions of terms and concepts.

1.2. Background of the study

1.2.1. Historical Background.

Obstetric fistula is a significant reproductive and public health problem in the developing world and surgical repair is the mainstay of treatment. It is a crippling maternal childbirth injury which can affect any woman or girl who suffer from prolonged or obstructed labour without timely access

to an emergency Caesarean section. In many low-income countries, where surgical capacity is limited, obstetric fistula may be avoided through bladder-catheterization. This conservative treatment closes the Vesico-Vaginal fistulas (VVF) without the need for surgery when treated in an early stage. An iatrogenic fistula is a fistula resulting from surgery performed by a medical person.

Globally, Obstetric Fistula afflicts 2- 3.5 million women and girls in the developing world, mainly those most impoverished and living in rural and remote areas. With an annual incidence of 50,000-100,000 women as suggested by World Health Organisation data (WHO 2003). But some health providers have proposed that the incidence may be as high as 2 to 5 cases per 1000 deliveries in areas that lack access to emergency obstetric care. Obstetric fistula is one of the major complications of childbirth, caused by obstructed labor. Unrelieved obstructed labor, which has social, nutritional and health care dimensions, as the main cause of obstetric fistula. The women live with the physical and psychosocial effects of obstetric fistula (OF).Studies in Africa have shown that 58-80% of women with obstetric fistulae are under the age of 20, with the youngest patient only 12 or 13 years of age. Obstetric fistula is considered among the most severe of these morbidities. It is suspected that most of the estimated 2 million women living with fistulas are from Africa, parts of Asia, and the Arab region.

Uganda has an estimated population of about 35 million; maternal mortality ratio is 438 per 100,000 live births which translate to about 6000 women dying every year due to pregnancy related causes. However, for every woman who dies, 6-15 survive with chronic and debilitating ill health such as obstetric fistulae. Obstetric fistula is a public health problem with an estimated prevalence of 2% of women of reproductive age.

UNFPA launched the global campaign to end fistula in 2003 and the Ministry of Health has recognized fistula as a silent morbidity among women and has been collaborating with various development partners such as TERREWODE, UNFPA, AMREF, and USAID/ENGENDER HEALTH-Fistula Care Plus, to ensure harmonized acceleration of prevention, treatment and social re-integration services.

According to Uganda's five year Obstetric Fistula Strategic Plan (OFSP 2012-2016), the number of women suffering from Obstetric Fistula in Uganda is estimated at 200,000 and about 2000 new cases occur yearly. Affected women are stigmatized, isolated and remain silent in the communities. They adapt living styles characterized by problem focused coping in order to reduce on isolation, rejection and stigma associated with fistula. They also use emotional coping mainly in form of avoidance

Coping, building on the life adjustments made in their physical, psychosocial and sexual experiences. There is a three-fold reduction in participation of women with fistula in community groups, with 1 in 10 only able to continue participation after sustaining fistula; and economic implications of Obstetric Fistula to women include loss of income, leadership roles in community development groups and self-esteem. Health programs need to go beyond closure of fistula and target communities and families to reduce stigma and isolation, and achieve social rehabilitation and reintegration which seem to be the most critical challenge at the moment. Today Social reintegration and rehabilitation worldwide has attracted a great concern due to the fact that, Women repaired of obstetric fistula (OF) often continue to be socially isolated, discriminated and stigmatized and need support to reintegrate them into communities and attain socio-economic wellbeing.

1.2. Theoretical Background

The study was guided by two theories namely; the Social Support Theory and Anu Kasmel's Empowerment theory. These theories were seen to suggest and address the relationship between Social reintegration and Social Economic Well-being of the women and girls affected by Fistula.

1.2.2. Empowerment theory by Anu Kasmel

Empowerment is identified as a principal theory of community psychology (Rappaport, 1981, 1984, 1987), and a key concept for communities to remedy inequalities and to achieve better and fairer distribution of resources for communities (Tones and Tilford, 2001, Braithwaite and Lythcott, 1989; Breslow, 1992; Minkler, Thompson, Bell, & Rose, 2001). Empowerment is a construct shared by many disciplines and arenas: community development, psychology, education, economics, studies of social movements and organizations. Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations (Israel *et al*., 1994).

It is the process by which individuals and communities are enabled to take power and act effectively in gaining greater control, efficacy, and social justice in changing their lives and their environment (Solomon, 1976; Rappaport, 1981, 1985; Minkler, 1992; Fawcett et al., 1994; Israel et al., 1994). This theory guided the study because it provided very important facts about understanding and control over personal, social, economic and political forces in order to take action to improve life situations. Details of the empowerment theory are found in Chapter Two.

The only problem with this theory is that, it focuses so much on empowering individuals and communities to achieve socio-economic wellbeing with minimum emphasis on the aspect of human rights which is so crucial, especially the reproductive health and economic rights of

individuals should never be ignored in the efforts to achieve socio-economic wellbeing (ICPD Program of Action and Human rights, 1994).

Social Support Theory

The Social Support Theory by Brain Lakey and Sheldon Cohen (1984) defines clearly how social relationships influence cognitions, emotions, behaviors, and biology. It presents an overview of the three important theoretical perspectives on social support research: (i) the stress and coping perspective, (ii) the social constructionist perspective, and (iii) the relationship perspective. The stress and coping perspective proposes that support contributes to health by protecting people from the adverse effects of stress. The social constructionist perspective proposes that support directly influences health by promoting self-esteem and self-regulation, regardless of the presence of stress. The relationship perspective predicts that the health effects of social support cannot be separated from relationship processes that often co-occur with support, such as companionship, intimacy, and low social conflict. The researcher found this theory helpful in critical examination of the relationship between Social reintegration and Well-being since it creates a better understanding about how social support influences health and well-being of women and girls affected by fistula.

1.2.3. Conceptual Background

In this perspective, the study has two concepts namely Social reintegration as the Independent variable (IV) and Well-being as the dependent variable (DV). Social Reintegration is viewed and defined differently by different scholars; According to majority scholars, Social reintegration is commonly defined as ‘any social intervention with the aim of integrating victims of a situation or certain health, economic, political and social problem in to the community. However, in the context of Obstetric Fistula, the restoration of a woman to a dignified place within her community

after fistula surgery is referred to as ‘’Social Reintegration’’ (Paul et. Al:, 2010,) Social reintegration is an appropriate intervention that helps women and girls affected with Fistula overcome physical, psychological and social economic challenges in order to enhance their return to communities and social networks of choice(National Obstetric Fistula Strategy 2011-2016, Uganda). TERREWODE defines Social reintegration as a process of providing equal opportunity, comfort and dignity to fistula clients with an aim of ensuring human rights for all. These comforts, opportunities and dignity which guarantee human rights of the fistula clients are done mostly after the surgical treatment. This definition recognizes that social reintegration contributes to social inclusion by strengthening the foundations of fundamental institutions of the society and the entire public. Social reintegration as an independent variable in the study was looked at in three dimensions that is, **Counseling (**Health Education, Family Planning, Group engagement, Individual engagement), **Skill Empowerment** (Income Generating activities, Training, Mentoring, and Coaching) and **Social Empowerment** (Human Rights, Public institutional, Involvement of Men, and Leadership).

Well-being is another concept that is defined as the state of being happy, healthy, or successful (Imel et. al., 2008). According to Oxford English Dictionary published by W.R. Chambers Ltd 1992, Well-being refers to comfort, good health, safety and happiness of a person or group of people. The researcher in the study referred to Social well-being as the mental and emotional state of being and Economic well-being as the ability to generate income and overcome poverty. Well-being as a dependent variable was measured in terms of **Social/Emotional well-being (**Family stability, Respect at house hold level, Self-esteem and House hold decision making, Social networks /groups and relationships), **Economic wellbeing (**Income levels/security, Investment opportunities/income generating activities, Diversified source of income, decision on expenditure

and reduced poverty level), and **Physical wellbeing (**Good nutrition, good hygiene, reduced stress and reduced cases of fistula).

1.2.4 Contextual Background

There are four key nongovernmental organizations (NGOs) that work closely with Ministry of health to uphold the campaign to end fistula in Uganda. These include; UNFPA, WHO, USAID EngenderHealth Fistula Care Plus and AMREF. A concerted effort by all these development partners undertaking Fistula care and management interventions such as advocacy and awareness raising, prevention and treatment of fistula leaves the role of social reintegration in the treatment of fistula is less considered. Implying that, much as a lot of effort is put in treating fistula, efforts to undertake social reintegration intervention for the women and girls affected especially after surgeries is still lacking. As such reintegration needs of the treated women are not known. However one NGO in Uganda (TERREWODE) decided to fill this gap by coming up with yet a holistic approach to the care and management of fistula, by undertaking, advocacy and awareness raising, prevention, treatment and social reintegration interventions so as to join hands with other NGO's in the elimination of Fistula in Uganda.

The Association for Rehabilitation and Re-orientation of Women for Development (TERREWODE) is a Ugandan based non-governmental organization headquartered in Soroti, Eastern Uganda. It is among Uganda's NGO's committed to improving the status of women and the girl child. It pioneers best practices for the elimination of Obstetric Fistula in Uganda. Formed in 1999, the over 14 year old organization was founded by Alice Emasu Seruyange (Founder & Executive Director) and women of TESO Sub-region. The founders were spurred in to action by their real life experiences and knowledge of Uganda's turbulent times, deteriorating reproductive and maternal health, lack of education, lack of access to legal protection, endemic poverty, and

negative traditional practices such as forced/child marriages that undermine the dignity and full enjoyment of Human rights by vulnerable women and girls. In 2001, when TERREWODE started a program on obstetric fistula, Uganda lacked the knowledge about the incidence and prevalence rates of obstetric fistula. Even qualified medical staff, repair equipment and medical supplies were lacking. This was partly because obstetric fistula was considered socially and traditionally embarrassing. But perhaps the most disturbing thing was the lack of national strategy and policy to guide in any intervention relating to treatment and management of fistula. This situation was perpetuated by the ignorance of the rights holders-including women living with fistula-about the fact that fistula can almost always be prevented and treated medically and that it was their duty to demand for maternal health services as a human right. This has changed. Access to fistula treatment is gradually improving with more than eight hospitals offering routine fistula repairs with about 25 active local surgeons, according to the Uganda Fistula Map launched in 2010. A national fistula strategy is in place. Ministry of Health and development partners like UNFPA, AMREF, EngenderHealth, The fistula Foundation and TERREWODE have continued to join hands in the campaign to eliminate fistula in Uganda (TERREWODE Five year Strategic plan-2012 -2016).

TERREWODE approaches fistula as both a public health and human right issue. It has developed a holistic fistula program to address prevention, treatment and social reintegration aspects of the condition. It has an innovative grassroots based strategy known as the Obstetric Fistula Awareness and Advocacy Network (OFAAN). The OFAAN, comprising of a diverse community volunteer work force provides community fistula education, identifies, refers and supports women and girls affected by fistula for treatment and social reintegration.

TERREWODE believes that, the first component of re-integration is helping the woman return to complete Physical, Social and Psychological Well-being. And the second component of re-integration is assisting the woman to achieve economic empowerment and independence. Economic empowerment is acquired through education in savings and credit, skills development and group formation and management. ‘’We feel that this component is essential for successful reintegration and allows women affected by fistula to be empowered and act as active advocates for safe motherhood’’, says Alice Emasu-TERREWODE’s CEO (Fistula Panel Discussion, 2013).

TERREWODE’s Fistula Reintegration Center located in Soroti District was officially launched by the Ugandan Ministry of Health on the 20thJune 2013 during the celebration of the International Fistula day in Uganda. The Center empowers women with knowledge and skills in income generating activities with the overall purpose of improving their lives, that of their families and communities. Classes offered include; vocational and entrepreneurial skills as well as literacy classes on critical issues like understanding obstetric fistula in the context of human rights, poverty, gender and inequality. The two weeks reintegration process prepares survivors to cope with the attendant psychological and physical challenges that result from the Obstetric Fistula condition and thus, leading them to total healing and empowering them to work towards regaining their human dignity. While in this program, survivors are encouraged to advocate for positive behavioral change in maternal health within their communities.

In addition, they are also equipped to provide care to women in similar condition. So far, TERREWODE has trained over forty (40) women and girls while imparting different knowledge and skills in them. The trained women and girls have formed fistula solidarity groups in their communities. To date, there are six (6) solidarity groups actively involved in Music, Dance and

Drama (MDD) for awareness creation on teenage pregnancy, obstetric fistula and income generation. The Solidarity groups also engage in other economic activities such as tailoring, beading, weaving, knitting, savings and credit schemes. However, despite TERREWODE's tireless efforts in the restoration of a woman to a dignified place within her family and community by upholding Social reintegration, there is still a big problem of low involvement by trained women and girls in economic activities, as a result their well-being may not have improved, some women especially with cases of multiple surgeries (indicator of incurable fistula) have failed to integrate to their families and communities implying that, they still suffer rejection and stigma after receiving treatment, hence requiring immediate reintegration response, some women conceive immediately after treatment and go through the same circle of trauma, and domestic violence incase fistula re-occurs therefore, leaving them with rampant attempts of committing suicide and critical need for social reintegration (Annual Fistula Programme Report 2013/14).

According to TERREWODE's Executive Director Alice Emasu Seruyange in her brief to a sect of donors, '' so far, no earlier study is done on the Social reintegration beneficiary population so as to understand properly the relationship between Social reintegration and Well-being of women and girls affected by fistula''. Worst still, to date,'' Champions of fistula are debating on whether or not Social reintegration is an important intervention to achieve Socio-economic Well-being of women and girls affected by fistula''. One side argues that, ''after treatment, a woman can return home successfully and will not suffer rejection and shame'', ''another side argues that, reintegration services were very vital to build the capacity and restore a woman to a dignified place within her community''. It's therefore, important that the causes to these issues/cases, is

investigated and keen attention needs to be paid to understanding the relationship between Social reintegration and Well-being of women and girls affected by Fistula, hence this study.

1.3 Statement of the Problem

Surgical treatment of a woman with fistula alone is not enough to contain the challenges that comes with obstetric fistula (*Emasu, 2013).*In Uganda, several attempts are being made by community based organisations, national organisations and international agencies to ensure women with fistula are reintegrated with psycho-social, skill empowerment packages in health/financial literacy, human rights, entrepreneurial skills savings and credit schemes (OFAAN Strategy, 2013). Despite these interventions, the social, economic, physiological well-being of the women and girls affected by fistula is wanting (TERREWODE annual report, December, 2014).Stigma and discrimination of women with fistula is rampant across the country, instability in families, low self-esteem, low hygiene, poor nutrition, low investments, low income and high stress levels, there is wide spread poverty as one of the major root causes of fistula and many have reportedly committed suicide (New vision, Friday, May 23, 2015). If the situation is not contained, there will be increased cases of fistula that will lead to not only increased couple separation/divorce, number of psychiatric cases, but rampant cases of death reported and the government will be burdened with high cost of taking care of orphans. While there are other factors that militate against the well-being of women after fistula surgical treatment, social reintegration seems to be a strong force. It is against this background coupled with the fact that from the available literature on fistulae, little is been documented about experiences of women and girls who go through socio-economic repercussions as a result of suffering fistula and have benefitted from provision of social reintegration services,

that this study examines the relationship between Social reintegration and Well-being of women and girls affected by fistula a case of Soroti district, Uganda.

1.4.1 General Objective.

The main objective of the study was to examine the relationship between Social reintegration and Well-being of Women and Girls affected by Fistula in Soroti District in Uganda.

1.4.2 Specific objectives.

1) To examine the relationship between Counseling support and Socio-economic well-being of the women and girls affected by Fistula in Soroti District in Uganda.
2) To investigate the relationship between skill empowerment support and socio-economic well-being of the women and girls affected by Fistula in Soroti District in Uganda.
3) To explore the relationship between social empowerment and socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda.

1.5 Research Questions.

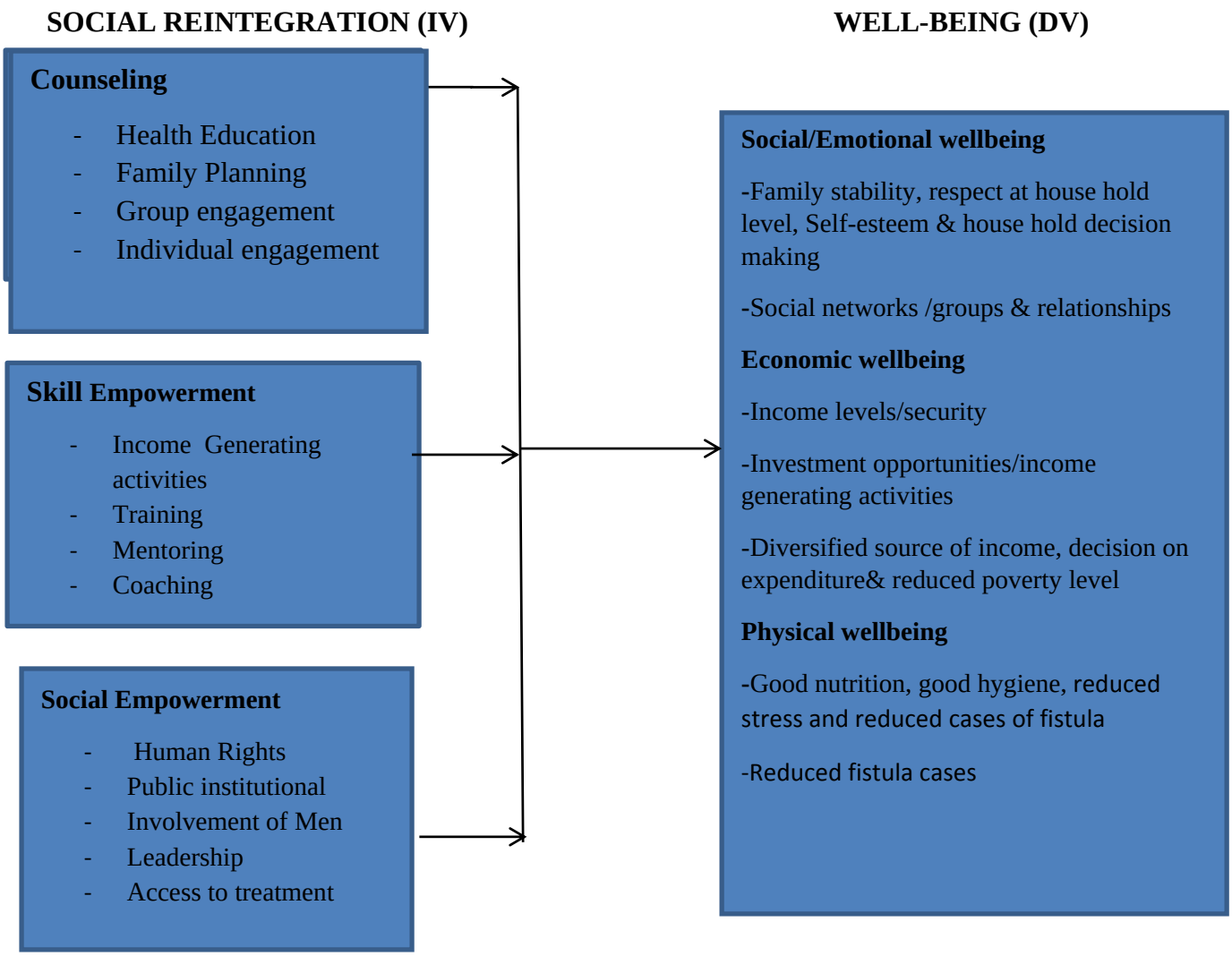
1) What is the relationship between Counseling support and Socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda?
2) What is the relationship between Skill empowerment support and Socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda?
3) What is the relationship between Social empowerment and Socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda?

