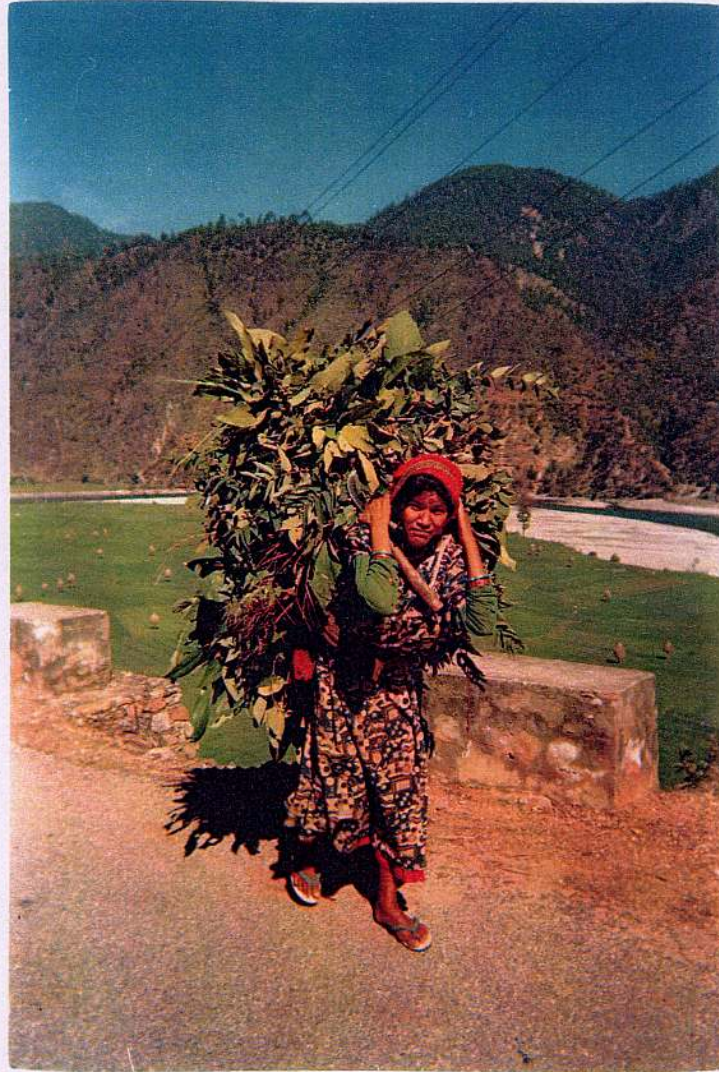


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An Ethnographic Approach to Understanding Prolapsed Uterus in Western Nepal



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Submitted in Partial Fulfillment of the
Requirements for the Degree of
Nursing Doctorate (N.D.)
University of Colorado Health Sciences Center
May 2000



DEDICATION

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"My grandmother had prolapse and she only gave birth to one child, a girl. The prolapse came six months after her only delivery. After the delivery, she slept in a shed outside of the house and she only ate rice and salt at that time, as was the custom. She stayed like that for 12 days, alone with the baby. After the prolapse, she put herbs in a cloth and inserted it inside herself using oil. It was difficult for my grandmother to fetch water and she never got rest. That's why she got it. Husbands should support their wives more."



Dedicated to the women of Nepal: May their voices be heard.



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Last but certainly not least, I thank my husband, Paolo Mario Bonetti. His encouragement and support is a constant buttress to the many spheres of my life, without which I would surely despair. Thank you with all of my heart.

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EXECUTIVE SUMMARY

Background & Rationale

An estimated 300 million women worldwide suffer from pregnancy-related healthcare complications (WHO, 1998). Pelvic organ prolapse (POP), a growing reproductive health concern, results from a lack of support within the pelvic cavity to maintain proper positioning of the pelvic organs. It has been widely acknowledged that women in developing countries suffer a higher incidence of POP than their counterparts in the developed world. Probable causes include early childbearing, multiparity, unsupervised labor and delivery, short spacing between births, remaining in a squatting position during long working hours and inadequate rest postpartum. In Nepal, significant research has been conducted on maternal mortality; however in-depth studies on maternal morbidity have yet to materialize. Treatment and prevention of POP is currently on the agenda of most health development programs, however no studies have examined the qualitative experience of POP among women suffering from the disease. Morbidities such as POP impact the well being not only of the women who suffer from them, but their families and communities as well.

Purpose

The study sought to understand the significance and effects of POP for Nepali women in the three districts of Western Nepal, Achham, Bardiya and Doti. The specific aims were to explore women's description of living with POP in order to comprehend the cultural meaning of POP, ascertain the perceived severity of POP in relation to other women's illnesses and to describe cultural beliefs about the causes, prognosis and treatment of POP.

Methodology

Employment of ethnomedical/ethnonursing models—valuing the patient as knower, expert and co-researcher—developed a description of prolapsed uterus in the context of the given culture. Two or three village development communities in each of the study districts were visited. Qualitative research involved 150 married men and women between the ages of 18-80 identified through convenience sampling. 120 of the participants were interviewed in focus group discussion format and 30 participants were interviewed individually. Open-ended interviews were used with the aid of field guides. Focus groups involved free listing concepts in order to define cultural domains specific to the experience of POP. Individual interviews were held with women self-identified with POP as well as healthcare workers.

Individual interviews focused on case specific questions and utilized quick-sort ranking in order to prioritize POP in relation to other female reproductive illnesses. Field notes recorded all focus group discussions, but individual interviews were taped and transcribed.

Analysis and Results

First, participants' responses were organized into pre-established categories. Categories were then analyzed and arranged into domains. Ethnographic methods choreographed a pattern analysis of the domains. Based on patterns, 13 themes were elicited and outlined. Analysis revealed POP negatively influenced women's emotional, mental, social and physical lives. Participants' responses unveiled a strong conviction about the disease's causes, prognosis and treatment options. The lifting of heavy loads during the postpartum period was strongly associated as a primary cause of POP. Additional causality perceptions included lack of nutritious food and weakness. The themes, ranging from hospital/medical distrust to the value of women, helped to orchestrate a socio-medical model for understanding POP in the given culture. Considering its social and medical causes and consequences POP was redefined in a culturally relevant context. Results were compiled into a research report and power point presentation for dissemination.

Implications for Nursing

The results provide data for the planning and implementing of prevention programs and IEC materials aimed at lessening the impact of POP. Understanding cultural barriers to disease prevention and treatment is paramount to reducing the effects of disease. Devaluing the cultural perspectives in turn depreciates the individuals within that culture—the resulting lack of communication stirs disrespect and animosity, which leads to intervention failure. With disease meanings outlined in an ethnographic light, healthcare providers can work in collaboration with existing perceptions and tactics.

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1. INTRODUCTION

1.1 Background

Pelvic organ prolapse results from a lack of support within the pelvic cavity to maintain proper positioning of the pelvic organs. The exact etiology is unknown, but contributing causes include multiparity, excess intra-abdominal pressure, tissue atrophy secondary to aging and estrogen loss, joint hypermobility, and congenital weakness (Youngkin and Davis, 1997; Nicholas and Randall, 1996; Norton et al, 1995; Mant et al, 1997; Gill et al, 1998; Fritzinger, 1997). Pelvic organ prolapse (POP) is on the rise and now accounts for a majority of gynecological surgeries. In the United States, over 390,000 surgeries occur annually for the correction of genitourinary prolapse (Norton et al, 1995). Mant et al (1997) report that uterovaginal prolapse is the admitting diagnosis for 20% of women awaiting gynecological surgery in England. Davila (1996) suggests that genital prolapse is present in at least 20% of postmenopausal American women. In China, uterine prolapse is one of two female diseases for which the government provides free care (She, Shao, and Weng, 1990).

Nepal, one of the world's least developed nations, faces a calamity of reproductive health issues and an almost epidemic proportion of prolapsed uterus. The World Health Organization states the following statistics concerning Nepal: the 1996 life expectancy at birth equaled 56 years and infant mortality rate per 1,000 live births equaled 122. The 1995 gross national product in per capita was USD \$200.00. Access to healthcare in 1993 was too low to be estimated statistically. Currently, the Nepali government is implementing a Second Long Term Health Plan, but several factors impede success. WHO cites difficult terrain, low gross domestic product, low literacy (especially among women), inadequate management skills and information systems, and lack of financial planning expertise as the major difficulties feeding Nepal's healthcare crisis (WHO/ICO, 1998).

According to WHO's press release on World Health Day 1998, pregnant women are at risk not because of "mere misfortunes or unavoidable natural disadvantages, but rather injustices that societies have a duty to remedy through their political, health and legal systems," (WHO, 1998). In 1998, the WHO reports 300 million women worldwide suffer from pregnancy-related healthcare complications. Joshi (1993) states that "The incident of uterovaginal prolapse in young women is high in developing countries." Elaborating, he lists probable causes of uterine support system failure to be early childbearing, multiparity, unsupervised labor and delivery, short spacing between births, maintaining the squatting

position during long working hours and defecation. In Nepal, significant research has been conducted on maternal mortality; however in-depth studies on maternal morbidity have yet to materialize. Morbidities such as POP impact the wellbeing not only of the women who suffer from them, but also the wellbeing of the families in which these women live. As with all reproductive health issues, the impact of POP may suggest it to be not just a reproductive disease, but a family disease, and thus, a community disease as well. The following study sought to elicit the perspective of women and men concerning culturally specific beliefs and attitudes towards pelvic organ prolapse. This study was completed in conjunction with the German Technical Cooperation's (GTZ) Nepal-German-Reproductive Health Project in three study districts in the Mid- and Far-western regions of Nepal, Bardiya, Achham and Doti.

1.2 Purpose of study

The purpose of the study was to understand the significance and effects of prolapsed uterus for Nepali women and families in the three study districts, Achham, Bardiya and Doti. The specific aims were to explore women's description of living with POP in order to comprehend the cultural meaning of POP, ascertain the perceived severity of POP in relation to other women's illnesses and to describe cultural beliefs about the causes, prognosis and treatment of POP. The rationale of study was to contribute formative data for larger, more detailed studies of the incident and prevalence of POP as well as to provide data for the planning and implementing of prevention and education programs aimed at lessening the impact of POP in the study districts.

2. LITERATURE REVIEW

2.1 Pelvic Organ Prolapse

2.1.1 Causes of POP

Exactly what contributes to the lack of pelvic support in a patient with pelvic organ prolapse is still largely a mystery. The number one contributing cause is generally agreed to be multiparity, generally understood to refer to having more than 3 children. During labor and delivery, the levator hiatus is stretched and as a result connective and muscular tissues of the pelvic cavity suffer damage. The birth process also displaces the pelvic floor and agitates the distal fibers of the pudendal nerve, which serves the external vulva. Nulliparous women, however, also develop POP. Leading causality theories for nulliparous women with POP include irregular endogenous collagen composition, which could cause connective tissue

weakness; if connective tissue is weak, collagen strength is often diminished (Davila, 1996; Drutz and Alnaif, 1998; Gill, 1998). Other causality theories involve lifestyle and occupational hazards, such as heavy lifting and strenuous activity, chronic health problems, such as pulmonary diseases, obesity, constipation, and any additional conditions that increase intra-abdominal pressure (Davila, 1999). Family history of prolapse, as well as personal history of pelvic surgery or trauma, predispose women to POP as well (Davila, 1996).

In 1999, Samuelsson et al published a study conducted with 487 Swedish women between the ages of 29 and 50. Women were asked to answer a questionnaire inquiring about demographics, personal and family medical history, medication history and specific symptoms associated with pelvic organ prolapse. Physical exams were also conducted. Results showed that an increase in age and parity correlated with a decrease in pelvic floor muscle strength. Descent of the uterus was found in 44% of parous women, yet prolapse that reached the introitus was only found in only 2% of women. A correlation between birth weight and prolapse was also noted and connected with a previous study by Timonen et al that discovered a third of patients suffering from prolapse had infants weighing over 4000g.

2.1.2 Associated Signs of POP

According to Davila (1996), prolapse presentation may span a broad range, “from obvious protrusion of a mass or bulge to less overt manifestations, such as pelvic pressure and low back pain, urinary incontinence, and obstructed defecation.” Urinary incontinence usually becomes the most bothersome symptom and is what eventually compels the patient to seek medical advice. Grody (1998) notes that most frequently mentioned complaints include “frequency, urgency, nocturia, difficulty initiating urination, prolonged voiding, and a feeling of incomplete emptying.” One hundred Indian women admitted for prolapse surgery were surveyed prior to their operations; the highest incidence of reported symptoms were “something coming down” at 98%, “difficulty in emptying bladder” at 75% and “backache” at 37% (Shah and Shah, 1974).

2.1.3 Evaluation of POP

Bladder and urethral function must be evaluated with prolapse engaged and with prolapse reduced. Urinary complications can manifest as simple stress incontinence and as chronic urinary retention—a life-threatening situation due to its potential to cause renal damage (Davila, 1996). Drutz and Alnaif (1998) stress the importance of “meticulous neurological assessment.” Davila (1996) and Grody (1998) caution practitioners to examine

patients in standing and lithotomy position as well as late in the day because prolapse tends to worsen as the day progresses and the body tires. Grody (1998) also insists an exhaustive history of voiding habits and patterns must be obtained in order to correctly evaluate the mechanisms of the prolapse.

2.1.4 Management and Treatment of POP

As always, successful management begins with accurate assessment and diagnosis. With POP, precise assessment includes identifying which vaginal segment has prolapsed and which support systems have failed (Davila, 1996). Treatment of POP begins with short-term options. Kegel exercises, preferably preformed in conjunction with biofeedback, and the use of pessaries are initial choices (Cundiff and Addison, 1998). Ideally, these forms of therapy can be mastered thus avoiding surgery. Lifestyle changes are paramount, including limits on heavy lifting and strenuous activity. Pessaries are devices, usually made of rubber, which fit snugly into the vagina in order to reduce the prolapse. Effective use of pessaries can not only reduce the actual prolapse, but decrease the symptoms as well (Davila, 1996; Cundiff and Addison, 1998). Interestingly, Davila reports the use of pessaries in early Greek and Latin literature.

Estrogen replacement therapy in postmenopausal women suffering from POP is imperative, according to Drutz and Alnaif (1998), Grody (1998) and Cundiff and Addison (1998). Hormones can strengthen the vaginal tissue and increase successful surgical outcomes as well as non-surgical therapies. The definitive treatment for POP is surgery.

2.1.5. Racial Differences

Shah and Shah (1974) state that genital prolapse is a “real problem” as well as a “common” in developing countries due to “lack of good obstetric care, malnutrition, poverty and doing heavy manual work in the immediate postpartum period,” (p.86). Interestingly, these reasons are not mentioned in the literature available in the West. Similarly, Das (1971) reported that women in Gauhati, India admitted with complications of pregnancy or labor due to prolapse were all multiparous, and 90% had a parity of four or more. Demographically, 36 out of 40 patients received no antenatal care, “belonged to field laboring families of the rural areas [and] most were malnourished and anemic” with over 80% showing a hemoglobin of 8.15 grams or less (p.261). Das also reports that village women “often engage in hard prolonged labor in a squatting position or in lifting and carrying heavy loads,” (p.262).

Because the exact etiology is still unknown, perhaps the West and East can learn from one another's hypothesis.

In 1993, Bump published a report investigating 200 consecutive American women patients referred to him due to urinary incontinence or severe prolapse. Of the 200 women, 54 were black. The comparison found that the prevalence of severe prolapse between the two groups was the same, but the black population had sustained more vaginal deliveries. Noteworthy also is that 65% of the black women were referred from staff clinics (serving the indigent in Virginia) and only 17% of the white women were referred from these same clinics.

Nicholas and Randall (1996) note the varying rates of prolapse incident in racial groups. Black women, as well as Oriental women, have significantly fewer reported cases of genital prolapse. After an extensive review of existing literature, they concurred that Caucasian, Egyptian and women from India suffer prolapse more frequently than Oriental (Chinese and Indonesian) and African American women, whereas black women from West Africa and South African Bantu women experience almost no genital prolapse. This range in racial incidence may be due to differences in connective tissue strength, shape and layout of the pelvis, as well as lifestyle differences, such as frequent squatting common in Asian cultures, especially for defecation. Upon dissection of cadavers, it was noted that Oriental women have highly developed levator ani muscles. Whether such development is genetic or acquired during their lifetime is still unknown (Nicholas and Randall, 1996).

Zacharin (1977) conducted an autopsy study based on general agreement among physicians within 17 different Chinese hospital in 4 major cities: prolapsed uterus was rare in Chinese women of low socio-economical status. As is well known, he states that the levator ani complex and pelvic cellular tissue provide the main support for the pelvic organs. Zacharin examined the pelvic structure of thirty women postmortem, all of whom were of low socio-economical status. Results suggested that the anatomical differences should, in part, be attributed to "generations of hard work and a diet, which makes obesity uncommon." In conclusion, Zacharin stated, "Such was the general uniformity in the 30 subjects studied that one may state categorically, the levator complex and pelvic cellular tissues in the Chinese of low socio-economical standing are exceptionally well developed, and provide anatomical reasons for the rarity of genital prolapse in these women."

In 1996, Brieger et al challenged Zacharin's conclusions. Brieger et al conducted a retrospective study in order to note any changes in incident rates of uterine prolapse in Chinese women over 20 years. Their results noted that 14% of all gynecological surgery

admissions carried a diagnosis of genital prolapse—a rate that clearly marks a change from the 1970's. The group acknowledges that many changes have occurred within the region—otherwise known as Westernization. Such changes include, but are not limited to, alterations in diet (from vegetables and grains to processed fats and carbohydrates), increased life expectancy, increase in the number of women, changes in birthing positions (from squatting to recumbent), changes in defecation and resting position (from squatting to sitting), and, finally, less women performing hard labor. Although Brieger et al stop short of claiming actual causes of the increased rate of genital prolapse in Chinese women, they strongly hint at the “legacy of the Western practices” as playing an integral role.

2.1.6 Nulliparous

Strohbehn et al (1997) conducted a study involving 647 women who underwent surgery for genital prolapse. The women were divided into two groups, one over age 35 and one under age 35, and retrospectively analyzed for different characteristics and types of prolapse between younger and older women. The results concluded that the younger women had a higher rate of “underlying medical conditions,” such as neurological damage to the pelvic floor, connective tissues diseases, and congenital abnormalities. Additionally, the older group had a broader range of prolapsed sites, whereas the younger group primarily sustained prolapse of the uterus.

Differences between nulliparous and parous women were investigated in a study involving 748 women who were diagnosed with either pelvic organ prolapse or incontinence (Harris et al, 1998). Results revealed that although nulliparous women were less likely to develop pelvic organ prolapse than their parous counterparts, little difference emerged in relation to incontinence between the two groups. Such results suggest that “other factors likely cause these problems, including genetic predisposition, changes in cellular and neurologic composition of tissue, amount and duration of stress to the pelvic floor, or other unknown factors.”

In India, pelvic organ prolapse is reported to occur in 1.5–2% of nulliparous women (Banu, 1997). Both Nichols (1993) and Fritzinger et al (1997) suggest only 2% of North American women with pelvic organ prolapse are nulliparous. Nichols observes, “often nulliparous prolapse will be associated with a lifestyle of heavy physical labor producing marked increases in intra-abdominal pressure.”

2.1.7 Increased Intra-Abdominal Pressure

Although multiparity is recognized as the primary cause of prolapse, some researchers, such as Heyns, credited excess intra-abdominal pressure as the main etiology (Nicholas and Randall, 1996). In 1996, Davis published an article outlining a high number of cases of uterine prolapse in nulliparous airborne trainees. Three women, all in the service and all having undergone laparoscopic uterine nerve ablation, or LUNA, were forced to resign from the armed services due to severe uterine prolapse. LUNA, a treatment for refractory dysmenorrhea, has been used with little fear of known side effects. Rigorous physical training is expected of all new army recruits; these women were involved daily in a four-mile run, sit-ups, pull-ups, push-ups, tower jumps, and parachute jumps. This combined activity causes a significant increase in intra-abdominal pressure. Davis (1996) concludes, "Continued rigorous exercise could have led to mechanical overload of the supporting elements of the uterus and exceeded the tissues' ability to regenerate, resulting in structural failure and prolapse." It is impossible to know if these women would have progressed to severe uterine prolapse had the LUNA procedure not preceded the strenuous physical training; however these three cases call forward the need to increase the understanding and etiology of pelvic organ prolapse.

