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Beyond the Medical: Embodiment and Socio-cultural Dimensions of Uterine Prolapse in Nepal

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Abstract

Uterine prolapse (UP), a condition deeply intertwined with cultural norms and systemic inequities, disproportionately impacts married women in the world, including Nepal. This study examines UP not solely as a medical condition but as a manifestation of socio-cultural and economic pressures that regulate women's reproductive health. In an in-depth qualitative interview with ten participants, recruited via purposive sampling, this study examined the embodied realities of women with UP. The results demonstrate the role of early marriage, multiple pregnancies, poor postpartum management, and arduous physical labour in the high incidence of UP. Participants described obstacles such as a lack of health care access, social stigma, and financial limitations that lead to postponing treatment and increasing their psychological suffering. Similarly, structural inefficiency in the health system and rigidly held gender norms further marginalize affected women. This study also suggests the importance of culturally appropriate, community-driven interventions in conjunction with broad-scale system changes to help ensure equal access to health care. According to the framing of UP through feminist anthropology and embodiment approaches used in this study, integrative approaches are suggested to tackle the gendered aspects of reproductive health inequality.

Keywords

Embodiment, Gender inequalities, Nepal, Reproductive Health equity, Socio-cultural norms, Uterine prolapse .

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1. Introduction

Uterine prolapse (UP) occurs when the uterus falls from its normal position due to a weakened pelvic musculoligamentous system (Walker & Gunasekera, 2011; Broms & Ingvarsson, 2012). Although many people primarily recognize UP as a medical problem, it also stems from broader societal factors. Systemic gender inequalities, traditional cultural practices, and economic hardships disproportionately impact women and contribute to the prevalence of UP. Though it spans millions of women globally, UP is especially strongly associated with low-resource contexts where structural and cultural barriers intersect (Walker & Gunasekera, 2011; Tega *et al.*, 2024). In Nepal, uterine prolapse has become an underseen crisis because it particularly affects women who are disadvantaged due to socio-cultural pressure and economic deprivations (UNFPA & Sancharika Samuha, 2007; Subedi, 2010).

Whereas uterine prolapse in higher-income countries is primarily found in postmenopausal women, in Nepal, it is frequently seen in the reproductive age group. In Nepal, between 9% and 35% of women suffer from UP, with approximately 200,000 requiring immediate surgical treatment (Pradhan *et al.*, 2008/2009). Globally, prevalence ranges from 4% to 40%, with low- and middle-income countries reporting higher rates (19.7%) (Walker & Gunasekera, 2011; Radl *et al.*, 2012; Chaudhary, 2014). These alarming statistics shows the extent to which social determinants-such as early marriage, repeated pregnancies, inadequate postpartum care, and physically demanding labour-play a central role because they exacerbate this condition (Bonetti *et al.*, 2004; Subedi, 2010).

The anthropological viewpoint attributes uterine prolapse to the pervasive socio-cultural practices and expectations of gender roles, as women's bodies are often considered objects of reproduction and labour. In Nepal, cultural discourses favouring male births lead women to ovulate multiple times in a short period, so that the pelvic structures weaken significantly, increasing the risk for UP (UNFPA & Sancharika Samuha, 2007; Chaudhary, 2014). Since patriarchal family systems reinforce these vulnerabilities, women are often forced to return to physically demanding work shortly after childbirth, even though they lack adequate rest, nutrition, or healthcare (Subedi, 2010). These structural pressures transform uterine prolapse into a social and embodied form of gendered labour exploitation and reproductive overextension.

Even though systemic pressures contribute significantly, a culture of secrecy regarding reproductive care further exacerbates the issue. Women suffering from UP frequently internalize feelings of shame and inadequacy, as if the condition is an inevitable consequence of childbirth or personal failure. This silence is reinforced by societal stigma so that women with uterine prolapse are often labeled as impure or incomplete and excluded from social, religious, and familial activities (Subedi, 2010; Radl *et al.*, 2012). Since discussions related to reproductive health are taboo, especially in rural settings, patriarchal dominance discourages women from seeking medical care. Therefore, many live with suffering in silence, afraid of being rejected by their families (UNFPA & Sancharika Samuha, 2007).