1.6 Hypothesis of the study

1) There is a significant relationship between Counseling support and Socio-economic well-being of women and girls affected by fistula
2) There is no significant positive relationship between Skill empowerment and Socio-economic well-being of women and girls affected by fistula.
3) There is no significant relationship between social empowerment and socio-economic wellbeing of women and girls affected by fistula.

1.7 Conceptual Frame work.

Conceptual frame work below shows a relationship between Social reintegration and Well-being of women and girls affected by fistula in Soroti District in Uganda. It explains the relationship between the key concepts used in the study and how they are linked to one another to produce the final outcome.



Source: *Developed and Modified by Researcher; from UN- Supporting efforts to end fistula (2012)*

Figure 1: Conceptual fame work showing the relationship between the variables of the study.

The conceptual frame work above shows that psychosocial support/therapy through counseling, Skills empowerment and Social empowerment are independent variables while Social/emotional wellbeing, Economic well-being and Physical well-being is dependent variable. It is conceptualized that the attainment of dimensions in the independent variables to fistula women and girls (victims) results in improved social economic and physical well-being in terms of high

income levels, investment opportunities, good number of income generating activities (IGAS), Diversified source of income and easy decision on expenditure, better social networks/groups/relationships, respect at house hold level among relatives, self-esteem, easy house hold decision making and improved quality of life and the reverse of all the positive results is true.

1.8 Significance of the study

The study examined the relationship between social reintegration and well-being of women and girls affected by fistula and suggests some ways of improving social reintegration intervention so as to achieve better socio-economic well-being of the affected women and girls. Itis significant in terms of policy, academic, and management contributions. The study findings are helpful to the government of Uganda, and all its development partners in the fight against fistula, to develop future policy strategies on fistula care and management while with a good focus on system strengthening and resource allocation to fistula work. It will further help the management of TERREWODE and all other NGOs undertaking social reintegration intervention -components of psychological-counseling support, skills empowerment, and social empowerment to learn and adopt appropriate strategies in program curriculum development and delivery, program content design and implementation of reintegration activities for improved well-being of survivors of fistula. The funding (Donor) community may use the findings of this study to improve on funding base and see value for fund and the great need for provision of social reintegration services to women and girls affected by fistula based on their actual needs. The findings of the study have added new knowledge and insights to the existing body of knowledge in the field of social reintegration and socio economic well-being of women and girls affected by fistula. Finally, the

study is important to the researcher since it served as a requirement for the fulfillment for the award of a Master's degree in management studies (Project Planning and Management).

1.9. Justification of the study

Little qualitative evidence is available on rehabilitation after obstetric fistula repair in sub-Saharan Africa. Earlier review by some researchers suggests that counselling services and community health education are priorities for these women and their families, and highlights the necessity for more high-quality, broad-scale, multi-setting research on rehabilitative needs of women post-repair. Further research should emphasise women's perspectives to better inform and improve interventions aimed at addressing the physical and social-economic consequences of obstetric fistula (Medical Journal, 2011).

Therefore, this high-qualitative and quantitative, broad-scale study addressed the existing gap in knowledge on rehabilitative needs of women post-fistula repair. The study answered the important question on if there exists any relationship between social reintegration and socio-economic, physical well-being of women and girls affected by fistula. This study further emphasized women's perspectives to better inform and improve interventions aimed at addressing the physical and social economic consequences of obstetric fistula.

1.10 Scope of the study

1.10.1 Geographical scope.

The study was carried out within Soroti District where TERREWODE's Reintegration Centre is located. Soroti district is found in Eastern Uganda and it is part of Teso- sub region. It is bordered by Amuria District to the north, Katakwi District to the east, Ngora District to the southeast, Serere District to the south, and Kabermaido District to the west.

1.10.2 Content scope

The study focused on examining the relationship between social reintegration and well-being of women and girls affected by fistula in Soroti District- Teso Sub-region, Uganda.

The research was restricted to women and girls affected by fistula (survivors) who have either fully or partly benefited from provision of social reintegration services. The study has two variables that is; Social reintegration (Psychosocial support, Skills Empowerment and Social Empowerment dimensions) as independent variable and Well-being of women and girls affected by fistula (Social, Economic and Physical dimensions) as dependent variables. It further established post-surgical experiences and the effect of social reintegration services on the social, economic and physical well-being of the women and girls affected. It also focused on capturing recommendations from the women and girls in respect to their socio-economic life experiences in families and communities and recommendations on how best provision of social reintegration services can be improved depending on the magnitude of their social-economic needs that was combined.

1.10.3 Time scope

The study focused on the period between 2013-2014. This is the period when TERREWODE's Reintegration Centre was officially launched and made operational. The very first Graduates and subsequent Graduates of the training center were passed on within the same period under study. To date, the center is operational and continues to receive women from all parts of Uganda for social reintegration.

1.11 Operational Definition of Terms and Concepts.

Obstetric fistula

Is defined as an abnormal connection between the urinary tract and the vagina or the rectum and the vagina that result in the continuous involuntary discharge of either urine or feaces into the vaginal vault. It is predominantly caused by neglected obstructed labor without prompt and skilled medical care. Due to the pressure of the baby's skull against the mother's pelvis, the woman's soft tissue is deprived of sufficient blood supply. If the mother survives, the injured pelvic tissue undergoes ischemia and stuffs away after birth, leaving a hole or fistula between the adjacent organs.

Social reintegration refers to 'any social intervention with the aim of integrating victims of a situation or certain health, economic, political and social problem in to the community'. However, in the context of Obstetric Fistula, the restoration of a woman to a dignified place within her community after fistula surgery is what I refer as social reintegration.

Counseling is used in the study context to mean provision of; Health Education, Family Planning, Group engagement, Individual engagement.

Skill Empowerment in this study refers to capacity building through Training, Mentoring, and Coaching, provision of skills in income generating activities. Training, as a dimension of skills empowerment is defined as 'the acquisition of knowledge, skills and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies.

Social Empowerment in this study refers to awareness and provision of knowledge about human rights leadership, role of public institutions, and male involvement in the fight against fistula in Uganda.

Well-being is another concept used in this study and is defined as the state of being happy, healthy, or successful (Imel et. al., 2008). The researcher in this study referred to Social well-being as the mental and emotional state of being and Economic well-being as the ability to generate income and overcome poverty. Well-being as a dependent variable in this study was measured in terms of; **Social/Emotional** Wellbeing refers to the mental and emotional state of being which is seen in family stability, respect at house hold level, self-esteem and house hold decision making, Social networks /groups and relationships.

Economic wellbeing in this study refers to ability to generate income and overcome poverty and shall be analyzed in way of income levels/security, investment opportunities/income generating activities, diversified source of income and decision on expenditure.

Physical wellbeing in this study shall refers to good nutrition, good hygiene and reduced stress that all lead to reduced cases of fistula and good health.

Fistula Woman/victim/Survivor- Woman and girl affected by fistula.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In this chapter, the researcher reviews related literature on Social reintegration and Socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda.

‘’Literature review provides the foundation on which research is built and helps the researcher to develop an understanding and insight into relevant previous research and the trends that have emerged (Saunders, Lewis, Thorn hill, 1988)’’.

The literature review enabled the researcher to re-examine the theories which guided the study. It helped to draw lessons from studies already conducted in understanding the relationship between Social re-integration and Socio-economic well-being of women and girls affected by Fistula in aspects of improved physical health, psychological support through counseling and socio-economic empowerment. The focus of the literature review on the relationship between Social reintegration and Socio-economic well-being provided more insights on the study variables which helped in ascertaining methodology and gaps for the study to fill. This chapter therefore presents theories that guided the study, actual literature review which was done as per the study objectives and summary of the review highlighting the gaps in the existing body of Knowledge and lessons learnt as this literature review was sourced from books, publications, the Internet and journals.

2.1 Theoretical review

Many scholars have come up with related theories on Social re-integration and Well-being but a few explain the researcher's area of study and these include; the Social Support Theory and Anu Kasmel's Empowerment theory.

Social Support Theory

The Social Support Theory by Brain Lakey and Sheldon Cohen (1984) defines clearly how social relationships influence cognitions, emotions, behaviors, and biology. It presents an overview of the three important theoretical perspectives on social support research: (i) the stress and coping perspective, (ii) the social constructionist perspective, and (iii) the relationship perspective. The stress and coping perspective proposes that support contributes to health by protecting people from the adverse effects of stress. The social constructionist perspective proposes that support directly influences health by promoting self-esteem and self-regulation, regardless of the presence of stress. The relationship perspective predicts that the health effects of social support cannot be separated from relationship processes that often co-occur with support, such as companionship, intimacy, and low social conflict. The stress-support matching hypothesis (Cohen and McKay, 1984; Cutrona and Russell, 1990) is perhaps the most explicit statement of how supportive actions should promote coping. The hypothesis is that social support will be effective in promoting, coping and reducing the effects of a stressor, in so far as the form of assistance matches the demands of the stressor. According to this view, each stressful circumstance places specific demands on the on the affected individual. The researcher finds this theory helpful in critical examination of the relationship between Social-reintegration and Wellbeing since it creates a better understanding about how social support influences health and well-being of women and girls affected by Obstetric Fistula.

Empowerment theory by Anu Kasmel

Empowerment is identified as a principal theory of community psychology (Rappaport, 1981, 1984, 1987), and a key concept for communities to remedy inequalities and to achieve better and fairer distribution of resources for communities (Tones and Tilford, 2001, Braithwaite and Lythcott, 1989; Breslow, 1992; Minkler, Thompson, Bell, & Rose, 2001). Empowerment is a construct shared by many disciplines and arenas: community Development, psychology, education, economics, studies of social movements and Organizations. Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations (Israel *et al*., 1994). It is the process by which individuals and communities are enabled to take power and act effectively in gaining greater control, efficacy, and social justice in changing their lives and their environment (Solomon, 1976; Rappaport, 1981, 1985; Minkler, 1992; Fawcett et al., 1994; Israel et al., 1994). This theory will guide the study because it provides very important facts about understanding and control over personal, social, economic and political forces in order to take action to improve life situations. Details of the empowerment theory are found in chapter two.The only problem with this theory is that it focuses so much on empowering individuals and communities to achieve socio-economic wellbeing with minimum emphasis on the aspect of human rights which is so crucial, especially the reproductive health and economic rights of individuals should never be ignored in the efforts to achieve socio-economic wellbeing (ICPD Program of Action and Human rights, 1994). Empowerment theory has been seen as a key strategy to mobilize citizens, organizations and communities for health action and to stimulate conditions for change. It is an approach aimed at facilitating community groups and individuals to "*empower* themselves", one that seeks "to recognize and value the health experience and knowledge that exists in the community and to use it for everyone's benefit"(Minkler, 1992). Empowerment is

identified as a principal theory community psychology (Rappaport, 1981, 1984, 1987), and a key concept for communities to remedy inequalities and to achieve better and fairer distribution of resources for communities (Tones and Tilford, 2001, Braithwaite and Lythcott, 1989; Breslow, 1992; Minkler, Thompson, Bell, & Rose, 2001). Empowerment is a construct shared by many disciplines and arenas: community development, psychology, education, economics, studies of social movements and organizations. Recent literature reviews of articles indicating a focus on empowerment, across several scholarly and practical disciplines, has demonstrated that there is no clear definition of the concept. Zimmerman (1984) has stated that asserting a single definition of empowerment may make attempts to achieve it formulaic or prescription-like, contradicting the very concept of empowerment. However, for health promotion practitioners, making empowerment operational in health promotion contexts is a crucial issue. Empowerment, in its most general sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations (Israel *et al*., 1994). It is the process by which individuals and communities are enabled to take power and act effectively in gaining greater control, efficacy, and social justice in changing their lives and their environment (Solomon, 1976; Rappaport, 1981, 1985; Minkler, 1992; Fawcett et al., 1994). According to Rappaport empowerment is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviors to social policy and social change (Rappaport, 1981, 1984). He has noted that it is easy to define empowerment by its absence but difficult to define it in action as it takes on different forms in different people and contexts. Israel et al., (1994) makes the distinction between psychological, organizational and community empowerment. Whereas psychological empowerment is concerned with individuals gaining mastery over their lives, the organizational empowerment focuses to collective capacities and

community empowerment on ‘the social contexts where empowerment takes place’ (Wallerstein and Bernstein, 1994).

Zimmerman (1995, 1999) has theorized that individual s. psychological empowerment operates through intrapersonal, interactional, and behavioral components (see also chapter VII). As an intrapersonal component, empowerment addresses the manner in which individuals think about themselves and includes concepts of perceived control, self-efficacy, motivations to control, and perceived competence. The interaction component of psychological empowerment assesses how people understand and relate to their social environment. Empowerment. Both terms (community empowerment and community capacity) describe a process that. Aims to increase community abilities, assets and attributes (Laverack, 2001; Gibbon et al., 2002). Capacity building takes on a wider meaning than just training and development of individuals as its long term aim is to take control and ownership of the process. Community capacity building is understood as a part of a wider policy agenda supporting civic participation, decentralization and local service delivery, the modernization of local government structures and community planning frameworks.

2.2 Psychological-Counseling and Socio-economic wellbeing of women affected by Fistula.

According to Wikipedia, (April, 2008), for a concept to be psychosocial means it relates to one’s psychological development in, and interaction with, a social environment. The individual needs not be fully aware of this relationship with his or her environment. It was first commonly used by psychologist Erik Erikson in his stages of social development. According to Erik, problems that occur in one’s psychosocial functioning can be referred to as ‘’psychosocial dysfunction’’ or ‘’psychosocial morbidity’. This refers to the lack of development or atrophy of the psychosocial

self, often occurring alongside other dysfunctions that may be physical, emotional, or cognitive in nature. In some women psychological dysfunction continues despite fistula repair because their reintegration experiences may be impacted negatively, secondary to the degree of isolation and stigmatization experienced while living with Fistula (Obstetric Fistula in the developing world, Marrakech, 2010, pages, 29, 31).

The ultimate strategy for dealing with the psycho-social impact of fistula is to reduce occurrence of obstetric fistulas. Indeed, this is precisely how the Western world solved the problem within its borders. Because obstetric fistulas are tied closely to overall maternal mortality, the best way to reduce fistula formation is to provide essential obstetric services at the community level with prompt access to emergency obstetric services at the first referral level.

2.3 Skill empowerment and Socio-economic wellbeing of women affected by Fistula

In order to understand Social reintegration and wellbeing of women and girls affected by Fistula which this study will undertake, the concept of Social Reintegration and wellbeing dimensions need to be understood. Social reintegration is commonly defined as 'any social intervention with the aim of integrating victims of a situation or certain health, economic, political and social problem in to the community' (Lievore, 2004). However, in the context of Obstetric Fistula, the restoration of a woman to a dignified place within her community after fistula surgery is referred to as ''Social Reintegration''. Social Reintegration is an appropriate intervention that helps women and girls affected with fistula overcome physical, psychological and social economic challenges in order to enhance their return to communities and social networks of choice (Obstetric fistula in the developing world, Marrakech, 2010). Social reintegration starts from the time when a woman is diagnosed with fistula to the time when she is discharged from Hospital and back to the

community where she is supported and monitored up to 12 months. ‘’It is the responsibility of all people to support efforts to socially reintegrate the women and girls’ (Alice Emasu, 2014).

Training;

Training is defined as ‘the acquisition of knowledge, skills and competencies as a result of the teaching of vocational or practical skills and knowledge that relate to specific useful competencies. Training has specific goals of improving one’s capability, capacity, productivity and performance that could lead to socio-economic empowerment and benefit (Nigman etal, 2006).Cole, (1997) emphasized that in designing training programme, the following questions have to be considered; what are we trying to achieve in this programme? What do we expect participants to achieve? What content is required to achieve these aims? How should this content be structured? What learning methods should be employed? Who should conduct the training? Where and when should training take place? To what extend should participants be consulted about the nature and scope of the program? How did we evaluate the success of the programme?