Jorgensen et al published a study in 1994 that investigated the connection between heavy lifting at work and the risk of genital prolapse in assistant nurses. Assistant nurses, responsible for heavy lifting in the work environment, suffer increased intra-abdominal pressure, identified as compromising the muscular structure of the pelvis. The researchers concluded that assistant nurses had a 60% increased risk when compared to the general female population of prolapsed uterus and "heavy lifting at work may be the underlying cause," (p.49).

2.1.8 Nutrition

Banu (1997) insists that child bearing and excess intra-abdominal pressures, while certainly common etiologies, are only viable explanations in the context of women who are predisposed to prolapse. Banu (1997) maintains that pelvic organ relaxation can be contributed to such diverse etiologies as poor nutrition and autosomal dominant genetic abnormality. Grody (1998) argues that nutrition plays an integral role nurturing "strong connective tissue and general good health." Good nutrition includes adequate fiber, which decreases constipation, a possible cause of increase abdominal pressure.

2.1.9 Kyphosis

Lind et al (1996) investigated correlation between thoracic kyphosis and advance uterine prolapse in Caucasian women. In a retrospective case-control study, 48 patients undergoing hysterectomy with severe uterine prolapse were matched with 48 women without prolapse. Lateral chest X-rays were taken of all women and spinal curvature was measured. For patients with uterine prolapse, the degree of thoracic kyphosis was higher than in the controls (a mean curvature of 13 degrees compared to 8.1 degrees). Lind et al reasoned that curvature was relevant because “the bony structures may be important in the prevention of pelvic organ prolapse by protecting the pelvic floor from downward vector forces . . . the lumbar spinal curve [may] act as a buffer, absorbing some of the vector forces headed to the pelvis.” As women age, thoracic kyphosis may heighten, thus initiating a loss of lumbar lordosis. Changes in the mineral content of bones—especially if a woman suffers from osteoporosis—and soft tissue changes play a role in the spinal alterations over time. These conditions, combined with multiparity and other risk factors, may help solve the prolapse puzzle.

2.1.10 Connective Tissue/Protein Collagen

The supportive cradle of the pelvic cavity depends largely on connective tissue for its effectiveness. Gill and Hurt (1998) point out that if POP is found in nulliparous women, etiology is most-often pathologic endopelvic connective tissue. Additionally, they link the strength of protein collagen to connective tissue’s capability. Nineteen types of collagen have been identified, but type I and II are the predominate types found in epithelial tissue; the fibrous protein is known to give skin, bones and muscles their strength (Jackson et al, 1996, p.1659). Collagen formation and subsequent character may also be related to decreasing levels of estrogen in postmenopausal women. In summary, they state “anatomic defects might develop as a result of biochemical alternations within the pelvic connective tissue.” Jackson et al (1996) analyzed vaginal-epithelial tissues from women of reproductive age who had been diagnosed with genitourinary prolapse. In comparison with controls, collagen turnover was four times higher in the prolapse group. Likewise, the prolapse group was associated with a “reduction in total collagen content and a decrease in collagen solubility,” (p.1658). In conclusion, they found that prolapse tissue has a loss of collagen caused by an increase in collagenolytic activity and a subsequent decline in the strength of the tissue.

Joint hypermobility usually exists concomitantly with connective tissue disorders and is commonly recognized as a clinical marker for connective tissue abnormalities. Norton et

al (1995) studied 107 women to determine an association between joint hypermobility and genital prolapse. Higher prevalence of cystocele, rectocele and genital prolapse was found in women with joint hypermobility than with the controls. Additionally, joint hypermobility and advanced stages of prolapse shared an association. Norton et al also cite a study by Al-Rawi and Al-Rawi (1982) that discovered 66% of 76 Iraqi women suffering from prolapse also had concomitant joint hypermobility.

2.1.11 Denervation

Allen et al (1990) used concentric needle electromyography (EMG) to study the striated muscle and nerve supply to the pelvic floor of 96 nulliparous women before delivery and post delivery. They found that women experiencing prolonged active second stage labor and larger babies suffered from more pronounced nerve damage. Nerve damage results in a loss of muscle strength and power and thus in most women “delivery substantially reduced the power of the pelvic floor to contract,” (p.774). In summary, they argued “vaginal delivery causes partial nerve damage of the pelvic floor in 80% of women delivering their first baby,” (p.777). This nerve damage, weakening the pelvic muscles, may be the first step on the road to prolapse.

After an extensive literature review, Gill and Hurt (1998) summarized that nerve degeneration caused by labor and delivery resulted from “direct compression of the nerves between fetal and maternal surfaces as well as by stretching the nerves.” Straining during defecation due to chronic constipation may also cause pudendal nerve damage.

2.2 Nepal

With a population projected to have hit 22.5 million in 1999, Nepal is categorized as one of the world’s least developed nations. Bordering India on the east, south and west and China on the north, Nepal remains a landlocked country. It is divided into regions and districts into order to better facilitate the complex chore of development by both government and non-government agencies. Its three main ecological zones, mountains, hills and Terai, are divided into five development regions, which are then divided into 14 zones and 75 districts. These 75 districts are, in turn, divided into Village Development Committees (VDC) and each VDC is further divided into Wards; nine Wards exist within each VDC. Thapa (1995) describes the conception by the United Nations Development Program (UNDP) of the Human Development Index (HDI). The HDI was conceived “to assess the relative position of each country with regards to three main dimensions of development: namely

longevity, knowledge and standard of living,” (p.4). Longevity is indicated by life expectation at birth; mean years of education and literacy measure knowledge; standard of living is indicated by “purchasing power based on real gross domestic product per capita adjusted for the local cost of living,” (Thapa, 1995, p.4). In 1993, UNDP rated 173 countries according to their HDI, Nepal ranked number 151; in 1994, Nepal ranked number 172 (Thapa, 1995, p.4). In 1991, Nepal’s 75 districts were assessed by HDI; the three study districts fall at the bottom of the list. Bardiya was ranked number 55, Doti was ranked number 62 and Achham was ranked number 69 out of 75. Thapa (1995) further reported that life expectancy was 58.9, 54.0 and 54.7. Literacy rate, by percent, was 30.7, 29.9 and 25.0. These three districts were chosen by the Nepal-German Reproductive Health Project due to their deficit, previous lack of support by development agencies and relative accessibility.

The maternal mortality rate for Nepal varies. According to the Family Health Division’s (FHD) 1998 maternal mortality and morbidity study, WHO/UNICEF (1996) cited the rate as high as 1,500 per 100,000 live births and the Nepal Family Health Survey estimated 539 per 100,000 live births in 1996. Although the disparity is high, both numbers claim a shocking loss of life: one maternal death every two hours (FHD, 1998). The FHD further states the total fertility rate to be 4.64 in 1996.

2.2.1 Health / Nutrition

Shah and Shah (1974) studied 100 consecutive cases of prolapse uterus admitted for surgery in Ahmedabad, India. They found that 83% of the women had a hemoglobin of less than 10 grams. Anemic by Western standards, these women were undoubtedly suffering from some degree of malnutrition. In 1998, Rai, et al studied 503 children in Nepal for the prevalence of intestinal helminthiasis. 261 children from the Central District and 242 children from the Eastern Region were examined for the existence of four different types of helminthiasis. In the Central Region, 57.5% of children hosted the parasite and in the Eastern District, 55.4% of the children hosted the parasite. The researchers also reported that over 80% of the households had no latrine, aiding to sanitation problems. Malnutrition and growth retardation are commonly recognized results of intestinal parasites. The widespread presence of parasites points to the precarious health and nutrition of the population.

Christian, et al conducted an ethnographic study of women with night blindness (“*ratauni*”) in the Southeastern Terai of Nepal (Christian et al., 1998). They found that although night blindness is rather uncommon in adults, this particular result of Vitamin A deficiency occurs in pregnant and lactating women in rural Nepal. In the third trimester of

pregnancy, the body presents a slightly increased need for Vitamin A due to a decrease in plasma retinol levels throughout pregnancy. Although night blindness causes disruption of daily activities during pregnancy, the condition resolves spontaneously after delivery. Night blindness is reported to have effected between 8% and 46% of Nepali women (Christian et al., 1998). Such statistics, which vary according to districts, suggest questioning the nutritional balance of Nepali women. The question arises, if Nepali women maintain a low intake of Vitamin A, what additional micronutrients are insufficient?

According to previous studies, Nepali women perceive that diseases can be caused by "*kamjori*," a type of physical weakness (Christian et al., 1998; Gittelsohn et al., 1994). Such weakness usually develops during pregnancy, lactation and other vulnerable physiological states. Nepali women tend to follow the Asian hot-cold food classification system. In such a system, cold foods are used to balance out hot diseases and hot foods are used to balance out cold diseases, (Christian et al., 1998; Gittelsohn et al., 1997). Striking a humoral balance promotes health. As with *kamjor*, these classifications are more serious when the body is in a physiologically vulnerable state. For example, lactating women avoid leafy green vegetables because they are considered "cold" and cause arthritis, swelling and other illness (Gittelsohn et al., 1997).

Gittelsohn et al., (1997) insist that adequate energy intake does not necessarily assure a diet has adequate micronutrient intake. Gittelsohn et al., (1997) studied 105 Nepali families using a combination of recall and observation methods to examine food allocation. They claim that the social and cultural status of individuals is governed by age, gender and kin relationship. Age defines ones productivity; children are valued for their potential for productivity in the future and adults are valued for their current productivity. Unfortunately, women contribute primarily to the running of the household, a job that is not as highly valued as one which brings in money. Gittelsohn et al (1997) suggests that female children economically drain the family. They state, "All inputs (e.g. food, education, health care) to female children are unlikely to be returned as they mature, except in labor extracted before they marry and leave the household. The lower value placed on women is social and cultural, as well as economic. Some investigators have noted that in Hindu societies women are viewed as potentially threatening to the patrifocal system," (Gittelsohn et al., 1997).

In an earlier study investigating intra-household food allocation, Gittelsohn (1991) found that adult males were allocated more food and larger shares of protein rich food, adult women ate last and therefore had less opportunities for second helpings and that adolescent girls were slightly disfavored in allocation as well. In their 1997 study, Gittelsohn et al found

that adult males are consistently favored in food allocation, with a significantly lower allocation going to females in their adolescent and reproductive years. These groups were at particular risk for Vitamin A and C deficiencies. They conclude:

“Gender-based differences in access to certain foods appeared linked, in part, to specific food beliefs and practices that reduce women’s consumption of micronutrient-rich foods, such as dietary restrictions during menstruation, pregnancy and lactation. Overlapping with these beliefs and practices, an overall pattern of discrimination against women in the intra-household allocation of food is evident in the study population.”

Messer (1997) agrees. After studying intra-household allocation of food and healthcare in Nepal, Madagascar, Mexico and Peru, she concludes that lack of adequate micronutrient and/or protein diets attribute to the skyrocketing female mortalities in these countries. Of special interest, she notes the Asian male-female life expectancy rate. In most developed countries, women far out-live men; in Asian countries, “survivorship ratios show fewer surviving females in most age cohorts,” (Messer, 1997, p.1676). Gittelsohn (1991) writes, “researchers have observed differences in morbidity and mortality within households, both of which suggest unequal food distribution,” (p.1141).

Many anthropologists suggest that food deprivation is directly related to a family’s economic status. Recent, development work, however, has focused on female income generating projects and micro-economics. Messer (1997) points out that “while income is usually a factor, deeply ingrained patterns of anti-female bias or gender-specific feeding do not disappear rapidly where incomes improve,” (p.1680). Thus, we turn to the phenomenon of self-deprivation. Nepali women tend to follow strict food rules according to “hot-cold” classification and food restrictions related to the reproductive stages, such as pregnancy and lactation/breastfeeding. It is difficult to unravel the basis of such rules: are women following sound cultural experience or are they fostering a culture that forces food restrictions to actualize male favoritism?

2.2.2 Cultural and Social Status

Several studies argue the second class citizenry of Nepali women (Christian et al., 1998; Reynolds et al., 1988; Christian and West et al., 1998; Gittelsohn et al., 1997; Messer, 1997). As a Hindu country still under strong influence of a God-like King, Nepal’s social structure is deeply embedded in a caste system. Each family’s financial and social status is mandated largely by their caste. Additionally, women are often viewed as a burden on

families—they will cost the family in dowry and also leave the family to live with the husband's family. Even though women do almost all of the household chores, such work is not viewed as “productive work,” or work that earns wages. Christian et al., (1998), reports that Maithili women in the Terai average more hours a day working than men do; their work is calculated as both productive and domestic. Interestingly, the men seldom contribute to domestic chores.

Christian et al. (1998) also found several socio-economic factors that influenced Nepali women's decisions regarding night blindness and its treatment. Family, neighbors and friends' opinions about the disease impacted women's treatment decisions. Additionally, willingness of husbands to assist their wives, lack of personal access to monies and lack of access to the market contribute to a woman's decision process regarding her night blindness. Obviously, the decision is not hers alone, but depends largely on her husband, family members and general the socio-economical situation.

The question of investment cannot go unexplored. In Nepali culture, where resources are scarce, girls are seen as a temporary investment. The girl child will leave the household to join her husband's home, taking with her all the years of food, education and training given to her. As Messer (1997) points out, “Male-biased ‘investment’ is common in patrilineal, patrilocal societies where inheritance is from father to son and sons set up housekeeping close to father's family,” (p.1676). In Nepal, the eldest son is expected to care for his parents in their old age. Because women move to another's home, they are socially and physically unable to care for their parents. Gittelsohn et al (1997) points out the difficulty of early adult years for Nepali women:

“A woman marries and moves into her husband's household, where she has a very low status. She is expected to do a great amount of the hard physical work, produce children and not complain about her state. In Pahrgeon, while usually permitted to eat their fill of staple foods, junior adult females receive subtle discouragement in the consumption of special foods (e.g. animal products, special fried foods). They are not encouraged to eat second helpings of these foods.”

In an earlier study, Gittelsohn (1991) reported that “adult junior females (i.e. daughters-in-laws) had very low status in the household and were expected to do most of the heavy domestic work,” (p.1152). This is, of course, the reproductive female.

The Family Health Division states in the introduction of their *Maternal Morbidity and Mortality Study*:

In developing countries like Nepal, these obstetric complications and chronic disabilities are aggravated by a number of socio-cultural

factors. Socio-economic status of women in Nepal is low and they are often neglected as children (there is a strong male preference), they are often poor, illiterate, undernourished and overworked. They are subjected to harmful practices and they have inadequate access to family planning and maternal health service (p.1).

With even their own health department acknowledging the massive disadvantages faced by women, Nepal can no longer afford to blame women's health problems on poverty or lack of infrastructure alone.

2.2.3 Activities of Daily Living (ADL)

Rai et al (1998) states that "over 85% of the 20 million population are engaged in agriculture, live in the village setting and have the low human development indexes," (p.92). Within the village setting, household chores, as well as farming chores, are expected of women. Common household chores include fetching firewood and water (often up and down steep slopes), washing the clothes, cooking, harvesting, planting, animal husbandry and childcare. With such a small percent of the population living in an urban environment, it is not surprising that the rate of prolapse is conceived as high. Rural women perform much more rigorous duties than their urban counterparts. In Shah and Shah's 1974 study, 44% of the women admitted for prolapse surgery performed "heavy manual labor," (p.86).

The Maithili women engage in several physically demanding domestic chores, including planting, harvesting, weeding, animal husbandry, firewood and fodder collection, cooking, cleaning and childcare (Christian et al., 1998). Gittelsohn et al (1997) also found that Nepali women are mostly occupied with household chores, such as fetching firewood and water, child rearing, and assisting in the family fields. Similarly, young girls are charged with the care of their younger siblings while young boys are sent to school. Messer (1997) points out that, "Recommended energy allowances often underestimate female energy needs as they underestimate activity levels . . ." (p.1679). Panter-Brick (1993) studied the seasonal impact on energy expenditure for pregnant, lactating and non-pregnant non-lactating Nepali women. The study investigated a population of Tamang women, a culture known for its lack of castes and gender preferences. Panter-Brick noted that Tamang women worked pounding grain, hoeing fields, cutting wood and carrying loads up and down slopes. She discovered that pregnancy and lactation had no impact on work demands, especially in the spring and monsoon season (growing season). As such, it may be deduced that women who are pregnant or lactating during the growing season may be at higher risk for pelvic organ

prolapse due to the inability to obtain adequate rest, either postpartum and/or during pregnancy. Without adequate rest, women in the perinatal period put additional strain on the muscles structures of the pelvis thereby jeopardizing a return to normal strength and positioning postpartum. Panter-Brick also reported that “the tasks habitually undertaken by rural Nepali women may appear backbreaking to the casual observer,” (p.627). It remains uninvestigated if these same tasks create excessive intra-abdominal pressure.

2.2.4 Labor and Delivery

Thapa (1996), in a study investigating maternal morbidity for perinatal patients in an urban hospital, reported that 37% of women admitted for delivery had labor that lasted over 18 hours; of these women, 55% perceived this to be a serious problem. 38.2% complained of “pain in the uterus” and 29.4% of the total study population reported feeling “as if their uterus was falling,” (p. 137). Shah and Shah (1974) reported that 8% of the women admitted for prolapse surgery had delivered without the assistance of a trained birth attendant. The Family Health Division of Nepal (1998) states that 92% of all women deliver at home—less than 10% of these births were attended by a healthcare practitioner.

2.2.5 Pelvic Organ Prolapse

Radha Ranabhat (1997) completed a study investigating the risk factors and beliefs of Nepali women about POP. The study was conducted within the out-patient department of the Maternity Hospital in Kathmandu. The results of the study shed light on an urban population’s understanding of the causes of POP. The risk factors which correlated with POP were found to be home delivery with untrained birth attendants, large infant size, increased intra-abdominal pressure due to illness, and young maternal age. The results implicated the most significant risk factor for POP was engaging in exhaustive work or lifting heavy loads early in the postpartum period. Ranabhat also notes that the 85.5% of the women reported feeling the prolapse when they lifted heavy loads. Additionally, 94.5% of the women believed that the prolapse occurred due to lifting heavy loads or performing exhaustive manual work. In a review of admission and discharge records at the Maternity Hospital, Ranabhat discovered that the prevalence of POP for that population in 1996 (from 2052 Baishakh to 2052 Chaitra on the Nepali calendar) equaled 11.53%.

2.3 The Study Districts: Bardiya, Doti and Achham

Bardiya district is located in the mid-western development region and within Nepal's plain or terai region in the southern part of the country. Bardiya's 368,458 people are divided into 34 VDC. The region's health infrastructure consists of one hospital, two primary health care centers, eight health posts and 21 sub-health posts. Because of its location, most of the population is involved in agriculture. The Tharu caste, composing over 50% of the population, is the predominate caste.

Doti is located in the far-western development region and within Nepal's hilly region. Doti's 192,83 people are divided into 54 VDC. One hospital, one primary health care center, ten health posts and 40 sub-health posts comprise the region's health infrastructure.

Achham district is also in the country's far-western development region and is home to 212,611 people. Achham's health infrastructure comprises one hospital, one primary health care center, 13 health posts and 80 sub-health posts.

2. METHODOLOGY

3.1 Theoretical Framework

Concepts from ethnomedical/ethnonursing models were employed in order to establish a theoretical framework. The researcher also drew from the concept of patient as knower, expert and co-researcher. The basic concept of ethnography, the description of culture, grounded the research foundation. Because the aim of the research was to understand the cultural context of prolapsed uterus as experienced and known by rural Nepali women, the inquirer strove to gain an emic view—"to discover and interpret the cultural meanings found within a connected group," (Strebert and Carpenter, 1999 p.149). Ethnography was selected for its emphasis on the subjective human experience as valuable and worthy. Strebert and Carpenter (1999) outline the work of P.R. Spradley (1980) in their text on qualitative research and nursing. Accordingly, the use of ethnography rests on three major principles: 1) to document and validate alternative realities as experienced by different cultures or sub-cultures, 2) to allow cultural theories to emerge (grounded theory), 3) to gain a broader comprehension of cultures and societies (Strebert and Carpenter, 1999). It is the researcher's belief that prevention and treatment of disease can only be effective if the disease process is understood in that particular culture's context and paradigm. The meaning of the disease must be conceptualized in relation to the population it effects. As our world continues to shrink into a global community, the importance of Spradley's third principle

grows. Understanding cultural barriers to disease prevention and treatment is paramount to reducing the global impact of disease. Devaluing a cultural perspective of disease in turn depreciates the individuals within that culture—the resulting lack of communication stirs disrespect and animosity, which leads to healthcare program and intervention failure. Such failure affects not only targeted communities, but global health as well. With disease meanings outlined in an ethnographic light, healthcare providers “may potentiate the strategies already in use by the groups,” (Streubert and Carpenter, 1999, p. 152).

