Author’s response to reviews

Title: A grounded theory of regaining normalcy and reintegration of women with obstetric fistula in Kenya.

Authors:
Anne Khisa (annekhisa@gmail.com)
Isaac Nyamongo (inyamongo@uonbi.ac.ke)
Grace Omoni (omonigrace@hotmail.com)
Rachel Spitzer (rfspitzer@sympatico.ca)

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Author’s response to reviews:

Reviewer Reports/ Comments

Comment: A grounded theory of regaining normalcy and reintegration of women with obstetric fistula in Kenya. This article aims to gain knowledge on reintegration process of former fistula patients. This knowledge is essential for the development of programs supporting women with treated obstetric fistula in communities. It also highlights the importance to customize these programs to women's specific needs, in particular in case of deemed incurable residual incontinence.

Response/ how we addressed specific comments

We appreciate the reviewers comment on the importance of the article; and have addressed specific comments in each section detailed below.

Reviewer reports:
Thank you for submitting your revised manuscript. This is a strong draft, but still requires substantial revisions. In particular, please revisit the reviewers comments from the previous round of review -- several substantive comments around methods and interpretation of results seem to have been overlooked. In your next response, please be sure to include in your cover letter a brief line-by-line response to each of the comments to make it clear how you have revised the manuscript to address them.

In addition, below I have provided some additional suggestions for how you may be able to shorten/tighten the manuscript to reduce overall word count, and open more space for you to directly
address reviewer comments.

Response; We have revisited the reviewers’ comments from the previous round of review, and tabulate each change made on the manuscript below. We have specifically also addressed the comments on methods and interpretation of results. Below is a line-by-line response to each comment.

P 2, line 14 – always or often? Might want to couch this as “Fistula illness often introduces…” Sentence has been changed to “Fistula illness often introduces crisis in women’s life.” Pg 2 line 14

p.2, line 25-28: This sentence is awkwardly worded and hard to follow. Please revise. The sentence is changed to “The purpose of this study was to explore experiences of women immersing back into communities and their return to normalcy after surgery in three VVF repair centers in Kenya.” P2 line 25-28

Introduction is quite lengthy. While much of this information is important, the level of detail is a bit overwhelming. I think it may be helpful to start with the objectives of your study and think through what information is necessary for a general reproductive health audience to be able to understand why your study is important and addressing a gap in the literature. We don’t need to know the entire state of the literature, but just enough to trust that you are well-situated and knowledgeable, and to be able to critically engage with the new findings you present.

The introduction has been shortened further.

Methods
Recruitment: Please address Reviewer 1 comment on number of women recruited, versus enrolled, dropped out, etc.

There were few women who declined to participate in second phase, namely…..

However, it is important to clarify that we did not have participants drop out of the study per se, since we used purposive sampling and stopped seeking participants once we reached data and thematic saturation. We are therefore not able to comment on whether a lot more women would have declined had we continued with the study. Notably, our participants remained available to discuss their health even at 19 months after surgery.

We did not experience any follow up activity jeopardizing the reintegration process, perhaps because we took ethical measures of informed consent and protection of study participants.

Pg8

Line 14-21
Please combine “Grounded theory methodology” and “Data analysis & Development of the theory” into a single sub-section (“Analysis”).

Once you do that I think you can streamline some of the explanation (e.g., the paragraph p 10 lines 32-52 provides an excellent overview of your process and should make up the bulk of the analysis section. You can add a few sentences on positionality, how data collection was unlinked from clinical visits, monetary costs, but do not need the level of detail provided here. As the reviewers note, these methods are generally understood by other practitioners, and some of the ways you have explained in your description are a bit confusing – less is more in this case.
Section merged and shortened further into 2 paragraphs
P 10, lines 20-30: This section about the campaign should move up to the section on sampling/characterizing the patient population.
Section moved to section named sampling
p. 21: I do think it is worth providing a brief explanation of these seven categories, as some of them may seem to overlap on first read. Perhaps rather than a narrative description, a table with bulleted items that characterize this category would be a useful way to keep this concise. See Table 1 in this article for a nice example of how this can be employed:
https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001847
A brief explanation of the categories is provided in Table 2
Pg.
The Continuum of Reintegration section seems like it could be easily incorporated into the Reintegration Process section.
The two sections have been merged under one section ‘Reintegration process, and continuum of outcomes’
p. 23 – I think you can be more concise here in giving the justification for your theory, as much is covered earlier in the manuscript.
Page 23 on towards a grand theory of regaining normalcy: theoretical tenets’ section summarized in 1 paragraph and figure.
Figures 1 & 2: In alignment with the previous reviewers, I would suggest revisiting the two figures. The schematics are quite basic, and do not clearly communicate what you are trying to get across. For example, in Figure 1, both enablers and disablers are visually elevating the entire continuum. However, it seems that your argument is that the enablers and disablers may be pushing women in one direction or another on the continuum. The conceptual model proposed by Lu and Halfon in 2003 in their work describing the life-course perspective might give you some ideas for how to more effectively engage the visual elements in these figures. If you can’t access the whole paper due to the paywall, you can find the figure quite easily through a Google image search.
Figures 1 and Figure 2 revised and merged into figure 1