2.4 Social-empowerment and Socio-economic wellbeing of women affected by Fistula

Psychosocial support is an approach to victims of disaster, catastrophe or violence to foster Resilience of communities and individuals. It aims at easing resumption of normal life, facilitate affected people participation to their convalescence and preventing pathological consequences of potentially traumatic situations (Travis, Solomon, and Waul, 2001).Repeatedly obstetric fistula results into society blaming the women with fistula for their condition, and some women even blame themselves. Many fistulae occur among poor, rural women. Women with fistula oftentimes are abandoned or divorced by their spouses, particularly when it becomes clear that the fistula will not go away. Nevertheless, the women, out of their own preference segregate themselves from others because of the embarrassment occasioned by the urine or fecal smell. This is extended from

her own children in a home to other community members. Some studies have further shown that women with fistula have no confidence mixing with others. This affects their participation in community groups and religious affiliations as well as accessing social amenities like medical services.

Some spouses leave their partners and this depends on the closeness that exists between them after sustaining fistula. In a study conducted in 2007 by Ramsey et al. in 25 countries, it was revealed in Kenya that 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 immediate family normally does not isolate them; it's the affected person who is normally not free to mingle with people so they give her space. For example, in a study conducted by Obed, 2010, 71% of patients were divorced or separated from their husbands. In yet another recent study of 899 fistula cases at the Evangel Hospital in Jos, Nigeria. It's also a fact that inability of the victims to satisfy their husband's sexual desires produces offspring and contributes to the economy of their household ultimately lead to the collapse of the marriage. In a study conducted in 2007 by Ramsey et al. in 25 countries, it was revealed in Kenya that the social and physical effects often render women unable to work or participate in community life and can cause them anxiety, depression, and other adverse psychosocial effects.

In India and Pakistan, some 70% to 90% of patients studied in 1990s had been abandoned or divorced. Facing familial and social rejection and unable to make a living by themselves, many women with fistula live for years without any financial or social support. Many fall into extreme poverty. At the Addis Ababa Fistula Hospital, one woman in every five reported begging for food to survive as a fistula victim. Some cannot cope with the pain and suffering and resort to suicide.

The social constructionist perspective proposes that support directly influences health by promoting self-esteem and self-regulation, regardless of the presence of stress. The relationship perspective predicts that the health effects of social support cannot be separated from relationship processes that often co-occur with support, such as companionship, intimacy, and low social conflict.

2.4.2 Economic Experiences

Studies have shown that women with fistula often experience economic hurdles in their life time after sustaining fistula that affects their normal well-being. Normally they are chased away from their homes, without support from their husband and without means of earning their livelihood amidst so many life needs including but not limited to medical costs, basic needs like soap used to wash her clothes all the time due to the foul smell; Since a majority of fistula victims come from the rural areas where farming is the mainstay of economy and subsistence for each household, it is expected that women should contribute their labor in cultivating the family land.

However, due to the VVF condition, victims are no longer able to contribute to the economic productivity of their household due to the drastic limitations for them to for example sell their local businesses, attend to their productive gardens because they end up being weak; instead they become an economic burden with highly reduced or even incomes this affecting their economic abilities. Their level of meeting personal and public accomplishments thus reduces drastically.

Most of the women are dependent on relatives and friends for food and begging or live on donations. They fail to meet the basic needs like buying clothes, paying for medical needs and often fail to make contributions to social requirements like funerals. There are cases of women who are fired from their jobs, cannot find work and are unable to conduct any income generating

activity like they used to do before they sustained fistula. They have no income they can control on their own and so cannot even afford the added costs to their health condition and other basic needs (Kabanda Obed, 2010).

2.5 Summary of literature review

This chapter reviewed scholarly literature on the key dimensions of Social reintegration; Psychosocial (counseling) support, Skills empowerment and Social empowerment from different authors. The literature review generally portrayed that relationship between Social reintegration and Socio-economic well-being do exist and the relationship factors mentioned above happened to explain best the good linkage between Social reintegration and Well-being of affected women and girls with fistula. Recent literature reviews of articles indicating a focus on empowerment, across several scholarly and practical disciplines, has demonstrated that there is no clear definition of the concept. Furthermore, other scholars have examined the issue of Obstetric Fistula and social-economic experiences of the affected women in the past. However, there was no empirical data on the issue of existing relationship between Social reintegration and Well-being of the women and girls affected by Fistula worse still, most of the existing information was from the developed world perspective and in order to have an African perspective, precisely a Ugandan one in a rural setting, whether same results would be found or otherwise. This research aimed to bridge this Gap by collecting and analyzing data regarding the relationship between Social reintegration and Well-being of the affected women and girls in Uganda. A case of Soroti District. This was especially so in regard to its main Social reintegration variables namely; counseling support, skills empowerment, social empowerment and Well-being variables namely; social/emotional well-being, economic well-being and physical well-being.

The literature reviewed in this study seems to be in support of the hypothesis of the study. This is because most of it seems to be indicating that much as there exists strong relationship between social reintegration and well-being, there is a significant challenge with well-being of affected women and girls which partly is as a result of inadequate psychosocial support through counseling, skill empowerment and social empowerment.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter covers the methodology used in the collection and analysis of data required in answering the research questions. It outlines the research designs, study population, sample size and selection, data collection methods, data collection instruments, validity and reliability of the research instruments, procedures in collecting data, data analysis, measures of variability and ethical issues

3.1 Research design

The study employed both qualitative and quantitative approaches. A case study design was used. This enabled the researcher understand in depth the relationship between Social re-integration and Well-being of women and girls affected by Fistula in Soroti District in Uganda. The researcher was able to cover a desirable quantifiable behavior of the respondents. A cross sectional survey was adopted. Data from a sample of the population was gathered once in a period of two weeks in order to answer the research questions. This was used because it is a simple and less costly design to carry out (De Vos, 1998). The qualitative approach allowed the researcher to meaningfully describe the distribution of variables, while the quantitative approach provided detailed numerical information about the phenomenon being studied. This triangulation of methods helped the researcher to solve the defects of the various methods used.

3.2 Study Population

Population is defined as a group of individuals, objects or items from which samples are taken for measurement (Kombo & Trom, 2006). The study population included the management staff plus volunteers on TERREWODE programme, the fistula survivors, and board of TERREWODE,

fistula surgeons and officials from Soroti district. According to TERREWODE records, these comprised of 40 Fistula Survivors, 4 Fistula surgeons, 6 Management staff, 20 Volunteers (OFAAN Members), 5 District Officials and 5 Board of Directors that made a total population of 80 people (TERREWODE BoD/ Staff list/Fistula survivor's data base 2013/14).The study population was partly literate as such able to read and write and for the illiterate, the researcher was able to get help from translators hence this enabled easy and wider acquisition of information within a short time by use of the questionnaire.

3.3 Sample Size and Selection

The sample size comprised of 74 people including 36 Fistula Survivors (direct beneficiaries of reintegration services), 6 staff (Managers and officers involved in organization's decision making process and implementation of programmes), 19 volunteers (deal directly with survivors and have better understanding of what a survivor goes through), 5 District officials (district managers who take part in decisions and deal with communities), 4 Fistula surgeons (directly involved with repair of fistulae) and 5 Board of Directors of the organization, inclusive the Executive Director (policy and decision makers). The sample size shall be determined according to Krejcie and Morgan (1970), who recommends a sample size of 74 for a population of 80 people. The table .1 below shows how sample was picked from population. After knowing the 74, I selected some purposively, while others were randomly selected.

Table I: Table for determining sample size from a given population and techniques used for the population sample.

Category	**Target(N)**	**Sample (S)Size**	**Sampling**
Fistula Survivors	40	36	Simple Random
Fistula Surgeons	4	4	Purposive
Volunteers (OFAAN)	20	19	Simple Random
District Official	5	5	Purposive
Management staff	6	6	Simple Random
Board of Directors	5	5	Purposive
Total	**80**	**74**	

Source: TERREWODE Staff/Board member's list 2013/2014. The Researcher

3. 4 Data Collection Methods

The study utilized data collection methods to improve data validity. Both primary and secondary data sources were accessed through; interviews, observation and questionnaires survey.

3.4.1 Questionnaire survey method

This is a data collection method which employs close or open ended questions to generate responses from a group of respondents. This method was used for respondents using close ended questionnaires which were issued out to the respondents for filling and then collected back by the researcher.

3.4.2 Interviewing

An interview is a data collection method where the respondent is asked questions and he /she gives an answer. It can be done through a face to face interaction as stated by Mugenda & Mugenda (2003), or through a telephone conversation. In this study, respondents participated in oral interviews and also engaged in an–depth interview (Amin, 2005). This enabled a deeper analysis based on their role and experience in undertaking or benefiting from reintegration services. Open ended questions were used. This allowed the researcher to obtain information on the issues of interest in depth due to the privacy involved in it.

3.4.3 Documentary review

Punch (1998) states that both historical and contemporary documents are rich source of data for social research. It is critical examination of public or private recorded information related to the issue under investigation. This helped the researcher to obtain unobtrusive information at pleasure and without interrupting the researched. It was also used to get additional information and for the purposes of triangulation. A number of documents including annual reports, field reports, newsletters, case studies, National Obstetric Fistula Strategy/policy, Social reintegration training manual and the Obstetric Fistula Advocacy and Awareness (OFAAN) Strategy were accessed by the researcher for the purpose as such the researcher was in position to get existing documented information from the organization.

3.4.4 Observation method

This method involved the use of the eye sight to make relevant judgments in this study. Sekaran (2003) argues that observation studies help to comprehend complex issues through direct observation and then, if possible, asking questions to seek clarifications on certain issues. It was

chosen because it enabled the researcher to make sense of the issues of interest on spot as they were, hence saving precious time.

3.5 Data collection instruments

The researcher used four instruments for collecting information, which included questionnaire, interview guide, documentary review check list and an observation check list.

3.5.1 Questionnaires

Questionnaires are used to obtain important information about the population and ensure a wide coverage of the population in a short time (Mugenda and Mugenda, 1999 p.71). The advantage of using the questionnaire method is that it allows respondents to freely express their ideas, give the researcher in depth knowledge about a research problem and relatively cheap. It helped the researcher to address the study objectives and research questions through the views and opinions of the respondents to the questions.

The questionnaire used a 5-point Likert-scale ranging from 5 (strongly agree) to 1 (strongly disagree). A Likert scale provides consistent responses and allows a participant to provide feedback that is slightly more expensive than a simple close ended question, but much easier to quantify than a completely open ended response (Patrick,2007).

3.5.2 Structured Interview guide

An interview guide involves oral questioning of respondents. The researcher conducted in-depth interviews with selected women and girls affected by fistula (survivors) in Soroti district. Personal interviews enabled the researcher to interact freely with the respondents during discussions and it was ideal for the illiterate class of interviewees.

Key informant interviews were conducted with selected community volunteers, district officials, Fistula surgeons, TERREWODE staff, and Board of directors, using the interview guide with specific questions seeking pertinent issues related to the study. The researcher was able to obtain varying views on the issues hence getting data required to meet specific objectives of the study and also guided the researcher in comparison of answers got. The answers to the questions posed during the interview were recorded and used to collect important information from selected key informants.

3.5.3 Documentary review check list

This was a key instrument in collecting data from documentary review on the topic because it is related to the actual status (Punch, 2000). Secondary data was collected through analyzing existing data for fistula survivor's wellbeing, relevant policies on management of fistula and social reintegration intervention. It contained a list of documents that were reviewed to provide necessary data for the study. Documents such as Annual reports, Obstetric Fistula Strategy and Policy, OFAAN Strategy, Case studies, Journals, Newsletters, and Social reintegration training manual on psychosocial support, skills empowerment and social empowerment were reviewed. This enabled the researcher to access existing information on what had happened earlier, and what is supposed to happen or how things are supposed to be.

3. 6 Validity and Reliability of the Research Instrument

3.6.1 Validity of the Research Instruments

Validity refers to the appropriateness of the instrument (Amin, 2005). That is whether an instrument measures what it is supposed to measure (Nachmias-Frankfort & Nachmias, 2005). A pilot study was carried out by the researcher and respondents with prior knowledge about the study

problem about the relevancy of the questions asked so that irrelevant questions are left out before being subject to the sample size population. Kothari (2004) urged that the content validity index should exceed 0.5 after pretesting of the instruments. Consistency in responses was checked on test- pretest of the questionnaires. The face validity was checked and approved with assistance of UMI supervisors who read through the tool and the questions they felt were not good enough were deleted.

3.6.2 Reliability of the Research Instruments

Reliability is whether and by how much measurements are consistent from one observation to the next (Nachmias-Frankfort & Nachmias, 2005). The researcher used test-retest technique to test reliability of the instruments. A target selected respondents in similar situation to those of the selected sample under study were given questionnaires. Their response was coded and analyzed and a reliability test computed to measure stability of the instruments in data collection. Bell (1999), asserts that reliability test helps the researcher in testing indicators of both independent and dependent variable. The reliability test value was analyzed using Cronbach's Alpha Reliability coefficient. This coefficient measures the internal consistence of a test and it generally increases when the correlation between the variables increases. It ranges from 0-1, the closer the value is to 1, the more reliable the instrument is at measuring the variables. According to De Vellis (1991) any value above 0.67 is acceptable reliability. To achieve this, data collected using 36 questionnaires was entered in to a computer program known as Statistical Package for Social Scientists (SPSS), which was instructed to compute the Cronbach alpha coefficient and the reliability was found to be 0.906 (See Table 3.2), which was above the recommended 0.67 or 0.70. Thus, the questionnaire was considered very reliable for data collection and as such, a reliable data was collected.

TABLE 3.2: Cronbach's Alpha

Variables	**No. of Item**	**Cronbach's Alpha**
Counseling	13	0.704
Skills Empowerment	8	0.535
Social Empowerment	9	0.722
Well Being Of Women	18	0.692
Overall		**0.906**

3.7 Procedure in Collecting Data

After approval of the research proposal by supervisors and following successful proposal defense, the researcher obtained an introductory/cover letter from the Higher Degrees Department of Uganda Management Institute (UMI) and permission from TERREWODE and authorities in Soroti district to conduct the research. Earlier notification was given to the relevant authorities. Different respondents were contacted so as to make earlier preparations to meet the researcher.

Each of the distributed questionnaires were accompanied with an introductory letter clearly stating the purpose of the study and giving a statement of confidentiality of the information given. One research assistant was recruited and trained to collect information from the different locations of the study with close monitoring by researcher, while the researcher personally collected information from the selected board members, senior management staff, fistula surgeons, and district officials. This was completed in 28 days. Then the data was processed to make a final report.

3.8 Data Analysis

Data analysis is the process concerned with data editing and error correction (Amin, 2005). This brings in order, structure and meaning to the mass of information gathered. Due to the variety of instruments used, both qualitative and quantitative data analysis were done by the researcher. Qualitative data collected through interviews was analyzed and evaluated immediately it was collected to determine its adequacy, credibility, usefulness, accuracy and consistency of information given by reading, categorization and coding data were the techniques used to analyze data generated from interviews. The questionnaires were checked for completeness, cleaned, edited before entering into the computer for data analysis.

3.8.1 Qualitative Data Analysis

According to Kelle and Seidel (1995) qualitative data is defined as data got from use of words, describe patterns, trends and relationships. The researcher obtained the above data from interview guide responses. The responses were transcribed, sorted and classified into themes and categories, in order to support the hypotheses tested. Detailed information was scrutinized, analyzed, collated and presented in form of paraphrases or quotes with permission of respondents and in some cases it was narrated or quoted verbatim. The analysis was done manually and responses were summarized in a narrative form. As a representation of the major findings of the study and some of the reported statements by key informants, the researcher used descriptive statistics of reconstructing meaningful data out of the respondents' views for data analysis and interpretation.

3.8.2 Quantitative data analysis

The questionnaires were checked for completeness, cleaned, edited before being entered into the computer for data analysis. Each question was categorized and edited for accuracy and

completeness of information. This ensured that all questions are pre-coded and after this process, the statistical package of social science (SPSS) versions 15 was used to generate descriptives including frequencies, percentages and later some inferential statistics. Frequency distribution of the variables was run to describe the data and cross- tabulations was done to look for associations between variables. The strength of association between variables was determined using bivariate analysis.

3.9 Measurements of variables

Measurement is a procedure in which a researcher assigns numerals-numbers or other symbols to empirical properties (variables) according to rules. Well-being of women and girls affected by fistula was the main variable of interest in this study. It was defined as comfort, good health, safety and happiness of a person or group of people. It was measured by looking at the available information on fistula survivors and social reintegration services offered by the organization to determine the socio-economic and physical well-being of the women and girls affected by fistula (fistula survivors).

Socio-economic and physical Well-being of women and girls affected by fistula was presumed to be dependent on counseling support, skills empowerment and social empowerment. This study majorly used the ordinal ranking scale, as such, a five point likert scale from 5=''strongly agree'' to 1=''strongly disagree'', respondents were asked to indicate how well each statement described the counseling support given to them. They were exposed to number of statements used to measure perceptions about skills empowerment and social empowerment given to them by the organization.

3.10 Ethical Considerations

Ethical approval was sought from Uganda Management Institute. Permission to conduct the study was obtained from TERREWODE organization in Case study district-Soroti. Ethics was practiced in this investigation as indicated below: (1)Informed consent was obtained from the study participants before they are interviewed (2)Confidentiality of all information obtained through questionnaire and records was ensured, use of anonymous identifiers and the principal investigator restricted access to the questionnaire(3)Participants in the study were on a voluntary basis. No treatment, benefits or standard care was denied to those who declined to participate in the study (4) Authors mentioned in this study are acknowledged through citations and referencing.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This chapter covers the presentation analysis and the interpretation of the findings. The results are presented according to the research objectives and the statistics were generated with the aim of generating responses that address the research questions derived from the research objectives. In the beginning of the chapter are the sample characteristics of the respondents, followed by findings according to the objectives and it concluded with presentation of inferential statistics together with its interpretation? The objectives that guided the study were:

- To examine the relationship between Counseling support and Socio-economic wellbeing of the women and girls affected by Fistula in Soroti District in Uganda.
- To investigate the relationship between skill empowerment support and socio-economic wellbeing of the women and girls affected by Fistula in Soroti District in Uganda and
- To explore the relationship between social empowerment and socio-economic wellbeing of women and girls affected by fistula in Soroti District in Uganda.