3.2 Research Question

What is the significance and effect of prolapsed uterus for Nepali women in Bardiya, Doti and Achham?

3.3 Sampling

The study took place within three districts in western Nepal. Within each district, two to three village development committees (VDC) were visited. Three to four focus group discussions were held in each district, one to two in each VDC. Five to ten individual interviews were scheduled for each district, or two to five individuals in each VDC. All-male groups were utilized in order to assure the male perspective was obtained. Participants were identified by means of convenience sampling or snowball sampling. Married men and women, with a broad range of age, 18—80 years old, were asked to participate in the focus group discussions. Additionally, individual interviews were held with health care workers—such as Traditional Birth Attendants (TBA) and Female Health Care Volunteers (FHCV)—and women of any age identified with prolapsed uterus. All identification was self-reported. No physical exams were conducted and no treatment was provided. Open-ended interviews and field guides encouraged discussions on women’s illnesses, diets, pregnancy and beliefs related to pelvic organ prolapse. The study occurred between February and May 2000.

3.4 Data Collection

Use of a research assistant (simultaneously acting as a translator) and a research aid was mandatory due to language barriers as well as the variety of dialects spoken within the districts. Field notes recorded the focus group discussions. Focus groups involved free listing exercises and a field guide aimed at defining cultural domains. Six main questions attempted to elicit specific domains.

1. What are the most common health problems experienced by women in this VDC?

2. What are the pregnancy customs?
3. What are women's activities of daily living?
4. What do you think causes prolapsed uterus?
5. What impact does prolapsed uterus have on a woman's life?
6. If a woman has prolapsed uterus, what kind of treatment can she get?

After focus groups, the field notes were translated, transcribed, reviewed and analyzed for domains/themes. FGD also involved one free-listing exercise. Free-lists were obtained by asking a question in order to determine a "gut reaction." The answer to the above question concerning most common illnesses was asked the same way and at the same time in each interview and FGD. The answers were then tallied and ranked according to times mentioned. The result is a list of the perceived most common women's illnesses.

Unlike focus groups, individual interviews were taped and later transcribed. Field notes were also taken during individual interviews. Individual interview questions were case specific allowing for clarification of themes. Individual interviews also involved quick-sort ranking. Quick-sort ranking prioritized a pre-determined set of women's reproductive health problems. According to the literature review and personal experience, five major reproductive health complaints were pre-determined in order to rank prolapse uterus against other common female illness. These five illnesses were presented to each individual interviewee. She was then asked to rank the series according to severity. The illnesses—or major symptoms of illnesses—were burning upon urination, white watery discharge, prolapse uterus, STD and weakness. Each individual interviewee was asked, "Between burning during urination and prolapsed uterus, which is more serious?" and "Between STD and white watery discharge, which is more serious?" and so on until all variables were ranked.

Practice interviews were conducted with the principal investigator, the research assistant and the research aid before the various districts were visited. Mock interviews sought to address facilitation guidelines as well as research principles.

3.5 Data Analysis

Streubert and Carpenter (1999) quote Spradley (1980) in defining ethnographic data analysis as "a search for patterns," (p. 161). Interviewee responses were first organized into categories. The categories were then analyzed for domains. Based on repetition and frequency of responses domains were elicited. These domains, occasionally branching into sub-domains, were analyzed for patterns. The patterns, in turn, were analyzed for themes. Taxonomic analysis searched "for the internal structures of domains" and theme analysis

searched “for the relationships among domains and how they are linked to the culture as a whole,” (Spradley, 1979).

In the first stage of analysis, participants’ responses were categorized according to the initial inquiries. The following questions guided this part of the analysis:

1. What were perceived as the most common health problems for women?
2. What were perceived to be the pregnancy customs?
3. Describe the perceived activities of daily living for women?
4. What were the perceived causes of prolapsed uterus?
5. What was the perceived impact of prolapsed uterus on women’s lives?
6. What was the perception of available treatment for women with prolapse?

Rigor is traditionally established through credibility, confirmability and transferability (Streubert and Carpenter, 1999). Credibility is demonstrated through “engagement” with the participants and the culture as well as through “member checks;” confirmability is demonstrated through an “audit trail;” and the “potential users” of the findings must establish transferability when the research is completed, (Streubert and Carpenter, 1999, p.29). For reliability, a codebook of repeating themes was established and coding decisions were documented.

3.6 Operational Definitions

- Pelvic organ prolapse: Lack of support within the pelvic cavity to sustain proper genital anatomy. Associated with a sense of pressure or heaviness in the pelvic region, stress incontinence and lower back pain. Also referred to as uterine prolapse, vaginal prolapse and genital prolapse.
- Activities of Daily Living: Daily tasks undertaken in order to function within household and social structures; such tasks enable individuals to meet daily survival needs. Examples include toileting, hygiene, dressing, gathering water and food, cooking and eating.
- Adequate Nutrition: The ability to meet nutritional needs as defined by interviewees.

3.7 Ethical Considerations

The Nepal Health Research Council and the Colorado Multiple Institution Review Board both granted permission to perform the study. Participant information sheets, explaining the study objectives and methods, were read to each participant before consent was taken. Via tape recorder, informed and voluntary consent was obtained from all

participants before interviews. Names were not recorded on any of the data. Women were interviewed in private, away from family members. No direct or implied health education, treatment, or referral for treatment was given or offered to study participants. A professional transcriptionist converted individual interview data from tape to paper. All tapes and transcribed information were stored in a locked place and destroyed at the completion of the study. There were no changes in the usual method of treatment and no direct or perceived risks existed related to participation in this study for subjects or investigators.

3.8 Study Limitations

In the Terai, many Tharu women are still working as bonded laborers. These women, presumably in the field for the day, were weakly represented. During several FGDs, women disclosed that they were in fact TBAs. These women should have participated in the individual format, however, for unknown reasons, they choose to disclose their profession after the FGD had begun. Finding the balance between maintaining a natural setting, thereby fostering intimacy and increased interaction, and ensuring confidentiality and privacy was a challenge. Nepali culture is full of curiosity; therefore, shutting doors and requesting others to leave an area created increased clamor and interest. People often would wander into the discussion group, be asked to leave, only to return again with more onlookers. Additionally, participants would sometimes leave the group to chase a stray buffalo or tend to a child's need. They would return, but their input was lost for the questions they missed. Due to the remote areas in which the research was conducted, the team was unable to return to the study sites for follow up and clarification post analysis. Because examination of female participants was not a part of the study, distinction between prolapsed uterus and other pelvic organ prolapse was not made. Women who identified themselves as having prolapsed uterus could actually have had vaginal prolapse, cystocele, rectocele or uterine prolapse. In retrospect, the study would be aptly named An Ethnomedical Approach to Understanding Pelvic Organ Prolapse in Western Nepal. All VDCs visited, although classified as remote, were on main routes. Perceptions and experiences of those living "off the beaten path" may have varied significantly. Finally, obtaining consent was very difficult. Not only because women were uncomfortable with the tape recorder, but also because the value of consent was not fully embraced by the assistants—nor was it easily understood by the participants. Additional limitations included the need for a translator, the presence of various dialects causing language struggles and lack of time for lengthy immersion in the culture.

4. RESULTS

The results were gathered at the closure of all fieldwork. Accordingly, they were analyzed and categorized into domains and sub-domains. Domains were loosely structured along the figuration of the questionnaire. Because of the richness of the quotations and the unique quality of individual expression, an abundance of these quotes, organized by domain, are displayed below. The ethnographic nature of the study encourages the results to relay not only facts, but also the feelings behind them. The first three domains deal with the breakdown of the participants' demographics, but the remaining domains tell the story and outline prolapsed uterus in a culturally specific model, thus placing the disease within a meaningful and relevant context. It is these domains that depict the perceived pertinence and impact of POP in the study districts.

4.1 Profile of Interviews and Respondents

Five focus group discussions (FGD) were held in Bardiya, three with women and two with men. Five FGD were also held in Doti, three with women and two with men. Six FGD were held in Achham, three with women and three with men. Each focus group included six to eight study participants. Thus, there were 38 FGD participants in Bardiya, 38 in Doti and 44 in Achham equaling a total of 120 participants in focus group discussions. Individual interviews (II) were also held. In Bardiya, 12 individual interviews were held within two VDCs. In Doti, eight individual interviews were held within three VDCs. In Achham, ten individual interviews were held within three VDCs. Therefore, a total of 30 individual interviews were held. Of the 30 individual interviews held, 24 of them were with woman POP and six were with health care workers (HCW). The total of all study participants equaled 150 individuals (see Table 1, p. 22). Of the 97 women, 21 were literate (22%); of the 53 men, 43 were literate (85%). In Bardiya, nine out of the 34 women interviewed were literate and 14 of the 16 men were literate. The mean age of all participants in Bardiya was 34 years. In Doti, four of the 31 women interviewed were literate and 11 of the 15 men were literate. The mean age of all participants in Doti was 39 years. In Achham, eight of the 32 women interviewed were literate and 20 of the 22 men reported literacy. The mean age of Achham's participants was 35 years. Several castes/ethnicities were represented in the study. Convenience sampling assured that multiple groups were recognized. Occupational castes were not clumped into one group; therefore, individuals were designated by the caste or ethnicity directly stated by the participant. Groups not shown in the chart numbered only one. They were Jogy and Newar in Bardiya, Magar in Doti and Sunar, Pariyar (untouchable), Shudra (untouchable) and Sarki (untouchable) in Achham.

Table 1: Breakdown of districts and number of participants

DISTRICT	BARDIYA			DOTI			ACCHAM		
	Rajapur	Taratal	Khirsain	Pachenali	Chativan	Mastamand	Bayalpatta	Mangalzen	
FGD	3	2	2	2	1	2	2	2	
Male	1	1	1	1	0	1	1	1	
Female	2	1	1	1	1	1	1	1	
Individuals	5	7	2	2	4	4	3	3	
Health Workers	2	0	2	1	0	0	1	0	
Women with POP	3	7	0	1	4	4	2	3	
Total Participants	50	46	46	46	46	46	54	54	
Focus Groups	5 (38 people)	5 (38 people)	5 (38 people)	5 (38 people)	5 (38 people)	5 (38 people)	6 (44 people)	6 (44 people)	
Individuals	12	8	8	8	8	8	10	10	

Table 2: Caste/Ethnicity breakdown of all participants

Caste/Ethnicity	Bardiya	Doti	Achham	Total
Chhetri	8	25	26	59
Tharu	21	0	0	21
Brahmin	10	3	6	19
Thakuri	0	13	0	13
Dalit	0	0	10	10
Gurung	4	0	0	4
Bisaakamaa	0	4	0	4
Kami (Blacksmith)	2	0	1	3
Damai (Taylor)	1	0	2	3
Tomota	0	0	3	3
Ghandharba	2	0	0	2
Muslim	0	0	2	2

4.1.1 Combined Findings of All Districts: 24 Women with POP

Twenty-four of the 30 individual women interviewed suffered from POP. Of those 24, 12 had a parity of 3 or less, three had a parity of 4 and 11 had a parity of 5 or more. However, only six of those women were 40 years of age or older. Eighteen of the women with POP were less than 40 years old. Eleven of the women interviewed with POP were less than 30 years old. In the 24 women, POP occurred after the first delivery in 10 of the cases. POP occurred after the birth of the second child in 3 of the cases and prolapse occurred after three or more deliveries in 11 of the cases. Multiparity, the leading associated cause of prolapse, is commonly considered to be a parity of three or more; yet in this study population, 13 of the women had POP after single or double parity. Only four of these 24 women delivered in a hospital; 17 women delivered at home and three delivered in a *goth* or shed located outside of the home. All women except those who delivered in the hospital reported that a *budhi* or “old woman” (usually the mother-in-law, grandmother or mother) assisted them during their labors. Of the 24 women with POP interviewed, only three were literate; therefore 21 of the participants were illiterate. Nine women had spontaneous abortions and three intentional abortions were reported. Twelve women reported losing at least one child, either due to premature termination of pregnancy, still births or childhood deaths, for a total of 24 deaths. The mean age for marriage was 14 years old, with 7 years old and twenty years old as the out-layers. The mean age for first delivery was 17 years old, with 15 years old and 25 years old as the out-layers. Five newly married women waited more than six months to move into their husband’s home, a practice sometimes observed when the age of the bride is quite young.

Table 3: Number of pregnancies in women with POP

# of pregnancies	n
1x	1
2x	4
3x	7
4x	3
>5x	11

Table 4: Age of women with prolapse

age range	n
20-29 years	11
30-39 years	7
40-49 years	3
50 and over	3

Table 5: Timing of prolapse

Subject	n
Number of Women with POP	24
POP occurring after 1 st delivery	10
POP occurring after 2 nd delivery	3
POP occurring after 3 rd delivery	3
POP occurring after 4 th delivery	2
POP occurring after 5 th delivery	2
POP occurring after 6 th delivery	4

4.1.2 Bardiya: Ten Women with POP Interviewed

Ten of the twelve individual women interviewed in Bardiya suffered from POP. Of those ten, six had a parity of 3 or less, one had a parity of 4 and three had a parity of 5 or more. However, seven of the ten women were less than 40 years old. Six of the ten women interviewed with POP were less than 30 years old. In the ten women, POP occurred after the first delivery in six of the cases. POP occurred after the birth of the second child in two of the cases and prolapse occurred after three or more deliveries in two of the cases. Multiparity, the leading associated cause of prolapse, is commonly considered to be a parity of three or more; yet in this study population, eight of the women had POP after single or double parity.

Table 6: Number of pregnancies in Bardiya women with POP

# of pregnancies	n
1x	0
2x	2
3x	4
4x	1
>5x	3

Table 7: Age of Bardiya women with prolapse

age range	n
20-29 years	6
30-39 years	1
40-49 years	1
50 and over	2

Table 8: Timing of prolapse in Bardiya women

Subject	N
Number of Women with POP	10
POP occurring after 1 st delivery	6
POP occurring after 2 nd delivery	2
POP occurring after 3 rd delivery	1
POP occurring after 4 th delivery	0
POP occurring after 5 th delivery	1
POP occurring after 6 th delivery	0

Two of the ten women were literate; all the women gave birth at home and none were assisted by trained personnel. All stayed at home during the immediate postpartum period. Three spontaneous abortions but no intentional abortions were reported. Four women reported losing a child due to premature termination of pregnancy, stillbirth or childhood death. There was a total of eleven lost lives or pregnancies. The mean age at marriage was 15 years old, with the youngest reported to be 13 years old and the oldest to be 18 years old. The mean age at first delivery was 17 years old, with 15 years old and 19 years old as the out-layers. Two brides waited six months or more to move into their husband's home. Three of the women were Tharu and three were Chhetri. The other four women were Damai, Gandharb, Jogi and Gaine, respectfully.

4.1.3 Doti: Five Women with POP Interviewed

Five of the eight individual women interviewed in Doti suffered from POP. Of those eight, one had a parity of 3 or less, one had a parity of 4 and three had a parity of 5 or more. Three women were less than 40 years old. Two of the eight women were less than 30 years old. POP occurred after the second delivery in one of the cases and after the fourth delivery in two of the cases. The other remaining two cases occurred after that the fifth and six deliveries. In this district, only one woman with prolapse was not also multiparous.

Table 9: Number of pregnancies in Doti women with POP

# of pregnancies	n
1x	0
2x	1
3x	0
4x	1
>5x	3

Table 10: Age of Doti women with prolapse

age range	n
20-29 years	2
30-39 years	1
40-49 years	1
50 and over	1

Table 11: Timing of prolapse in Doti women

Subject	n
Number of Women with POP	5
POP occurring after 1 st delivery	1
POP occurring after 2 nd delivery	0
POP occurring after 3 rd delivery	0
POP occurring after 4 th delivery	2
POP occurring after 5 th delivery	1
POP occurring after 6 th delivery	1

All women with prolapse were illiterate; one gave birth in the hospital, one gave birth in a *goth* and three gave birth at home. Only the woman who delivered in the hospital was assisted during delivery by trained personnel. All women stayed at home during the immediate postpartum period, except for one woman who stayed in a *goth*. Three out of the five women lost a child either due to premature termination of pregnancy, still birth or childhood death. There was a total of six childhood deaths or pregnancy losses. The mean age for marriage was 15 years, with the youngest reported at eleven years and the oldest recorded at twenty years. The mean age at first delivery was 18 years, with 15 years and 23 years marking the out-layers. Of the five women interviewed, three were Chhetri and two were Bisaakamaa.

4.1.4 Achham: Nine Women with POP Interviewed

Nine of the ten individual women interviewed suffered from POP. None of those women were over 40 years of age. Three of the women interviewed with POP were less than 30 years old. In the nine women, POP occurred after the first delivery in three of the cases.

POP occurred after the birth of the second child in one of the cases and prolapse occurred after three deliveries in two of the study population cases. Therefore, at the time of prolapse, six had a parity of 3 or less, three had a parity of 6 or more. In this study population, four of the women had POP after single or double parity.

Table 12: Number of pregnancies in Achham women with POP

# of pregnancies	n
1x	1
2x	1
3x	1
4x	1
>5x	5

Table 13: Age of Achham women with prolapse

age range	n
20-29 years	3
30-39 years	5
40-49 years	1
50 and over	0

Table 14: Timing of prolapse in Achham women

Subject	N
Number of Women with POP	9
POP occurring after 1 st delivery	3
POP occurring after 2 nd delivery	1
POP occurring after 3 rd delivery	2
POP occurring after 4 th delivery	0
POP occurring after 5 th delivery	0
POP occurring after 6 th delivery	3

Three women delivered in a hospital, four women delivered at home and two delivered in a *goth*, or shed located outside of the home. Except for the women who delivered in the hospital, labors were reported to be attended by a *budhi*. The women all spent the immediate postpartum period in the same location as the delivery, thus two remained in the *goth*, three in the hospital and four at home. Of the nine women with POP interviewed only one was literate; eight of the participants were incapable of writing their own name. Two women had spontaneous abortions and two women reported intentional abortions due to bad timing or poverty. Five out of nine women lost a child either due to premature termination of pregnancy, stillbirth or childhood death. There was a total of seven childhood deaths or pregnancy losses. The nine women with prolapse began menstruation between the ages of 12

and 16 for a mean age of 13 years for menstrual onset. The mean age for marriage was 12 years old, with 7 years old representing the youngest and 16 years old representing the oldest. Only two women, a 7 year old and a 14 year old, waited for six months or more before moving to their husband's home. The women first delivered between the ages of 16 and 25, five of them at the age of 17 creating a mean of 16 years old. All women reported spending four to five days each month in the *goth* during their menstruation, a fact that held true only in Achham. Three women were Dalit, two were Tamota and the remaining four were Damai, Chhetri, Brahmin and Sarki.

4.2 Free-listing: Perceived Healthcare Problems

Through the free listing exercise, major healthcare concerns of women were discerned in all three districts. In the beginning of each interview, both individuals and focus group discussions, participants were asked simply "What are the most common health problems for women?" Their spontaneous and informal lists were compiled and the ones most frequently mentioned represent the perception of the areas' most common illnesses (see Table 15).

