Nepalese women suffering from uterine prolapse

A participant observational study in a maternity hospital in Nepal.

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ABSTRACT

Background:

Uterine prolapse is a condition in which the muscles and supporting ligaments holding the uterus in place gets too weak to keep the uterus in position. This causes the uterus to drop into the vaginal canal and results in a downward malposition of the uterus. Risk factors for uterine prolapse are among others pregnancy and delivery, improper delivery techniques, heavy work during and soon after pregnancy and heavy lifting. In Nepal uterine prolapse is one of the main causes for ill-health among women of reproductive and post-menopausal age. According to the United Nations Population Fund (UNFPA), the high number of affected women in Nepal is due to, among other reasons, the lack of skilled birth-attendants, women carrying heavy loads, lack of contraceptives and giving birth to many children.

Aim:

The aim of our study was to gain knowledge of how patients with uterine prolapse are cared for in a maternity hospital in Nepal.

Method:

An ethnographic approach was used to meet the aim of our study. Data was collected by four weeks of participant observations in a hospital in Kathmandu. The observations were complemented by interviews with patients and staff.

Findings:

The most striking part found in our material was the limited resources and their impact on the care provided to patients with uterine prolapse. The quality of the care was compromised by the lack of good facilities, material resources and manpower. This created a frustration among the staff as well as an unnecessary suffering for the patients. We identified three main categories in the data collected; Prerequisites for caregiving, Consequences for the patients and Consequences for the caregivers. These themes are presented in sixteen subheadings lifting different aspects of how the lack of resources affected the care.

Content

INTRODUCTION

Uterine prolapse is a condition which occurs among women all over the world. With access to proper healthcare it is a condition easily prevented and treated (1). In Nepal uterine prolapse is one of the major health problems of women of re-productive- and menopausal age. Because of low familial and social position, illiteracy, cultural traditions and patriarchal structures women of the Nepalese society are vulnerable to health problems. These are also factors that make the reproductive health situation of Nepalese women very poor (2).

Due to the remoteness and difficult terrain in Nepal the access to health care is severely restricted. Even when health care services are available there are factors that prevent women from getting the care they need. Women are often deprived of the right to make decisions concerning their own health care, including timing and spacing of pregnancies. Usually the husband decides about health care expenses, and women are not always allowed to travel alone which further complicates the process of seeking medical care (3).

Up until today the debate on uterine prolapse is very limited, both in the family and in the society. Nepalese women suffering from uterine prolapse often keep the condition a secret, being afraid of condemnation and feeling ashamed. There is also a lack of knowledge about the condition and as a result many women avoid seeking care (2,3).

Both of us were interested in questions regarding women's health in developing countries and in particular conditions that were connected to the social position of women. One of us had been to Nepal before and when talking to Nepalese contacts about women's health, uterine prolapse was mentioned as a major issue. We found uterine prolapse among Nepalese women a complex and interesting subject that we wanted to investigate further. As nursing students we were primarily interested in the care provided.

Our aim was to gain knowledge of how patients with uterine prolapse are cared for in a Nepalese hospital and how the prerequisites of the hospital affect the care. We hope that our findings will contribute to new insights for all involved and serve as a basis for reflection on this topic. Furthermore, we believe that our findings will be a valuable asset for us and our colleagues in Sweden. Swedish health care is not without limitations of resources. We believe that reflecting on this matter is of great importance. Being aware of resources, their impact on the care and how you make the most out of them is important for Swedish nurses as well as Nepalese.

BACKGROUND

NEPAL

Table 1: Nepal Country Facts

Official name	Sanghiya Loktantrik Ganatantra Nepal/Federala demokratiska republiken Nepal
Area - km2	147 181 (2010)
Population	29 852 682 (2010 estimate)
Capital	Katmandu, population 990 000 (2010 estimate)
Government	Republic
Currency	Nepalese Rupee (NPR) 1 US Dollar (USD) = 90.59933 NPR

(4,5,6)

Nepal is a landlocked republic located in Southern Asia in between India and China. It has a population of approximately 29 million of which 990,000 (2010) live in the capital Kathmandu (7). The official language is Nepali which is closely related to Hindi, but there are several other languages and dialects spoken by different ethnic groups of Nepal. Furthermore English is commonly spoken among people in business and government (4,7). Nepal is the seventeenth poorest country in the world and the poorest country of South Asia (5). In recent years the number of poor people has declined, mostly due to increased incomes from citizens working abroad. International aid and tourism also contribute to the possibility of growth for Nepal. However, 25% of the population still live below the poverty line. Nepal is one of the least developed countries in the world and more than 80% of the population live in rural areas. Agriculture is the most common livelihood and the industries are mainly processing the agricultural products such as jute, tobacco, grain and pulse. Only about 7% of the population works in the industries (4,7).