The challenges faced by women with uterine prolapse extend beyond cultural taboos to structural barriers in health care access. Many regions face inadequate healthcare services, with limited facilities often staffed by untrained personnel who are not equipped to address critical medical needs. Although interventions such as pelvic floor exercises, ring pessaries, and hysterectomy are available, they are inaccessible to most women because of poverty, illiteracy, and a lack of autonomy in healthcare decision-making (Subedi, 2010; Chaudhary, 2014). Government-mandated surgical camps offer a temporary solution, but they fail to address causative social factors or provide long-term, community-centric supportive systems (UNFPA & Sancharika Samuha, 2007).

The lived experiences of women with uterine prolapse further illustrate how the condition is deeply entwined with socio-cultural perceptions of womanhood and reproduction. Since women's health is often bowdlerized to fit social expectations of productivity and propriety, their bodies are relegated to arenas of cultural signification and labour. Whenever women lose reproductive ability or sexuality after uterine prolapse surgery, they are frequently stigmatized, so they face additional emotional and relational burdens (Radl et al., 2012). Such encounters indicate that the gendered politics of the body tie an individual's health to cultural representations of femininity and social worth (Henslin & Biggs, 1991).

This paper analyzes uterine prolapse not only as a clinical issue but also as an expression of broader social, cultural, and structural processes. Through the lived embodiment of married women in Chaudandigadhi Municipality-10, Udayapur, it attempts to uncover the cultural silence, gendered inequalities, and structural hindrances that shape their realities. From this perspective, the research seeks to assess whether current public health interventions are practical and to propose lasting, community-based, culturally contextual, and empowering strategies to combat the socio-cultural causes of uterine prolapse so that women can regain agency and a sense of self-worth by reclaiming their health.

2. Literature Review

2·1 Feminist Anthropology

Feminist anthropology, as defined by Walter (1995) and Lewin and Silverstein (2016), is a transformative field that critiques and rocentric paradigms and emphasizes the intersections of gender, power, and culture. Although it emerged in the 1960s, it challenged traditional narratives such as the "Man the Hunter" model. Scholars like Ortner (1974) and Slocum (1975) highlighted women's agency and the relational nature of gender. Over time, the field shifted to analyzing gender as an inter-sectional construct shaped by race, class, and other axes of oppression (Walter, 1995).

A central concern of feminist anthropology is representation. It also challenges the idea of objective authority in traditional anthropology. Walter (1995) supports reflexive and participatory approaches to ensure knowledge production is more inclusive. Similarly, Abu-Lughod (1991) suggests the concept of the "halfie", stressing how crucial positionality is for ethical engagement. Feminist anthropologists emphasize the use of collaborative methods and narrative storytelling as ways to disrupt hierarchies in the creation of knowledge (Lewin & Silverstein, 2016).

The field has addressed issues such as reproductive health and neoliberalism. For example, Scheper-Hughes and Lock (1987) critique universalist biological assumptions, whereas Kingfisher's work highlights neoliberalism's disproportionate impact on women and explores avenues for resistance (Lewin & Silverstein, 2016). Even though feminist anthropology has seen successes, it faces challenges in balancing its activist roots with its institutionalization (Lewin & Silverstein, 2016).

Since feminist anthropology continues to shape the discipline, it integrates intersectional frameworks and ethical reflexivity so that global inequalities are addressed. Moreover, it promotes more inclusive and participatory anthropological practices.

2·2 Anthropology of Body and Embodiment

The anthropology of body and embodiment looks at the body as a space where cultural, social, and political processes take shape. It moves away from the traditional Cartesian idea of separating the mind from the body. However, it assumes the body to be not only an experiential subject of life but also a shaped object of material and social realities (Scheper-Hughes Lock, 1987; Csordas, 1990, Ojha, 2023). With this methodology, social meanings are inscribed and articulated by his/her bodily activity, and the body plays a key role in understanding identity, agency, and social relatedness (Mascia-Lees, 2011).