Table 15: Results of free listing

Bardiya	Doti	Achham
Swollen feet +++ (3)	Irregular bleeding	POP ++++++++ (12)
Stomach pain +++(3)	Intrauterine Fetal Demise	Stomach pain ++++++ (7)
Dizziness ++ (2)	Headache	White watery discharge +++++(6)
Back pain ++ (2)	Stomach pain	Irregular bleeding +++++ (6)
Weakness ++ (2)	White watery discharge	Back pain ++++(4)
Dysmenorrhea ++ (2)	Weakness	Weakness ++++ (4)
Body pain	Back pain	Delivery complications ++++ (4)
Headache	Numbness and tingling	Headache +++ (3)
Fever		Dysmenorrhea +++ (3)
Abortions		Uterine Cancer +++ (3)
Burning upon urination		Hand and feet pain +++ (3)
Vaginitis		Chronic cough +++(3)
HIV/STDs		Fever +++ (3)
Cervical cancer		Retained placenta ++ (2)
Fistual		STD/HIV ++ (2)
White watery discharge		Diarrhea ++ (2)
		Dental problems
		Asthma
		Infertility
		Miscarriage
		Chest pain
		Hemorrhage
		Vomiting

“My labor was two or three hours long.” (II)

“For all of my pregnancies, my labor lasted two hours.” (II)

“My labor was two hours long.” (II)

In general, pushing during labor seemed not to be prolonged. Prolonged pushing has been reported in some developing countries where supervised births are rare. Lengthy hours of pushing could subject women to a prolonged increase in intra-abdominal pressure, a possible associative of prolapsed uterus. The participants’ statements, however, concluded healthy pushing patterns.

“After two days, I began to push and I pushed for two hours.” (II)

“I only pushed five to six times and the baby came out.” (II)

“My labor didn’t take too long, so I only pushed three or four times.” (II)

“Pushing usually only lasts for one hour.” (II)

“I only pushed one or two times for each delivery.” (II)

“I only pushed maybe six or seven times.” (II)

“I only pushed two or three times.” (II)

“I pushed just two or three times, not more than that.” (II)

“During both of my labors, I only pushed for one hour.” (II)

Of course, out-layers existed, but they were few.

“My labor lasted for two days.” (II)

“Women usually push for 6 to 7 hours. It depends on the situation and how long their labor lasts.” (FGD, men)

“Some women push after two to three hours, but in rare cases, after two to three days. It depends on their labor.” (FGD, women)

4.4.3 Family Size

Questions were asked to elicit an understanding of the desired family size.

Comparisons were made between the desired size and the actual size. Interestingly, both women and men reported wanting or feeling families should be smaller than they were.

Women expressed desiring fewer children than they actually birthed.

“Women should have two children, but most have eight.” (FGD, men)

“Women should have two boys and one girl, but I had five children.” (II)

“Women should have two to three kids, but generally they have five. These days it is a little less.” (FGD, men)

“Women want one son and one daughter, but most of them have seven or eight children” (FGD, men)

“I only wanted two sons and one daughter, but I got six children.” (II)

“I wanted two sons and one daughter, but I had four altogether.” (II)

It is unclear if the reported desired size reflects intensive awareness and education programs targeting population control or whether this reflects a change in traditional patterns.

4.5 Women’s Work: Activities of Daily Living

4.5.1 Description of ADL

Activities of daily living (ADL) are defined as activities that make up the essential tasks of existence. Without completing these tasks, survival becomes bleak. In the West, ADLs usually omit work, but in the study districts traditional ADLs, such as cooking and cleaning, were paralleled daily chores. Women and men were asked to describe the daily lives and work of women. The work described was often demanding, but more noteworthy, it was essential to the continuity of the household. Without the completion of such work, the family would dissipate. For example, one women’s FGD participant stated,

“We can’t survive without doing our work. To survive we have to eat, so we must work. We are living in a hilly area, so without working, we can’t survive.” (FGD, women)

In describing the sphere of women’s work, a male FGD participant stated plainly,

“All daily work is women’s work.” (FGD, men)

Another participant confirmed,

“Women do everything except plowing.” (FGD, men)

The descriptions of the daily work did not differ much between genders or districts.

“We women fetch the water, cut the grass, collect the firewood, do husbandry, work in the field, cook, de-husk the rice, clean the rice, clean the house, clean the dishes, paint the house, do the laundry, carry the fertilizer and watch over the children.” (FGD, women)

“Women make gravel from larger stones for the house. They must carry the gravel from the river to the road.” (FGD, men)

“Women’s work is in the fields, cutting the grass, carrying water, milling, cooking, eating, collecting the firewood and watching the children.” (FGD, women)

“They cut the grass, cook the food, watch the children, collect the firewood, bring the water, work in field, mill, grind the grain, watch over the animals, carry the fertilizer.” (FGD, men)

“Women do all the work inside the house, and bring the grass, collect the firewood, watch the cattle, serve the husband and work in the fields too.” (FGD, men)

“Women’s work is to cut the grasses, collect the firewood, fetch the water, de-husk the rice, work in the field, cook, watch the animals and have babies.” (FGD, women)

“My work is to fetch water, cook, cut the grasses, gather the firewood, de-husk the grains, collect fodder and fertilizer and watch the kids and the animals and look over the home.” (II)

“I collect grass, look after the children, work in the field, shop and sell fruit from Mangalzen down in Sanfe, watch the animals, cook.” (II)

“I collect firewood and fodder, look after the animals, de-husk the rice, cook and look after the children.” (II)

When asked about men’s contributions, one male participant retorted,

“Sometimes we help by looking after the children, but we never cook or do laundry. That is their work.” (FGD, men)

4.5.2 The Squatting Position

Because literature has suggested a possible association between the squatting position and weakened pelvic musculature, participants were asked which tasks were completed in this position. Again, answers were so similar, that saturation was quickly obtained. General agreement listed several activities as requiring the squatting position, namely cooking, defecating, fieldwork, eating, laundry, de-hulling/milling grains, cleaning dishes, painting the house, cleaning the house and child birthing. When asked how many hours each day this position was maintained, answers varied and therefore consensus was not obtained.

“If I am in the field, I squat all day. If not, just two to three hours a day.”

“I don’t know how many hours I am like this!”

“I squat for maybe one to two hour a day”

“If we are in the field, we sit like this all day.”

4.5.3 Rest

Due to the large work demands placed on women during the day, participants were questioned about the amount of rest available. Answers were fairly uniform between genders and districts.

“We don’t have time to rest. For us, rest is when we comb our hair.” (FGD, women)

“After they die, they can rest.” (FGD, men)

“Ones who have wealth . . . will take enough rest. But those who are poor cannot get meals without working.”

Rest, an essential quality of the healthy lifestyle, appeared to not be given significant value in the districts visited. The history of long working hours maintains a tradition that denies its women much needed rest.

4.6 Community Understanding of Prolapse

4.6.1 Ways of Knowing

Participants were asked to describe how they know who has prolapse. Their responses were paired into verbal knowing and visual knowing. Interestingly, often the men learned about cases through verbal means, but women tended to rely on visual means. For example, women's FGD commented as such:

"We can see the prolapse, that's how we know! When the woman leans over to fill the water jug, we can see it." (FHCV)

"When they walk we can see a big bulge from behind, so we know they have it. Also, when they squat we can see it. It looks like a man's penis." (FGD, women)

"We only know about it because of the way these women walk and sit." (FGD, women)

"Sometimes we can see it, other times we learn by word of mouth." (FGD, women)

"Women with this disease ask other women if they have it, so we know they have it." (FGD, women)

Men, on the other hand, responded as follows:

"When other women tell us, we know!" (FGD, men)

"We learn about who has it through word of mouth." (FGD, men)

"We just talk and then we learn about it." (FGD, men)

"We learn about it indirectly. Our wives will say, 'If I work too hard, I'll get like Rita (a woman with prolapse).' That's how we learn." (FGD, men)

What is glaringly missing in these answers is a place of sharing and thereby information exchange. Lack of direct information often fosters rumors and incorrect knowledge.

4.6.2 Knowledge of Prolapse

Knowledge varied among groups and districts, however unifying factors did exist. As one woman in a FGD pointed out,

"Even illiterate people know that it will definitely happen to the one who will undertake heavy work, like carrying grains, fetching water and carrying heavy loads from the fields." (FGD, women)

Other women's discussions revealed an understanding of different types of prolapse. These descriptions fit loosely into the medical grades, or stages, of prolapse.

"There are two types of prolapse, male and female. If it is the male kind, it is the long kind, and women can't have any more children. If it is the female kind, then women can have more children." (FGD, women Bardiya)

"If it is a male one, it is very difficult to live with. If it is the female one, the woman can still have babies and it is not as difficult as the male one is." (FGD, women)

4.6.3 Perceived Progression

Although variations in perceived onset were recorded, participants clearly knew that onset fluctuated with circumstance and individual cases.

“Sometimes women get it immediately after their first baby. Sometimes it will take six months. Other times it takes five or six babies.” (FGD, women)

“They will get it 13 or 15 days after delivery.” (FGD, women)

“Some women get it after their first pregnancy, some women get it after their third. Not all women are the same.” (FGD, men)

“Some will get this suffering six months after delivery and some after one year.” (HCW)

“It can happen at any time.” (HCW)

“There is no fixed time when this diseases starts. Some women get it immediately after their first baby, other women get it after their menstruation stops.” (FGD, men)

“We don’t know exactly when it comes out, but if a woman coughs a lot during the delivery, it can come out.” (FGD, women)

When asked to describe POP’s progression, answers were a little more scattered.

“First comes water and then comes a cough and then it feels like everything in your stomach comes out, especially when you cough.” (FGD, women)

“It starts after delivery when the uterus doesn’t return to it normal shape. At that time, if the woman lifts a heavy load, it comes out.” (HCW)

“For the last three years, it hasn’t gone back inside. Mine is really big now.” (II)

“Maybe for some women it will get smaller. Maybe because the body gets old and shrinks. Maybe the uterus shrinks and get smaller too. But maybe for some women it also gets bigger, but I don’t know why.” (FGD, women)

The apparent lack of knowledge regarding prolapse’s progression probably stems from multiple sources. Direct sharing of information is not common, therefore, women probably are not encouraged to educate others on disease progression. Lack of healthcare education fosters the community’s medical ignorance. Additionally, lack of treatment cultivates an attitude of resignation.

4.6.4 Perceived Curability

In general, interviewees perceived POP to be incurable. Occasionally, respondents associated severity of prolapse with its ability to be cured.

“If the prolapse is small, it can be cured. But if is a total prolapse, there is no cure.” (FGD, women)

“If I see a doctor, maybe he can cure it, but it won’t be cured by itself.” (II)

“If there is a cure, we don’t know about it.” (FGD, men)

“It can’t be cured, but I think it can be made tighter.” (HCW)

“There is no cure.” (II)

“There is no local cure, if there is a doctor’s cure, we don’t know about it.” (FGD, women)

“In the very beginning it maybe curable, but otherwise, there is no cure.” (FGD, women)

4.6.5 Commonality

During the FGD usually one or two women would reveal they suffered from prolapse. Similarly, one or two men would reveal that their wives suffered from prolapse. It was not uncommon for one or two members of the women’s group to also admit that their aunt or grandmother or mother or sister-in-law suffered from prolapse. Likewise, it was never difficult to find individual women to interview who were suffering from prolapse.

“Not all women get it. She who works a lot, she who is weak, women like that get it.” (II)

“Everybody doesn’t get it, but many people do.” (II)

“Not all people get it, but lots of people do.” (II)

“All people get it, everybody.” (II)

“I think 75% of women get it.” (FGD, men)

Some respondents felt prolapse was more elusive.

“Only a few people get prolapse.” (II)

“Only some women get it.” (FGD, women)

“It is not a simple disease, you can’t get it like a cold.” (II)

“I think 5% of all women get it.” (FGD, men)

Overall, all male and female groups knew what prolapse was and all participants had at least heard of the disease.

4.6.6 Perceived Significance

Participants generally perceived that prolapse was a problem greatly affecting women’s lives. The prolapse was perceived as being painful and therefore causing difficulties in performing daily work.

“Of course prolapse is a problem, I got it!” (II)

“It is a big problem for me because it makes work difficult and it makes me weak.” (II)

“It is a big problem for me because it is outside of me. The fact that it is outside is a problem. Working in the field and carry heavy things is difficult. Sometimes a husband will leave his wife because of this.” (II)

“Prolapse is a big and important problem because women must do heavy labor, but if they have prolapse, they can't do it.” (FGD, men)

“This is a big problem for me because it affects my work and we women have a lot of work to do. (II)

“It is an important problem. In villages, women have to do a lot of hard physical work, but they can't do this if they have prolapse.” (II)

Additionally, prolapse was perceived to hinder family relations. Predominately, however, prolapse upset the women suffering from it because they perceive it affects their ability to raise children and be productive members of their families.

“This is a big problem for me. For living, we need work. Carrying heavy loads, we raise our children. After the prolapse, I cannot work, that's why I have such worry.” (II)

“This is important because if they get it they can't work I the fields and then it is hard to care properly for the house and children.” (HCW)

“This is a big problem. Because of this, some women die. Women are, all in all, chief of the house. So if their body is weak and not working well, it affects the lives of all the family members. If they die, this is the biggest tragedy of all.” (FGD, men)

4.7 Perceived Causes

In order to assess the communities' perception of possible causes of prolapse, several questions were asked in order to cover all conceivable understandings. The central questions asked were, “Who gets prolapsed uterus?” and “Why do women get prolapsed uterus?” Although these questions appear to resemble one another, different participants comprehended different meanings. For example, some groups were able to answer one question but not the other. For convenience, the answers to who and why questions were combined into one sub-domain. Women identified as having prolapse were asked, “How did you get prolapsed uterus?” The answers were startling in their similarities and enlightening in their breadth. Several personal stories revealed interesting cases studies, thereby composing a separate sub-domain.

4.7.1 Who Gets It and Why

Women and men were very clear on the possible causes of prolapse uterus. Every individual interviewee and almost every member of the FGD associated prolapse with performing hard physical labor in the postpartum period. Women specifically mentioned

carrying grass, milling the rice with a foot pedal and cooking with large, heavy pots as work that causes prolapse.

"I got it because of a heavy work load. I am alone, so there is no one to help me." (II)

"Yes, these days many women come as they mostly involved in fieldwork, naturally it will come out." (HCW)

"Women who lift heavy loads immediately after their delivery have this problem, they are more affected. Like those who fetch water in big buckets, or carry loads of wood or do the *dhiki* (foot milling). Also those who hold the baby all the time." (FGD, women)

"Immediately after delivery, if the woman does heavy work, like carrying a heavy pot and firewood, that makes the uterus fall." (FGD, men)

"After delivery, women have to do a lot of heavy work. Like farming and carrying heavy loads. Two years ago we didn't have any running water, so they had to fetch the water too (four kilometers away). That is why it happens to them." (FGD, men)

"Sometimes they get it because, if they have a big family, they have to use a really big pot for cooking the rice and if they lift it, it [the uterus] falls." (FGD, women)

"I know why women get it. Listen! After delivery, the uterus is weak. If she doesn't rest and works hard, there is pressure in her stomach and the uterus pushes down and out." (FGD, women)

"If people are rich, then they have people to help them and they don't get it. But people like us, we get it." (FGD, women)

"Women who carry the heavy load get it." (FGD, women)

"Women who do heavy work get it." (FGD, women)

"I got it because of weakness and too much heavy physical fieldwork." (II)

A lack of nutritious foods was also frequently perceived to have a causal relationship with POP. Many groups and individuals associated potential causes together. For example, diet and nutrition were frequently mentioned in conjunction with lifting heavy loads. Weakness was also interlaced within their perceived causality.

"Those who lift heavy loads and are malnourished get it." (FGD, men)

"People who lift heavy loads, those who are weak, those who don't get enough food after delivery and those who work immediately after labor, they get prolapsed uterus." (FGD, women)

"My delivery took place at home. I didn't have any rest, being the only daughter-in-law, so I had to work hard in my home and it fell out."

"It happens from lifting heavy loads." (FGD, men)

"Women get it because of lifting heavy loads and a lack of nutritious food. During, before and after pregnancy they suffer from lack of rest." (FGD, men)

"Weak women, women who carry heavy loads, women who don't get enough nutritious food, they get prolapsed uterus." (FGD, men)

"I got it from weakness and too much physical work in the field." (II)

"Lack of nutritious food can also cause this problem." (II)

"Those who have many babies, who have a lack of nutritious food, who carry heavy loads, they get it. Sometimes if someone lifts a heavy load within three to four months after delivery, they will get it. Also if they do this kind of work during the pregnancy, they may get it." (FGD, women)

"Women who don't get nutritious food get it." (FGD, women)

"I got it because of a lack of vitamins. If I had taken vitamin pills, it would not have happened."

"Lack of awareness and lack of nutritious food cause prolapse." (FGD, men)

"We aren't sure of the exact cause of prolapse, but we think it may be because of heavy work during and after pregnancy and also less food during that time." (FGD, men)

"I don't know why it happened to me, but I don't get a lot of nutritious food and so my body doesn't have a lot of strength—maybe this is why I got it." (II)

"It can also come from lack of fruits and green vegetables and heavy labor." (FGD, men)

"Prolapse comes from having a lot of work and not enough food." (FGD, women)

"Superstitions can cause it. Like if you have a bay, don't eat this or that. Don't eat egg, potatoes or green vegetables during the resting time after delivery." (FGD, men)

Although occasionally weakness stood on its own as a perceived cause, mental tension was frequently discerned to have a joint impact as well.

"The women who are very weak get it, even before they have any children!" (FGD, women)

"It happens because of the weakness."

"Weakness causes it." (FGD, women)

"Women with weakness get it." (FGD, men)

"Weakness, mental tension and lack of nutritious food." (HCW)

"Not everyone will get this, but those who don't have enough food and who are really worried—because worrying makes you weak—and those who have no money for treatment, only they get it." (II)

"Prolapse comes from mental tension." (FGD, men)

"It is caused by . . . mental tension, which causes a lack of appetite and then they get weak." (II)

"When women worry, it makes them weak and they can't eat which adds to the weakness." (FGD, women)

Use of birth control was blamed as a causative factor twicem

"Women who have many children and who use birth control pills can get it." (FGD, men)

“Birth control pills and Depo shots destroyed my uterus.” (II)

Although it was occasionally mentioned by study participants, multiparity seemed to be relatively insignificant as far as perceived causality for POP was concerned. The overall perception did not closely associate multiparity or short spacing between births as a direct cause of POP. Multiparity was, however, identified as a health concern. Only one participant, a TBA, mentioned the lack of supervision during birth as a possible cause. Additionally noteworthy was the belief several women held that if a woman coughs a lot during the delivery, her uterus would fall in the postpartum period.

“If they give birth every year and have a difficult labor, they can get it.” (FGD, men)

“I got it from not having good food, lifting a heavy load too much and having a child year after year, in a row.” (II)

“After delivery, the vagina doesn’t close back to its normal size. Because the size is so big, the uterus falls out.” (II)

“If you give birth many years in a row, you might get it.” (FGD, women)

“If a woman coughs a lot during delivery, that can cause it.” (FGD, women)

“If a woman coughs too much it can happen.” (FGD, men)

“Those who don’t get any help during labor get it.” (FGD, women)

Interestingly, several participants also perceived that sex within the first 15 days of the postpartum period contributed to prolapse. In one FGD with men and one with women, dissatisfaction in sexual relations could cause a woman to have prolapse.

“I think prolapse comes from dissatisfaction with one’s sex life.” (FGD, men)

“Having sex during the first 12 or 13 days after delivery can cause prolapse.” (FGD, women)

“If a woman has intercourse just before delivery they will get prolapsed uterus.” (FGD, men)

“Sex within 15 days of delivery can also cause prolapse.” (FGD, women)

“Those who have sex within 15 days of delivery, they can get it.” (FGD, women)

“Women who have intercourse 15 days after delivery, they can get it too.” (II)

Rest, commonly associated with too much heavy physical labor, was occasionally singled out as its own etiology.

“Not getting enough rest [causes it].” (FGD, women)

“Only the women who don’t take rest will suffer with [prolapse].” (HCW)

“They don’t rest enough after delivery” (FGD, men)

A few out-layers presented within FGD concerning causality. Although one revealed frustration, another hinted at the religious conviction and acceptance, which permeates this dominantly Hindu society. Still another woman focused not on the actions that result in prolapse, but the environment in which prolapse flourishes—the implication is a non-supportive family.

“If it is written in your fate, you will get it.” (FGD, women)

“You can get it for no reason at all.” (FGD, women)

“In my opinion, if the woman’s family is helpful and good, they won’t suffer from this disease. But if they are staying with a rude family, they may get this disease.” (II)

4.7.2 Case Studies

When women were asked how they got it, their stories came out fast and concise. No one hesitated; no one pondered her answer. Their stories depicted, without doubt, the perceived cause of prolapse to be actions that result in an often sudden increase in intra-abdominal pressure. Although the events preceding these moments are not told—and are inevitably complex and paramount to each individual woman’s etiology—the below stories tell their own powerful and poignant tale.