4.2 Sample Characteristics

The characteristics of the sample that were considered important in this study were marital status, age range, current occupation, mode of social reintegration program attended and years lived with fistula.

4.2.1 Marital Status

The question was set asking the respondents about their marital status and response was as shown in the table follow

Table 3: Marital Status of Respondents

Marital status	Frequency	Percent	Cumulative Percent
Married	14	38.9	38.9
Divorced	15	41.7	80.6
Others	7	19.4	100.0
Total	36	100.0	

Source: Primary Data

From the table above it is indicated that 14 respondents (38.9%) of the respondents were married, 15(41.7%) were divorced and 7(19.4%) belonged to other status like separated, and cohabiting. This means that majority of the respondents who were fistula victims were divorced and as such majority of them suffer trauma, isolation, stigma and homelessness and hence making emotional well-being of importance to this study. This probably is a major contribution to women's attempts to commit suicide or leave a miserable life for the rest of their lives should there be no effort made by government, civil society organizations and community leaders to come to the rescue of such divorced women.

4.2.2 Age range

The question was set asking the respondents about their age range and response was as shown in the table follow.

Table 4: Age range of respondents

Age range	Frequency	Percent	Cumulative Percent
16-25	11	30.6	30.6
26-30	3	8.3	38.9
31 and above	22	61.1	100.0
Total	36	100.0	

Source: Primary Data

From table 4 above it is indicated that, 11(30.6%) respondents belonged to an age range between (16-25) years, only 3(8.3%) belonged to that of (26-30) and majority of the respondents belonged to an age range of 31 and above years. This means that since our respondents were 31 and above then their response is worthy relied on.

4.2.3 Current Occupation

In the same manner the question was set asking the respondents about their current occupation and response was as shown in the table follow.

Table 5: Current Occupation of Respondents

Variable	Frequency	Percent	Cumulative Percent
Student	3	8.3	8.3
Business women	29	80.6	88.9
Farmer	4	11.1	100.0
Total	36	100.0	

Source: Primary Data

From table 5 above it is clearly indicated that 3(8.3%) of the respondents were students, 29(80.6%) were business women and only 4(11.1%) were farmers. This means that majority of the fistula victims were engaged in business and this corresponds to the findings that majority of the respondents were divorced, since majority of divorced women resort to small businesses according to Enterprise Uganda Survey in 2008, because of their limited access to land to do farming.

4.2.4 Mode of Social Reintegration Program Attended

The question was set asking the respondents about the mode of social reintegration program attended and response was as shown in the table follow.

Table 6: **Mode of Social Reintegration Program Attended**

Variable	Frequency	Percent	Cumulative Percent
Center based	36	100.0	100.0
Field based	0	0	0

Source: Primary Data

Among the two options provided in the questionnaire on mode of reintegration the result revealed that all the respondents indicated center based other than field based program

4.2.5 Years Lived with Fistula

The question was set asking the respondents about the years lived with fistula and response was as shown in the table follow.

Table 7: **Years with Fistula**

Variable	**Frequency**	**Percent**
1-3 years	12	33.3
4-7 years	14	38.9
8 and above	10	22.2
Total	36	100.0

Source: Primary Data

Regarding the years lived with fistula table 7 above indicate that14 (38.9%) stayed with fistula for a period between (4-7) years,12(33.3%) of the respondents had stayed with fistula for a period between (1-3) years, 8 (22.2%) had stayed with fistula for a period of 8 and above. This means that, majority of respondents had stayed with the disease for a period above one year at least. This enables us to understand if well-being could be having anything to do with age. This does not seem to be the case in this particular study.

4.3 Findings on Social Reintegration

Under this section the concept of social reintegration of women and girls with fistula, the independent variable was studied in terms of three components counseling support, skills empowerment and social empowerment. Even the results are presented accordingly in subsequent sub sections.

4.3.1 Counseling of Women and Girls with Fistula and wellbeing

Counseling is one of the components of social re-integration that was studied. The results are summarized in Table 8 below. Under this objective a mean value close to 1 represents strongly disagreed, mean value close to 2 means disagree , mean close to 3 indicates a state of undecided about the question asked, for a mean close to 4 means agree and those close to 5 means strongly agreed.

Table 8: Counseling of Women and Girls with Fistula

	N	Mean	Std. Deviation
I have received community health education counseling services	36	2.11	.979
Methods used in health education counseling services are effective	36	1.81	1.117
I recommend reproductive health counseling to all women	36	4.75	1.273
I recommend health education counseling for all girls in school	36	3.78	1.124
I understood my reproductive rights after counseling	36	2.53	.971
I am able to counsel other women on family planning	36	1.67	.986
Family planning counseling is an effective tool against fistula	36	3.78	1.267
Family planning counseling gave me choice	36	1.94	1.094
Group engagement counseling has been given to us	36	2.06	1.145
Group counseling is more insightful	36	2.67	.986
We took joint action after group counseling	36	2.78	1.267
I benefited from additional individual counseling	36	1.94	1.094
I avoided risks of complications after individual counseling	36	3.06	1.530
Valid N (list wise)	36		

Source: Primary Data

The result from the above table shows different response in terms of mean and standard deviation. The response on whether the respondents had received community health education counseling services (Mean=2.11, Std Dev =.979). This means that on average majority of respondent disagreed with the statement meaning that fistula survivors do not receive community health education counseling services. Much as qualitative findings confirm this, documentary review findings reveal that, there is community health education counseling services provided to the

women and only that it is inadequate meaning not many women benefit from it. This may be due to the lack of funding to reach yet many more affected women. The implication of this on dependent variable (DV) is that, when community health education counseling services is lacking, there is high possibility of fistula re-occurrence as such social, economic and physical well-being of women is negatively affected. However, a positive well-being is expected where community health education counseling services are adequate and benefiting majority women.

On whether the methods used in health education counseling services are effective (Mean=1.81, Std Dev =1.117). On average majority of respondents strongly disagreed with the statement, implying that the methods used in health education counseling services are not effective.
Community health education counseling services and methods used to provide the same were not well understood by the women and girls (fistula survivors). This finding does not mean that there are no efforts put in place by the case study organization (TERREWODE) to provide community health education counseling services. But perhaps the time frame given to achieve community health education counseling services is too small to create better understanding of the subject, coupled with no or very low education levels and issues of language barrier among women and girls to whom community health education counseling services were given. This therefore means that, when the right methods are employed and community health education counseling is adequate, women's social well-being tends to improve and vice versa.

Women and girls trained much as un decided on the question as to whether they understood their reproductive and health rights, were able to recommend reproductive health counseling to all

women and health education counseling for all girls in school. This they were able to do with the little understanding of the training session on reproductive and education health.

Women and girls (fistula survivors) had little knowledge about family planning as such they were not in position to counsel other women on family planning. But with the little knowledge got during the two weeks of training at TERREWODE's reintegration center, the women were able to understand the fact that family planning counseling is an effective tool against fistula, implying that they knew fistula was a challenge that would be reduced by using family planning counseling tool. The women could not agree to the statement that family planning counseling gave her choice due to the fact that, family planning counseling services provision are in adequate. This negatively affects the social well-being of the women and the opposite is true once family planning counseling is improved.

Qualitative finding has it that, group engagement counseling and additional individual counseling was seen not to be common to women and girls with fistula. As such, majority of them did not see it insightful. This does not mean that group engagement and or additional individual counseling was not completely given, but perhaps the women have not had enough time to understand and retain the knowledge given to them by yet trained personnel of the organization. This mostly results from women's low level of education, language barrier, old age in the case of elderly women who can no long perceive and understand new knowledge and the short duration of training could yet be another limiting factor since one or half a day was such a short time to achieve group and individual counseling. The implication of this on dependent variable is that, when individual or group counseling is inadequate, the social well-being of women is negatively affected and once individual/group counseling improves automatically social well-being of women is expected to

improve. Hence a strong positive relationship defined between independent variable and dependent variable.

On whether the respondents recommended reproductive health counseling to all women (Mean= 4.75, Std Dev =1.273). On average majority of respondents strongly agreed with the statement, implying that they recommended reproductive health counseling to all women. This is on the recognition that, reproductive health counseling was useful in the well-being of women and girls in that if taken seriously, it can help reduce fistula cases in the community by women embracing their reproductive roles and rights. However, documentary review findings reveal that, majority of women (80%) who were successfully counseled on their reproductive health concerns adhered to antenatal visits, timely delivered in health facilities and were able to avoid fistula. This means that, counseling of women and girls especially on their reproductive health has a great impact on the physical, social, economic well-being of women with fistula.

On whether respondents recommended health education counseling for all girls in school (Mean=3.78, Std Dev =1.124). Averagely, respondents agreed with the statement, implying that the health education counseling for all girls in school was inadequate. Qualitative findings agreed to this and it is seen by the women as a one of the sure ways to eliminate fistula in their communities. Meaning adequate health education for school girls makes them aware of their body development and also gives them life skills to be able to cope and avoid fistula. Documentary findings indicate that, already 11 schools in the 8 districts of Teso sub-region benefit from TERREWODE's school empowerment program for adolescent girls. The gap seen is in the fact that, many more schools needed to benefit from such a nice program and also the boys seem left

out yet they are very important partner to be involved especially in fighting issues of teenage pregnancies and early marriages. Therefore, where there is adequate health education provided, well-being of women and girls is expected to improve and vice versa.

On whether the respondents understood their reproductive rights after counseling (Mean=2.53, Std Dev =.971). Majority of the respondents were undecided on the statement, this implies that the respondents were not familiar with the counseling as a right. Qualitative findings reveal that, women are provided counseling on their reproductive rights except because of limited time given for such an important counseling, there is inadequacy observed. The implication of this on the dependent variable is that, where reproductive rights are not understood by women cases of fistula are seen to rise and well-being of women negatively affected. But counseling on reproductive rights is adequate women tend to understand their reproductive rights, hence a positive effect on social, economic and physical well-being of women is expected.

On whether women and girls were able to counsel other women on family planning (Mean=1.67, Std Dev =.986). Majority of respondents disagreed with the statement, implying that they did not know counseling of women on family planning. This finding evidently reveals the lack of counseling of women on family planning meaning women cannot achieve better well-being with the lack of counseling on family planning. This further means that, as number of children rises due to the lack of family planning knowledge, fistula re-occurrence cannot be ruled out as such the well-being of the affected women is at stake. Implying negative effect on social, economic well-being of women.

When the respondents were asked whether family planning counseling is an effective tool against fistula (Mean=3.78, Std Dev =.1.267). On average majority respondents agree with the statement, implying that they knew fistula was a challenge that would be reduced using family planning counseling tool. The implication of this finding on the dependent variable (well-being) is that, adequate family planning counseling has a strong positive effect on social well-being of women and girls affected by fistula and vice versa.

Family planning counseling gave me choice (Mean=1.94, Std Dev =1.094). Majority of respondents on average strongly disagreed with the statement. This means that, women and girls have not choices to make because of inadequate family planning counseling services. Qualitative findings equally confirms this, meaning that social, economic and physical well-being of women is negatively affected once family planning counseling is inadequate and women continue to give birth to unlimited or un planned number of children yet born under difficult conditions of poverty, poor access to timely and quality health care hence, resulting in to fistula. But where family planning counseling is adequate, well-being of women and girls is expected to improve.

On whether group engagement counseling was given to girls and women (Mean= 2.06, Std Dev =.1.145). On average majority of respondents disagreed, implying that group engagement counseling was not common to women and girls with fistula. Meaning this might not have been well handled due to limited time or lack of capacity by trainers. The implication on DV is that, the social well -being of women is negatively affected by the in adequate group counseling where women miss to bond with each other for continual psychosocial support. The opposite of this is

true n that, once group counseling improves social well-being of women is expected to improve as well, hence a strong correlation.

Group counseling is more insightful (Mean= 2.67, Std Dev =.986). On average majority of respondents were undecided as group counseling was not common to them. Qualitative finding reveals that, group counseling takes place only that, due to language barrier and limited time given, women do not understand one another or else time is too short to share the un limited fistula experience hence women's emotional well-being gets affected negatively.

On whether the respondents took joint action after group counseling (Mean=2.78, Std Dev =1.267). Still majority of respondents were undecided, consistent with the fact that they rarely participated in group counseling programs. The qualitative interviews showed that group counseling took place but there were challenges of language barrier and there was no enough time for social interaction to allow openness of members during counseling. As noted by a respondent:

> '' *We were given group counseling session during the two weeks center based training except the time given to be in groups was so small and some group members could not understand what goes on in groups due to language barrier, much as there was translation done, one could not rule out distortion of meaning of information, besides we come from different cultural backgrounds and needed time to appreciate one another so as to make group counseling insightful", a 31 year old woman I interviewed explained during the study.*

This therefore means issues of language barrier and adequate time for counseling need to be addressed if the social well-being of women is to improve. Vice versa. The above finding further shows that group counseling may not have been effective and thus women with fistula may not have been helped to gain self-esteem despite the group counseling. This literally means women needed more time be given and interpreters used if group counseling is to have positive effect on

well-being of women. Where this does not improve, it will have a negative effect on the social well-being of the affected women.

On whether the respondents benefited from additional individual counseling (Mean=1.94, Std Dev =1.094). On average majority of respondents disagreed, implying that respondents did not benefit from individual counseling either. Qualitative and documentary finding reveals that, individual counseling is provided but due to limited time allocated it is best to say individual counseling for the affected women is inadequate and this negatively affects social well-being of women and girls. However, once individual counseling is improved, better social well-being of women is expected.

Whether the respondents avoided risks of complications after individual counseling (Mean=3.06, Std Dev =1.530). Majority of them seemed undecided as they seemed not aware of the risk about counseling. Qualitative interviews with individual women after the individual counseling session reveal that, time was never enough to achieve complete individual counseling as seen in some of their statements:

'' I very much liked the session of individual counseling because it was so practical but we were given very limited time by the trainers who reminded us about the fact that, this was a two weeks training with many sessions that needs to be completed within the shortest time possible as such we did not benefit much from individual counseling", One woman explained. (A 25 year old woman during center based two weeks training).

All in all, counseling of women and girls with fistula within the Eastern Region is inadequate if it exists and this makes counseling as a component of social reintegration lacking among women and girls with Fistula. This could partially explain why the social wellbeing of women and girls

with fistula is not good. As a result, cases of failure to reunite with family/community, re-occurrence of fistula, trauma, stigma, isolation, psychiatry problem and attempts of suicide are rampant in the region and Country as a whole.

4.3.2 Skills Empowerment vs. Well-being

Skills empowerment was another component of social re-integration of women and girls with fistula disease. The results from the field survey questionnaires are summarized in Table 9 below

Table 9: Skills Empowerment

	N	Mean	Std. Deviation
I have been trained to do a self-help business	36	2.44	1.501
I have been mentored to do business after fistula	36	2.06	1.145
I have been coached on skills for successful living	36	1.67	.986
I value standards in branch campuses just like in main campus	36	2.97	1.082
I started an income generating activity after fistula	36	2.39	1.022
I benefited from government support for starting my business	36	1.56	.969
I benefited from NGOs for the start of my business	36	1.64	1.150
I am capable of coaching other women with skills	36	1.78	1.267
Valid N (listwise)	36		

Source: Primary Data

The result from table 9 above shows different response in terms of mean and standard deviation as in earlier sections on responses. On whether the fistula survivors had been mentored to do business after fistula (Mean=, 2.06, Std Dev =1.145). On average, majority of respondents disagreed with

the statement. This means that, very few fistula survivors are mentored to do businesses. Still on whether, the fistula survivors had been coached on skills for successful living (Mean=, 1.67, Std Dev =.986). Respondents on average strongly disagreed with the statement. This means that, there was limited coaching of fistula survivors. On whether, the fistula survivors were capable of coaching other women with skills (Mean=, 1.78, Std Dev =1.267). Majority of respondents disagreed with the statement implying that, survivors could not coach their fellows with different skills. This does not mean that the survivors never attended two weeks center based training and the field based training, they did but due to lack of capital some could not start income generating activities, even then the training was not adequate as indicated during qualitative interviews with participants, some had this to say:

> *"I attended the two weeks canter based training by TERREWODE where we were taught income generating basic skills in tailoring, weaving, beading, baking, music, dance & drama and savings and credit scheme (basic book keeping, group leadership). The only challenge I had was in understanding the series of sessions within such a limited timeframe and congested training room whereby I could hardly remember and practice what was taught. A 35 year old woman I interviewed explained during the study.*

This means that for skills empowerment to have better positive effect on well-being of women with fistula, there needed to be more time given for the women to understand training contents. Therefore, with the limited time for training given as revealed by study finding, women's well-being may be impacted negatively whereby, the limited knowledge acquired coupled with unconducive learning environment cannot enable the women to retain or practice knowledge and skill obtained within the two weeks.