Discussion
Please note Reviewer 1 push-back on the use of the word “paucity.” Perhaps it is more appropriate to characterize this literature as somewhat limited in scope.
The reviewer reservations on the idea of ‘paucity of studies’. We gratefully accept the suggested alternative that refers to “the existing literature on reintegration of fistula patients as limited in scope”. This later sentence also best describes our intended meaning of the sentence.
Page 6 line 25-25
More generally, you can tighten here by commenting on how your findings fit into the literature as a whole, rather than compare/contrast with each study individually. This will help reduce word count, and will be clearer for the reader in trying to interpret how the present findings contribute to the field.
Policy implications – this section seems to come out of left field. This is the first time you talk about policy, funding streams, etc. and I’m not sure that the manuscript currently presents a compelling argument for a “revolutionary shift in care and financing” as you have done little to describe existing programs that either meet or fail to meet women’s needs re: reintegration. This seems like an overreach and I would suggest cutting, particularly given that the prevalence of the issue is relatively low as compared to the other maternal health issues you mention that receive greater funding and attention and you have not made a case for diverting funds from those priorities to this one.
We agree with the reviewer’s position that not sufficient evidence and background has been provided in previous sections to suggest the policy and finance recommendations. We therefore have
Reviewer 1 Comments
    Response/ how we addressed specific comments
    Page number

Reviewer #1: A grounded theory of regaining normalcy and reintegration of women with obstetric fistula in Kenya.

This article aims to gain knowledge on reintegration process of former fistula patients. This knowledge is essential for the development of programs supporting women with treated obstetric fistula in communities. It also highlights the importance to customize these programs to women's specific needs, in particular in case of deemed incurable residual incontinence.

We appreciate the reviewers comment on the importance of the article; and have addressed specific comments in each section detailed below.

The grounded theory methodology is ambitious. The long field work and the quality of the resulting data should be emphasized.

However, the epistemological positioning is unclear. Likewise, analysis and discussion would benefit from deepening. The authors have the merit of presenting a first theory/model of the reintegration process after fistula treatment, but the model is oversimplified and purely linear. Emphasis of the rigor and quality of data is made in the methods section.

In addition, we present a more complex theory/model of the reintegration of fistula treatment. We have strived to avoid oversimplifying the model, but also kept the information in a meaningful form and that which communicates better to readers. We hope that this figure is now at an acceptable level of complexity, and that they will be published along with the article.

Page 11

Figure 1 (annex page)

Abstract
- Some results announced in the abstract are not develop further in the article: Moral challenges? Informal health care? (p2)

    This sentence has been moved to the background section of the abstract which is the most appropriate section.

“Fistula illness introduces a crisis in women’s life begetting feelings of shame and serious disruption to their social, psychological, physical and economic lives, in addition to dealing with moral and hygiene challenges.”  Page 2
We use qualitative research to generate a theory that explains the strategies that can improve the process of healing... (p3). The generated theory explains the process of reintegration. The proposed strategies are hypotheses emerging from the reintegration theory; they are not explained by the theory. This correction has been made on page 4, to give more clarity.

'We used qualitative research to generate a theory that explains the process of reintegration for fistula patients after surgery. We propose strategies that can improve the reintegration process, which are hypotheses emerging from the reintegration theory.'