“On the 12th day after my 6th child, I was weeding the field. When I came home, I sat in the squatting position and it came out on its on.” (II)

“It happened to me five days after the birth of my fourth child. I went out to collect and carry the fodder and it fell out.” (II)

“It happened to me six weeks after the delivery of my first child. I felt sick when I was still a new mother. I did not eat good food. It was hot . . . I had to lift heavy things.” (II)

“I grew weak and it happened when I lifted up a heavy container. I used to lift up water containers, grass fodder, firewood loads, etc.” (II)

“I got it 17 days after my first delivery. It was winter and I was sitting by the fire in a squatting position. I sneezed and at that moment, it came out.” (II)

“Fifteen days after my delivery, I took the ox out to graze. One ox ran away. I had to catch it, so I ran after it. After I took a few fast steps, it fell.” (FGD, women)

“I have prolapsed uterus. It started five years ago, after my husband died. It was the same year of my last delivery. After my husband died, my responsibilities increased. I bought oranges in Mangalzen and took them to Sanfe to sell (6 hours of steep terrain each way). I did this to have money to raise my children. It was too much walking and too much of a heavy load on my back. That’s why I got it.” (II)

“After my first child, it came out. After 13 or 14 days, I cooked about 7 kilos of rice. The pot was very heavy. When I finished cooking, I asked my sister-in-law to pick up the pot and put it on the ground. But she didn’t listen, so I did it myself. The prolapse came right then.” (II)

when I got it and also why I got it. At the same time, my daughter-in-law became paralyzed. Because she couldn't move, I had to lift her. When I was lifting her, it came out." (II)

"Six days after my delivery, I went to wash the clothes. I was carrying the wet clothes home and it came out." (II)

Although every story was not told and a few women stated they were unsure of exactly when their prolapse started, a clear pattern emanates from these answers.

4.7.3 Symptoms

FGD and individual women were asked several questions in order to ascertain an understanding of the known symptoms of prolapse. It was difficult to gain an understanding of pain levels, as pain tolerance differs dramatically between western and eastern cultures. Nonetheless, answers were collected and coordinated into groups according to perceived symptomology. The most commonly reported symptom of prolapse was *seto pani*, which is commonly translated as "white watery discharge."

"In-laws feel dirty if a woman has prolapse. These women discharge a lot of water with a foul smell. Even if she washes her clothes, the foul smell and dirtiness stay. Sometimes it bleeds, sometimes these women don't like to eat and they become weak. It is difficult for them to walk and work." (HCW)

"When they have prolapse, water is always coming from them." (II)

"Women with prolapse have water pouring out of them and it smells bad." (FGD, women)

"I always have white watery discharge [since the prolapse happened]." (II)

Several women hinted at discomforting symptoms traditionally reported in the west, such as cramping and lower back pain.

"They feel their whole stomach is bloated. Some women cannot walk properly with this. (FGD, women)

"When it comes out and won't go back inside, it hurts a lot in the stomach." (FGD, men)

"When I work carrying heavy loads, I have lots of lower back pain." (II)

"When it falls I have abdominal pain." (II)

"If they have it, they feel back pain, weakness and they feel dizzy." (FGD, women)

"I feel uneasiness when I sit and I feel pain when I walk and work." (II)

"Sitting, standing, walking it can hit your thigh, that is very painful and difficult." (II)

"It feels like my life is broken. It feels like life is over because, when it comes out, it is very painful. When it comes out, it hurts so much I cannot bear the pain. I feel sometimes like an electrical current is passing through my body." (II)

A review of the literature demonstrates that often women don't visit healthcare providers until symptoms become unmanageable, such as when they interfere with urination and defecation. These problems were known in the study districts as well.

"This disease causes pain and it also brings an uneasy feeling. And sometimes it is difficult to urinate and defecate." (FGD, women)

"Prolapse is painful. It is difficult to walk, to urinate and also to defecate." (FGD, women)

"Women with this problem have to pee a lot." (FGD, men)

Although the affect on menstruation is reviewed elsewhere, the following statements relate to the pain prolapse causes during menstruation.

"During menstruation, if my clothes touch the prolapse it hurts. It bleeds too, a different kind of blood than menstrual blood." (II)

"I feel very uneasy. When I sit, I feel uneasiness and I become dizzy due to weakness. When I work, I also feel uneasy. It hurts a lot during my menstruation." (II)

For many women, the prolapse did not remain continuously outside of the body, but rather fluctuated in its position.

"When I lay down, it goes inside, but when I stand up, it always comes out again." (II)

"It goes inside of me when I rest and sleep, but when I begin to work, it again falls." (II)

"It comes out when I do heavy work. But I have to work. When I cook, I have to lift heavy pots and utensils and it falls out then. It also falls when I sit in the squatting position." (II)

These quotes shed light on the implications of prolapse in terms of pain and daily discomfort. The frequent use of the term "uneasy" depicts a rather constant sensation of low-level disruption in one's daily life.

4.8 Lifestyle Changes/POP's Impact

The perception of how prolapse impacts one's life was intensely investigated. Study participants were asked several questions aimed at discerning the disease's impact on emotional and physical spheres as well as its impact on traditional healthcare domains, such as pregnancy and delivery, sexuality, marriage, menstruation, work and family life. The results are compiled into several sub-domains presented below.

4.8.1 Emotional Impact

The sentiments expressed below offer a vivid picture of the communities' perception of living with prolapse. The results show a community that isolates and shuns women with prolapse. They also reveal the internalized humiliation with which these women struggle.

“It is very sad for these women because family members and neighbors insult them.” (FGD, women)

“I feel uneasy when I sit, walk, clean the dishes and even when I sleep.” (II)

“Sometimes they will hide due to their shame.” (HCW)

“Some women feel no shame, but some women do.” (HCW)

“These women feel humiliated and they don’t want to talk to anyone, so they withdraw from social situations. The community insults them. Mother-in-laws say to them, ‘You can’t work! Why are you only at home?’ These women can’t work, so it is humiliating.” (FGD, men)

“If you get it, you get weak and you can’t work properly. It also is difficult to walk. This makes a big change in life.” (HCW)

“This very disease causes mental tension and disturbances.” (II)

“Some women feel it is difficult to raise their children and even to walk. They feel pain. Their family members, both men and women, call them dirty.” (FGD, women)

“If there is anybody to talk to, they will talk to them. Our husbands and mother-in-laws tell us not to use or touch clothes of women with prolapse.” (FGD, women)

“We don’t like to talk about this.” (FGD, women)

“These women cannot work and they cannot eat a lot, so life for them is gone.” (FGD, women)

“They feel scared because they are always worried about when it will fall out.” (FGD, women)

“Air comes out of my vagina and makes a big sound. It makes me feel humiliated to sit down in front of any men.” (II)

“When it happens, it is like there is no difference between life and death.” (FGD, women)

4.8.2 Physical Impact

Similar to emotional impacts, the physical descriptions of life with prolapse are bleak.

Most frequently mentioned difficulties included walking, sitting and carrying heavy loads.

“After a big meal it comes out. So I have fear to eat lots of food. If I carry the heavy load, I have to walk with my feet crossed so it doesn’t fall out.” (II)

“It hurts especially when it falls out. It also hurts when I push it back inside. It doesn’t hurt after that too much. It only hurts when it falls again. It never feels comfortable. It is dangerous for my life, but we have no money so I have never left home.” (II)

“It is difficult to walk. It doesn’t hurt, but it is difficult to walk.” (II)

“Women with prolapse can’t walk or sit straight.” (FGD, women)

“When I lay down to sleep, it goes inside. Before and after sleeping, it stays just barely inside of my vagina. That feels really uncomfortable, so I put my feet up when I sit.” (II)

The pain associated with prolapse may be sporadic for some women, but for others this pain inhibits their activities of daily living.

“These women can’t carry heavy loads, and they also can’t eat a lot. If they eat a lot, it falls out.” (FGD, women)

“It comes out sometimes, but it doesn’t always hurt. White watery discharge comes out all the time. While working in the fields, doing laundry and cooking it feels really uncomfortable.” (II)

“It feels like a poke or a stick on my leg. It is an uncomfortable feeling. When I cough, it comes out and it hurts a little.”

“It hurts a lot, especially after it comes out, like when I walk or lift anything heavy.”

“The vagina hurts a lot. I don’t know exactly but women who have it can’t sit, so they have to sit sideways. They can’t work and can’t bend over easily. They can’t sit in a squatting position, can’t eat a lot of food because if they do it will press down on the uterus and make it come out. They can’t cough either, or it will come out.” (HCW)

“Prolapse really hurts and if you have it you can’t walk.” (FGD, women)

“It hurts. It feels like some thing pokes inside the vagina and when it comes out it looks like a penis.” (FGD, women)

“When they walk, it really hurts.” (FGD, women)

4.8.3 Impact on Pregnancy and Delivery

Responses to questions on pregnancy and delivery varied more than any other domain or sub-domain. Additionally, responses were similar in all districts. Some participants felt that prolapse had no effect on these areas:

“There is no direct effect on pregnancy or delivery.” (FGD, women)

“There is no effect on her next babies.” (II)

“There is no effect of the ability to have another baby.” (HCW)

“It didn’t effect my ability to have more babies.” (II)

“If she gets the small one—we call it the male kind—she will be able to have children again. If she get the big one—we call it the female kind—she cannot have children again.” (HCW)

Yet others felt strongly the impact was not only significant, but dangerous as well. Such reactions, in fact, reflect the truth of the disease: it depends on the severity (grade/stage) of prolapse as well as the environment and individual health of the patient.

Pregnancy

“They may be able to have another child, only the delivery may become difficult. But it doesn’t effect the ability to get pregnant.” (FGD, men)

“Some women can have more children, some can’t. It depends. If it is the *baaThe* (female goat) kind, they can have children. If it is the *bake* (male goat) kind, then they can’t.” (FGD, women)

“If it is a long one, *bake* (male goat), no babies can come. If it is a round one, *baaThe* (female goat), then babies can come. There is only an affect on delivery if it comes out with the baby, then it can be very difficult.” (II)

“I heard it can make getting pregnant difficult.” (II)

Delivery

“It didn’t effect the births, but right afterwards, it came out and it caused a lot of pain.” (II)

“A women with prolapse has a greater chance of dying during labor.” (FGD, men)

“Delivery can be difficult and some women may die, that’s what we heard.” (FGD, men)

“If the round and small one comes out, the baby can come out easily, but if the long one comes out, the baby will not come out easily.” (II)

“It is harder to give birth if you have prolapse.” (FGD, women)

“Women can still give birth to babies after prolapse, but we heard it can be dangerous.” (FGD, women)

“I’m not sure myself, but I heard that during pregnancy, the uterus will come out a lot. Also if you eat a lot, it will come out. I heard women with prolapse may die during delivery.” (FGD, women)

“If the woman has prolapse, we have to push it inside so that the baby can come out first.” (HCW)

“I thought that the baby had come out, but instead I saw another thing coming from there. I pushed that uterus in with one hand and pulled the baby out with the other.” (HCW)

“I got prolapse after my first child, about three months after the delivery. After that, when I delivered my other babies, the prolapse came out first. The women had to push the prolapse back inside with one hand and pull the baby out with the other.” (II)

Several responses clarified the traditional method of handling delivery with a prolapse patient. Auxiliary nurse midwives (ANM), female health care volunteers (FHCV) and traditional birth attendants (TBA) all appeared to be familiar with how to handle such complications.

4.8.4 Impact on Sexual Intercourse

Like the answers to questions regarding impact on pregnancy and delivery, answers regarding the effect of POP on sexual intercourse also varied. Several participants commented that the severity of the disease related to the severity of the affects on sexual intercourse.

“There are two types of prolapse. One is called *boke* (male goat) and it is the long type. The other is called *baaThe* (female goat) and it is the round kind. If it is the *boke* type, intercourse is difficult and in that case the husband may take another wife. But if it is the *baaThe* type, there is no affect.” (FGD, women)

“The one which goes inside will have little affect [on sex], but the one which is difficult to put inside will definitely have an affect.” (FGD, women)

"If it is small it doesn't affect sex. If it is big, those women can't have sexual intercourse."
(FGD, women)

Considered in this light, women with low-grade prolapse and women who only knew of low-grade cases responded according to their knowledge base.

"It doesn't hurt me during sex." (II)

"Prolapse has no affect on sexual intercourse because it only happens when someone stands up, but it goes away when they lay down." (FGD, women)

"It doesn't affect a woman's sex life, because if she lays down, it goes inside." (HCW)

"Sex intercourse is not affected. You can have sex with a woman who has prolapsed uterus." (FGD, men)

Women with higher grades of prolapse, experience increased impacts on sexual intercourse, the most problematic of which is pain.

"At first, it was painful, but now it is okay." (II)

"It really hurts to have sex and white watery discharge comes out." (II)

"There is definitely an affect on sex. In the beginning of intercourse, it hurts, but then it stops. For me, it doesn't go inside during sex." (II)

4.8.5 Impact on Marriage

Although many of the following statements could be considered under the domain of emotional impact or affect on family life, even perhaps under impact of sexual intercourse, the quotes were so strong, so specific that they demanded their own domain. Most compelling is the threat to a woman's place within the household.

"When someone gets it, they can't work so the husband may marry again because these women can only do simple work and they cannot do the heavy labor." (FGD, men)

"Some women might not tell their husbands due to the fear of the husband taking another wife or hateful behavior by the husband or fear of him telling others." (FGD, women)

"If it goes back inside, the husband will never know about it. If it doesn't go inside, sometimes the husband will take a second wife." (FGD, women)

"If a husband can't have sex because of the prolapse, he will go outside of the marriage for sex, usually with another man's wife. Women have affairs too, but not women with prolapse." (FGD, men)

"Some husband insult their wives because of the prolapse. They say, 'I'll bring another wife.' But a few husbands do think about treating their wives. They say, 'I'll take you to the hospital.'" (FGD, women)

"My husband? If we didn't have children, he would have married again. But we had children and he had grown old. He was already aged." (II)

Still other comments illuminated a lonely world in which women retreated, as previously revealed, due to shyness and humiliation.

“There is no effect on menstruation.” (HCW)

“It doesn’t change menstruation, but women with it walk differently during that time.”
(FGD, women)

“There is no change in menstruation.” (FGD, women)

“There is no effect on my menstruation, it just flows. But I do worry about miscarriages.”
(II)

Still other respondents reported changes in menstrual frequency and bleeding tendencies.

“Sometimes a woman will get her period two times in one month, sometimes she may get it three times in one month.” (FGD, men)

“Some women [with prolapse] have irregular menstruation, like two times in one month.”
(FGD, women)

“Now I have a lot of bleeding and my stomach hurts a lot during that time.”

Even though not all women with prolapse reported difficulties during menstruation, several told of increased pain and discomfort.

“Before the operation, it hurt a lot. I bleed a lot of the time with a really heavy flow. After the operation, my menstruation stopped.” (II)

“Just before and also during menstruation, it hurts a lot.” (II)

“It hurts during menstruation to use a cloth for the blood.” (II)

When my menstruation starts, it feels like my uterus is starting to fall [again].” (II)

4.8.7 Effects on Daily Life

Previously women’s ADLs were established and described in detail. Another set of questions investigated the impact of POP on these ADL. Because women’s lives are essentially centered around work and family, answers were sorted into two corresponding categories.

Work

Participants maintained little variation in descriptions of POP’s effect on work. Almost unanimously, interviewees perceived the impact to be severe.

“When I carry heavy loads or work in the field, I always fear that it will suddenly fall.” (II)

“Women with prolapse can do all of their normal chores, except for those which are done in the squatting position.” (FGD, men)

“No, prolapse doesn’t affect these things. Well, they must do their chores, so even though it does [affect work], they must do it.” (HCW)

“I can’t work like I used to.” (II)

“I can’t carry heavy loads and I can’t work too much in the fields.” (II)

“In our village, women must work. Even though they work day and night, there is still not enough food. If they cannot work [because of the prolapse], how can they get enough food? In this case, it is better to die than to live.” (FGD, men)

“For me, doing the fieldwork, cultivating the maize, harvesting the wheat, these are difficult because it keeps falling out. It is almost impossible to do.” (II)

“When they get it, they stop working! If they have some energy, they housework, but they can no longer work in the fields.” (FGD, men)

Family life

Family life, integral to a sense of value and well-being, was also perceived as jeopardized by POP. Interestingly, it was almost impossible to segregate the perceived impact on work from the highly intertwined impact on family life. Community perception clearly viewed these two categories as unified. They are isolated here only for convenience and to correlate to a western analysis.

“I started doing less housework and also less work in the field. It also made it difficult to watch after the children.” (II)

“I can’t walk right, so it affects everything I do.” (II)

“There is a great affect on her family life because she can not longer do work.” (FGD, men)

“It definitely affects family life and that is why the family and also the woman feel very sad.” (FGD, women)

“Women with prolapse can’t work, so how can they raise their children? How can they buy clothes for their children? How can they pay the school fee? (FGD, women)

“My mother-in-law always argued with me because I could not do a lot of work, so in this way my family life was impacted.” (II)

“It affects fieldwork. If they cannot work properly in the field, production is less and then they cannot raise the children properly due to less food.” (FGD, men)

“Because of the prolapse, they become weak and cannot work. This increases their worry and then this affects family life. They think too much and this creates tension.” (FGD, men)

“It has its affect on family life for sure. The family worries and it is an economical burden because these women need to go to the hospital in India.” (FGD, men)

“Because of the prolapse, they cannot properly look after their children and they can’t do heavy physical labor. So, yes, prolapse affects family life. For example, if the mother-in-law is fighting with the daughter-in-law, the mother-in-law won’t give food to the daughter-in-law or the kids. (FGD, men)

“If the baby cries, the mother can’t hold the baby for long if she has prolapse” (FGD, men)

“It hurts a lot and that makes it difficult to work, which affects my family life. In this way it affects my children.” (II)

This section perhaps provides some of the richest discoveries. In the minds of the community members, it is here that the sum impact of prolapse is captured. The perceived value of a

woman is apprehended in between the recorded lines and voices. The value of a woman is the sum of the quantity and quality of her work.

4.9 Treatment Perceptions

Interviewees were asked several questions relating to treatment. Their answers expressed a wide range of knowledge among participants, but little variation occurred between districts. Their perceptions were categorized into sub-domains, namely treatment availability, home remedies and barriers to obtaining treatment.

4.9.1 Availability

Responses ranged from lack of knowledge about treatment, to expounding on the lack of local medical facilities to touching upon the lure of India.

“There is no treatment.” (II)

“I don’t know anything about medicine, local or hospital medicine. I just don’t know.” (II)

“We don’t know anything about treatments.” (FGD, men)

“There is no local treatment available to cure this problem.” (FGD, women)

“I haven’t gone for treatment. There is no place for treatment.” (II)

“I never sought any treatment.”

“There is no local treatment. If someone is rich, they can go to India for treatment.” (FGD, men)

“There is no treatment here. If they are wealthy, they can go to the hospital in India or in Nepalgunj, but because of our poverty, they don’t go anywhere.” (FGD, men)

“There is no treatment available in this village. Rich people can go to the hospital, but for poor people, they can only do home treatments, like hanging the woman upside down and eating nutritious food.” (FGD, men)

“There is no treatment available here. If her husband is understanding, then he can take her to the hospital. But he will take her out of this district.” (FGD, women)

Other women expressed the lack of quality care available:

“I went to Kathmandu for treatment, but I wasn’t healed. The doctor put in a ring, but the ring gave me a high fever. Then it fell out and so I threw it away.” (II)

“I went to the hospital in Bardiya and an American doctor gave me a ring. But when I went home, I started having heavy bleeding. When I went back, months later, for a check up, she said the ring no longer suited my body. Then the doctor took it out and told me to do these certain exercises, twice in the day and also in the morning and night. She also gave me some medicine and I ate it.” (II)

“I tried a lot of cures from the doctors, but nothing helps.” (II)

Such failed treatments attempts foster confusion, frustration and mistrust within the community towards modern medicine and healthcare facilities.