Although this perspective became prominent in the late 20th century, it draws heavily on ideas from phenomenology, structuralism, and post-structuralism. Mauss (1936) introduced the notion of “techniques of the body” and showed how the bodily actions of the subject are ultimately products of the cultural framework of the society. Thereafter, Merleau-Ponty (1962) argued for the primacy of the body as the source from which we build a vision and a relationship with the world. Foucault (1979) extended this notion, as it showed us how historical and political regimes exert control and causality over bodies through mechanisms of the power of biopolitics and discipline. Building on this, Bourdieu’s concept of habitus demonstrated how our bodily habits reflect and reinforce social hierarchies (Bourdieu, 1977).

Embodiment studies view the body as both a biological reality and a product of social and cultural forces. It connects the physical with the symbolic (Scheper-Hughes & Lock, 1987). The body is influenced by cultural norms, power dynamics, and everyday practices, such as rituals or medical interventions, which give it social meaning (Mauss, 1936; Douglas, 1966). Embodiment focuses on lived experience, showing how our sensory and emotional experiences internalize and express cultural values (Merleau-Ponty, 1962; Csordas, 1994). Power is central to the regulatory process of how bodies act, because social mechanisms frequently control them to conform to normative expectations and generate, according to Foucault (1979), "docile bodies". Simultaneously, the notion of intersectionality draws attention to the ways gender, race, and class interact to create the body as a site in which social inequalities are challenged and reinforced (Mascia-Lees, 2011).

Engaging with the body as a dynamic entity and as embedded in culture, the anthropology of embodiment offers a useful perspective on the way social structures, norms, and power relations affect human lives. It reminds us that our physical selves are deeply tied to the world around us and that the body is more than just biology-it is a powerful reflection of society.

2·3 Framing the Body: Gender, Power, and Cultural Politics

This study employs feminist anthropology and the anthropology of body and embodiment as theoretical frameworks because they provided critical insights into how cultural norms, gendered expectations, and systemic inequalities shaped women's health experiences. Feminist anthropology challenged androcentric readings and studied the interplay between gender, power, and culture, which very well fits the issue of how societal practices such as premarital/early marriage, multiple pregnancies, and inadequate postpartum care served as a major burden to women (Walter, 1995; Lewin & Silverstein, 2016).

The anthropology of embodiment complemented this by focusing on the body as a site where social, cultural, and political processes converged. It highlighted how structural inequalities and cultural stigmas were inscribed and experienced through the body, shaping women's perceptions of pain, discomfort, and self-worth (Scheper-Hughes & Lock, 1987; Csordas, 1990). This perspective allowed me to explore the lived realities of uterine prolapse, emphasizing how cultural silence and patriarchal norms regulated women's bodies and limited their autonomy (Foucault, 1979).

Together, these frameworks revealed the deeply socio-cultural dimensions of uterine prolapse, moving beyond a medical understanding to address the intersection of power, stigma, and lived experience. They also informed the exploration of community-based interventions, highlighting the importance of collective action and structural change in fostering health equity.

3. Methodology

In this paper, the embodied realities and socio-cultural dimensions of uterine prolapse among married women in Chaudandigadhi Municipality-10, Udayapur, Nepal-a region characterized by its rural context and cultural practices-are deeply analyzed. I used a qualitative ethnographic research design and conducted in-depth, in-person interviews with a sample of ten participants, from November to December 2024, selected through purposive sampling. Moreover, in order to establish trust and encourage open discussion, I ensured anonymity and confidentiality by using pseudonyms to create a safe environment for participants to share their personal experiences without fear of stigma or judgment. Similarly, I applied thematic analysis to code and analyze the data. In addition, I evaluated participants' perceptions of uterine health, cultural norms, and their experiences within the existing healthcare system. Thus, the current study identifies systemic difficulties associated with female uterine prolapse and draws attention to the need for culturally appropriate and equitable health services interventions.

4. Findings

Uterine prolapse is a serious health issue that affects many married women in Chaudandigadhi Municipality-10, Udayapur, Nepal. Even though it's common, there is still a lack of understanding about the condition, with plenty of misinformation and gaps in knowledge. Factors like early marriage, multiple pregnancies, poor postpartum care, and deeply rooted societal norms all contribute to the increased risk. The impacts are multifaceted, disrupting women's physical, emotional, social, and economic lives. Cultural stigmas and rigid gender roles further prevent women from seeking timely care, while structural barriers such as limited healthcare access and economic constraints compound the challenges.