Page 4

Introduction

- Mention of Sub-Saharan prevalence of OF to allow comparison with the Kenyan one. Prevalence of obstetric fistula in Sub-Saharan Africa is provided; additional reference added. This changes the order of the numbered references.

Page 4

- Obstetric fistula (OF) as a chronic illness? Some could argue that obstetric fistula is a trauma with chronic consequences, others that 'fistula illness' ends with the regain of continence. The characterization of fistula as a chronic illness should be argued; in particular to justify the needs for reintegration. See Maulet 2015 and Hanning 2014.

The characterization of obstetric fistula is argued, in more detail, providing three references. We thank the reviewers for the two reference suggestions which have enriched or work.

Page 5-6

Terms like 'healed fistula patient' and 'treated patient' need to be clarified. Many aspects of healing stated in the introduction have been studied. See Yeakey, Weston, Wilson and Zeleke.

The term 'healed fistula patient' was used to mean 'continent and devoid of other physical symptoms'. This phrase is thus used in the revised manuscript for clarity. Page 15

Later on, reintegration is referred to as 'treatment outcome' (p19)

'Reintegration outcome' is the intended phrase and meaning of our manuscript. This phrase has been changed, replacing 'treatment outcome'.

Whilst surgical treatment is part of the reintegration process, and often starts off the reintegration process for fistula patients, it is not the only focus of our study. Rather, we have presented the entire process of reintegration, citing four possible reintegration outcomes and factors that impede or improve this process.

Page 19

- A very critical study of OF care philosophical underpinning was recently published by anthropologists Hanning and Heller. (p6)

Our discussion includes:

Whilst Heller and Hannig (2017) study is quite important in challenging the popular image of a fistula patient as one who is an outcast and a social pariah, it does not suggest how such patients should be helped to navigate the reintegration process after surgery, or if at all for these patients, reintegration is necessary. The authors did not comment on the fate of patients after fistula surgery.'

Page 26

- Research question formulation (p5): needs of fistula patients or former patients in Kenya? Do women still consider themselves as patients once back in their communities?

Clarification is made as to why we refer our study participants as fistula patients thus:
Here, we use the term patients because our study participants had undergone surgery, and upon discharge, we expect the healing process to continue, as well as the care process for physical, psychological and socio economic needs. Indeed, women are expected to return to fistula repair clinics six weeks after discharge for a follow up visit, and a series of other visits thereafter, depending on the findings. Fistula care is therefore not only within the admission period in hospital but in the subsequent period. It is however not clear whether women still perceive themselves as patients after surgical operations and discharge, and although this line of questioning would be an interesting find, it was beyond the scope of this study.

Page 5, 6

Methodology
- Recruitment (p7) A tree chart or timeline might be helpful to synthesize recruitment process and data collection process.
Total of patients contacted, total of patients initially accepting, total of patients refusing or dropping out after initial agreement or after a period of time. This information could contribute to research ethics and reintegration strategy: how long should one follow up former fistula patients without jeopardizing their reintegration process Whilst this suggested tree chart would be useful, we did not keep record of women who declined to participate in second phase, instances which were few. However, it is important to clarify that we did not have participants drop out per se, since we stopped seeking participants once we reached data and thematic saturation, and are therefore not able to comment on whether a lot more women would have declined had we continued with the study. Notably, our participants remained available to discuss their health even at 19 months after surgery.

We did not experience any follow up activity jeopardizing the reintegration process, perhaps because we took ethical measures of informed consent and protection of study participants.

- Most participants had visited the hospital several times … (p7, line 42). Clarify if they visited hospital providing fistula surgery or other hospital/health center before being referred. It probably does influence their journey, hence their experience.

Clarification:
As stated earlier on page there is an entire paper that published the health seeking behavior and treatment pathways of fistula patients in detail. (Khisa et al, 2017)

However to make the sentence more clear, it has been rewritten thus:

‘Most participants (96.6%) had visited the hospital or health centre several times before obtaining corrective surgery, either as referrals or first time clients in the fistula centre; and a further 40.7% had obtained multiple surgeries for the ailment, both facts that signify a long and arduous journey to obtaining treatment for their illness.’

