Reviewer’s report

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

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Reviewer: Nathalie Maulet

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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.

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.

CONTENT

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

Introduction
- Mention of Sub-Saharan prevalence of OF to allow comparison with the Kenyan one.
- 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.
- 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. Later on, reintegration is referred to as 'treatment outcome'(p19)
- A very critical study of OF care philosophical underpinning was recently published by anthropologists Hanning and Heller. (p6)
- 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?

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.
- Most participants had visited the hospital several times … (p7, line 42). Clarify if they visited hospital providing fistula surgery or other hospital/health centre before being referred. It probably does influence their journey, hence their experience.
- 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?
- Explain what where the cost of participating in research. What costs are you referring to? Social costs for participants? Costs of the research?
- 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. 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? On going information campaign on fistula in Kenya at time of the study that could have influence fistula returnee perception?
- Data analysis
'Ve 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?

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

- 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 partialy 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.

- 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 come later when she will be treated or will have to cope with a permanent condition of residual incontinence and associated comorbidities.

- 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.

- Figure modelizing the reintegration process is very basic.

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)

- Transferability of the model is an assumption.

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?

Discrepancies throughout the text:

- 121 participants in plain summary p3?
- Narratives at 6 and 12 (p9) or 19 (p2) months?
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)

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