4·1 Reframing the Body: Awareness and Knowledge Gaps in Uterine Prolapse

In Chaudandigadhi Municipality-10, Udayapur, women shared their experiences of uterine prolapse. It was surprising how little people knew about the condition. It was not just that there was a lack of medical understanding; there were cultural taboos and so much silence around it. The stories I heard were heartbreaking, not just because of the physical pain but because of the shame, the isolation, and how long it took for many of these women to get help.

Aasha (pseudonym), a 38-year-old mother of two, was one of the first women I talked to. She spoke quietly but with determination. *"For years, I had constant back pain and a heavy feeling in my pelvis"*, she told me. *"I thought it was just normal for a woman my age"*. She only found out what was wrong when a community health worker came to her village. *"When I finally understood what was happening to me, I decided to get help"*, she added, clearly relieved. It made me wonder how many other women like Aasha were living with this without even knowing what it was.

Rupa (pseudonym), a 45-year-old mother of four, had a similar story but with a slightly different twist. *"I thought my discomfort was just part of aging"*, she admitted. Unlike Aasha, Rupa only discovered her condition when a neighbor insisted, she attend a screening camp. That's where she found out she had second-stage uterine prolapse. *"I didn't realize it was something that could get worse if ignored"*, she said. It's painful to think how much earlier she could have gotten help if she'd had access to this information sooner.

Some women delayed getting treatment because of misinformation or reliance on home remedies. Sita (pseudonym), a 41-year-old farmer, told me about her experience. *"When the symptoms started, I tried herbal treatments"*, she said. *"I'd heard about uterine prolapse, but I didn't think it was serious until it got worse"*. Eventually, she had no choice but to go to a government hospital for surgery. Then there was Kamala (pseudonym), a 36-year-old shopkeeper. Her story was different. *"I learned about uterine prolapse at a seminar, but I couldn't afford the treatment right away"*, she said. It was only with the help of an NGO that she finally managed to get the care she needed.

For some women, the condition was completely unfamiliar. They didn't even have a name for it. Laxmi (pseudonym), a 32-year-old from a remote village, said her family thought her symptoms were spiritual. *"They took me to a healer, but nothing changed"*, she said. Things only started improving when someone referred her to a hospital after her symptoms worsened. Tara (pseudonym), a 28-year-old, went through something different but just as frustrating. *"I kept being told it was a urinary tract infection, but the treatments never worked"*, she said. It took seeing a specialist to finally get the right diagnosis-uterine prolapse.

On the other side of things, I met women who had taken steps early on to look after their health. Mina (pseudonym), a 29-year-old first-time mom, told me how she learned about uterine prolapse through social media. *"I read about it and started doing Kegel exercises during my pregnancy"*, she said. Because of that awareness, she avoided serious problems and now encourages other women in her village to take preventive measures. Gita (pseudonym), a 40-year-old teacher, shared her story, too. *"When I recovered from mild prolapse, I felt it was my responsibility to help others"*, she said. Gita now runs health camps, teaching women what she wishes she had known earlier.

What stood out the most, though, was how stigma stopped so many women from speaking up. Bina (pseudonym), a 47-year-old woman, told me about the shame she felt. *"I didn't even tell my family"*, she admitted. It was her daughter who finally convinced her to attend a health camp. *"Getting counseling and treatment was a turning point"*, she said. Now, she talks about her experience openly to help other women. Radha (pseudonym), a 34-year-old mother of two, had a different story. For her, it wasn't stigma but lack of knowledge that made things worse. *"I started heavy work just a week after giving birth"*, she said. Later, a midwife explained how important rest was, but by then, it was too late.

These women's stories stayed with me. This highlighted how much suffering could be avoided if there was more awareness. Women like Aasha and Rupa only found help through community health programs. Sita and Kamala had to struggle with financial difficulties or wasted time on remedies that didn't work. On the other hand, Mina and Gita gave me hope-they showed how knowledge can change lives. Bina and Radha reminded me just how much harm stigma and ignorance can do.