Page 7

- Information on the research team (p8) could be included in the paragraph on positionality (p9). Research team profile (nurse, social science student, others) and previous contact with participants should be clarified as it might influence results (trust factor): did the researchers met with participants at fistula hospital? Did the same researchers met with participants at 6 and 19 months?
Research team is referred to as a ‘visiting health research team’ (p10), was medical staff part of the research team, was data collection for this study organized together with medical follow-up of former patients?

Information on the research team is provided on page 10
There was no medical team or follow up visit organized alongside the visits by research team to interview the participants, for all 60 participants.

Page 10

- Explain what where the cost of participating in research. What costs are you referring to? Social costs for participants? Costs of the research?

Page 10 clarification made:
The participants did not bear any monetary cost to participate in this study, since we visited them in their residence for the interviews.

Page 10

Grounded theory methodology (p8)
The grounded theory methodology is well known and keeping theoretical explanation simple is sometimes best. The justification of the grounded theory methodology is unclear and some theoretical terms are unnecessary and/or confusing.

From writing experience, reviewers have always asked for a sufficient description of what grounded theory methodology is. Given our wide public and population health readership audience who may not necessarily be qualitative researchers, we would like to keep this succinct methodological description for easier reading.

Page 8

The ontological positioning (what is the reality) seems to be confused with the epistemological one (How to get to know the reality).

The grounded theory usually comes under a constructivist epistemology. Studies inspired by realist epistemology tend to focus on interactions, mechanisms and context which is not the case of the reviewed article.

Indeed, even if context influence is mentioned several times throughout the paper, no information on the micro nor macro contexts is provided. Urban or rural communities, community specificities, family specific position within the community? Ongoing information campaign on fistula in Kenya at time of the study that could have influence fistula returnee perception?

We used Corbin and Strauss steps in Grounded Theory which is totally different from the steps suggested by Cathy Charmaz, who advances a constructivist grounded theory approach.

We however wish to draw our reviewers attention to the Glaserian argument that classical grounded theory is not necessarily constructivist; and that ‘all is data’ in classic grounded theory. We however feel this methodological debate should not necessarily be included in our article, since our focus was on emergent theory and not the merits and demerits of the three traditions of grounded theory as advanced by 1) Barney Glaser 2) Corbin and Strauss 3) Charmaz. We have offered a sufficient description of Corbin and Strauss which we applied.

Our study has been anchored on critical realism worldview to the way knowledge is acquired. This is stated on page 9

All data presented has provided a form of contextual description in terms of the situation in which each fistula narrative is presented. The limited space and nature of journal article may have restricted how much contextual information was included. We now provide general contextual information in the first paragraph, however it is not feasible to provide the context of all 60 individual participants, unless by supplementary material. We seek the editors guidance on this matter.
Data analysis

'We defined reintegration…' is in contradiction with the statement of adopting patients’ perspectives (etic vs emic definition of reintegration).

Regaining normalcy is sometimes presented as a synonymous of reintegration and sometimes as an outcome of reintegration?
A more detailed definition of what regaining normalcy means for patient could be provided to clarify this point.

What is the central category that holds the proposed theoretical model together? Is it the reintegration process or the dependence for sustenance?

Correction:
This sentence has been changed to ‘Grounded in this data, we describe reintegration as ‘a state in which the obstetric fistula patient regains optimal physical, psychological and social wellbeing and ‘normalcy’ akin to that of before fistula illness’

“In our findings, regaining normalcy is a phrase that best describes the participant’s description of the process of reintegration. It is as though, with the fistula illness, an anomaly, a disorder had occurred to them. Part of their journey after surgery is then spent in seeking that in their life that was normal, before the illness disrupted their lives. We therefore use the term regaining normalcy synonymously with reintegration. The central category that holds our proposed theoretical model together is the reintegration and regaining normalcy process”.

Results
- Explanation of the three phases in women's journey and overlapping of these 3 phases in participants narratives is important. Has it influenced the analysis, it could be more appropriate in the methods section.

This explanation has been retained at the opening of the results section because the model presented in figure 2 entails the three overlapping phases. It is thus helpful to the reader to be mindful of these three overlapping phases being presented in the diagram in the results section.

- Results present a typology of reintegration. This typology is a result of authors analysis, not an outcome of reintegration process itself.