4.9.2 Home Remedies

Questions aimed at discovering treatment options were posed to all FGD and individual interviews. Questions were phrased in a medical fashion, such as, “If a woman gets prolapse, what can she do about it?” and “What makes it feel better?” Answers were diverse, informative and enriching. Many participants told of local herbs used to relieve symptoms of POP.

“Local medicine is *phariphul* and also mixing honey and *ghee* together and eating it. It doesn’t provide a cure, but it gives the body some energy.” (FGD, men)

“It never gets better. I used *phariphul* (herbal remedy) but it didn’t help. (II)

“During the first ten days after delivery, we give *phariphul*, (local herb) as is our custom. It helps, but it doesn’t cure.” (FGD, women)

“We use *phariphul*, *baabre*, *ghee*, oil, coconut, dates, almonds and we cook and eat these things. If it is only a small prolapse, it may go inside.” (FGD, women)

“We eat special herbs, like *souf*, *jauno* and *seula*. We eat these with *ghee* by making them into a paste.” (FGD, women)

“Without an operation, I think it still can be cured by herbs.” (FGD, men)

Still other participants told of a common treatment that poses a threat to women’s health. The practice of hanging upside down for an indefinite period of time may follow logic, however its potential side effects render it unjustified if not inhumane.

“A woman should hang upside down until it goes inside. Then relief will come.” (FGD, women)

“Women can hang upside down.” (FGD, women)

“I heard that if someone helps put it back inside, it feels better. But the doctor did that to me and it didn’t work. So I had the operation. Mine was really big. I also heard that if a woman hangs upside down, then it will go back inside, but I never tried that.” (II)

“I heard herbal doctors can fix this. But only if women go in the very beginning. If you hang them upside down, it can be fixed.” (HCW)

“Some women get help to have it put back inside. They can also hang upside down for 15 or 20 minutes.” (FGD, women)

Another group of answers addressed remedies relating to food and the traditional hot-cold classification system.

“If she gets it, a woman must eat nutritious food and take herbal medicine because these things help.” (HCW)

“If I don’t eat cold food and eat only warm food, that makes it feel better. They told me not to eat cold food.” (II)

An even more popular remedy enlisted the help of another woman, usually a mother or a mother-in-law; many women claimed this remedy cured their prolapse.

“We heard that some women push it back inside.” (FGD, men)

“My mother put it back inside of me. She used tumeric and oil on a cotton cloth.” (II)

“If it is a fresh one, mustard oil and *rakshi* (locally brewed alcohol) will help [to get it back in place]. But if it is an old one, nothing helps.” (FGD, women)

“We don’t know what the real treatment it, but some women mix *rakshi* and mustard oil together and soak cotton cloth in it. Then they insert the cloth into their vaginas. This can be done at any [stage]. Some women say there is an injection that cures it at the hospital.” (FGD, women)

“When I first got it, my mother-in-law gave me a compress using cotton cloth and caraway seeds. I lay down in a prone position and she inserted it inside to set my uterus right. Then it was healed. She used our local healing ways. But then five years later, I had this child and [it feel out again].” (II)

“There is some relief if they fold a cloth into fours and then soak it in mustard oil and insert it inside. Sometimes the cotton falls out immediately, but sometimes within a few hours. Some women, who have money, they can go to Nepalgunj and talk with doctors. They get an injection and others can get an operation, but we are poor. We just think, ‘This is God’s gift.’” (FGD, women)

“I have cared for four women with this problem. If they come three days to one week after delivery with this problem, I take sugar from the sugar cane, mustard oil and *rakshi* and make a paste. Then I take cloth and wet it with this paste and push it way up inside of her. The cloth must be in a round ball. All the women are healthy now. After a few days the cloth falls out, but the uterus stays inside.” (HCW)

4.9.3 Treatment Barriers

Barriers to treatment were many and complex. For convenience and clarity, these responses were categorized into four sub-domains, namely emotional, financial, social and age. Although participants’ answers did not create a sub-domain for physical, the previous quotes convey that lack of healthcare facilities demands recognition as a treatment barrier.

Emotional

As previously outlined, many study participants perceived POP to evoke humiliation and embarrassment in those who suffer from it. Such emotional withdraw created a barrier to receiving healthcare.

“They are shy even to talk about this thing, so seeking treatment is even more difficult.” (FGD, men)

“Women are shy, we don’t go for treatment because we don’t want to get insulted by others. These are the reasons we don’t seek treatment.” (FGD, women)

“Women don’t seek treatment because they feel embarrassed.” (FGD, men)

“Women don’t seek treatment because they are shy and they have no awareness.” (FGD, men)

“They don’t seek treatment because they want to protect their dignity.” (FGD, men)

“Women are shy. They fear being insulted by others.” (HCW)

“Women avoid treatment because of money problems and domestic reasons. For example, they don’t want to bring shame to their families.” (FGD, women)

Financial

Similarly, the well-established sense of poverty etched out another barrier to care.

“We are poor so I never thought about treatment.” (II)

“I heard there is an operation that fixes it, but it is expensive and we can’t afford it.” (FGD, women)

“I am trying to save money, then I will go to the hospital.” (II)

Social

Traditional customs and norms prevented other women from perceiving that it was socially acceptable to seek care at a medical facility. The inescapable female sphere—house and field—and the unrelenting role of caretaker erected yet another treatment barrier.

“My husband suggested I go to the hospital. But it is not okay to go to the hospital alone. Who is able to take me to the hospital?” (II)

“If we went for treatment, who would take care of the cattle and the household chores? Who could we seek to help us? Who could we ask to watch the house?” (FGD, women)

Age

Another barrier to care noted was age. Although the majority of the women with prolapse interviewed were young, a few were elderly. These select interviews revealed a hidden barrier. Age, in this light, related directly to women’s value, and thus their ability to work.

“If they are young, they may want treatment, but if they are old, no one cares for treatment, not even the woman herself.” (FGD, women)

“I don’t seek treatment because I am old and no benefit is expected from me, even after treatment. There is no way around this.” (II)

4.10 Perceived Prevention Needs

A final series of questions were asked to all participants in all districts. The questions addressed the perceived needs of the community to prevent, treat and address the issue of prolapsed uterus. Although occasionally of value, the majority of the answers were scattered and random. The sensation was one of lip service and jargon picked up through various development agencies passing through the districts. Interestingly, most individual interviews

and female FGD hesitated, or failed altogether, to answer these questions. Below is a selected compilation of answers in order to provide the reader with the communities' perception.

"After delivery, women must rest for at least eight weeks. A woman should only carry what she feels she can handle. In the village, women must have sex again 15 days after delivery. This system should change. Men should wait three months for sex. Men and women both need awareness." (II)

"We need medicine from health posts and also programs to address this problem." (FGD, men)

"We need a health camp that comes from time to time. We need both herbal medicine and doctor's medicine. We need to know more about herbal treatments that are available locally. We need to know the reasons why this happens and also we need awareness programs." (FGD, men)

"We need help running this hospital and to utilize the equipment available in the hospital. The most important thing is to encourage and raise awareness about going to the hospital. The hospital must get better equipment, doctors and staff so that proper care and treatment can be given." (FGD, men)

"Programs should try to prevent this. They should give out medicine." (II)

"Health programs should organize consciousness raising programs." (FGD, men)

"You should provide a doctor and some medicine." (FGD, women)

"Programs should provide us with less work to do. They should give us medicine and treatment too." (II)

"This is a very important problem. After we get this, we can't work and we can't walk." (FGD, women)

"A health post should be opened in this village. We also need a nutritious food supply." (FGD, men)

"Women should try not to lift such heavy loads. We also need to eat nutritious foods." (II)

"If women don't lift heavy things then they won't get it. We need to stop this practice. Also, women should not sleep with their husband's in the early postpartum time. We need to take good care during this time." (II)

"We really want these things and you should implement a program because you are here interviewing us. Don't just ask us questions, act too." (FGD, men)

"Women must get rest during the time immediately after the birth." (FGD, men)

"We need nurses and TBAs and also antenatal care programs." (FGD, men)

"For at least two months before and after delivery, women should not have any sexual intercourse. They should also get nutritious food." (FGD, men)

"We really need to remove superstitions from our society." (FGD, men)

"We should give women more time to rest, more nutritious food, create less tension and decrease the heavy loads they carry." (HCW)

"We need treatment and to develop a fund for awareness programs. Most of the people are poor and they cannot go out of Achham for treatment so we need to bring operation facilities to Achham." (II)

seto pani or white water discharge. In Doti, participants were much more reluctant to partake in the free listing exercise. Participants fell silent and required extensive prompting in order to coax contributions from them. Although no diseases were mentioned twice, several were mentioned once, namely bleeding, intrauterine fetal demise, headache, stomach pain, white watery discharge, weakness, backache and numbness and tingling.

In Achham, the most commonly mentioned problem was uterine prolapse. It must, however, be taken into account that the majority of the participants knew the study's focus prior to the interview. Nonetheless, the participants in Bardiya and Doti also knew that prolapse was the focus of the study, yet prolapse was never mentioned. Stomach pain was the second most commonly mentioned problem. *Seto pani* was the third most frequently mentioned disease. The fourth most commonly reported concerns were *kamjor* or weakness, abdominal pain and fever. The fifth most frequently mentioned problems were cough, back pain and irregular menstruation. STD/HIV, diarrhea and "hand and feet pain" were the sixth most mentioned problems and headache, abortions (spontaneous and intentional) and uterine cancer were the seventh most mentioned diseases. Other diseases mentioned, but only once, were asthma, problems with DEPO injections, infertility, dysmenorrhea, chest pain, vomiting, tuberculosis, dental problems, urinary tract infection and *paaTne ra paakne*, which refers to the vagina not returning to its natural or pre-pregnant shape post-delivery.

Only five diseases were mentioned in all three districts: stomach pain, backache, weakness, headache and white watery discharge. Abdominal cramps, backache and white watery discharge are all documented symptoms of prolapse; therefore potentially noteworthy consideration should be given to the similarity between the known symptoms of prolapse and these health problems.

Interestingly, the most commonly mentioned problem throughout all districts and all individual interviews, focus group discussions and informal interviews was *seto pani*, or white watery discharge, even though it was only mentioned once in the free-listing exercise in Bardiya and Doti. Although commonly associated with STDs, *seto pani* can also result from anemia (a hemoglobin of less than 10) due to atrophy of the vaginal mucosa. Although not necessarily a problematic symptom according to the medical perspective, the perceived concern regarding *seto pani* was serious. Similarly, women and men alike, from both districts and all VDCs, voiced worry about *kamjor* or weakness. Anemia, reported to affect almost 70% of women in these districts, can also cause generalized tiredness, which could, in turn, be easily perceived as weakness. Possible reason for such concern could be the belief that substances leaving the body create weakness. Discerning the definition or meaning of

weakness was beyond the scope of this study; however, it is a very real and vital concern of the study participants. Strong associations between *seto pani*, *kamjor* and POP did exist. To the best of my knowledge, however, correlation between anemia and POP has not been established.

It cannot go without mention that eliciting information from participants regarding the free-listing exercise was significantly easier in Achham. While repetitive solicitations were mandatory to achieve answers in Bardiya and Doti, participants in Achham grasped the question, the concept and the purpose of the exercise with ease.

5.2 Perceived Severity

Although the original research plan called for quick-sort ranking to be completed in each of the three study districts, this exercise proved to be beyond the conceptual grasp of the participants in Bardiya and Doti. Tried repetitively in Bardiya and Doti, this exercise left the research team exhausted, frustrated and puzzled. The women in these regions simply could not grasp the mental task of choosing between two diseases the one that was the biggest problem. Rather than try to force an understanding, possibly skewing results, this exercise was dropped from the analysis where these districts were concerned. In contrast, the women of Achham completed the exercise quickly and without additional prompting or explanation. This exercise assessed the perceived seriousness of prolapsed uterus in comparison to other previously identified women's illnesses. The Rural/Rapid Participatory Appraisal, conducted in 1999 by members of the Nepal-German Reproductive Health Project team, supplied the additional health problems. These health concerns were weakness (*kamjor*), STDs and white watery discharge (*seto pani*). Burning upon urination (*pisaab polne*), the primary symptom of urinary track infections (UTI), was added based on experience. These five major health concerns were paired up in all possible twosomes creating ten pairs. Each individual was asked to choose the most problematic health concern. "Most problematic" (translated as "*thulo samasya*") was not defined, but rather each individual was allowed to define it subjectively. It was, however, explained that we were not asking which problem was most common, but rather which was more serious. Prolapse was chosen as most serious condition by five of the ten participants. UTI and STD were chosen as most serious by two out of ten participants. One participant's results ended in a three-way tie between *kamjor*, POP and STD. Three of the five participants who ranked POP highest, ranked STD as the second most problematic health concern. UTI had one second ranking and six third rankings. *Kamjor*, although never ranking first, did rank second two times and third once. Prolapsed uterus

ranked first five times, second three times and third two times. STDs ranked first twice, second four times and third two times. *Seto pani* never ranked first or second and only ranked third once; it received fourth place five times and fifth place three times. This may be due to the fact that it is so frequently experienced by women and is largely viewed as a symptom caused by a larger, more problematic condition. The high ranking of prolapsed uterus, of course, could be due to the knowledge that POP was the subject of the research and therefore participants could have been eager to please. Additionally, all the women who ranked health concerns were women who suffered from prolapse themselves. Nonetheless, they all appeared to concentrate sincerely on this particular task. STDs (*bhirungi*) ran a close second to POP, especially with its frequent ranking as the second most problematic health concern. This score may reflect the concern women feel in relation to the frequent and widespread migration to India by working-age men. It is common knowledge that these men bring “home” STDs picked up in Indian city brothels. Growing concern and understanding of this problem, hopefully, reflects the budding willingness and readiness of the community to embrace change.

5.3 Hospital/Medical Distrust

Lack of sufficient and adequate healthcare resonated in all interviews and FGD. Although investigation of healthcare facilities and programs was beyond the scope of this study, it was not difficult to see why participants felt strongly about the inadequacies of the current situation. Health posts and sub-health posts were often two room cement blocks lacking in running water, toilets and medical equipment. Health assistants complained of lack of medicines, supplies and equipment as well as lack of continuing training. Latrines were almost non-existent. Hospitals were difficult to reach and often mistrusted. Many people cited going to India for care. As one individual interviewee stated, “I went to the health post to seek care, but they didn’t know about this problem there. He said there was no medicine for me there. He told me to use local herbs. They gave me medicine for my children once, but it didn’t work.” This type of experience creates a positive feedback loop: due to inadequate supplies, treatment is often unavailable; therefore mistrust in the person and/or infrastructure is established; rumors are spread and individuals shy away from seeking care. Additionally, sufficient healthcare provider and patient education is not available. For example, another individual interviewee reported, “Women shouldn’t have more than three babies, so I got a Depo shot. For six months, I bled so I stopped the Depo and had more babies.” In this case, inadequate patient education created a lack of congruent care and

subsequently a lack of trust in modern medicine. Similarly, an elderly woman complained of confusing diagnoses when she told her story: “My fourth child was a miscarriage. Four or five days after the miscarriage I began to bleed from my mouth, just a little bit from my mouth. Then I had a chest X-ray. It was clear. I took medicine, but I don’t remember what kind or for how long or how much, but even now, every now and then, I cough up blood. I went to the doctor again and he said it was because of the hot weather.” There is a gap between what modern medicine can do and a cultural feeling that it should be able to cure everything. The cultural practice of withholding patient education, such as not explaining medications, reinforces this gap. During one female FGD, a participant voiced what she had heard: “Some women say there is an injection that cures [prolapse] at the hospital.”

In the village setting, rumors and stories are told rampantly, explaining much of the confusion in the knowledge base. As with most rumors, negative ones are most widely circulated. An individual interviewee reported, “A woman told me that one woman was hospitalized for three days during her delivery, but was unable to give birth, so they discharged her home.” A traditional birth attendant (TBA) complained, “In our neighborhood, a Tharu woman was sent home from the hospital after they gave her five bottles of saline and the placenta still didn’t come out. [It was] two or three days after delivery.” Still another individual interviewee, in recounting her medical history, commented, “I went everywhere to heal this asthma and this cough. Nothing worked.”

Although these stories may seem superficial, if considered collectively, they illuminate an undercurrent of medical distrust and incompetence. Such “bad press” creates an obstacle between the medical infrastructure and the community. As long as such stories circulate, the system set up to serve the people will continue to be rejected as a place of refuge and healing. This theme interlaces with the domain of treatment barriers, as distrust is the largest impediment to seeking care.

5.4 The Lure of India

Without a doubt, the reported trend for seeking healthcare-depicted villagers sojourning to India. Villagers prefer to make the long journey to Bombay than to manage the relatively short trip to Nepalgunj for care. In Bombay, they report, relatives will feed and house them for free and the Indian government will supply free or very inexpensive healthcare. It is so common to go to India that it seems strange to consider a hospital in Nepal. The result of such rampant dependence on India bears an aftertaste of distrust and disappointment in the Nepali healthcare infrastructure. Even more dangerous, traveling to

India for healthcare has obtained somewhat of a status symbol—if you or your family members seek care in India, money must be plentiful and you are considered lucky. As one woman with prolapse triumphantly stated, “I forced my husband to take me to India for the family planning operation.” Another woman commented, “We don’t know about treatments, but if we are rich, we will go to India.” Men also see India as the only treatment opportunity, “If they have this problem they go to India and have it taken out. Because so many men work in India.” One man had only heard of one case of POP. He reported, “A woman in Ward 8 had it, but she went to India to take it out. She lives in India now.” In one FGD, women distinguished good husbands from bad husbands by delineating treatment options for prolapse: “If it goes back inside, the husband will never know about it. If it doesn’t go inside, sometimes the husband will take a second wife. Sometimes they will take their wife for a cure in India.” At last, one woman made a plea, “For those of us who can’t go to India, we need a hospital.”

At least part of this lure can be understood from the woman’s perspective. Several individual interviews revealed that women who lived in India during the time of their pregnancy did less heavy physical labor than their counterparts in Nepal. For example, one participant stated, “I was in India, so I had no load to carry or work in the field to do. I just did normal household work. I rested for 15 days after the delivery and then started normal work inside the house, like cooking, cleaning, laundry.” As such, India becomes a place of ease and comfort.

The promise of India must be investigated and remedied. Western Nepal, it seems, loses much of its valuable human resources to India. Potential financial income for the healthcare sector is also lost to hospitals in India. Although reasons for temporary migration to India were not within the aim of this study, discussions reveal lack of employment opportunities and free hospital care as the main culprits.

5.5 Superstitions, Rumors and Incorrect Knowledge

Although well documented in many publications, it is important to address the local beliefs which may be considered superstitions and, in many cases, detrimental to women’s health. Although from an outsider’s point of view these traditional cures may seem like superstitions, it is crucial to note that from the insider’s perspective they are true. In ethnographic terms, they are known as “cultural truths.” The most pervasive—and dangerous—rumor that arose repetitively was the belief that hanging her upside down could heal a woman with prolapse. Even a FHCV believed this to be true as she stated, “If you

hang them upside down, it can be fixed.” Another FHCV stated, “If women sit in the squatting position, the hole in the cervix will grow bigger and there will be some wounds and also air may enter inside of the uterus.” Although she may be referring to specific symptoms of prolapse, her presentation is faulty, thereby contributing to the mystery and confusion of reproductive health. Additional examples of superstitions potentially endangering women include an individual interviewee who described how her retained placenta was expelled: “My grandmother filled my mouth with hair and then I began to vomit and the placenta came out.” Another group of women reported, “When we are pregnant, we want to sleep, but the women tell us if we sleep the baby will be born with a long head. They also tell us, ‘The more you work, the easier it will be to delivery your baby.’” Albeit there is value in these two examples—the increase intra-abdominal pressure caused by vomiting could dislodge a placenta and exercise does ease the length and intensity of labor—their presentation suffers from lack of moderation as well as a patient education framework. Without proper understanding of causality, auxiliary rumors spread, such as this young woman’s statement about POP: “I’m not sure myself, but I heard that [if you have POP], then during pregnancy, the uterus comes out a lot. Also if you eat a lot, it will come out. I heard women with prolapse may die during delivery.” Such statements illuminate the random quality of the rumors heard.