It is clear that this issue is not just about treating a medical condition. It's about breaking the silence, educating communities, and making healthcare accessible and affordable. More than that, it's about creating a culture where women feel safe to talk about their bodies and seek help without fear or shame. These stories taught me so much, and I hope they inspire others to take action-because no one should have to suffer in silence.

4·2 Entangled Causes: Socio-cultural and Structural Dimensions of Uterine Prolapse

When I spoke with women in Chaudandigadhi Municipality-10, Udayapur, their stories made one thing clear: uterine prolapse is not just about a medical issue. It is intricately intertwined with their daily lives, culture, and the systems they inhabit. Every conversation I had left me with more layers to think about.

Radha's story is one that is hard to forget. She went back to doing heavy household chores just a week after giving birth. *"I had to take care of my family"*, she said, almost as if she did not have a choice-which, honestly, she did not. Lifting heavy loads and pushing her body too hard without rest left her with early signs of uterine prolapse. Sita told me a similar story but for a different reason. She had her pregnancies too close together, with barely any time for her body to recover in between. *"I didn't know I needed time to heal"*, she admitted softly. She did not complain, just lived with it quietly for years, even though it was making her life harder.

Then there is the cultural side of things, which makes it even worse. Laxmi, who got married as a teenager, shared how she became pregnant soon after her wedding. *"In my village, you must conceive soon after marriage"*, she said, her voice carrying the weight of expectation. Her body was not ready for the strain of pregnancy and childbirth at such a young age, which left her vulnerable to complications. Tara, on the other hand, talked about what happens when there is no proper medical care available. *"I gave birth at home with the help of an untrained attendant"*, she told me. Without skilled hands during labour, the complications went unnoticed until they turned into bigger problems later in life.

Economic struggles? That is another part of the story. Kamala, for example, worked nonstop throughout her pregnancy. *"I couldn't afford to rest or eat nutritious food"*, she said plainly. She was exhausted, malnourished, and under immense pressure, but what could she do? Then there was Mina, who knew that heavy labour during pregnancy was risky. Still, she said, *"Financially, I couldn't stop working"*. Like so many other women, she put her family's survival ahead of her own health, and over time, her condition got worse.

What really stood out, though, was how much societal expectations kept women from taking care of themselves. Bina, a soft-spoken woman in her forties, told me how her family relied on her to handle everything at home. "*If I didn't work, who would?*" she asked, as if the question answered itself. Even though she was in pain, she kept doing heavy physical tasks because there was not another option. Rupa's story was just as frustrating but in a different way. When she told her husband about her symptoms, he brushed them off. *"He said it was just aging"*, she said, shaking her head. Without his support, she put off getting medical help until things had gotten much worse.

Even women who knew they needed to be careful were not always able to act on that knowledge. Gita knew that she should avoid lifting heavy loads after giving birth, but, as she explained, "*There was no one else to do it"*. That lack of help, whether from family or community, forced her back into physically demanding work, risking her recovery.

And then there is the healthcare system-or lack of it. Laxmi told me how far she had to travel to get to a clinic. *"The nearest health center is hours away"*, she said. Instead of going there, her family tried traditional remedies. *"They tried rituals, but nothing worked"*, she said, recalling how long she waited before finally seeking proper medical care. For Radha, the problem was not distance but a lack of proper guidance. She relied on a local midwife during her pregnancies and did not get the postnatal care she needed. *"I didn't know how to take care of myself"*, she admitted. Without someone to tell her, how could she have known?

The more I listened to these women, the more I realized that uterine prolapse is not just one thing. It is not just about heavy lifting or closely spaced pregnancies or bad healthcare. It is all of it-wrapped together in a mix of physical strain, cultural norms, economic struggles, and a system that often fails women when they need it most.

What these women need is not just medical treatment. They need information. They need healthcare they can reach and afford. And they need a society that values their health enough to let them rest, recover, and speak up without feeling ashamed. Radha, Sita, Laxmi, Kamala-they all deserve better. Moreover, they deserve a system that supports them and gives them the tools to protect their health. Fixing this problem is not simple. It is going to take more than just quick fixes. It will take education, cultural change, and better support systems. But listening to these stories made one thing crystal clear: we cannot ignore this any longer. These women have been strong for so long, but it is time they got the help and support they have always deserved.