Clarification made on:
We argue that the varied typologies of reintegration outcomes are a result of the reintegration process; reintegration in our view is both a process and a desirable outcome for fistula patients.

- Reintegration typology is illustrated by typical profile of participants. Have untypical profile been taken into account? The typology could be refined by presenting some untypical profiles or narratives. Analyse of untypical cases is part of the grounded theory methodology.

Clarification:
Our analysis took into consideration the untypical narratives of fistula patients in line with grounded theory methodologies. Indeed, the participant characteristics in table 2 present a very wide range of participant characteristics, namely age, first or subsequent pregnancies, no of surviving children, total no of fistula repair surgeries, time in years lived with fistula surgery and the whether the woman had a home or institutional and skilled delivery during the labour that caused fistula illness. Further, we present untypical outcomes of reintegration such as new integration, which is not mentioned in the literature before.
- Reintegration status seems to match with incontinence status: fully reintegrated participants are continent, partly reintegrated participants have some improvement in their continence and not reintegrated participants still suffer from incontinence. Incontinence status of newly integrated participants is lacking in the article. Was any fully reintegrated participant suffering from residual incontinence, was any partially reintegrated participant continent? The relative importance of continence status should be emphasized within the model. Continence unsurprisingly appears as a (the) main enabling factor of reintegration.

Clarification added for emphasis:

‘Our study reported verbatim the women’s experiences of reintegration, without performing physical examination to determine the continence status of women. Our model does not refute nor emphasize the place of continence in reintegration; there were partially reintegrated women who were continent and others partly continent. However, both complained about a disabling factor to reintegration, such as having issues with fertility and therefore did not consider themselves fully reintegrated nor living normal life as before fistula illness. Factors beyond continence, namely fertility, divorce and separations, poverty and dependence on others for sustenance and failing to perform gender roles were some of the disabling factors.’

- As stated by authors, reintegration is a process. Time data or narratives highlighting evolution of the reintegration within a time period is lacking (except for partly reintegrated). Likewise, influence of participants past experience (number of years with fistula, number of surgery) on their reintegration process is minimal.

- First verbatim (p13) shows that this participant is not thinking of her reintegration, she is still considering herself as a patient, still in search of treatment. Reintegration seems to be a secondary issue to her. Should this participant be considered as partially reintegrated or is it another type of participant for whom reintegration is 'on hold'? Could one hypothesise that reintegration might come later when she will be treated or will have to cope with a permanent condition of residual incontinence and associated comorbidities.

We acknowledge the reviewers comment and acknowledge our study’s limitation in addressing this important question.

Clarification added for emphasis:

‘Basing on our data, and as confirmed by the reviewer, there was a progression to better states or to worse states of reintegration especially for partly reintegrated. Our data was however not sufficient to test the influence of a participants past experiences in time lived with illness and other factors on their reintegration. Whilst we acknowledge the limited scope of our study, we highly recommend that this could be studied further to enrich our understanding of the influence of the illness experience on reintegration outcomes.’

- Enablers and disablers are just opposite factors (continence/incontinence, married/divorced). They are of different nature: some are linked to individual health, other are the result of interactions with family or community and others are linked to context.

- The focus on dependence for sustenance highlights their interactions. Moreover, they are presented as static: enablers interact with one another (causal loops) and enablers could become disablers in some situation/context (e.g: divorce could be considered as an enabler to a new integration.

We appreciate this comment of the reviewer in interpreting our findings. We however are of the view that the model presented shows interactions between enablers and disablers, and that they are not just opposites of each other. An example of description of ‘dependence for sustenance’ offered on page
Page 21

- Figure modeling the reintegration process is very basic. We present a basic figure that most accurately captures our study findings and is grounded in the data. Whilst there are complexities in each woman’s narrative, grounded theory methodology helped us develop a model that fits, and embodies the complete range of experiences of reintegration for women after surgery for obstetric fistula. Figure 1

Figure 2

Discussion

- There is a growing interest in post repair condition of fistula patient. So, I am not so sure one can still argue that there is a paucity of data on this subject today.
- Results of this study could be compared with the paper of Donnelly 2014 that also suggests strategies to improve quality of life post-repair.
- Sexual and reproductive health post-repair is often mentioned as a criteria to reduce stigma and smooth reintegration process (Donelly 2014, Delamou 2017)

We acknowledged the growing interest in post repair condition of fistula patients by the cited authors, and have already referenced the work of Delamou (2017) and Donelly (2014) in the introduction section. We, in the revised manuscript, compare our findings with these two authors

However, only one study in Uganda has set out to focus on the complete realm of reintegration outcomes, thus we conclude that there is a paucity of data on what a reintegration model would look like for fistula patients.