During one interview the interviewee was describing her delivery and the research assistant responded with surprise when the woman reported that her paternal grandmother was present for her delivery. The research assistant said, “It is said that if the paternal mother and grandmother accompany the delivery, one will have more labor pain, no?” The interviewee replied, “Maybe, but I had my [maternal] grandmother with me who helped me have a quick delivery because I am her most beloved granddaughter.” Attitudes and emotions such as these are difficult to dispel but remain critical to comprehend in order to better grasp the culture at hand. Without an understanding of the relevance and importance of local traditions, outside influences and projects will never take root.

Yet another result from faulty understandings and too much contradictory information is an attitude of resignation. This was exemplified in one female FGD wherein one woman, talking about why women suffer, sighed, “We just think, ‘This is God’s gift.’” Such disposition is often responsible for the high burnout and frustration found within the healthcare culture. As one traditional birth attendant stated, “I tired my best to bring change, but due to the social circumstances and the traditional culture, I am unable to create change according to my thoughts. In the case of work, I cannot do what I like because of village

society.” Another participant, a male teacher, upheld this sentiment when he stated, “The people are illiterate and they believe in fate. Education is difficult.”

5.6 Socio-Economical Influences

A clear concept of wealth changing a woman’s fate emerged from the analysis. Often times, comparisons were made between the rich and the poor with the rich fairing far better than the poor did. During a FGD, men commenting on women’s perinatal rest reported, “During the last three months of pregnancy, women rest. But it depends on their socio-economic status. If they are laborers or bonded laborers, then they don’t get any rest. But if they have a good socio-economical standing, then they can rest. My guess is that 5% of women can rest during pregnancy. The others work until they deliver.” Most potentially damaging, however, was the impact poverty appears to play on general health. Responding to inquiries about why women work so hard when they know it impairs their health, women responded, “We can’t live without doing our work. To survive we have to eat, so we must work.” Yet another group responded, “We are living in a hilly area, so without working we can’t survive.” As such, POP etiology is also viewed as relating to socio-economic factors. For example, a woman partaking in a FGD stated, “It happens to the poor ones, not the rich ones.” Similarly many women commented that if a woman came from a wealthy family, she could receive more rest in the postpartum period because the family could afford help.

Financial status also influenced treatment options and the decision to seek care. Suggested one woman during a FGD, “Some women, who have money, they can go to talk with doctors. They get an injection and others can get an operation, but we are poor.” This sentiment was echoed in another women’s FGD: “Cure? I don’t know. I heard there is an operation that fixes it, but it is expensive and we can’t afford it.” Poverty was also demonstrated to affect communication between husband and wife. One elderly woman with prolapse commented on why she didn’t tell her husband about her condition, “I didn’t talk to my husband about this. We woke early and started work right away. We were poor. We worried about so many things.”

Although these finding are not surprising, they are nonetheless disturbing. Once again, we see that women’s health cannot be examined and remedied on a singular plane, but rather must be addressed in a holistic fashion.

5.7 Lack of Nutritious Food

In Bardiya, this theme was mentioned occasionally by the women interviewed in the focus groups. It was not mentioned by the men. In Doti, however, this theme resounded in each focus group and in all individual interviews other than the two interviews with ANM. Participants were clear that they were not lacking only in quantity of food but in quality as well. It was in Doti that lack of nutritious food was also singled out as a perceived contribution to the etiology of POP. This theme also resounded in each focus group and in all individual interviews in Achham as well. Here, too, participants were clear that they were lacking in quantity and quality of food. Similarly, lack of nutritious food was designated as a cause of POP. Through interview analysis, participants' responses illuminated the interplay between lack of nutritious food and the cycle of ill health. Less than adequate nutritional intake creates weakness, which in turn leaves the body vulnerable to other ailments, such as fever of unexplained origin and prolapse uterus. One woman with prolapse stated, "I don't know why it happened to me, but I don't get a lot of nutritious food and so my body doesn't have a lot of strength—maybe that's why I got it." Another woman stated, "Not everyone will get this disease, but those who don't have enough food and who are really worried, because worrying makes you weak, . . . only they get it." The weakness also contributes to an impaired ability to do the work necessary for a healthy family. Piecing together different opinions paints a grim cycle: If a woman suffers from a lack of nutritious food, she becomes weak; if a woman is weak, her ability to do adequate work decreases; if her work suffers, she cannot obtain enough good crops or surplus money to buy the needed food; if she becomes too poor, she cannot afford nutritious food for herself or her family. For example, one participant in a women's FGD said, "Women with prolapse can't work, so how can they raise their children? How can they buy clothes for their children? How can they pay the school fee?" Taken a step further, the cycle shows an impoverished, weak woman incapable of pregnancy or sustaining another life. Because children are valued not only as an asset—to eventually help ease the workload—but also the extension of a woman's value, this cycle is disastrous not only for her, but for the whole family as well. Another participant, a man in a FGD, stated, "Because of the prolapse, they become weak and cannot work. This increases their worry and then this affects family life . . . this [cycle] creates tension." Bearing no or few children not only deprives a woman of emotional fulfillment, but it also stigmatizes her as worthless, inadequate and problematical. Several women mentioned that if a woman's ability to bear children is hindered, her husband might take a second wife. One elderly woman with prolapse sighed, "My husband? If we didn't already have children, he would

have married again.” Once again, an external problem—lack of nutritious food—becomes not only an economical concern, but a women’s rights issue, a reproductive health concern, a family health concern and a psychological concern as well. Lack of nutritious food may seem, on paper, like a problem for food relief programs, but it is a direct result of a patriarchal society that devalues and suppresses women and it maintains a direct impact on reproductive health. Separating the social, health and economical problems will not work. It is crucial to embrace the complexities in their current intermingled existence in order to understand them. Similarly, addressing the junctures of these domains is the only way to provide real and lasting cures.

5.8 Lack of Rest During the Perinatal Period

Both men and women reported that women had little resting time. Women were quick to report that they had no time to rest, often rising between 4 o’clock and 5 o’clock in the morning and not lying down again until 9 o’clock in the evening. This schedule did not change with pregnancy. Even when participants knew that rest was essential, it rarely was received. Men from one FGD explained, “Women must get rest, but due to the circumstances, it isn’t available. Only very few people get rest. Four or five days ago, a woman went into the jungle alone, but came back with a baby.” One woman with prolapse described her personal situation: “I only rested for nine days. On the 10th day, I came home from the *goth* and started doing all my regular work.” Other women in FGD echo this pattern, “Until our delivery, we have no time to rest. We only have time to give birth,” and “We rest for two or three days after the delivery. Then we do the household work. After 11 days, we start fieldwork again.” One female FGD revealed that even though rest is taken during the immediate postpartum period, it is still not complete rest: “Even though they rest for eight to ten days after the delivery, still they must care for the newborn and themselves with baths and massage. They must wash all their dirty clothes.” Women living with a small family bear a larger burden, as another female FGD relayed, “If there is no one in the home, the woman can only rest for three days after the delivery.” Still another female FGD agreed, “If a woman lives in a nuclear family, she can’t take rest. Even during the first ten days after her delivery she cannot rest. She has to do the light household chores.” Because women’s work in these districts consists of physically demanding labor, lack of rest during the perinatal period should alarm both healthcare providers and institutions. When compared with the reported case studies, lack of rest during the perinatal period appears to suggest a

strong correlation and possible causal relationship between prolapse and lack of rest during the postpartum—period.

5.9 Carrying Heavy Loads

The most resonating perceived cause of POP was without question carrying a heavy load. Participants continually and unequivocally expressed this judgement. Women in a FGD claimed, “Women who lift heavy loads immediately after their delivery have this problem, they are more effected [with prolapse]. Like those who fetch water in big buckets, or carry loads of wood or do the *dhiki* (foot milling).” Another group expressed, “Sometimes they get it because, if they have a big family, they have to use a really big pot for cooking the rice and if they lift it, [the uterus] falls.” Still another woman exclaimed, “I know why women get it. Listen! After delivery, the uterus is weak. If she doesn’t rest and works hard, there is pressure in her stomach and the uterus pushes down and out.” The men also shared this conviction. One male FGD stated, “Immediately after delivery, if the woman does heavy work, like carrying a heavy pot and firewood, that makes the uterus fall.” Another group agreed, “After delivery, women have to do a lot of heavy work. Like farming and carrying heavy loads. Two years ago we didn’t have any running water, so they had to fetch the water too (four kilometers away). That is why it happens to them.” Even the less confident group of men concurred, “We aren’t sure of the exact cause of prolapse, but we think it may be because of heavy work during and after pregnancy and also less food during that time.”

Most importantly, the women with prolapse felt carrying heavy loads caused their prolapse. One woman said, “I got it because of a heavy work load. I am alone, so there is no one to help me.” Another woman confirmed, “I got it because of weakness and too much heavy physical work, like fieldwork.” Yet another confirmed, “It happened when I lifted up a heavy container.” Still another accented, “I got it because I carried fertilizer, like mud, a very heavy load.” An elderly TBA acquiesced, “Yes, these days many women [are] mostly involved in fieldwork, so naturally it will come out.”

This powerful documentation supports theories suggesting increased intra-abdominal pressure as a culprit in the prolapse puzzle. Women in these districts perform intensive physical labor as part of their activities of daily living (ADL). These ADLs subject them to a repetitive and unrelenting barrage of increased intra-abdominal pressure, which over time appears to influence the strength of the pelvic structure.

5.10 Single Traumatic Event

Perhaps one of the most resounding and noteworthy themes to emerge from the study rests in the fact that several of the individual women with prolapse could recall the exact moment they first felt the prolapse. Most of the case studies revealed a very specific event or action that acted as a prelude to the prolapse. For example, one woman recalled, "I got it 17 days after my first delivery. It was winter and I was sitting by the fire in the squatting position. I sneezed and it came out right then." Another woman said, "Fifteen days after my delivery, I took the oxen out to graze. One ox ran away. I had to catch it, so I ran after it. After I took a few fast steps, it fell." Another woman reports, "On the 12th day after the delivery of my sixth child, I was weeding the field [all day]. When I came home, I squatted by the fire and [at that moment] it came out on its own." Yet another woman told this story: "After my first child it came out. After 13 or 14 days, I cooked about seven kilos of rice. The pot was very heavy. When I was finished cooking, I asked my sister-in-law to pick up the pot and put it on the ground. But she didn't listen, so I did it myself. It came out right then." An elderly woman shared her story with a similar theme: "Five years ago, my husband and 20 year old son died. It came out then. Within one year they died and I was very worried and sad. I didn't care about food at that time . . . At that same time, my daughter-in-law became paralyzed. Because she couldn't move, I had to lift her. One time when I was lifting her, it came out." Still another woman recalled, "Six days after my delivery, I went to wash the clothes. I was carrying all the wet cloths home and it came out."

Each case study locates an exact point of support failure and each case involves a sudden and extreme increase in intra-abdominal pressure. Whether it is a sneeze, a fast leap forward, the lifting of a heavy pot or simply a slight increase obtained through the squatting position, the pelvic musculature was unable to sustain the increased pressure. Only one article in the literature review, documenting cases in American female military air-born trainees, addresses the problem of a "single traumatic event" leading to prolapse, but these findings support the need for further investigation. Additionally noteworthy is the fact that four of the five presented case studies identified POP which occurred in the immediate postpartum period—a time known to be affected by weakened pelvic bony and muscle structures. During the immediate postpartum period, the body is still under the strong influence of ovarian and placental hormones aimed at relaxing the pelvic cavity. The actual experiences and innate knowledge of these women demonstrate the susceptibility of the pelvic cavity to permanent structural damage during the immediate postpartum period. Although increased intra-abdominal pressure is a candidate for pelvic organ prolapse

causality in a fair amount of the literature, little research, if any, directly documents its precise impact on the first moment of prolapse.

5.11 Work, Workloads and the Value of Women

As clearly demonstrated in the results section, women's workloads are overextended. In general, both male and female participants believed women worked long hours throughout the day. The work reported was not varied. All participants mentioned the same activities, namely, cooking, cleaning, laundry, animal husbandry, gathering firewood and grass, carrying firewood and grass, gathering and carrying fodder and clay, painting the house, seeding, harvesting, milling grains and child raising. One man casually assured us that, "All the work except plowing is done by women." Women's attitudes were functional. One woman retorted, "We can't live without doing our work. To survive we have to eat, so we must work." In a FGD, another woman stated, "We don't have any choice, we must work." When questioned about opportunities to rest during the day, one female FGD participant replied, "We don't have time to rest. For us, rest is when we comb our hair!" Another sighed, "After we die, we can get some rest." This attitude explains the fear and social stigma associated with getting POP.

Analysis of the research findings concludes, without a doubt, that prolapse greatly impairs a woman's ability to work. Because work, for better or for worse, is central to women's lives this consequence must be taken seriously. When participants were asked if prolapse was considered a big problem, their response inevitably resounded yes; yet the surprise lay within the reasons why. One woman with prolapse confessed, "This is a big problem for me because it affects my work and we women have a lot of work to do." During a FDG, men clamored, "When they get [prolapse], they stop working! If they have some energy, they do housework, but they can no longer work in the fields." Women in a FDG proclaimed, "This is a very important problem. After we get this, we can't work." Still again, men retorted, "Prolapse is a big and important problem because women must do heavy labor, but if they have prolapse, they can't do it."

Analysis clearly emanated a direct link between female value and the ability to work. For example, while discussing the necessity of work in a FGD, one woman stated, "A few women who really can't carry the heavy loads will carry a lighter one, but still she must work." Being incapable of working directly threatens their place in the family structure. Exemplifying this theme, men outlined the problem as such: "Women [with prolapse] feel humiliated and they don't want to talk to anyone, so they withdraw from social situations.

The community insults them. Mother-in-laws say to them, ‘You can’t work! Why are you only at home?’ These women can’t work so it is humiliating for them.” Another member of a male FGD responded, “In our village, women must work. Even though they work day and night, there is still not enough food. If they cannot work [because of POP], how can they get enough food? In this case, it is better to die than to live.” Not only is their traditional position jeopardized, but their role as mother is questioned as well. Women in a FGD exclaimed, “Women with prolapse can’t work, so how can they raise their children? How can they buy clothes for their children? How can they pay the school fee?” An auxiliary nurse midwife (ANM) said, “This is important because if they get it they can’t work in the fields and then it is hard to care properly for the house and children.” Another group of men clarified, “[Prolapse] effects fieldwork. If they cannot work properly in the field, production is less and then they cannot raise the children properly due to less food.” Their family life may further be disrupted through remarriage, as one male participant explained: “When someone gets it, they can’t work so the husband may marry again because these women can only do simple work and they cannot do the heavy labor.” The value of a woman’s life is so deeply associated with work that an elderly woman with prolapse reported, “I don’t get treatment because I am old and no benefit is expected from me, even after treatment. There is no way around this.”

Although these sentiments shy away from comparing women to animals, one male in a FGD indirectly affiliated the two: “There are so many buffalo and cows with this problem, but now we understand women get this problem too.” In this light, women and animals share not only workloads and diseases, but social status as well. It is at this crossroads that a woman’s value is amassed: her place in the family, in the marriage, in the community and in the society, her role as a mother, a wife, and a daughter-in-law is summed up—and entangled—in her ability to work.

5.12 Women as Replaceable

Individual interviews all too often revealed the fear of replacement by other wives. These women were acutely aware of the precarious nature of their current life situation. Young wives especially revealed concerns that their husbands would find new wives if they were rendered unable to work due to prolapse. Some women reported threats from husbands or mother-in-laws of new wives if they decreased their workloads. Other women perceived such strong threats to their security that they refused to tell their husbands about their prolapse. It appears this fear comes from the extreme emphasis on work as the primary role

of women. Men must marry in order to have someone to sustain the fields and run the household. If food or money is short, it is the women who pick oranges and travel to sell them for extra funds. Daughters must be born in order to provide much needed respite for the mothers. Much of their work involves carrying heavy loads on their backs up and down steep, mountainous terrain. Through the eyes of participants, these tasks necessitate life; if they don't happen, survival vanishes. If a woman—the wife—cannot perform them, then someone else must. From a cultural perspective the only person who performs these task is a wife. Therefore if problems arise concerning a woman's ability to work, the answer is simple: get a new wife.

Although the practice of polygamy is not widespread throughout Nepal, it is not uncommon to find men with two wives. Usually, a man only takes a second wife if the first wife is unable to produce children or is unable to support the family through her work. Even though a few first wives get along with second wives, it is more common that it signifies difficulty in the original marriage and a role-change for the first wives. As such, their placement—and therefore security—is threatened. Several participants spoke of second wives as a caveat. For example, in a FGD one woman stated, "If [POP] goes back inside, the husband will never know about it. If it doesn't go inside, sometimes the husband will take a second wife." In another setting, a woman participating in a FGD explained the types of prolapse, while alluding to its potential impact "There are two types of prolapse. One is called *boke* (male goat) and it is the long type. The other is called *baaThe* (female goat) and it is the round kind. If it is the *boke* type, intercourse is difficult and in that case the husband may take another wife. But if it is the *baaThe* type, there is no effect." In yet another FGD, men mimicked this alarm, "When some one gets it, they can't work so the husband may marry again because these women can only do simple work and they cannot do the heavy labor." Another man in a different group explained, "If a husband can't have sex because of the prolapse, he will go outside of the marriage for sex, usually with another man's wife. Women have affairs too, but not women with prolapse." Still another FGD revealed a similar response from women: "Some husbands insult their wives because of the prolapse. They say, 'I'll bring another wife.'" An individual interviewee reported, "Sometimes a husband will leave his wife because of this."

If women with prolapse remain shy and humiliated, the ability to efficiently detect and treat the disease will suffer. The complex association between workloads, female value, female roles and prolapse must be understood comprehensively in order to effectively direct improvement campaigns.

5.13 Social Stigma

Nepali culture, as previously established in the literature review, regards women as inferior to men. As a result, they remain subordinate to men and largely hidden within the homes or fields, their sphere of work. Nepali women depend upon their husbands and in-laws for a sense of placement within the socio-cultural structure. The Nepali word for home is *ghar* and it refers to the place where you live. A woman, however, has another special place—her *maithi*, or the home of her parents. While she is living in her parent's home, as a child, this home is her *ghar*. But once she is married and moves to her in-laws' home, this new house becomes her *ghar* and her old home becomes her *maithi*. More than symbolizing the emotional change of family, this word play represents the change in the woman's object of devotion, and thus in whose hands her fate rests. Therefore, displeasing in-laws endangers her security. Within this context, women with prolapse are stigmatized additionally. As with certain diseases, disrepute is sometimes projected on those who suffer from them. Such is the case, according to several study participants, with prolapse uterus and the social structure in the study districts. Because prolapse is associated with an impaired ability to work, women with prolapse suffer emotional consequences. Derogatory words most commonly used were "dirty," "scold," and "filthy." For example, a female FGD participant stated, "Some women [with prolapse] feel it is difficult to raise their children and even to walk. They feel pain. Their family members, both men and women, call them dirty." Another woman commented, "In-laws feel dirty if a woman has prolapse. These women discharge a lot of water with a foul smell. Even if she washes her clothes, the foul smell and dirtiness stay." Still another female FGD participant stated, "If there is anybody to talk to, they will talk to them. Our husbands and mother-in-laws tell us not to use or touch the clothes of women with prolapse." This statement casts light on the isolation from which women with prolapse suffer: their loneliness not only from lack of confidants, but also the segregation from participating in a common female custom, the sharing of clothes. The degradation from in-laws apparently results from the kinship recognized between family members. Husbands, it seems, do not provide refuge. As a female FGD member points out, "Sometimes it goes back inside, so husbands may never know about it. And sometimes it won't go back inside, so they scold us." The insults can even take the form of a threat, as another woman in a FGD highlighted, "Some husbands insult their wives because of the prolapse. They say, 'I'll bring another wife.'"

Even health care workers see prolapse as affecting the value of a woman. One FHCV, in describing the impact of prolapse, stated, "Prolapse is a serious illness. Women's lives become weak because of this. She becomes half of a human being, but she still has to do much work everyday." The women themselves appear to internalize these insults and therefore deny themselves the physical and emotional support they need. A female FGD participant stated, "Women avoid treatment because of money problems and domestic reasons. For example, they don't want to bring shame to their families." Another woman commented, "Women are shy, we don't go for treatment because we don't want to get insulted by others." Men, who stated that women don't seek treatment because "they feel embarrassed" and "because they are shy and they have no awareness," echoed this sentiment. To men, it seems prolapse also questions a woman's integrity. One man stated, "They don't seek treatment because they want to protect their dignity."