4·3 Embodied Realities: The Multifaceted Impact of Uterine Prolapse

When I sat down to speak with the women in Chaudandigadhi Municipality-10, Udayapur, I was not prepared for how deeply uterine prolapse affected every part of their lives. It was not just about the physical pain. It was about what it did to their confidence, their relationships, and even their place in the community. Every woman's story was unique, but together they painted a picture of just how much this condition takes from them.

For Aasha, it started with the physical struggles. *"It's hard to walk or stand for long"*, she told me, describing the constant back pain and the feeling of heaviness in her pelvis. It wasn't just the pain-it was how it made her depend on others for even the simplest tasks. *"I feel like a burden"*, she said, her voice barely above a whisper. You could tell how much it hurt her to feel that way, not just physically but emotionally too.

Rupa's story was different, but just as heartbreaking. She talked about the stigma that comes with the condition. *"People whisper behind my back"*, she said, looking down at her hands. In her community, uterine prolapse was not seen as a health issue. Instead, it was treated like her fault, as if she had been careless or done something wrong. Because she could not manage her household chores, her in-laws were constantly criticizing her. The emotional toll of that isolation was clear-it was not just her body that was suffering.

Then there was Kamala, whose story brought up the financial side of things. She explained how her symptoms forced her to cut back on work, which meant less income for her family. *"When my symptoms got worse, I had to borrow money for surgery"*, she said. The debt she took on for her treatment hung over her like a shadow, making recovery even more difficult. Mina, another woman I spoke with, knew that working during pregnancy was risky but felt like she did not have a choice. *"Financially, I couldn't stop working"*, she said simply. What struck me most about these stories was how often women had to put their family's needs above their own health, no matter the consequences.

The social pressure to keep going, no matter what, came up again and again. Bina told me how her family expected her to keep everything running at home, even when she was in pain. *"If I didn't work, who would?"* she asked, like it was not even a question. And Rupa's experience was just as frustrating. She said her husband dismissed her complaints entirely. *"He said it was just aging"*, she told me, shaking her head. Without his support, she waited far too long to get the medical help she needed.

Even the women who knew what they should do could not always act on it. Gita told me she was aware of the importance of rest after childbirth, but that did not change her situation. *"There was no one else to do it"*, she said. She went right back to lifting heavy loads and managing the house, even though she knew it would make things worse.

And then there were the stories about the lack of healthcare access. Laxmi explained how the nearest health clinic was hours away. *"They tried rituals, but nothing worked"*, she said, describing how her family relied on traditional healers for months before she finally sought proper treatment. Radha talked about how her reliance on a local midwife during her pregnancies meant she never got the guidance she needed after giving birth. *"didn't know how to take care of myself"*, she admitted. Without any clear advice, how could she have known what to do?

The more I listened, the more it became clear that uterine prolapse is not just one thing. It is not just physical; it is not just cultural; it is not just economic-it is all of it, layered together in a way that leaves women carrying a burden they should not have to.

What these women need is not complicated-they need access to information, healthcare that they can afford and reach, and a community that does not judge them for something that is not their fault. They need rest and support and to not feel like their health is a luxury they cannot afford.

The women I spoke with-Aasha, Rupa, Kamala, Laxmi, and so many others-are unbelievably strong. But their strength should not come at the cost of their health. They deserve better. They deserve a world where they do not have to choose between taking care of themselves and taking care of everyone else. Fixing this problem is not going to be easy, but it is something we have to do. These stories are a reminder of what is at stake-not just for the women themselves, but for their families and communities too.

4·4 Navigating Barriers: Addressing Prevention and Treatment Challenges

When I started to talk with selected participants, I began to see just how many obstacles stand in the way of preventing and treating uterine prolapse. Their stories were full of struggle-not just with their bodies, but with a system and culture that often-made things worse. Every woman I spoke with had a different experience, but the challenges they described were all interconnected.

Laxmi's story made me think about the basic logistical challenges these women face. She lives in a remote area where the nearest hospital is hours away. *"We can't even afford the transportation"*, she said. At first, she tried going to a traditional healer, but that only made things worse. Her symptoms became so unbearable day by day that she had no choice but to visit a hospital. By then, the delay had already made her condition much harder to treat.