Introduction pages 5, 6

Discussion page 21

Transferability of the model is an assumption.

Clarification:

The results of our study, being qualitative, are transferable to women with obstetric fistula in similar contexts in Kenya.

This is not an assumption but rather a methodological strength in qualitative research.

We have in the same paragraph suggested that for the model to be generalizable, it would need to be tested in further (quantitative) research

Page 23

FORM

Some details are specific to Kenyan context and unfamiliar to international readers

- 30 counties on how many in Kenya? (p.7)
- What are ’chamas’? (p12)
- Subsaharian prevalence of OF compare to Kenyan prevalence?
- clarification made; 30 of 47 counties in Kenya
- meaning of ‘Chamas’ provided in square brackets on page 14
- Prevalence of obstetric fistula in Sub-Saharan Africa has been provided
Discrepancies throughout the text:
- 121 participants in plain summary p3?
- Narratives at 6 and 12 (p9) or 19 (p2) months?

Corrections made:
- 60 participants
- Narratives at 6 and 12 to 19 months

Page 9
Repetitions
- Characteristic of study participants is presented… The characteristics of participants whose results are presented (p7)

- The transcripts were imported and managed in Nvivo (p8)... transcripts were then imported… (p10)

- Three steps of data analysis …(p9 & p10)

Repetitions removed:
- Deleted ‘The characteristics of participants whose results are presented are summarised in the Table 1 below:’
- Deleted ‘The transcripts were imported and managed in Nvivo (p8)... transcripts were then imported’

Reviewer 2 Comments

Abstract
Page 2/Line 18: The objective paragraph presents three different points:

- explore experiences of women immersing back into communities…
- contribute to theory in the substantive area of fistula care
- answer the question: what strategies improve obstetric fistula patients' social reintegration

In the current state of the abstract, it is a bite confusing. For consistency and clarity, the objective of the doctoral research "contribute to theory in the substantive area of fistula care" can be removed.

Removed:
‘the objective of the doctoral research
"contribute to theory in the substantive area of fistula care"

Page 2
Page2/Line 25: You may not need to mention that this is a doctoral research.
Conclusion: Which kind of implications for current practice? Can you be a bit more specific?

Sentence mentioning doctoral research has been removed.

Page 2

Introduction
This chapter will gain in clarity if the authors structure it better, by grouping all the sentences where they formulate the objectives of the paper.

Page 7/Line 9: You can keep "60" only and remove "sixty"

The chapter has been re-organised.

Word ‘sixty’ has been deleted

Page 8

Page 9/Line 20: Authors mentioned that "conducting narratives at six and 12 months post discharge allowed for repeated measurement and comparison". Can they provide further explanation of what was measured? Or maybe is "measurement" the most appropriate concept to use here?

Whilst the term ‘repeated measurement’ is used in grounded theory methodology, we acknowledge that it may be confusing to readers. We have replaced it with “Conducting narratives at six and after twelve months post discharge allowed for several opportunities to hear the participant’s story as it unfolds and to compare events within the same participant’s story. This technique, referred to as repeated measurement in grounded theory methodology, produced rich and nuanced data for our study.” Page 10

Page 8/Ethics
You may move the Ethics paragraph to the end of the Methods section

The ethics paragraph has been moved to the end of methods section

Page 13

Page 9/Line 33: Write on "its own biases" rather than "on their own biases"?

Sentence rewritten for clarity:

‘Conducting qualitative research requires the researcher to reflect on their personal biases and assumptions as they approached the study.’

Page 10

Page 9/Line 35 to 46: Those two assumptions are interesting but should be better and accurately reported. You should also better describe how they were formulated.

For the second one especially: how did you conducted thee exploratory study? Is it a separate study? or is the data collected from those eight women an integral part of the current study?