On whether fistula survivors started an income generating activity (Mean=, 2.39, Std Dev =1.022).on average majority of respondents disagreed, implying that Fistula survivors lack income

generating activities in Soroti district. After all there was no or limited support from government and even NGOs to the victims of fistula to start business. As data shows on whether the fistula survivors benefited from government support for starting their businesses (Mean=, 1.56, Std Dev =.969). On average majority of respondents disagreed with the statement. This means that fistula survivors have no special arrangement from government in supporting their businesses. Also whether, fistula survivors benefited from NGOs for the start of their businesses (Mean=, 1.64, Std Dev =1.150). Majority of respondents on average strongly disagreed. This means that survivals of fistula lacked capital but also the trading seem not to have been empowering enough. As evidenced some victims started the income generating activities, but these enterprises did not live longer due stigmatization associated with fistula. As a respondent noted that;

> *"I got exposed to skills in income generating activities during TERREWODE's center based training and wanted to do farming but did not have land to farm on since my husband divorced me due to incurable fistula and married another woman. With some small startup loan from the organization, I started some small business of baking mandazi and chapatti but due to the fact that, I continued to leak urine and suffered stigma, and isolation as a result of failed surgeries and no one could buy from me given my poor fistula condition, the business collapsed, to date I am traumatized, homeless, suffering absolute poverty and think often of committing suicide", One woman explained. (A 33 year old woman waiting for yet another fistula repair and socio economic support)*

This explanation simply means the well-being of women with seemingly incurable fistula can be terribly affected negatively despite efforts in place to support such women. Her landlessness as a result of divorce is a clear sign of lack of male involvement in addressing issues of fistula in particular and maternal health in general. Continuing to leak urine has a lot to do with failed surgery either due to the lack of skilled expert knowledge by surgeons or other illness that could not allow for clinical procedure to be carried on such a women. Her failure to sell food items due to leakage of urine and the experiences of being stigmatized and isolated by community indicates

the lack of community and individual empowerment to recognize and value the health experience and knowledge that exists and to use it for every ones benefit (Minkler, 1992). The need for aggressive community sensitization/awareness rising on health conditions such as fistula becomes key.

I value standards in branch campuses just like in main campus (Mean=, 2.97, Std Dev =1.082). Majority of the respondents seemed undecided on the statement. This implies that the respondents never either understood the question or it was not familiar to them. On whether the survivors of fistula were trained to do self-help business (Mean=, 2.44, Std Dev =1.501). On average majority of respondents disagreed with the statement. This means that fistula survivors were not trained to do self-help businesses. However, secondary data collected provides that, this does not mean that there was completely no training conducted but rather it means that very few fistula survivors who got trained could either practice or remember the lessons taught due to the short duration of training which left them most times ill equipped. Hence negatively affecting the women's economic well-being. However, where skills empowerment is adequate, economic well-being of women is expected to largely improve.

4.3.3 Social Empowerment

The third component of social re-integration was social empowerment**.** The results are summarized in Table 10 below.

Table 10: Social Empowerment

	N	Mean	Std. Deviation
I have been trained on human rights	36	1.94	1.094
I have been trained on hygiene needs in fistula management	36	2.03	1.464
I have been trained on sanitation needs in fistula management	36	2.11	.979
I am an advocate for end fistula campaign	36	4.81	1.117
I am a sister friend to other fistula survivors	36	1.75	1.273
I am capable of engaging public institutions for support	36	1.78	1.124
I am capable of leading other women with fistula	36	3.14	1.437
I am capable to negotiate with my husband on all family issues	36	2.16	1.539
I am not afraid to be called a women living with fistula	36	2.22	1.072
Valid N (list wise)	36		

Source: Primary Data

From Table 10 above, shows different response in terms of mean and standard deviation. On whether the fistula survivors had been trained on human rights (Mean= 1.94, Std Dev =1.094). Majority of respondents averagely disagreed with the statement. This means that there was inadequate training of fistula survivors on human rights. On whether the survivors of fistula had been trained on hygiene needs in fistula management (Mean=2.03, Std Dev =1.464). Majority of them disagreed with the statement, implying that there was inadequate hygiene training for fistula management in Soroti district. Still on whether, the survivors had trained on sanitation needs in fistula management (Mean=2.11, Std Dev =.979). On average respondents disagreed with the statement meaning that sanitation training for fistula management was inadequately done. This negatively affects physical well-being of women especially where there is in adequate training in hygiene and sanitation which worsens fistula woman's health condition and cripples her from

engaging or succeeding in economic activities for instance, who can buy chapatti from a woman leaking urine who at the same time is not clean. But where there is sufficient hygiene and sanitation training for women, well-being of the affected women is expected to improve.

On whether, survivors were advocates for ending fistula campaign (Mean=4.81, Std Dev =1.117). On average majority of the respondents agreed with the statement. This means that survivors of fistula were much willing to end fistula occurrence, but they lacked what to do. On whether, a respondent was a sister friend to other fistula survivors (Mean=1.75, Std Dev =1.273). On average respondents disagreed with that statement. This means that not all fistula survivors had a sisterly relationship to other fistula survivors. On whether fistula survivors were capable of engaging public institutions for support (Mean=1.78, Std Dev =1.124). Averagely respondents disagreed with the statement. This means that survivors were not capable of engaging public institutions for support. On whether survivors of fistula were capable of leading other women with fistula (Mean=3.14, Std Dev =1.437). Majority of them seems undecided about the statement. Although qualitative interviews with the participants revealed the fact that most solidarity groups formed by fistula survivors are led by women, whereby, the group chair persons, secretaries and treasurer are all women (survivors). This means that, social empowerment once properly provided leads to improved social economic well-being of women and vice versa.

On whether, the victims were capable of negotiating with their husbands on all family issues, (Mean=2.16, Std Dev =1.539). On average majority of fistula victims disagreed with the statement. This means that women with fistula were unable to negotiate with their husbands on all family issues. On whether victims were not afraid to be called a women living with fistula (Mean=2.22,

Std Dev =1.072). On average majority of respondents disagreed with the statement. This means that victims were afraid to be called a woman living with fistula, so they are still traumatized. This finding further means that, women and girls with fistula still suffer stigma, isolation and cannot negotiate with husbands meaning the lack support from their male partners and this negatively affects physical, social and economic well-being of women and girls affected by fistula. The opposite is true when women get counseling support and men are involved as partners, social economic well-being of women is expected to improve.

4.4 Well Being of Women and Girls with Fistula

Well-being of women and girls with fistula was the dependent variable that was studied in terms of three components that is emotional well-being, economic well-being and physical well-being. The results from the field on the same is as presented in table 11 below

Table 11: Well Being of Women and Girls with Fistula

	N	Mean	Std. Deviation
Emotional well being			
I have a stable family	36	1.61	1.128
I have a right in my household property	36	1.92	1.317
My views are respected in my family	36	2.28	1.301
I am a member of the village social network	36	2.11	.979
I participate in all community meetings	36	1.81	1.117
I am relating well with my husband	36	1.75	1.273
I have never thought of suicide because of fistula	36	1.78	1.124
My friends respects my bravery of living with fistula	36	4.72	1.323
I am a living example of a fistula survivor	36	2.25	1.052
Economic wellbeing			
I have a reliable source of business income	36	1.78	1.124
I am a member of women saving group	36	1.58	1.273
I am self-reliant	36	1.83	.971
I have at least two sources of income	36	2.19	1.411
I decide on when to spend my income on my own	36	2.22	1.072
I have supported other women with soft loans	36	1.61	1.128
Physical well being			
I think my health situation has improved	36	1.92	1.402
I am physically fit to take care of my self	36	2.42	1.228
I am physically fit to defend my rights	36	3.83	1.384
Valid N (listwise)	36		

Source: Primary Data

On emotional well being

The first section of this table presents findings on emotional well-being. From the table above it is indicated that respondents response on whether fistula survivors had stable families (Mean=1.61, Std Dev =1.128). On average majority of respondents disagreed, meaning that families with fistula survivors were not stable. During qualitative interviews, respondents were able to explain this further by bringing in the key aspects of culture and male involvement. Some had this to say:

> *"Most often victims of fistula live a life of rejection, are looked at as outcasts. Once a girl or woman suffers from fistula, her once loving husband, friends and relatives all abandon her due to the intolerable circumstances. The majority still do not understand what fistula is and its causes. Some think it is witchcraft, others think it is a curse, while there are those who think fistula is simply a woman's problem. As such once a woman or girl due to one reason or another becomes a victim, automatically she is rejected, abused. Our culture believes in male dominance. In cases of sexuality our culture believe men can have sex whenever they want and that women must always be submissive. Some fistula survivors therefore have had their husbands force them into sex, even before they have fully healed, making the victims conditions to worsen", a key informant I interviewed explained during the study.*

This literally means that there is not enough counseling support provided to the women, coupled with the lack of male involvement in addressing the effects of fistula on women. This is clearly seen in survivors of fistula not having stable families. The effect of this on study dependent variable (DV) is that, weak counseling support and poor involvement of men as partners leads to poor or bad social and economic well-being of women. Vice versa.

On whether survivors had right to their household property (Mean=1.92, Std Dev =1.317).on average majority of them disagreed with the statement, implying that they did not have right to their household property. On whether the views of fistula survivors were respected in their families (Mean= 2.28, Std Dev =1.301). Still respondents disagreed, implying that, there was no respect of

views of fistula survivors in their families. On whether fistula survivors were members of village social network (Mean=2.11, Std Dev =.979). On average majority of them disagreed, implying that they were either not allowed to participate or were excluded because of their health conditions. This finding means that, rejection, denial, deprivation, stigma and isolation were as evident as revealed by the women's responses and this has a gross negative effect on their social economic well-being already. However, this situation can be reversed especially other factors such as male involvement, and involvement of cultural and opinion leaders to look in to issues of culture inflicting on health, economic and social rights of women. Once this is achieved, women's social and economic well-being is expected to improve. Meaning that other than focusing efforts on social reintegration intervention dimensions of counseling support, skills and social empowerment alone, other factors such as involving men and cultural leaders should be considered seriously so as to ensure better social economic well-being for women and girls.

During the qualitative interviews, one participant had this to say:

> *"Fistula victims need medical treatment for the physical ailments; they need protection from fistula recurrence and should live a normal life like any other women or girls", A senior fistula surgeon explained.*

On whether the survivors of fistula participated in all community meetings (Mean=1.81 Std Dev =1.117). On average majority of them strongly disagreed, implying that they did not participate. On whether women with fistula related well with their husbands (Mean=1.75 Std Dev =1.273). Still on average majority of them strongly disagreed. This means that women with fistula did not have good relationship with their husbands. On whether survivors of fistula had never thought of suicide because of fistula (Mean=1.78 Std Dev =1.124). Majority of the respondent on average

disagreed with the statement. This means that sometimes, these victims think of committing suicide, as seen in Appendix 13 of study report-women talk about their experiences.

One Consultant obstetrician/gynecologist/fistula surgeon during the qualitative interviews with the researcher had this to say:

> *"Repair of fistula and involvement of partner and relatives are crucial among other key factors that may affect the physical, social and economic wellbeing of fistula victims".*

During qualitative interviews with affected women, the following were narrated:

> *"I was a happy woman before getting this problem of leaking urine (fistula) but now I feel my life has been so much affected that for 11 years now. I can no longer attend community meetings, church, funeral and any type of gathering despite social empowerment sessions attended during the two weeks center based training organized by TERREWODE. I feel uneasy smelling (referring to foul smell) in public. It can be humiliating and shameful. Often I felt like committing suicide given the level of isolation, stigma, discrimination and homelessness", (29 year old woman who has symptoms of incurable fistula).*

On the contrary, while interviewing community volunteers, another woman was quoted as saying:

> *"When voices of the affected women matter, they sing; they dance; they ululate, attracting a large gathering of villagers-men, women and children. These are members of Amorican Women Fistula Solidarity Group village troupe in Mukura Sub-county, Teso sub-region. Initially, the women troupe did not have male members. But now the lead vocalist s a male in this all-gender inclusive group. Men are a major target –group to end fistula".*

All the above findings indicate clearly how crucial it is to support women with fistula and also involve men in this support so as to ensure better well-being for women and girls affected by fistula. This further means that, where counseling support, skills and social empowerment s weak, social economic well-being of women is negatively affected.

On whether, friends of fistula survivors respect her bravery of living with fistula (Mean=4.72 Std Dev =1.323). On average majority of respondents agreed with the statement. On whether some

victims of fistula were a living example of, a fistula survivor (Mean=2.25, Std Dev =1.052). On average majority of the respondents disagreed. This means that, there are many people as example in Soroti district with fistula. Generally, the emotional well-being of victims of fistula is not good as many of them wish to even commit suicide because of social exclusion, that demand for immediate medical attention in terms of improved and successful surgeries and effective social re-integration intervention especially where victims have registered failing surgeries and have to cope with the condition for the rest of their life.

Economic wellbeing

Economic well-being was another measure of well-being of women and girls with fistula. The questions on the same were asked and their response is as shown below. On whether the victims of fistula had reliable source of business income (Mean=1.78, Std Dev =1.124). Majority of them disagreed with the statement. *Analysis of qualitative data revealed that, this occurrence was majorly due to inadequate skills empowerment, lack of startup capital and land so as to engage in income generating activities such as farming, hence resulting in to vicious circle of poverty.*

> *'you cannot train people for a period of two weeks and expect them to understand and gain skills in important areas like human rights, hygiene, sanitation and economic skills, these all needed a lot of time for a woman to be able to have good knowledge and skills for better social, economic well-being'', (A 33 year old fistula survivor and beneficiary of social reintegration services).*

On whether the victims of fistula were members of women saving group (Mean=1.58, Std Dev =1.273). Majority of them disagreed on average. Meaning that few fistula victims were members of the women saving group. On whether the victims were self-reliant (Mean=1.83, Std Dev =.971). Results from the field indicate that, on average respondent disagreed, implying that victims were not self-reliant.

During qualitative interview with key informants-District official from Soroti Community Development Office, the following was explained:

> *Culturally women do not own property, sometimes they even have no control over the proceeds from sales, so even where some fistula survivors have had skills training and are engaging in income generating activities, they have no control over their incomes and therefore they continue to be socially disempowered*

On whether, the fistula victims had at least two sources of income (Mean=2.19, Std Dev =1.411). Majority of them on average disagreed, meaning that the victims had limited sources of income. On whether the victims of fistula decided on when to spend their income on their own (Mean=2.22, Std Dev =1.072). Majority of the respondents disagreed, implying that some other people decided on them and on whether victims of fistula supported other women with soft loans (Mean=1.61, Std Dev =1.128). Majority of them disagreed, meaning that the victims did not have enough income. Generally it can be concluded that, the economic well-being of victims of fistula is bad as they don't have reliable sources of income, they are not incorporates in village savings groups, and many of them do not have a say on their own income.

Physical well being

Physical well-being was also studied under general well-being of women and girls with fistula and the results presented under relate to the same. The response on whether, the victims thought their health situation had improved (Mean=1.92, Std Dev =1.402). On average majority of them disagreed with the statement. This implied that victims of fistula have not at any single time believed in improved health. On whether, the victims felt physically fit to take care of themselves (Mean=2.42, Std Dev =1.228). Majority of them disagreed with the statement, implying that their

physical well-being was compromised by the fistula and on whether, victims were physically fit to defend themselves, rights (Mean=3.83, Std Dev =1.384). Majority of the respondents agreed. Another respondent was quoted as saying:

> *"The reproductive roles assigned to women by the society negatively affects the physical wellbeing of a woman or girl. Whether fistula victims or not women must fend for their families to sustain their survival. Hence the routine and repetitive chores such as fetching water, collecting firewood, cooking, taking care of their children remains a woman's roles. This leaves a fistula victim not only physically drained but also emotionally tormented", (Soroti district Senior Community Development Officer).*

Generally the physical well-being of women and girls with fistula is demanding as their health is bad, as also their physical well-being was compromised by fistula. Therefore, much more effort needs to be done to improve their general physical well-being.

4.5 Inferential Analysis

Under inferential analysis two inferential statistical variables are used that is Pearson's Correlation Coefficients to establish the relationship between variable and regression analysis to test the influence of one variable on the other. Under this objective by objective interpretation is done.

4.5.1 Pearson Correlation Analysis

As the objectives are states in a relationship manner, it was paramount for the study to compute the Pearson Correlation coefficients of the independent variables and dependent variables in order to establish the relationship between variables.

Table 12: Showing Correlation Coefficients of Variables

		Counseling	Skills empowerment	Social Empowerment	Well being
Counseling	Pearson Correlation	1			
	Sig. (2-tailed)				
	N	36			
Skills Empowerment	Pearson Correlation	.932	1		
	Sig. (2-tailed)	.000			
	N	36	36		
Social Empowerment	Pearson Correlation	.873	.834	1	
	Sig. (2-tailed)	.000	.000		
	N	36	36	36	
Well Being	Pearson Correlation	.940	.887	.847	1
	Sig. (2-tailed)	.000	.000	.000	
	N	36	36	36	36

Source: Primary Data

From the Table 12 above it has been indicated that the correlation coefficient between counseling and wellbeing of women and girls with fistula is 0.940. This means that there is a strong positive relationship between counseling and wellbeing of women and girls with fistula. This implies that anything affecting counseling greatly impacts on wellbeing of women and girls with fistula.

The results also indicate that the relationship between skills empowerment and wellbeing of women and girls with fistula is 0.887. This also means that there is a strong positive relationship between skills empowerment and wellbeing of women and girls with fistula. The table also indicates that the relationship between social empowerment and wellbeing of women and girls

with fistula is 0.847. This means that there is a strong positive relationship between social empowerment and wellbeing of women and girls with fistula disease.

4.5.2 Regression

Table 13: Showing model Summary, Anova and regression Coefficients of Variables

Model summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.942a	.888	.877	.16330	.888	84.150	3	32	.000

a. Predictors: (Constant), social empowerment , Skills empowerment, Counseling

ANOVAb

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	6.732	3	2.244	84.150	.000a
	Residual	.853	32	.027		
	Total	7.585	35			

a. Predictors: (Constant), social empowerment , Skills empowerment, Counseling

b. Dependent Variable: Well being

Coefficient

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.494	.107		4.612	.000
	Counseling	.687	.161	.796	4.253	.000
	Skills empowerment	.049	.138	.059	.358	.723
	Social empowerment	.069	.082	.103	.838	.408
a. Dependent Variable: Well being						

Source: Primary Data

From the model summary table above it is indicated that, Adjusted R Square = 0.877 between social re-integration programs and well-being of women and girls with fistula in Soroti district, suggesting that social re-integration alone predicted 87.7% variance in well-being of women and girls with fistula in Soroti district whereas other factors predicted . This means other factors predicted 12.3%. The R2 of 0.877 t of 4.612 and the significance of 0.000 suggests that social re-integration is a strong predictor of well-being of women and girls with fistula in Soroti district.