For Kamala, it was not geography but money that stood in the way. She understood her condition but said medical care was simply not an option for her. *"There were always more pressing expenses"*, she told me. She kept putting off treatment until her symptoms became severe. Financial aid from an NGO finally allowed her to get surgery, but by then her recovery was much more difficult than it should have been.

Then there was Sita, who highlighted how cultural silence around reproductive health stops women from seeking help. In her village, no one talks openly about these kinds of issues. *"When I told my family about the pain, they said it's just part of being a mother"*, she shared. Hearing that from her own family made her feel like seeking help was unnecessary-or even selfish. It was years before she attended a local health camp and got the diagnosis and treatment she needed.

The lack of education about what causes uterine prolapse came up over and over again. Rupa had no idea that lifting heavy loads after giving birth could be dangerous. *"Nobody told me I needed to rest"*, she said. Because of that ignorance, she kept working, worsening her condition without even realizing it. Even after her diagnosis, she found it hard to follow her doctor's advice. She simply did not have the support at home to take time off from her responsibilities.

Gender roles and family expectations also made things even harder. Radha explained how her in-laws expected her to return to work immediately after childbirth. *"Resting too long was seen as a* *weakness"*, she said. That kind of pressure left her with no chance to heal properly. Her worsening symptoms created even more stress for her family, who were already struggling to manage without her help.

The stigma around uterine prolapse kept so many women silent. Bina shared how ashamed she felt about her condition. *"I didn't want anyone to know"*, she said. For years, she kept her symptoms to herself. It was only after her daughter insisted that she attend a health camp that she finally received treatment. Even after her recovery, the stigma was still there. She hesitated to talk openly about her experience, afraid of how people might judge her.

The lack of trained healthcare providers in rural areas made things even worse. Tara gave birth at home with the help of an untrained attendant. *"There was no one to guide me"*, she said. Without proper care, she went back to heavy labour just days after giving birth, which led to her developing uterine prolapse. When she finally sought help, the local clinic did not have the specialists she needed. She had to travel far to get care, which added financial and logistical stress to an already difficult situation.

Even when women tried to seek help, systemic inefficiencies often got in the way. Mina shared how she went to a hospital after noticing her symptoms but faced long waiting times and a lack of female doctors. *"I felt so uncomfortable that I didn't go back"*, she admitted. The delay made her condition worse, and it became another example of how the system fails even the women who try to access it.

Even women who were trying to raise awareness faced barriers. Gita, who advocates for women's health in her village, explained the resistance she faces. *"Men in the village dismiss it as unnecessary"*, she said. Their attitudes make it even harder to prioritize women's health in a community where it is already treated as an afterthought.

These stories are a clear reminder of how financial struggles, cultural norms, systemic failures, and rigid gender roles all come together to make uterine prolapse such a difficult issue to address. It is not enough to treat the symptoms. These barriers need to be broken down, one by one. What these women need is access to information so they can protect themselves. They need healthcare that is close, affordable, and welcoming. They need communities that will support them, not shame them. The women I spoke with-Laxmi, Kamala, Sita, Rupa, Bina, Tara, and Gita-are incredibly strong. But strength alone is not enough. They deserve systems that work for them and cultures that value their health. It will take time to fix these problems, but it has to start somewhere. These stories are proof that change is not just necessary-it is long overdue.

5. Discussion

As I thought about the stories the women in Chaudandigadhi Municipality-10, Udayapur shared with me, one thing became very clear-uterine prolapse is much more than a medical condition. It is a vivid example of how deeply socio-cultural inequalities and systemic neglect shape women's lives. These stories were not just about health; they revealed how cultural norms and structural barriers dictate women's experiences of pain, stigma, and limited access to care. Drawing on feminist anthropology and embodiment theory, these narratives serve as a lens into the intersections of gender, power, and health.