Interestingly, the presentation of a family member's problem within a family structure that clearly values the significance of family kinship does not call for collaboration or mending. Rather, such circumstances summon isolation and degradation. In this sense, a woman's problem is not regarded as a family problem. Without family and community members accepting women's problems as family problems, solutions are rendered near to impossible. This theme is one that repeats itself through the data analysis.

5.14 Learned Helplessness

Throughout the research, examples of subordinate status emerged. However degrading, no comments were more abject than the ones inflicted by women upon themselves. Several individual interviewees spoke with not only a dejected tone, but also with an air of resignation. For example, a young woman sighed, "What to do madam, because of being a woman, I have suffered. I know nothing and understand nothing. And so, in the mornings I begin to clean." Yet another young woman, when asked if she spoke with others regarding her prolapse, responded, "I am too simple to talk about this with others." When asked a standard opinion question, another woman remarked, "How many children to have? I don't know. These days, everyone says to have two." Her answer suggests she habitually does not think for herself. This lack of independence—and concomitant helplessness—fosters the gap between male and female community members. The community view of women appears to be easily summed by this female health care volunteer's (FHCV) simple explanation, "Women are weak." With such a pervasive attitude, it is difficult to expect village communities to treat women as a valuable asset. Similarly, it is

difficult to hope women will learn to value themselves. An elderly woman stated, “Now my age has passed already. What makes me feel better then? I don’t care for myself because I am already old—there is no use for caring.” Another elderly woman wistfully mumbled, “I feel I must do something, I must try. But even if I ask my son, he is not interested in helping me. He is busy with his work, with other jobs. I don’t want to disturb him. I heard there are hospitals in some places.” Counter-acting this sense of worthlessness must be a corner stone in any improvement program.

5.15 The Male/Female Chasm

The one theme that threaded its way throughout all themes and all domains is the pervasive chasm that divides the Nepali men and women. For example, it has been clearly established that women must work for placement, value and per custom. Nonetheless, men in one FGD stated, “We tell our wives not to do heavy work or work that takes too much energy, we tell them only to do the light work.” Even though several groups outlined the extensive workload of women, participants in another male FGD stated, “I don’t think women work more than men.” Whereas all participants agreed that women received little or no rest during the day, another group of men complained about their own lives, “What is rest? We don’t know.” Even though countless participants validated the lack of rest pregnant women received, one male FGD reflected, “During the last three months of pregnancy, women rest.” These examples outline that men do not necessarily grasp the true experience of women’s lives.

Women’s FGD, however, expressed concern over the lack of awareness men maintain concerning women’s lives and issues. One group retorted, “How do males get ideas about this problem if women don’t even know about their own uterus?” A group of Tharu women mused, “I don’t think Tharu men and women talk about this. I don’t think Tharu men even know about this problem.” As mentioned in the discussion on workloads, women are circuitously likened to animals. As one man explained, “We only know how to cure the animals with [prolapse], not the women with it. The animal doctor comes to the village regularly and gives medicine to the animals, but still they suffer. But we don’t know about our women.” Such contemplation suggests that men are more in touch with animals than they are with their own wives, sisters and daughters.

6. CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

Although the results from this study are in no way representative of Nepali women—and therefore not generalizable—their significance and saliency should be heeded. The findings provide detailed insight into the perceived knowledge base and effects of prolapse for rural Nepali women. An ethnographic framework and qualitative methods reexamined prolapse in a culturally relevant manner, thereby reshaping how prolapse is understood and what prolapse *means* for those who suffer from it.

Twenty-four women with prolapsed uterus were identified and interviewed. The majority of those women, 11, were under 30 years of age. Of those 24 women, 16 women were less than or equal to 35 years of age. These participants, therefore, represent a fairly young and active, as well as a reproductive, age group. More surprisingly, prolapse occurred after the first delivery in ten of the 24 women interviewed. Multiparity, the most often associated cause of prolapse, cannot reasonably be considered a major etiological factor of within this study population.

Study participants, both male and female, were extremely knowledgeable about POP, providing in depth details of its causes, associations and varied effects on daily life. It is difficult to not conclude that such widespread knowledge is a direct result of the number of women who suffer from this disease. High prevalence was further implied by the ease finding women with prolapse assumed.

The researcher observed a considerable amount of hard labor among women. Many pictures were taken of women—young and old—carrying large loads of leaves, firewood, fertilizer and wheat on their backs. With a rope holding the load together, which is then wrapped around their heads, the majority of the carrying weight falls on the upper backs of the carrier. In order to support this amount of weight and still walk erect, the abdominal muscles are activated. Such activity leads to an increase in intra-abdominal pressure, a current etiology theory of pelvic organ prolapse. Data analysis reveals that, in the study population, the perceived cause of prolapse uterus is undoubtedly due in part to hard physical labor in the immediate postpartum period. Such labor is often referred to as “carrying heavy loads.” It is the researcher’s belief that this work increases intra-abdominal pressure, causing a downward pressure on the uterus. Because the structures supporting the organs within the pelvic cavity are weak due to the birth process, the uterus (and/or possibly other organs) prolapses into the vaginal vault.

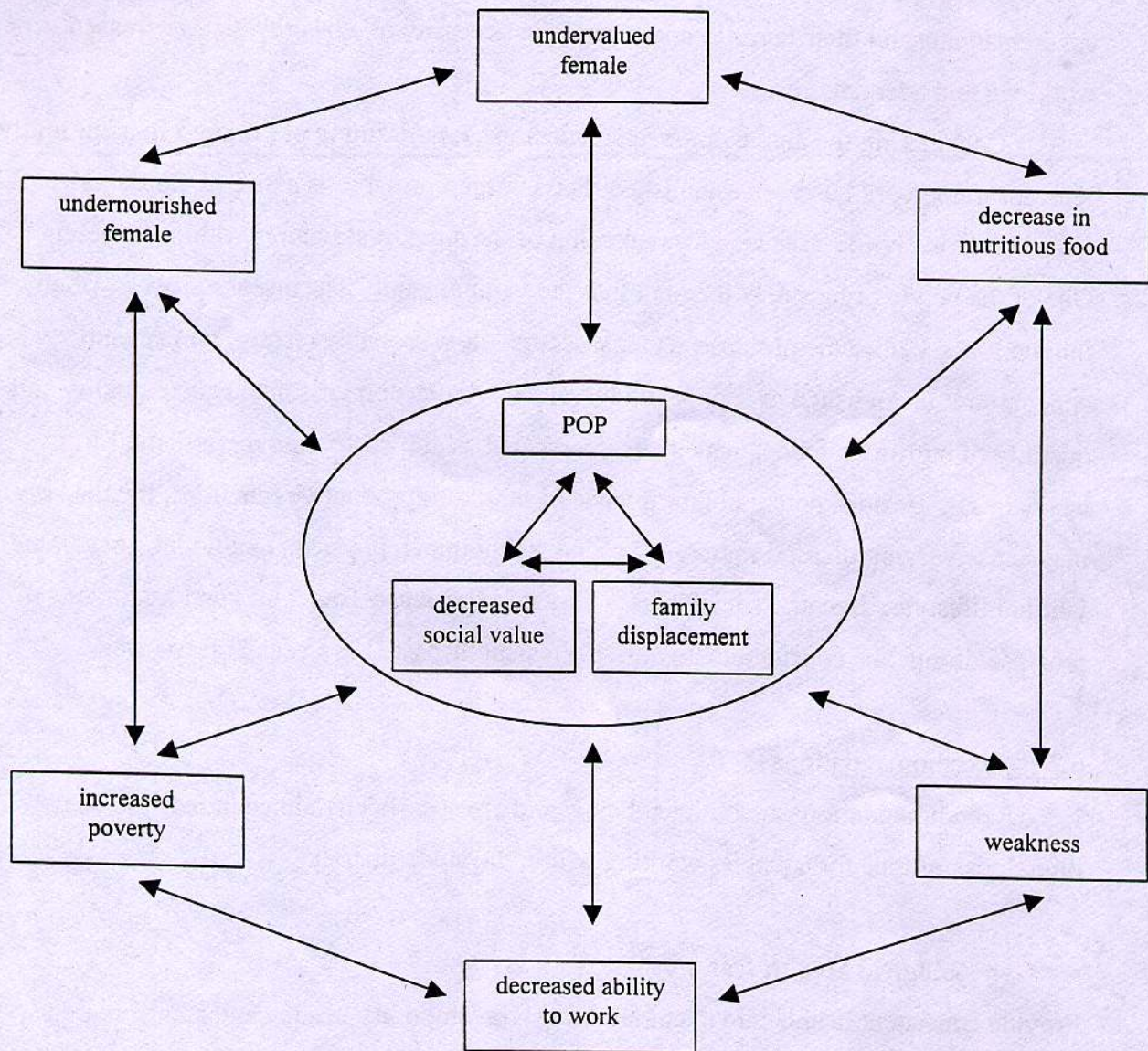
Several participants with POP were capable of recalling the exact moment when the prolapse “fell.” Such stories compel professionals in reproductive health to investigate the significance of the possible etiology of a single traumatic event. Participants also expressed repetitive concern about the lack of nutritious food available within the communities. Frequently, the lack of quantity and quality of food was associated with stemming from *and* causing *kamjor*, or weakness. Lack of nutritious food was clearly identified as a perceived cause of POP. Due to the abundance of literature that establishes anemia, known to cause generalized weakness, as a predominant problem throughout Asia, worthy future investigations include a possible correlation between POP and anemia.

Study participants described the lives of women with POP as difficult, painful and lacking in significance and meaning. The range of the perceived impact of prolapsed uterus on lifestyle was broad and deep: women suffered in the realms of work, family, marriage, child-raising and social interactions. The implications of such impacts were perceived to bear direct negative consequences on her emotional and physical life. Most importantly, participants’ words portrayed a woman with POP as a less valuable human being. The impact of prolapse on women’s status takes an additional toll when considering their already subordinate social position. Such ingrained cultural placement and value must be addressed if preventative and curative programs hope for success. Due to the serious impact of POP on multiple aspects of one’s well being, the study findings suggest that prolapse is a significant morbidity for the study population. Future studies should investigate the morbidity and mortality potential of POP.

The findings also highlight the power of qualitative data in bringing to light the more silent spheres of disease consequences. Considering the particulars of Nepali women’s lives, ethnographic theory was essential in outlining a meaningful context for POP. In order to visualize the female cycle of illness in Nepal, an ethnomedical diagram depicting the social, economical and medical interactions has been developed (See Table 17). In this diagram, the interconnectedness of the different spheres directly affecting women’s health, specifically POP, are outlined. As the communities’ stories shared, prolapse cannot be fully understood outside of its cultural domain. Without consideration of the factors influencing women’s health, the disease process is alienated from its co-founding factors. Treatment with ring pessaries and surgery will help individual women, but unless prevention and education looks at the larger socio-medical picture, the epidemic of prolapse will surely continue. The intricate socio-medical cycle begins with the undervalued female, usually starting at the birth of the girl child, and follows an almost deadly path of decline. Breaking

out of the cycle for an individual takes a series of extraordinary circumstances: a supportive husband, caring in-laws, positive financial circumstances, unusual social setting and a strong will. To encourage the end of such a destructive cycle for a whole society will take more than just dislodging—or alleviating—one link of the cycle. It will demand cooperation across government, non-government, development and private sectors. It will take careful and thorough amelioration of each link in the socio-medical cycle.

Table 17: A Socio-medical Model for Understanding POP



The findings presented here maintain implications for populations around the world. Researchers in other communities should investigate the ADLs of women suffering from prolapse. Additionally, specific studies should examine correlation between both a sudden

and a continuous increase in intra-abdominal pressure and pelvic organ prolapse. A tool for measuring the physical intensity of ADLs should be developed. After extensive field testing, a score should be established that correlates the ADL intensity with a predisposing risk for POP. Healthcare professionals should bear in mind the extent of the impact POP may have on individual and family lives. Particular attention should be given to assessing the emotional, social and economical impacts of prolapse. Building rapport with clients is necessary in order to determine the extent of the impact. Careful and clear education should be provided to patients with prolapse in order to diminish confusion and frustration about the occasionally insidious nature of the symptoms. Special attention should also be given to ensure patients and their families understand the necessity of a healthy diet, decreased workload and adequate rest.

Considering the above outlined conclusions, a re-defining of prolapse in a culturally relevant framework has been established: Pelvic organ prolapse is a disease outcome whereby various processes lead to weakening of the support structures within the pelvis. One of the pelvic organs may then fall into the vaginal vault. The disease process, often initiated long before the prolapse actually occurs, most probably results from several concomitant factors such as socially undervalued women and girls, inadequate quality and quantity of nutritious foods, inadequate observance of the postpartum period and lifting heavy loads. Besides potential interference of normal reproductive functions, the disease may cause varying disruption of one's social, economical, physical, emotional, sexual and familial lifestyle. Because social factors play into the causes, outcomes and treatments of prolapse, it must be considered not only a physical disease, but a social one as well.

6.2 Recommendations

Recommendations are outlined below and are specifically aimed at feasible near-future possibilities for agencies working within the study districts.

- **Gynecological Health Camps**

Provide consistent health care to communities via temporary health camps until regular services are in place. Annual camps should specifically address prolapsed uterus.

Additional reproductive health needs, such as STD and family planning, should also be met; however, emphasis should be given to POP cases. Qualified female physicians and nurses

should be invited to provide quality care on a short-term basis. During the camps, informal education regarding prolapse and its prevention should be provided.

- **Additional Research**

Support and encourage additional qualitative and quantitative research. Specifically, design data mining into the health camp framework via questionnaires and screenings. Ideas include investigation of possible correlation between anemia and prolapse by obtaining hemoglobin readings for all women who are diagnosed with prolapse. Examine any and all concurrent pathologies, such as STDs and bacterial infections. Try to gather prevalence and incidence data when and if possible. After health camps initiate the practice of ring pessaries, obtain follow up qualitative data regarding women's reaction to treatment with pessaries.

- **Provide Training**

On-going training for health care workers in all the study districts should be enhanced. Specifically, training for ANM on assessing pelvic organ prolapse, including degrees of prolapsed uterus, and fitting and managing ring pessaries should be provided. Again, use the health camp template for training. Educational training for FHCV on the potential causes, associations, symptoms and impacts of pelvic organ prolapse should be provided. A special meeting with locally active men should be prepared in order to facilitate male participation in caring for women with prolapse. If possible, develop a training module for the assessment and management of POP.

- **Information, Education and Communication (IEC)**

IEC activities should be implemented and current activities should be intensified. Programs, classes and interactive learning exercises that combine male and female participants should be favored. Gender equality programs should be supported and buttressed in hopes of narrowing the gap between men and women socially as well as what defines "men's work" and "women's work." IEC materials should address potentially harmful practices such as hanging women upside down. Billboards warning against the effects of lifting heavy loads and observing only a very short postpartum period should be developed and displayed in prominent places along intersections, trails and in main market areas. Pamphlets written at a low literacy level with ample pictures should be designed and distributed in order to increase

awareness of the associate causes, symptoms and impacts of POP as well as prevention practices.

- **Empower Local Health Care Workers (HCW)**

Many of the prevention and treatment methods for POP involve behavior changes. Asking individuals to instigate change can create skepticism and possibly distrust. Encourage local HCWs to develop rapport with clients by visiting them on a regular basis in order to assess their healthcare needs and answer any questions. Provide a small room, conveniently located, staffed by various HCW on a rotational basis where individuals can seek answers, express concerns and gain educational counsel. Encourage local pharmaceutical storeowners to partake in educational activities in order to increase the knowledge base of those who dispense medicine. Encourage local pharmacies to stock a variety of ring pessaries.

- **Improve Hospital Public Relations**

Currently, hospital mistrust abounds and a shocking number of community members travel to India to seek necessary healthcare. Hospital relations with the community need to expand. Schedule all health camps within hospitals in order to familiarize community members with the hospital grounds and improve the hospitals' image as productive. Lobby resident doctors to hold regular hours and consistent care. Host informal education classes on hospital grounds. Ensure hospitals maintain a consistent supply of necessary medicines and equipment, for example, ring pessaries.



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APPENDIX A

FIELD GUIDE FOR FOCUS GROUP DISCUSSIONS ~ Women

WHAT ARE THE MOST COMMON HEALTH PROBLEMS FOR WOMEN?

1. How many hours a day do pregnant women get to rest? Does this change as the pregnancy advances?
2. When do pregnant women stop working? When do they start working after the birth?
3. In general, how long does labor last?
4. During labor and delivery, when do women start to push?
5. How many children should most women have? How many children do most women have?
6. Please describe the daily life of women? Household chores, field work, farm work, child raising, etc.? What months create more work? Describe the physical labor.
7. What activities are done in the squatting position?
Sitting? Cooking? Defecating? Field work? Eating? Delivery? Laundry?
8. How many hours a day are women in a squatting position?

9. HOW DO YOU KNOW WHEN SOMEONE HAS POP?

10. What is the local term for prolapsed uterus?
11. Is prolapsed uterus common?
12. Who gets it?
13. WHAT DO YOU THINK CAUSES POP?

14. Describe what it feels like please.

15. Why do women get it?

16. WHAT IS THE PROGRESSION OF POP?

17. How soon after delivering a baby does the prolapse happen?

18. How does POP start? How does it change over time?

19. WHAT CHANGES IN LIFESTYLE RESULT FROM POP?

20. Does it affect the ability to have another baby?

21. How does it affect sexual intercourse?

22. How does it effect menstruation?

23. How do husbands react to it?

24. Do husbands and wives talk about these things?

25. Do women talk about POP?

26. How do women learn about POP?

27. Does it affect family life?

28. Does it affect household chores? Work in the fields? Child raising?

29. If a woman has prolapse and is pregnant, how does the prolapse affect the pregnancy?
Labor and delivery?

30. IF A WOMAN GETS POP, WHAT KIND OF TREATMENT CAN SHE GET?

31. If it happens, what should a woman do about it? What makes it feel better?

32. Is there a cure?

33. WHAT ARE THE REASONS WOMEN MAY NOT SEEK TREATMENT FOR POP?

34. Is this an important problem?

35. Should health programs try to prevent it from happening?

36. Do you want to know more about it?

37. What changes should happen to prevent prolapse in the future?

38. Is there anything else we should know?

39. If you could talk directly to the Ministry of Health, what would you say?

APPENDIX B

FIELD GUIDE FOR INDIVIDUAL INTERVIEWS ~ Women with POP

WHAT ARE THE MOST COMMON HEALTH PROBLEMS FOR WOMEN?

1. What changes occurred during your pregnancy? Changes in food? Changes in work? Changes in feelings?
3. How many hours a day did you get to rest when you were pregnant? Did this change as the pregnancy advanced?
4. When did you stop working? When did you start working after the baby was born?
5. Who attended your labor?
6. How long was your labor?
7. Do you remember when you started pushing in labor? How many hours did you push?
8. How many children did/do you want?
9. Please describe your daily life? Household chores, field work, farm work, child raising, etc.? Please tell me about your physical labor.
10. What activities do you do in the squatting position?
Sitting? Cooking? Defecating? Field work? Eating? Laundry? Labor?
11. How many hours a day are you in a squatting position?
12. What is the local term for prolapsed uterus?
13. Is prolapsed uterus common?
14. Do you have a prolapsed uterus?
15. When did you get it (after which pregnancy)? How soon after delivering your baby did the prolapse happen?
16. How did you get it?
17. Why did you get it?
18. Please describe what it feels like.
19. What makes it feel better?
20. Have you sought any treatment?
21. Is there a cure?
22. Did it effect—or has it affected—your ability to have another baby?
23. How does it affect your sex life?
24. How does it effect your menstruation?
25. How does your husband feel about it?
26. Do you talk to your husband about it?
27. Does it affect your family life?
28. Does it affect your household chores? Work in the fields? Child raising?
27. How do you think prolapse effects pregnancy? How does prolapse effect labor and delivery?
28. Do you feel prolapse uterus is a problem for you? Is this an important problem to you?
29. Should health programs try to prevent it from happening?
30. Do you want to know more about it?
31. What changes should happen to prevent prolapse in the future?
33. Should anything else be done?
34. Is there anything else we should know?
35. If you could talk directly to the Ministry of Health, what would you say?