This implies that in order to improve well-being of women and girls with fistula in Soroti district, in terms of emotional economic and physical well-being more emphasis need to be done on social re-integration programs.

CHAPTER FIVE

SUMMARY, DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The research sought to examine the relationship between Social reintegration and Well-being of women and girls affected by fistula in Soroti District in Uganda.

This chapter presents the, discussion of findings, conclusions drawn from the findings and the recommendations. This is done according to the research objectives which were; to examine the relationship between Counseling support and Socio-economic wellbeing of the women and girls affected by Fistula in Soroti District in Uganda, to investigate the relationship between skill empowerment support and socio-economic wellbeing of the women and girls affected by Fistula in Soroti District in Uganda and to explore the relationship between social empowerment and socio-economic wellbeing of women and girls affected by fistula in Soroti District in Uganda.

5.2 Summary of the findings

Summarized result per Person Correlation shows that there is a positive and significant relationship between the components of Social reintegration and Well-being of women and girls affected by fistula in Soroti District, Uganda. This implies that improvement in the components of social re-integration (counseling support, skills and social empowerment) greatly has a positive effect on the Well-being of women and girls affected by fistula and vice versa.

The findings on each objective are each discussed and interpreted in the next sub-section.

The empirical result by and large rejects the proposition of the study that there is no significant relationship between social reintegration and wellbeing of women and girls affected by fistula. It can therefore be summarized that setting a stronger dimension of social reintegration significantly influences better quality of life (improved well-being).The implication of the above findings to the social support theory and community empowerment theory can be explained as follows;

While most of the findings in this study were of positive significance, this could be explained by earlier findings from Solomon, 1976; Rappoport, 1985; Israel etal, 1994, Imelet.al. (2008) and other scholars who argued using the two mentioned theories to suggest that power and control, efficacy and social justice in changing the lives and environment of women communities was critical and well-being as a state of being happy, healthy or successful must be achieved for the women. The researcher strongly sees clear evidence for the great need for Government and all its development partners to join hands and come up with stronger policies and strategies that will strengthen provision of social reintegration services to the women and girls affected by fistula so as to improve on their well-being. Resources allocation to the fistula social reintegration intervention and replication of good practices such as one by TERREWODE in Soroti district should benefit other districts in Uganda as a matter of program scale up. The Ministry of Health which is a line ministry should have strong collaboration with Partner NGOs and all other stake holders so as to ensure effective policy, strategies adherence and implementation. Also to follow closely on Government commitments towards improvement of Maternal, neonatal, and adolescent health in order to eliminate fistula in Uganda.

5.3 Discussion of findings

This section is sub divided in to three sub sections. The first sub section discusses the relationship between Counseling support and Socio-economic well-being. The second sub section discusses the relationship between skills empowerment and the socio-economic well-being. The third sub section discusses the relationship between social empowerment and socio-economic well-being.

5.3.1 The relationship between counseling support and socio-economic wellbeing;

Findings from quantitative analysis reveals a strong positive correlations (r=0.940). Similar finding was also recorded in the qualitative results. This finding is consistent with earlier results from Obed Kabanda (2010) who had argued that women's social experiences are positively sewed. However, this finding was disagreed by Marrakech (2010) who argued that in some women psychological dysfunction continues despite fistula repair because their reintegration experiences may be impacted negatively, secondary to the degree of isolation and stigmatization experienced while living with Fistula. The researcher however does not agree completely with this finding given the fact that, such chronic cases of isolation and stigmatization can easily be dealt with especially where counseling support strategies, methods are improved and this is seen to positively affect well-being of women with fistula.

5.3.2 The relationship between skill empowerment support and socio-economic well-being

Majority of women and girls affected by fistula (survivors) from the study findings were seen not to have income generating activities in Soroti district, despite two weeks center based training and field based support by TERREWODE. Quite number of reasons could explain women's lack of involvement in income generating activities ranching from, the short duration of training (two weeks only), kind of training environment in terms of limited space, survivors bear with congestion and heated room that limits concentration and understanding, language barrier, low level of

education,/level of illiteracy, some women given their low level of education take long to understand and gain skills, landlessness due to separation or divorce limits women who want to engage in commercial farming, lack of male involvement (the women are not supported by their male counter parts). Another reason for lack of income generating activities is the lack of startup capital. Most fistula survivors suffer from lack of seed money to start an income generating activity and this seems to be a critical reason among the so many reasons advanced. However, Tones and Tilfor; 2001 in their empowerment theory emphasized the great need for empowering communities and ensure remedy to inequalities to achieve better fairer distribution of available resources.

The fistula victims felt they had no special arrangement by either development partners or Government in supporting their business. They agreed to the fact that Government has put in place various programmes like CDD (Community Driven Development) programme which is meant to target women and girls of all status and the Youth Livelihood project (YLP) which targets youth (18 – 30 years). But fistula survivors continue to be marginalized as such do not benefit from these programmes. They are looked at as social out casts, sick women who can no longer be useful to the society. This implies that there is still limited support from Government and NGOs towards rehabilitation and re-orientation of fistula survivors in Soroti district.

Mentoring and couching of fistula survivors on self-help businesses was found to be lacking. Meaning for the few survivors who have benefited from mentorship and couching to do business, majority either forget the little knowledge and skill they got from the training or they simply lack startup capital to practice what they have learned. They women therefore cannot couch or mentor other women since they themselves lack the ability to do so. This confirms the empowerment theory that was used to support this study and it states that, empowerment, in its most general

sense, refers to the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations (Israel *et al*., 1994). The lack of income generating activities exposes the women to yet another level of poverty whereby they cannot afford basic needs such as food, health and shelter since they have no reliable source of income. This comes down to (Kabanda Obed, 2010), who said that women have no income they can control on their own and so cannot even afford the added costs to their health condition and other basic needs.

The findings also indicated that the relationship between skills empowerment and well-being of women and girls with fistula is 0.887. Implying that there is a strong positive relationship between skills empowerment and well-being of women and girls with fistula. Meaning if women are given the right knowledge and skills and they have capital to start businesses whereby they are able to generate, save, and have a reliable source of income so as to afford basic needs such as food, shelter and health. They are able to take independent financial decisions as they are self-reliant and able to support other women with Loans through the savings and credit schemes. They are respected and able to decide at house hold level. Their social, economic and physical well-being generally improves and the opposite is true where they women lack skills and knowledge and cannot have income to afford basic needs in life.

5.3.3 The relationship between social empowerment and socio-economic wellbeing

The table 12 in chapter 4 clearly indicates that the relationship between social empowerment and wellbeing of women r=0.847. This means that there is a strong positive relationship between social empowerment and wellbeing of women and girls with fistula.

Women and girls felt training on human rights, hygiene and sanitation were inadequate and this was mostly attributed to the lack of time. Meaning there needs to be adequate time given for women and girls to be able to understand issues related to their human rights, hygiene and sanitation. The researcher tended to agree with reproductive and economic rights of individuals as emphasized by ICPD program of action and human rights, 1994. The common argument here is that, issues of rights should never be taken lightly. People need to be empowered and given proper understanding of their full health economic, social and political rights for the betterment of one's well-being.

Women and girls become advocates in the fight against fistula as seen clearly in the findings of the study. Quite number fistula survivors are much more willing to end fistula occurrence. But most times due to the limited time for training (only two weeks), they women find themselves handicapped especially on what to say and how to say it during advocacy and awareness raising on fistula and other maternal health, human rights, and public health issues.

Majority of the fistula survivors are still not able to support one another in way of having a sister friend. This seem more due to the fact that, time spent at the training center is not enough to know a person much more in detail so as to develop trust. Besides, the women are widely spread across the country and needed more opportunities to meet often in order to pair up easily. This means dependent variable is negatively affected when women do not get support from one another. But where women are supported to be able to support one another, their social well-being is expected to improve. Women are unable to take up leadership positions and even engage with public institutions for support, let alone failing to negotiate with husbands on family issues. The

researcher does believe that much as the women may not have adequate social empowerment, the cultural mind sets, stereo types about the fact that a woman's role stops at child birth and the kitchen, therefore women can never be leaders, cannot engage with public institutions, policy makers and worse still not allowed to negotiate with husband or even take decision on family issues at house hold level, also because in most times men have been seen in the lead nearly in all levels, women have tended to think that they (men) must always be the ones to lead since they are used to it that way. Women have been made to believe they cannot be good leaders. These among other factors contribute highly to women's limited participation in leadership, and engaging with husband, and public institutions. There is also this ''feeling'' in women that how can a woman like us lead, they have tended to support men leaders more than women leaders. This comes down to (Cohen and Swim, 1995: Melamed, 1996; Witkowski and Leicht, 1995), who said that early socialization determines the jobs women and men consider socially acceptable.

5.4 Conclusions

(i) The relationship between Counseling support and Socio-economic wellbeing of the women and girls affected by Fistula in Soroti District in Uganda.

The study found a significant strong positive correlation between Counseling and well-being of women (r=0.940.) Similar results were also found in qualitative and documentary review. The study therefore concludes that counseling support results into greater well-being of women and girls affected by fistula. However, despite efforts made by TERREWODE, Government of Uganda and it's development partners such as UNFPA, AMREF, ENGENDERHEALTH and WHO, to ensure provision of treatment and social reintegration to women and girls affected by fistula, Counseling support of women and girls with fistula within Soroti District is inadequate and this

makes counseling as a component of social reintegration lacking among women and girls with Fistula. This partially explains why the social/emotional well-being of women and girls affected by fistula is not good as clearly seen in number of divorce cases, failure by women to take decision at house hold level, failure to associate with family members and community at large as revealed by study findings and discussed by researcher. It is concluded that, the ultimate strategy for dealing with the psycho-social impact of fistula is to reduce occurrence of obstetric fistulas and continual concerted efforts by government and its development partners to provide adequate counseling support to the affected women will have a great positive impact on the well-being of the women and girls affected by fistula.

(ii) Relationship between skill empowerment support and socio-economic well-being of the women and girls affected by Fistula in Soroti District in Uganda.

The relationship between skills empowerment and well-being of women and girls with fistula was r=0.887. Therefore there is a strong positive relationship between skills empowerment and well-being of women and girls affected by fistula. The skills empowerment support as a component of social re-integration of women and girls with fistula in Soroti District is still lacking as seen in study findings, majority of women and girls affected by fistula can still not engage in income generation activities, lack financial independence, can't afford basic needs. This study therefore, concludes that improvement in skills empowerment support does have a positive effect on the well-being of women and girls with fistula, this component of social re-integration needs to be emphasized.

(iii) Relationship between social empowerment and socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda.

The study found a strong positive relationship between social empowerment and well-being of women (0.847). There is a general lack of social empowerment support among women and girls affected by fistula and this could partly explain the well-being of the affected women and girls in Soroti District. The wellbeing of women and girls affected by fistula is generally bad. The emotional wellbeing of victims of fistula is not good as many of them wish to even commit suicide because of social exclusion, that demand for effective social re-integration programs. The economic wellbeing of victims of fistula is bad as they don't have reliable sources of income, they are not incorporates in village savings groups, and many of them do not have a say on their own income. The physical wellbeing of women and girl with fistula is demanding as their health is bad, as also their physical well-being was compromised by fistula. Therefore, much more effort needs to be made to improve their general physical wellbeing. In conclusion, there is a general lack of social empowerment among women and girls with fistula, low involvement by public institutions, low involvement by male partners and this could partly explain the poor well-being of women with fistula in Soroti District. The implication of this to government and all its development partners is that, when they have appropriate policy, strategies and promising innovations in place to provide social empowerment, they will achieve better social, economic and physical well-being for women and girls affected by fistula.

5.5 Recommendations

Basing on the above conclusions the researcher makes the following recommendations:-

(i) The relationship between Counseling support and Socio-economic wellbeing of the women and girls affected by Fistula in Soroti District in Uganda.

Based on the study findings, there is the need for Government to allocate resources to NGOs undertaking social reintegration so as to improve on methods used to counsel fistula survivors and duration taken to counsel women needs to improve as well. For example two weeks is never enough to asses if a woman was emotionally okey and could be in position to counsel other women, therefore, increase on the number of weeks from two to at most 4 weeks is recommended.

Our cultural believe in male dominance. In cases of sexuality our culture believes men can have sex whenever they want and that women must always be submissive. Some fistula survivors therefore have had their husbands force them into sex, even before they have fully healed, making the victims conditions to worsen. Most often men think fistula is a women's issue and are less concerned. Men should be brought on board, because fistula victims need their support, love and care and understanding. Male involvements therefore very crucial. Men can be made change agents especially those whose wives are affected by fistula. Up holding and replicating TERREWODE's Music Dance and Drama for healing therapy and easy socialization, reintegrating with community is recommended.

(ii): Relationship between skill empowerment support and socio-economic well-being of the women and girls affected by Fistula in Soroti District in Uganda.

Government needs to come up with clear and favoring economic policies and increase on funds allocation to the private sector.

There is great need to review training curriculum and increase on duration taken to train fistula survivors so as to impart economic and life skills in them and make them relevant to the society.

With quality skills empowerment women should be able to engage in income generating activities and take independent financial decisions, become active members of savings and credit schemes, and be capable of taking good care of themselves, their family and contribute to the development activities of the Nation.

Culturally women do not own property, sometimes they even have no control over the proceeds from sales, so even where some fistula survivors have had skills training and are engaging in income generating activities, they have no control over their incomes and therefore they continue to be socially and economically disempowered. Hence the urgent need of male involvement and involvement of community leaders, cultural and religious leaders so as to improve on cultural settings and believes.

Concerted effort by Government, all development partners and other key stake holders is highly recommended if women and girls affected by fistula are supported to regain their dignity, empower them to attain financial independence so as to contribute to their well-being and that of their families. Also to be able to positively contribute towards Governments development efforts. For example, a fistula survivor who is well empowered socially, economically, and physically will be able to pay taxes and improve other people's lives as well.

(iii)Relationship between social empowerment and socio-economic well-being of women and girls affected by fistula in Soroti District in Uganda.

There is an urgent need for improvement in the social reintegration component of social empowerment by Government, all development partners, public institutions, and all other key stake holders. The women need to have space created for them to be able to voice their issues for action so as to improve on their well-being. Developing, and setting clear structures to implement

social policies so as to support women are key. Therefore, provision of platforms so as to listen to women issues in order to review or establish policies become crucial.

Male involvement and improvement in cultural believes is recommended so as to have women emerge as leaders, take decisions, negotiate freely with husbands over family issues/assets, join community meetings instead of culturally believing their role stops at the kitchen and child bearing.

Lastly, TERREWODE's holistic fistula approach and successful social reintegration model needs to be replicated in other parts of Uganda and number of countries globally. Therefore the great need for a Capacity Building Strategy in Social reintegration so as to support other partners is necessary.

5.6 Limitations of the Study

The main limitation of this was; the study only focused on Soroti District as case study district (unit of analysis) as such, there may be no knowledge of effect of social reintegration on well-being of fistula women in other districts. This limitation leads to the need for future research which will investigate the relationship between social reintegration and well-being of women and girls affected by fistula in other districts of Uganda especially where social reintegration services are being provided so far.

5.7 Contribution of the study

As seen in the definition of social reintegration and well-being of women and girls affected by fistula. It has not been easy to clearly define the relationship between social reintegration and well-

being. However, the major contribution of this study is that there is a significant and positive relationship between social re-integration and wellbeing of affected women. This contributes to better understanding by development partners and all other key stake holders of the existing relationship between the two variables, in order to step up social reintegration intervention so as to improve on the physical, social and economic well-being of women and girls affected by fistula.

Secondly, the study provides empirical evidence for policy makers in higher Government positions to understand the Well-being complexities and challenges brought by lack of Social reintegration intervention. Consequently they can come up with better policies, strategies so as to improve on critical components of social reintegration like counseling support, skills empowerment and social empowerment. Not forgetting intervening factors such as Male involvement, and cultural reforms.

Finally, the study adds to the board of existing knowledge and creates room for further research in the area of social reintegration of survivors of fistula in Uganda and globally.

5.8 Areas for further study

Having examined the relationship between social reintegration and well-being of women and girls affected by fistula in Soroti District in Uganda, the researcher (principal examiner/investigator) suggests the following areas for further research:

1. Factors affecting social reintegration intervention for women and girls affected by fistula in Uganda.
2. Socio-economic re-integration needs for women and girls with incurable fistula in regaining their dignity in Uganda.

3. Factors affecting resources allocation to obstetric fistula treatment and reintegration intervention in Uganda.

Further studies can also be conducted on the same or related topic but rather with a larger sample size from all districts in Teso sub-region, Eastern Uganda and other parts of Uganda where social reintegration services are rendered to women and girls affected by fistula. The issue of fistula causing divorce is yet another interesting area of study.

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APPENDIX 1: QUESTIONNAIRE FOR RESPONDENTS

Survey questionnaire for women and girls with fistula

Social Re-Integration and well-being of women and girls affected by fistula in Uganda. A case study of Soroti district

Dear respondents,

I am Lillian Awizia, a master's degree student from Uganda Management Institute undertaking the above study. I request you to kindly fill in this questionnaire using the guideline below. Your responses will be treated with utmost confidentiality.

SECTION A: BACKGROUND INFORMATION

Please tick one option regarding your background.

A1. Your current marital status: 1. Married ☐ 2. Divorced ☐

A2. Age range: 1. 16-25 ☐ 2. 26-30 ☐ 3. 31 and above ☐

A3. Current Occupation ☐ A. Student ☐ B. Business women C. Farmer ☐ D. Civil servant ☐

E. Number of children ☐ none of the above ☐

A4. Mode of social reintegration program attended:

1. Center Based. ☐
2. Field Based ☐
3. Both ☐

A5. Education level:

1. None ☐
2. Primary ☐
3. Secondary ☐

4. Tertiary ☐

A6. Cause of the fistula:

1. Delayed labor ☐
2. Poor access to Health facility ☐
3. Other factors ☐

A7. Years lived with fistula:

1. 1-3 years ☐
2. 4-7 years ☐
3. 8 and above ☐

SECTION B: Social Reintegration

For each statement below, please tick one alternative that corresponds with your opinion. Use the following scale: 1=strongly disagree (SD), 2=Disagree (D), 3=Undecided (UD), 4=Agree (A), 5=strongly agree (SA).