One of the most striking patterns in the women's stories was how little awareness there was about uterine prolapse. Women like Aasha and Rupa believed their symptoms were just normal parts of aging or childbirth. Because of this, they did not seek medical care right away. In societies where, reproductive health is often stigmatized or dismissed, this silence is sadly common. Many women hear things like, *"It's just part of being a woman"*, which stops them from speaking up or asking for help. Feminist anthropology sheds light on this silence, showing how cultural norms systematically limit women's ability to take care of their own health. What stood out to me is that this silence is not passive-it is enforced by societal expectations that prioritize women's roles as mothers and caregivers over their well-being.

The physical realities of uterine prolapse also revealed how deeply systemic inequalities leave their mark on women's bodies. For example, Radha returned to heavy household chores just days after giving birth, and Sita's closely spaced pregnancies left her body with no time to recover. These stories showed how cultural norms impose relentless physical strain on women. Embodiment theory, especially Csordas' (1990) idea of the body as a lived experience, helped me understand how these cultural scripts are internalized. Over time, women begin to see pain and discomfort as inevitable, something they just have to live with. This reminded me of Mauss' (1936) concept of "techniques of the body", which explains how cultural practices shape not only how women move and work but also how they perceive their own health and suffering.

Economic barriers were another recurring challenge in the women's lives. Kamala delayed her treatment simply because she could not afford it, and Laxmi relied on traditional healers because medical care was too far and too expensive. These situations echoed what researchers like Bonetti *et al.* (2004) have found-poverty and geographic isolation make it much harder for women in rural areas to get timely and effective healthcare. What struck me most was how this neglect feeds on itself. Limited access to healthcare worsens women's conditions, which then deepens their financial struggles, trapping them in a vicious cycle that feels impossible to escape.

The emotional toll of uterine prolapse was just as significant as the physical and financial burdens. Bina and Rupa talked about feeling ashamed and isolated because of their condition. *"I didn't want anyone to know"*, Bina confessed, explaining how stigma kept her from seeking help for years. This kind of silence is not just personal-it is enforced by societal attitudes that frame uterine prolapse as a personal failing rather than a health issue. Foucault's (1979) concept of biopower was helpful in understanding this dynamic. Social norms regulate women's bodies, forcing them to prioritize their roles as caregivers and labourers over their health. In this sense, uterine prolapse is more than a physical condition-it is a manifestation of systemic power dynamics that exploit women's bodies and silence their voices.

Even in the face of these challenges, some women's stories showed incredible resilience and agency. Mina and Gita stood out for their determination to break the cycle of neglect. Mina took proactive steps to prevent further health issues, and Gita became an advocate for awareness in her community. Their actions reminded me of feminist anthropology's emphasis on women's agency within structural constraints. Even in difficult circumstances, women find ways to challenge and reshape cultural norms (Lewin & Silverstein, 2016). These stories highlighted how community-based initiatives can create spaces for education, advocacy, and real change. From these narratives, I realized that uterine prolapse is not just a health problem-it is a socio-cultural issue rooted in inequality. Thus, addressing it requires more than just medical solutions.

6. Conclusion

This study reveals that uterine prolapse is not only a medical problem, but also a social problem. In addition, it is also the representation of cultural values, systemic disadvantage, and social disadvantage that women in rural Nepal experience every single day. The stories I heard were powerful. They characterized the invisible suffering of women who are affected by physical pain, lack of emotional contact, and stigma. These women often face these difficulties without access to support and resources necessary to seek help. It became evident that uterine prolapse is related to more profound problems in society.

Similarly, addressing this problem is not as simple as providing medical treatment. It requires a bigger approach. Education is crucial to help women understand their bodies and recognize the signs early. Advocacy is just as important to break harmful cultural norms and remove the stigma that stops women from seeking care. Healthcare systems also need to change. Women in rural areas need access to affordable care, no matter where they live or what their financial situation is.

Community awareness programs have been observed to make a difference. Women are already challenging the silence and speaking out. Their actions show what is possible when women are empowered. But there is still a long way to go. Healthcare policies need to prioritize rural women and focus on prevention as well as treatment. The stories I heard have stayed with me. They have taught me that real change starts when women are encouraged to speak up and advocate for themselves. Listening to women's experiences is key to understanding the realities of inequality and creating solutions that work. This research aims to inspire action, not just to treat uterine prolapse but to address the cultural and systemic problems that allow it to persist. No woman should have to suffer in silence.

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