Nepal is located on three ecological zones, the flat river plain in the south, the hilly region in central Nepal and the mountains of Himalaya in the north. The landscape of Nepal, with its great differences in altitude, makes it hard to construct roads. The infrastructure is consequently poor. More than two thirds of the roads are unpaved and some districts still are not connected to the road network (4). The poor infrastructure means a big challenge for Nepal regarding health and development (8).

The diverse population of Nepal consists of a large number of groups defined by above all ethnicity, language and a complex caste system (4). Nowadays the caste system is prohibited, yet it is still present in the Nepalese society. The caste system and the patriarchal structure of Nepal affect exposed groups, such as women and minority groups, as for instance by reducing their access to health services (8). Up until 2006 Nepal was officially a Hindu state, but is now a secular nation (4). A majority of the Nepalese people define themselves as Hindus. The second largest religion is Buddhism, followed by Islam (7).

Nepal has suffered from political instability for about two decades. A multiparty democracy was introduced in 1990 and since then there has been 20 governments (5). In 2008 the former kingdom of Nepal was declared a federal democratic republic and the monarchy was abolished by the newly elected Constituent Assembly. The drafting of the constitution is still an ongoing process. The current Prime Minister Baburam

Bhattarai is working together with the leaders of the main political parties to be finished with the draft by May 2012 (7).

Health

Life expectancy in Nepal is 65 years for males and 69 years for females. This can be compared to Sweden where the same number is 79 for males and 83 for females. The infant mortality rate in Nepal is high in comparison to Sweden. In Nepal the probability of dying before the age of five is estimated to 48 per 1000 live births, while only three infants per 1000 live births die in Sweden (9,10).

The risk of being affected by infectious diseases is high in Nepal. Food or waterborne diseases such as diarrhea, typhoid fever and hepatitis A is a health issue in Nepal. There are also vector borne diseases like malaria and Japanese encephalitis (7). Diarrhea is the most common cause of death in children under the age of five. Malnutrition causes 38.8% of the children in Nepal to be underweight, globally the same number is 7% (7,11).

Health care system in Nepal

There are three categories of health care providers in Nepal: public, private and Non-Governmental Organizations (NGO) (12). For every 10 000 inhabitants of Nepal there are thirteen nurses and midwifes and two physicians (11). There are five hospital beds per every 1000 of Nepal's inhabitants (7).

In Sweden the total expenditure per capita is 3690 USD compared to 69 USD in Nepal (9,10). The public spending on health in Nepal is low. The government expenditures only cover roughly 37% of the total expenditure. Almost two-thirds of the money spent in health care in 2008 came from private sources. Out of these more than 70% came from out-of-pocket sources (13).

In 1997 the Nepalese Government decided on a long term health plan in which the issue of women's health is stressed. The plan states that the health status of vulnerable groups like women, the rural population, the under privileged and the poor must be improved. This is to be achieved through extended primary health care system in the rural areas, more trained health care providers, training and community participation and through involvement of NGO: s and private sector in health services (14). The government provides free health care and 1000 NPR to every woman that seeks help for uterine prolapse or gives birth at a hospital. The money is meant to cover transport charges and other expenses (K, Bajracharya. Personal communication. 2012-02-05). Nepal's health policy encourages social justice and equity but there are still significant health gaps between rural and urban areas and the rich and the poor (8). There is also a problem with accessibility to health facilities for the people in the rural areas of this mountainous country (3).

Women's Health and status

The World Health Organization (WHO) about reproductive health:

> "*Within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease*

or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.
Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (15 no p).

Women of the Nepalese society are particularly vulnerable to health problems. Their low familial and social position, illiteracy, cultural traditions and patriarchal structures are all factors that make the reproductive health situation of Nepalese women very poor (3).

The maternal mortality rate in Nepal is estimated to 380 per 100 000 live births, compared to the global average of 260 deaths per 100 000 live births (11). Surveys made in 2006 showed that the number of births assisted by skilled personnel were approximately 19 %. Most births occurred in rural areas (88%) and out of these only 14 % were attended by skilled birth attendants. In the same year less than half of the married women used contraceptives (44%) (16). Almost a quarter of the female population is suffering from malnutrition (17).

Women of Nepal often consider giving birth as a procedure that does not require any special arrangements before, during or after delivery. Conceptions like this stem from a lack of knowledge about the need to rest after delivery. This complicates efforts to get more women to give birth in institutions with skilled personnel and for women to understand the importance of resting and not performing hard physical work too soon after delivery (18).