We now offer a better description of the personal assumptions we had before the study. These are simply the beliefs we held going into the study, and had no particular method of formulation. It is a methodological requirement to declare our assumptions before going into the study.

The exploratory study reported was different from this study. The section has been rewritten to Page 11

Page 9/Line 10 to 15: You may move these phrases related to the data analysis into the Data Analysis and theory development paragraphs on page 10.

The data analysis and development of theory section has been moved next to grounded theory methodology, for better readability
Page 9&10: You present several aspects that showed the power imbalance; You mentioned that some
women were in position
to negotiate their stance. Beyond the neutral dressing, do you use any other element to minimize the
power imbalance?
We posed as ‘student researchers’, explaining that we wanted to learn from our participants
about the illness, a phenomenon we report as naïve positionality in page 13 and Page 13, 14

Page 10/Line 38: Do you have any reference for this definition? Fistula itself may be favoured by a set
of poor existing
conditions - physical (for instance a foeto-pelvic disproportion) or socio-economic (for instance
"extreme" poverty). Does normalcy means for you a recovery to those existing poor existing conditions
or a recovery to a state that is better than the one set by the preexisting conditions? Does a recovery to
normalcy protect against recurrences of fistula for instance?
We have rewritten this paragraph, also in response to reviewer 1.

The clarification here is that our descriptions of reintegration and new integration are grounded in the
data, which is the emic perspective, as from the voice and perception of the participants. Page 12

Results
Page 11/Line 11 to 25: This is not part of the results. You have mentioned those points in the
background and it is redundant
to repeat it again here.
Clarification:
We retain these lines in the results section because they are introducing the reintegration framework,
figure 2, which contains all the three thematic phases in women’s narratives. Removing them will leave
the framework without description, and leave the reader hanging and open to their own interpretation.

Page 15 paragraph 2
Page 11: Since the study is qualitative and the sampling fully purposive, is it appropriate to report the
percentages? What do they mean?
Clarification:
‘The percentages and proportions presented describe the characteristics of women whose narratives we
have presented. They are appropriate and serve a descriptive purpose only, given that the sample was
fully purposive. They should not be used for statistical inference.’ Page 8

What do "normalcy" means for participants of the study? How do they defined the ideal state expected
after recovery? What are the consistent expectations? are their any kind of priority order in those
expectations?
A definition of reintegration and regaining normalcy is provided on page 12

Page 12
Page 12/Line 55: What does the participant ID reporting add to the content of the paper? I suggest you
remove it.
The participant ID was used in place of the participant’s name, to ensure that their real identity
is not disclosed nor published, in following the consent information. The style of writing has remained
close to data of real persons and their contexts and this ID serves that purpose.

Page 12-14
Page 6: "Being continent" is included in the definition of the reintegration scenarios. Is it an enabling
factor of reintegration or is it part of the reintegration scenario itself? The same concern apply to the
other factors. Can you clarify?

Further did you consider the enabling or disabling influence of factors like the education, economic status, preexisting health status of the woman, the supportive nature of the family, the age of the woman, the reproductive history etc. on the reintegration scenario?

Being continent is an enabling factor to reintegration, as the other factors included in the ‘enablers’ circle.

We considered all factors that emerged from the data, as narrated by the women, in Grounded theory fashion. All these factors are what we have reported in our write-up. Whilst some of the factors raised by the reviewer here, like supportive nature of family, emerged and were included in the framework. Others like preexisting health status were not mentioned by the women, and thus have not been included.

Figure 1
Page 17/Line 22: Why did you exclude the "dependence for sustenance" from the definition of reintegration and develop a separate paragraph for it?

Clarification: Due to space limitations we weren’t able to fully describe each enabling or disabling factor to reintegration, only presenting this particular example. Dependence for sustenance is a category that emerged in the analysis of women’s narratives of the reintegration process, representing the helplessness women feel in the immediate period after surgery. It is a part of the reintegration model, as a key disabling factor to reintegration. The section has been reorganized to highlight this example.

A new section header: continuum of reintegration is typed in to make easier readability and flow of the section.

Page 19
Overall comment: The whole text should be edited to remove repeated ideas, for clarity and concision.
- Repeated lines deleted
- Text has been edited, throughout the article, for better clarity and concision
- References numbers have been changed to reflect the new citations, and reordering of sections

All pages