No	Counseling	SD	D	UD	A	SA
B.1	I have received community health education counseling services	1	2	3	4	5
B.2	Methods used in health education counseling services are effective	1	2	3	4	5
B.3	I recommend reproductive health counseling to all women	1	2	3	4	5
B.4	I recommend health education counseling for all girls in school	1	2	3	4	5
B.5	I understood my reproductive rights after counseling	1	2	3	4	5
B.6	I am able to counsel other women on family planning	1	2	3	4	5
B.7	Family planning counseling is an effective tool against fistula	1	2	3	4	5
B.8	Family planning counseling gave me choice	1	2	3	4	5
B.9	Group engagement counseling has been given to us	1	2	3	4	5
B.10	Group counseling is more insightful	1	2	3	4	5
B.11	We took joint action after group counseling	1	2	3	4	5

B.12	I benefited from additional individual counseling	1	2	3	4	5
B13	I avoided risks of complications after individual counseling					
	Skill Empowerment	**SD**	**D**	**UD**	**A**	**SA**
B.14	I started an income generating activity after fistula	1	2	3	4	5
B.15	I benefited from government support for starting my business	1	2	3	4	5
B.16	I benefited from NGOs for the start of my business	1	2	3	4	5
B.17	I value standards in branch campuses just like in main campus	1	2	3	4	5
B.18	I have been trained to do a self-help business	1	2	3	4	5
B.19	I have been mentored to do business after fistula	1	2	3	4	5
B.20	I have been coached on skills for successful living	1	2	3	4	5
B.21	I am capable of coaching other women with skills	1	2	3	4	5
	Social Empowerment	**SD**	**D**	**UD**	**A**	**SA**
B.22	I have been trained on human rights	1	2	3	4	5
B.23	I have been trained on hygiene needs in fistula management	1	2	3	4	5
B.24	I have been trained on sanitation needs in fistula management	1	2	3	4	5
B.25	I am an advocate for end fistula campaign	1	2	3	4	5
B.26	I am a sister friend to other fistula survivors	1	2	3	4	5
B.27	I am capable of engaging public institutions for support	1	2	3	4	5
B.28	I am capable of leading other women with fistula	1	2	3	4	5
B.29	I am capable to negotiate with my husband on all family issues	1	2	3	4	5
B.30	I am not afraid to be called a women living with fistula	1	2	3	4	5

SECTION C: WELL BEING OF WOMEN AND GIRLS WITH FISTULA.

Please tick one score that accurately reflects your opinion on your wellbeing in the community institution. Use the Scale of; 1=strongly disagree (SD), 2=Disagree (D) 3=Undecided (UD), 4=Agree (A), 5=strongly agree (SA).

No	**Emotional Wellbeing**	**SD**	**D**	**U**	**A**	**SA**
C.1.	I have a stable family	1	2	3	4	5
C.2	I have a right in my household property	1	2	3	4	5
C.3	My views are respected in my family	1	2	3	4	5

C.4	I am a member of the village social network	1	2	3	4	5
C.5	I participate in all community meetings	1	2	3	4	5
C.6	I am relating well with my husband	1	2	3	4	5
C.7	I have never thought of suicide because of fistula	1	2	3	4	5
C.8	My friends respects my bravery of living with fistula					
C.9	I am a living example of a fistula survivor					
	Economic Wellbeing	**SD**	**D**	**U**	**A**	**SA**
C.10	I have a reliable source of business income	1	2	3	4	5
C.11	I am a member of women saving group	1	2	3	4	5
C.12	I am self-reliant	1	2	3	4	5
C.13	I have at least two sources of income	1	2	3	4	5
C.14	I decide on when to spend my income on my own	1	2	3	4	5
C.12	I have supported other women with soft loans	1	2	3	4	5
	Physical Wellbeing	**SD**	**D**	**U**	**A**	**SA**
C.15	I think my health situation has improved	1	2	3	4	5
C.16	I am physically fit to take care of my self	1	2	3	4	5
C.17	I am physically fit to defend my rights	1	2	3	4	5

THANK YOU VERY MUCHFOR YOUR TIME.

APPENDIX 2: INTERVIEW GUIDE FOR KEY INFORMANTS

- Board Members
- Management Staff

1. What is your comment on the relationship between social re-integration one key intervention undertaken by TERREWODE (psychosocial support, skill empowerment & social empowerment dimension) in relation to physical, social and economic wellbeing of women and girls affected by Fistula in Soroti district?

2. Why do you think the relationship is as you have described?

3. What are some of the factors that may affect the physical, social and economic wellbeing of fistula victims other than skills empowerment, social empowerment and psychosocial support?

4. What independent comment can you give on male involvement as one of the factors affecting physical, social and economic wellbeing of women and girls affected by fistula?

5. Briefly state TERREWODE's thematic areas. What in your opinion should change about TERREWODE's social re-integration intervention in order to improve on social and economic wellbeing of women and girls affected by Fistula?

6. What obstacles do exist in TERREWODE's efforts to rehabilitate and re-integrate women?

7. Briefly state the importance of TERREWODE's unique OFAAN strategy. Why are solidarity groups and other social networks important to Fistula survivors?

8. Do you see any impact of TERREWODE's social re-integration intervention in Soroti District? (Briefly explain)

9. What should change/improve if impact is not much?

10. What is your independent comment on Funding of TERREWODE's Fistula Programme especially the Re-integration component? Is there sufficient funding? What should change? (Briefly explain)

Fistula Surgeons

1. How would you explain wellbeing of Fistula woman in Medical terms and how would you link it to Social re-integration?

2. What is your comment on the relationship between social re-integration and socio-economic wellbeing of women and girls affected by Fistula in Soroti district?

3. Why do you think the relationship is as you have described?

4. What are some of the factors that may affect the physical, social and economic wellbeing of fistula victims other than skills empowerment, social empowerment and psychosocial support?

5. What independent comment can you give on male involvement as one of the factors affecting physical, social and economic wellbeing of women and girls affected by fistula?

6. Do you see any impact of TERREWODE's social re-integration intervention in Soroti District? (Briefly explain)

District Officials

Name, Title, Number of years as a civil servant or politician, Gender, Date

1. What is your comment on the relationship between social re-integration socio-economic wellbeing of women and girls affected by Fistula in Soroti district?

2. Why do you think the relationship is as you have described?

3. What are some of the factors that may affect the physical, social and economic wellbeing of fistula victims other than skills empowerment, social empowerment and psychosocial support?

4. What independent comment can you give on male involvement as one of the factors affecting physical, social and economic wellbeing of women and girls affected by fistula?

5. What in your opinion should change/improve about TERREWODE's social re-integration intervention in order to improve on social and economic wellbeing of women and girls affected by Fistula?

6. Briefly comment on any Government service provision that is intended to complement TERREWODE's Social Re-integration Intervention efforts towards the physical, social and economic wellbeing of women of girls affected by Fistula.

TERREWODE volunteers

Current Designation/Location, Number of years of service as a Volunteer OFAAN Member…NO/YES, Gender, Survivor….NO/YES, Date, Time

1. What is your comment on the relationship between social re-integration and social economic wellbeing of women and girls affected by Fistula in Soroti district? Not forgetting to highlight on TERREWODE's unique OFAAN Strategy.
2. Why do you think the relationship is as you have described?
3. What are some of the factors that may affect the social and economic wellbeing of fistula victims other than psychosocial support, skill and social empowerment?
4. What independent comment can you give on male involvement as one of the factors affecting social and economic wellbeing of women and girls affected by fistula?
5. Give a comment on your field experience in terms of social networks/groups/relationships, respect at house hold level among relatives, self-esteem and house hold decision making. In other words, how do you assess the level of social wellbeing of the women and girls affected by Fistula?

6. What is your comment on economic wellbeing of the affected women and girls in terms of level of incomes, investment opportunities/startup capital, involvement in income generating activities (IGAS), diversified source of income and decision on expenditure, ownership of land and property?
7. (i) In your own opinion based on your field experience to date, what do you think can best be done to support the women better in order to improve on the level of their economic wellbeing?

   (ii) How in your own opinion, can social wellbeing of the women and girls affected by Fistula be improved?
8. In your opinion has field based training and psychosocial supports have anything to do with social and economic wellbeing of women and girls affected by Fistula?

   (Please explain)
9. Give a general comment on counseling methods and appropriateness of counseling. Any comment on how the applied counseling methods can be improved?
10. In your opinion, do trainees retain and apply knowledge and skills attained during and after training? (What shows).

    If not what could be the reason?

The end

Thank you very much

APPENDIX 3: Documentary checklist

Particulars of documents	**Themes/ information to have been collected**	**Comment**
Annual reports	-Performance of SR activities -Number of beneficiaries (Fistula Survivors) -SR areas of achievement & challenges -Status of the women supported -Funding level for fistula	Document availed for review
Field activity reports	-No of women reconnected with families & communities -No of women in to income generating activities -Success stories -Male involvement -Leadership by women -Challenges faced by beneficiaries	Document availed for review
Case Studies	-Success stories -Survivors well-being status -Challenges	Document availed
News articles	-Case studies -Success stories -TERREWODE's efforts -Policy issues -Challenges	Document availed
Training Manual	-Topics covered -Duration -Method of teaching -Relevance/Gaps	Document not availed
-National Obstetric Fistula Policy/Strategy -Obstetric Fistula Advocacy & Awareness (OFAAN) Strategy	-Social reintegration intervention -Well-being of fistula survivors -Funding to fistula care & management -Field based Social reintegration	Document availed

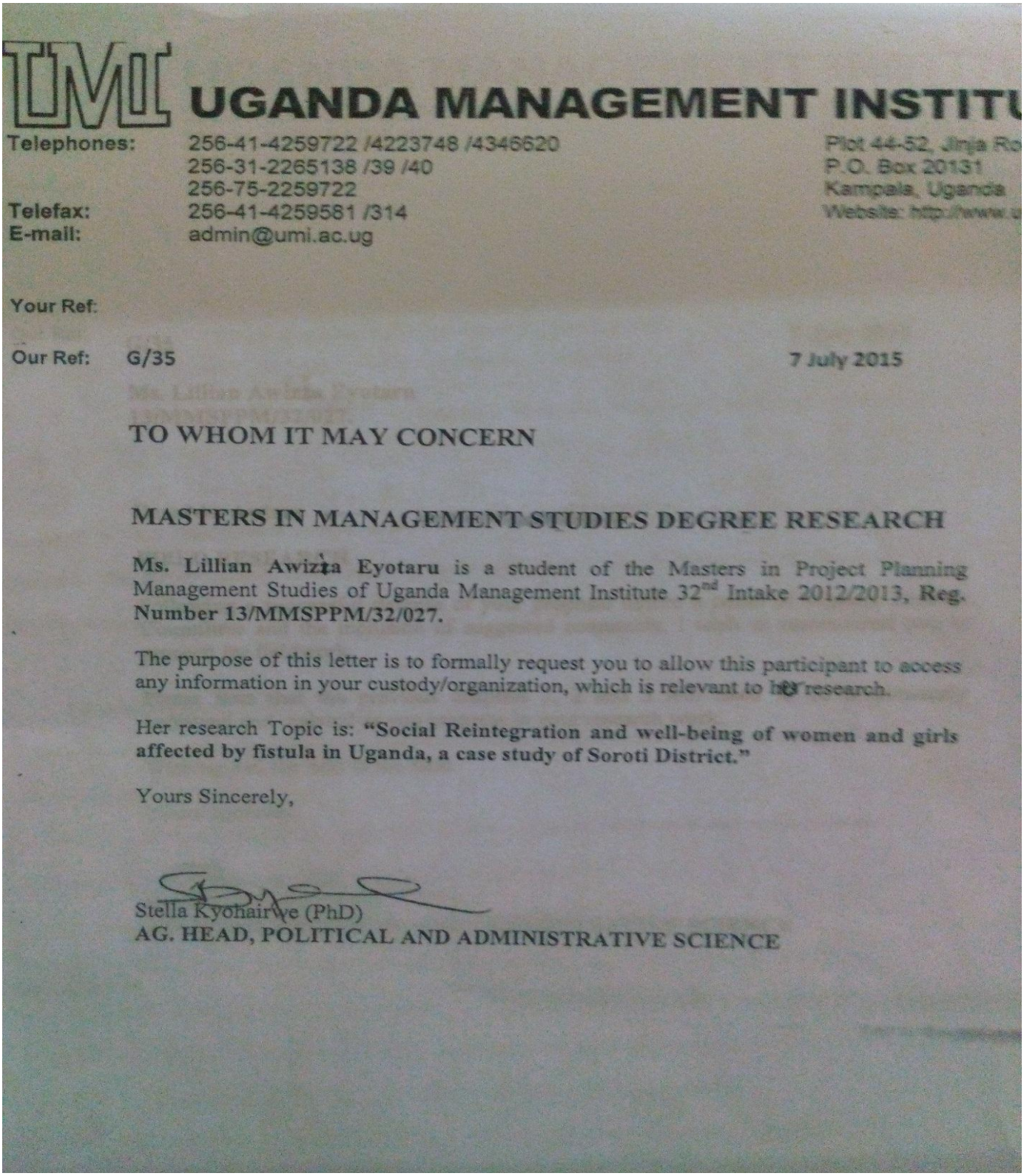
APPENDIX 4: Observation checklist

Activity observed	Duration	Comment
1. No of women socially reintegrated and own income generating activities	1 week	-
2. Duration & method of training, modules taught	1 week	-
3. No of women reintegrated and with no income generating activities	2 weeks	
4. No of Women happily re-united with families, able to take decisions at house hold level, own property & Land	2 weeks	-
5. No of women who still suffer stigma, isolation, rejection, & discrimination	1 week	-
6. No of women able to use family planning methods	1 week	-
7. Type of economic activities engaged in	1 week	-
8. General Socio-economic well-being of women & girls	2 weeks	-

APPENDIX 5: Work plan/Time table and Budget estimate

ACTIVITY	DURATION (DAYS/WEEKS/MONTHS)	DATE	BUDGET (SHS)
1. Proposal writing	3 months	February – May 2015	100,000= (Printing, Spiral binding &photocopying)
2. Proposal defense	1 day	June, 2015	N/A
3. Pretesting Instruments	2 days	8th-9th July, 2015	50,000=
4. Data collection	30 days	July – August,2015	1,650,000=(Transport cost, meals, accommodation, air time, internet cost)
5. Data Analysis	2 months	August-September, 2015	N/A
6. Report writing	2 months	September – October, 2015	300,000=(Editing, Printing, Binding)
7. Dissertation defense	1 DAY	Pending Approval	N/A

APPENDIX 6: Field Letter from UMI



UGANDA MANAGEMENT INSTITU

Telephones: 256-41-4259722 /4223748 /4346620
256-31-2265138 /39 /40
256-75-2259722
Telefax: 256-41-4259581 /314
E-mail: admin@umi.ac.ug

Plot 44-52, Jinja Ro
P.O. Box 20131
Kampala, Uganda
Website: http://www.u

Your Ref:

Our Ref: G/35

7 July 2015

TO WHOM IT MAY CONCERN

MASTERS IN MANAGEMENT STUDIES DEGREE RESEARCH

Ms. Lillian Awizia Eyotaru is a student of the Masters in Project Planning Management Studies of Uganda Management Institute 32nd Intake 2012/2013, **Reg. Number 13/MMSPPM/32/027.**

The purpose of this letter is to formally request you to allow this participant to access any information in your custody/organization, which is relevant to her research.

Her research Topic is: **"Social Reintegration and well-being of women and girls affected by fistula in Uganda, a case study of Soroti District."**

Yours Sincerely,

Stella Kyohairwe (PhD)
AG. HEAD, POLITICAL AND ADMINISTRATIVE SCIENCE

APPENDIX 7: Recommendation Letter from UMI to Researcher

UMI

UGANDA MANAGEMENT INSTIT

Telephones: 256-41-4259722 /4223748 /4346620
256-31-2265138 /39 /40
256-75-2259722
Telefax: 256-41-4259581 /314
E-mail: admin@umi.ac.ug

Plot 44-52, Jinja R
P.O. Box 20131
Kampala, Uganda
Website: http://www

Your Ref:

Our Ref: G/35

7 July 2015

Ms. Lillian Awizza Eyotaru
13/MMSPPM/32/027.

Dear Ms. Awizza

FIELD RESEARCH

Following a successful defense of your proposal before a panel of Masters Defense Committee and the inclusion of suggested comments, I wish to recommend you to proceed for fieldwork.

Please note that the previous chapters 1, 2 and 3 will need to be continuously improved and updated as you progress in your research work.

Wishing you the best in the field.

Yours sincerely,

Stella Kyohairwe (PhD)
AG. HEAD, POLITICAL AND ADMINISTRATIVE SCIENCE

APPENDIX 8: Researcher's Application Letter to TERREWODE

The Executive Director,

TERREWODE,

Central Avenue, Soroti municipality,

Plot 266 Buye,

P.O. Box 537,

SOROTI.

Dear Madam,

Ref: **PERMISSION TO CARRY OUT AN ACADEMIC RESEARCH IN YOUR ORGANIZATION.**

I am a student from Uganda Management Institute doing a Master's degree in Management Studies and majoring in Project Planning and Management. I would wish to carry out the above mentioned research in your organization on the topic, *Social Reintegration and Well-Being of Women and Girls Affected by Fistula in Uganda. A Case Study of TERREWODE in Soroti District.* I wish to make it very clear here that, this being purely an academic research, the findings will be treated confidential. I therefore request for your kind permission for a go ahead to proceed with research (data collection) as this research is very important to my academic future.

Thank you very much.

Eyotaru Lillian Awizia

RESEARCHER

APPENDIX 9: A Table for Determining Sample Size from a Given Population

Sample size(s) required for the given population size (N)

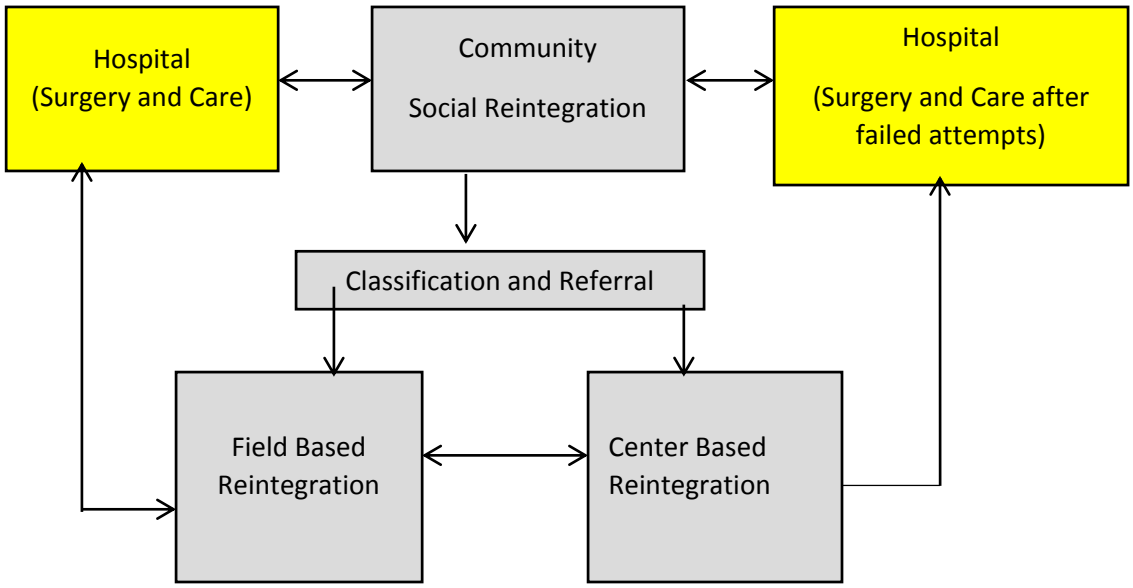
N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	181	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Source: Krejcie& Morgan (1970) tables, adapted from Amin (2005).

Key: N= Population S=Sample size

APPENDIX 10: TERREWODE's Social Reintegration Approach

TERREWODE's Social Reintegration Approach at Community Level



APPENDIX 11: Map of Uganda showing the exact location of the Case Study District (Soroti)

Map courtesy of US State Department website
(no copyright restrictions)

APPENDIX 12: Case study of a fistula survivor. She can smile today.

She can smile today but Agwang had it rough with fistula

BY CAROLINE ARIBA

There she was, coiled under a tree with a swarm of flies buzzing around her as though she were stale food. The air stung with nothing but urine, which had slowly traced its way through her skirt. She had barely had the day's meal and dared not seek it either. No one wanted to be associated with her; for they called her the 'village witch' or was it 'the cursed one!' But no, it was no sorcery, neither was it a curse; it was fistula! And this is the story of Alice Agwang; a woman who developed an obstetric fistula after three days of labour pains.

She told her story during a recent fistula surgical camp at Soroti Regional Referral Hospital organised by United Nation Population Fund (UNFPA). Now, the flies are gone, the stench is no more but all the same; it is her story! This tale can be traced back to early 2000 when the mother of two, who hails from Mukura sub-county in Ngora district, had to walk several kilometres from her village to a main hospital in Ngora.

AGWANG DISPLAYS SOME OF THE CRAFTS SHE HAS LEARNT TO MAKE AT THE REHABILITATION CENTRE

AGWANG NARRATES HER STORY FROM THE FISTULA SURGICAL CAMP AT SOROTI REGIONAL REFERRAL HOSPITAL

Problems begin

It was no easy labour, in fact, three days later, the baby was not yet born but the pain had intensified. When time came for the birth of her child, it was a still birth, even worse; one that left her damaged! No child, but with tears in her vagina. Experts call it obstetric fistula, just another condition mothers risk getting during child birth.

However, that was not the beginning, Agwang left hospital with not a clue of what had happened. A strange thing kept happening, her skirt would keep getting wet and yet she could not explain why. At first she brushed it off thinking that she was simply numb from the loss of her baby and decided to ignore thinking it would go away.

"But no, it did not. Oh my God, I was simply passing urine on myself like a little child!" Agwang recalls.

Embarrassed, she did not mention it to anyone, lest she got shunned like the woman who had a similar condition in her village. So, to keep anyone from knowing, she needed to simply avoid them, after all, the few that dared approach her, cast a nauseating look of her.

"So I would pretend to be doing something and embarrassing times.

But soon, her husband who had abstained from sex in order for her to heal from child birth, lost his patience and demanded for sex. It was only a matter of time before he learnt of the situation.

"It is the witchcraft from your home making you leak" her husband lamented.

A few weeks later, her husband had got another woman and she was pushed out of her spacious hut to a tiny one, secluded from the family's main compound.

"As if that was not bad enough, he told my children not to step in my compound because I am a witch!"

Her teeth hurt from eating raw mangoes and so she ventured out to find food. That was a bad idea. Ateso as she walked past their homes.

"I was not called Agwang anymore, my name was now Urine? And as the children shouted my name, their parents laughed," with these words, Agwang goes silent for a while. Yes, the pain was raw! Her brothers tried to visit whenever they could, to bring her some food but their wives did not want her in their compounds. Their excuse was that her condition was contagious!

But that did not hurt as much as watching her husband throw away ten years of marriage.

"One day I returned from the bush where I would look for my wild vegetables and found my children crying. When I tried to ask why, my co-wife asked if she was the one who told me to urinate on myself!"

sorts but she dared not do anything because she was deemed the cursed one who moved with urine and flies. Her only solace was the stolen moments with her children when neither her husband nor his new wife was there.

"I would just cry and beg them to forgive me."

A sigh of relief at last

One particular day as she sorted her wild vegetables, she had an announcement on the radio by a local organisation called, The Re-Orientation and Rehabilitation of Teso Women for Development (TERREWODE).

"It said that there were doctors coming to cure women who urinate on themselves. I am telling you, I nearly ran mad. I did not have a coin, but I was willing to walk for days to see those doctors and cry before them," she said with a glow in her eyes.

Luckily, it was a fistula surgical camp, and all the hospital costs had been taken care of by UNFPA.

"When I got there, I met women like me and through TERREWODE, we shared stories. After my operation, I was taught how to make and sell crafts, but above all, I now talk to fellow women and tell them not to worry," this was the first she smiled as she held up her crafts with pride. Today she is a member of TEREWODDE where she weaves a few items for a living. Her name is back to Agwang, not

APPENDIX 13: Newspaper article featuring women attempting suicide following fistula

INTERNATIONAL DAY TO END FISTULA
New Vision
ADVERTISER SUPPLEMENT

Obstetric fistula cases on the rise in Uganda

By Carol Ariba

An obstetric fistula according to the Ministry of Health, can be defined as an abnormal opening between the vagina and the bladder or rectum of a woman as a result of childbirth. This opening results into constant leakage of urine and or faeces through the vagina. In Uganda, the health ministry and partners recognise that obstetric fistula is indeed a problem. In the 2012 annual report, it is stated that 200,000 women are known victims of the condition.

UNDERSTANDING FISTULA

Peter Kivunike Mukasa, the technical specialist and advisor on Fistula Prevention and Management at the health ministry says most fistula cases are caused by childbirth lasting more than 24 hours.

"The pressure of the baby's head can injure the tissue in the birth canal creating a hole between the birth canal and the bladder or rectum," he says.

He further says that it is this hole in the birth canal that later causes continuous and uncontrollable leakage of urine, faeces and sometimes both. He also says that other obstetric causes include a destructive delivery which may be caused by instrument vaginal delivery and/or cesarean section delivery with or without hysterectomy which is the removal of the uterus.

A symphysiotomy, which is a surgical procedure carried out during a complicated delivery could cause uretero-vaginal fistula, he says. The less common non-obstetric causes of fistula according to Dr. Mukasa include trauma to the anal or vaginal areas which usually range from various conditions.

"Sexual violence, accidental trauma, female genital mutilation, infection like tuberculosis, HIV among many could also cause fistula," he says.

He further says that congenital abnormalities (those abnormalities people are born with), malignancy or advanced cervical cancer, latrogenic also known as mistakes made during surgery, radiotherapy, a procedure that is done on cancer patients, is sometimes damaging and could also cause fistula.

Dr. Daniel Ekwau of Mulago Hospital says almost all fistulae can be prevented if women have access to skilled maternity care during pregnancy and childbirth which is one of the most sensitive times. Couples, he says, should seek antenatal care at least four times during pregnancy to monitor the health of the women and the baby and identify any problems before they blow out of proportion.

"Plan ahead to give birth in a health facility with the help of a skilled health care provider, and the preparation includes setting aside funds and transport," he says. He believes this will come in handy in case there any complications that is mostly the cause of fistula.

He also parents should ensure that girl children have enough food and a nutritious diet that helps in the development of their bodies. Also, the girls should try as much as possible to avoid early pregnancy until at least after the age of 20, that way they lower the risk of getting fistula.

Sr. Mary Kaqoro of Kayunga Hospital leaves a fistula social support meeting at Kayunga district community hall with an elderly woman who recently benefited from fistula repair surgery. TERREWODE has supported 120 women in Kayunga to access fistula repair surgery since 2003. Photo by Catherine Mwesigwa Kizza

WHY FISTULA NUMBERS CONTINUE TO GROW

The United Nations Population Fund has linked the growing number of Fistula cases to the rise in teenage pregnancy.

"Statistics show that four out of every 10 girls aged between 15 and 19 are either pregnant with their first child or have already had a baby. Studies have also shown that girls in that age bracket face twice as much risk of obstetric fistula than their counterparts in their twenties," Esperance Fundira, UNFPA's country director spoke recently during the International Midwife's Day in Mityana.

As such, the organisation has also found that 1,900 new cases are still occurring in this country every year.

"Globally, the statistics of fistula stand at approximately 3.5 million with an estimation of about 50,000-100,000 new cases occurring annually, most of which are in Sub-Saharan Africa and Asia," Fundira said while speaking at a family planning stake holder's meeting last year in Imperial Royale hotel in Kampala.

For Helen Namaganda, a senior midwife at Soroti Regional Referral Hospital, the biggest challenge in the battle against Fistula is teenage pregnancy but also ignorance of the condition.

"The biggest fuel adder to this condition is that many fistula victims are ignorant of its presence and are silent victims of the embarrassing and heavily demeaning condition," Namaganda says.

"Some don't even know that they are facing that condition and with time they learn to accept it which society makes them believe is a punishment or curse for what they did," she says. But mostly, she says that these mothers give up when they learn of the cost of repairing a fistula which is about $300-$600, a sum that they can barely dream of affording.

In Uganda, the health ministry in their 2012 report on maternal health estimates that 2,000 repairs are done every year.

"This is a very small number compared to the 200,000 women that are battling the condition and is very worrying," Alice Emasu, a known fistula activist spoke during a fundraising dinner for the victims last year at the Imperial Royale hotel in Kampala.

Even for those that somehow stumble onto the money, they are faced with the next challenge which is where to have the procedure done. "They find that the procedure can't be done in the neighboring clinics and therefore have to travel long distances to repair centers for this," she says. For those centres where the repair is done for free, the women sometimes have to wait for weeks to get repaired due to many numbers, shortage of supplies and equipment among others.

To try and solve this, the Government of Uganda has partnered with Amref Health Africa in Uganda, UNFPA among other stakeholders. In general, a lot more has got to be done to prevent, treat and reintegrate women with fistula into the communities that have heavily shunned them, or deemed them outcasts.

WAY FORWARD

Amref Health Africa in Uganda's focal person on maternal health Patrick Kagurusi says that to deal with issues of Fistula, the country ought to deal with issues of fertility.

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Women talk about their experiences

Irene Mirembe, 24years old, got fistula while delivering her first child at the age of 20.

I wanted to commit suicide. I thought I was useless but a doctor told me I still had a purpose. I had no family or friends except the doctors and nurses. I spent eight months in hospital. Dr Mwanje had warned me in advance that he was not sure my fistula could be successfully repaired. So after my first surgery, I was still leaking. I was operated a second time by a visiting doctor. This operation was also not successful. I spent all my support money from doctor friends and TERREWODE on buying diapers. After my third operation, I got well. My family has failed to believe that my condition has been resolved. It is TERREWODE that is with me. I am done with men. All I want is to go back to school. If only I would get skills to teach girls and women to say no when they are not interested in sexual advances.

Fatuma Namubiru, got fistula while delivering her first child.

Despite it being my first pregnancy, I got no problem until delivery time. When labour came, they took me to a clinic. I spent three days there in labour. On the night of the third day, the midwife was still insisting that I could push. I asked her to let me go to a big hospital. She finally let me go but by the time I got to Kayunga hospital, I was almost unconscious. They took me to the theatre but told my family that I would probably not make it. I left the theatre after 12 hours. The doctor told me if I had been older, he would just have thrown away my uterus. It was totally torn. He had repaired it, but the labour left me leaking. Fortunately I had announcements calling for women with my conditions two weeks after leaving hospital. I went to Mulago hospital and was repaired. I am better though not yet completely healed

As told to Catherine Mwesigwa Kizza

APPENDIX 14: Case study of a fistula survivor featuring male involvement as SR component

be the bundle of joy, instead turned into the genesis of her troubles. Three days of labour pains at Dokolo health centre IV without birth signalled trouble.

"As the kicks of the baby in my womb died away, tension rose higher.

"When the medical personnel realised that the situation was getting out of hand, I was referred to Lira Hospital. At the hospital, the baby was pulled out but stayed alive for only three minutes before passing on," Nema narrates.

The difficult childbirth came along at a grisly price – the uncontrollable leakage of urine that flowed uncontrollably through her vagina (obstetric fistula). As a temporal measure, the medical personnel at the abnormal opening between the vagina and bladder or rectum of a woman that results in a constant leakage of urine or faeces through the vagina. About 200,000 women of reproductive age are suffering from fistula in Uganda, according to the 2011 Uganda National Demographic survey.

After a month leakage, doctors at Lira Hospital referred Nema to Mbale Hospital for corrective surgery to rectify the fistula. A housewife married to Private Tonny Ochero, a UPDF soldier who had been deployed on the AMISON mission in Somalia then, Nema's meagre finances could barely foot the cost of her transport from Dokolo to Mbale, let alone the cost of upkeep at the hospital.

Fate, however, smiled her way in July last year. A fistula camp organised by various surgeons in Soroti district, finally saw Nema operated upon and her fistula repaired. The return of her husband, Ochero, from the mission in Somalia in October, added to her joy. But this was short-lived.

"My husband started asking for sex. Doctors had advised that I abstain from sex for six months to allow the wound to heal. I had just completed two months. When I tried explain to my husband this, he blew a fuse and went wild accusing me of infidelity. He couldn't even believe my medical documents. That marked the end of our marriage," Nema says.

Photos by Daniel Edyegu

Rebecca Kadaga and the founder of the Association for Rehabilitation and re-orientation of Women Alice Emasu at a fundraising dinner at Imperial Royale

village in Ngora sub-county, Ngora district, didn't wait for things to get out of hand in the course of her recovery. After undergoing surgery to repair obstetric fistula during the fistula camp in Soroti last year, she ensured the doctor shared the matter with her husband, Samson Mallinga, on phone as he didn't escort her for surgery.

"I knew the medical form would not be convincing enough to ward off sexual advances from my husband in the course of recovery. So I requested the doctor to speak to my husband on phone before discharging me from the hospital. He understood and never made any sexual advances in the eight months of my recovery," Nyanjura narrates.

Expert's view

Husbands should accompany their wives for surgery

Florence Nema a former fistula

Alice Emasu, the executive director of The Association for Rehabilitation and Re-Orientation of Women for Development (TERREWODE), a national civil organisation agitating for treatment of women with fistula, says whereas there are no recorded statistics to indicate the magnitude of sexual abuse from men on their spouses during post-fistula recovery, the vice remains a major setback on the fistula campaign nonetheless.

"Because sex is sacred, many women who are sexually abused by their husbands under such conditions are cagy to discuss their plight in public. Often, husbands threaten their women with either divorce or getting another wife. So the woman succumbs to the threat and gives in to sex. They won't even realise that this is actually rape," Emasu explains.

She says as a remedy, they always ask the female spouse facing such sexual advances to come organisation for counselling.

Dr. Tom Otim, a senior consultant obstetrician and gynaecologist at Mbale Hospital explains that doctors always recommend for the patient who has undergone the fistula surgery to abstain from sex for three months. Otim explains that this is meant to allow for complete healing.

"The reason we recommend three months of no sex is that the closed fistula scar and wound incurred on the patient during the fistula surgery takes long to heal. Any rigorous sexual activity during this period is likely to make the fistula recur," Otim explains.

The main challenge in having male spouses comply with this medical recommendation, however, is that few men accompany their spouses for the fistula surgery, Otim says.

"The ideal situation is that after surgery, we counsel the couple so that the husband understands the from sexual intercourse during the three months of recovery. When they (husbands) know, they can restrain. But the reality is that that most women come for fistula surgery without their husbands," Otim observes.

He adds that whereas some women are lucky as to bear children after the fistula surgery, many fail to conceive thereafter.

"One of the factors is that after long obstructed labour, the baby may rapture (injure) the uterus (womb). So we have to remove it in the course of surgery. Besides, during obstructed labour, general infections could block the fallopian tubes. We have also learnt lately that the psychological torture after a fistula operation also impedes women from conceiving again. Because the woman is mentally tortured, her body fails to manufacture the eggs," Otim

Agnes Nyanjura a former fistula patient

treatment of husbands toward their female spouses after surgery has a