Due to remoteness and the difficult terrain in Nepal the access to health care is severely restricted. Even if health care services are available there are other factors that prevent women from getting the care needed. Women are often deprived of the right to make decisions concerning their own health care, including timing and spacing of pregnancies. Usually the husband decides about health care expenses, and women are not always allowed to travel alone which further complicates the process of seeking medical care (3). Consequently Nepalese women in general do not have the same access to and possibility to utilize basic services as men do (7).

UTERINE PROLAPSE

Anatomy and patophysiology

Uterine prolapse is a condition in which the muscles and supporting ligaments holding the uterus in place gets too weak to keep the uterus in position. This causes the uterus to drop into the vaginal canal and results in a downward malposition of the uterus (19). This causes the vaginal walls to fall down toward or out of the opening of the vagina (20).
There are four different components of uterus prolapse which can occur isolated or in some combination:

Cystocoele: Prolapse of the anterior wall of the vagina, which usually makes the bladder descend and herniate the vagina
Rectocoele: Prolapse of the posterior vaginal wall, rectum and sometimes the small or large bowel protrudes into the vaginal canal.
*Enterocoel*e: The small intestine bulge into the vagina like a hernia (20,21).
Dispenses: Uterus descends into or out of the vagina (20).

There are different stages of prolapse: (I) the leading edge of the prolapse is more than 1 cm above the hymen, (II) the leading edge of the prolapse is less than 1cm proximal or distal to the hymen, (III) the leading edge of the prolapse is more than 1 cm below the hymen but protrudes no further than 2 cm less than the vaginal length, (IV) complete eversion of the total length of the vagina (21,22).

In stage two or three there is a risk of developing decubitus ulcers at the cervix or vaginal wall. This is due to the prolapse being in contact with the women's clothes or thighs chafing (3).

Symptoms

Although women suffering from uterine prolapse may experience many symptoms there is only one symptom that is specific for the condition. The uterine prolapse specific symptom is the feeling of something bulging out of the vagina, a foreign body sensation (20). Other symptoms that uterine prolapse patients have reported are a sensation of heaviness in the pelvis, vaginal bleeding, increased vaginal discharge, chafing, painful or difficult sexual intercourse and low back ache (1,20).

Because of the close position of the uterus to the bladder and bowel, the symptoms of uterine prolapse can come from these organs. Bladder incontinence, which leads to frequent urination, a sense of not being able to empty bladder or the feeling of sudden needs to empty bladder are common. Constipation or the need to use the fingers to ease the defecation can be a consequence of prolapse (1,20).

Risk factors

The two main risk factors for uterine prolapse are pregnancy and delivery which causes a severe distention of the connective tissues. The risk increases if the repair of any perineal injuries are neglected or not done properly. Other risk factors are aging and postmenopausal hormone changes, chronic constipation, improper delivery techniques, delivery in young age, an infant birth weight over 4500g, frequent pregnancies, undernourished mothers, heavy physical work during and soon after pregnancy, heavy lifting and prolonged labor (19-21,23).

Treatment

Uterine prolapse is preventable and easily treated. In first stage prolapse pelvic exercises are recommended to prevent a worsening of the condition (3,20). In second stage a vaginal pessary, similar to those pessaries used for birth control, can be used to keep the uterus in place. This treatment is often sufficient and no surgery will be necessary. A pessary can also be used while waiting for surgery (1,20). In third stage prolapse surgery is required. Surgery might also be required if treatment with pessary is not working. For some women the pessary will not stay in place due to week ligament

support or a wide vaginal opening (20). The surgical options include hysterectomy (removal of the uterus) or the Manchester operation. The Manchester operation aims to recreate the anatomy of the women's pelvis by amending the stretching or disruption of the connective-tissue attachments and if necessary removing the cervix (20,21).

Uterine prolapse in Nepal

Uterine prolapse is one of the main causes for ill-health among Nepalese women of reproductive and post-menopausal age (24). It is estimated that some 600 000 to 1 million women suffer from uterine prolapse of which 200 000 is in need of immediate surgery (18,19).

According to the United Nations Population Fund (UNFPA), the reason for the high number of affected women in Nepal is, among others, the lack of skilled birth-attendants, women carrying heavy loads, child marriage, lack of contraceptives and giving birth to many children (23).

Due to traditional gender roles, lack of knowledge about and the stigma surrounding uterine prolapse, many Nepalese women do not seek health care for their condition. They often keep the condition a secret, being afraid of condemnation and ashamed because it is the genitals that are affected (3). Further the women might not be in a position where they are allowed to make decisions regarding their own reproductive health (18,19). Women suffering from uterine prolapse risk being rejected by their husbands, family and even by the community (18). Often the affected women do not know that the condition is common and treatable (18,19).

Uterine prolapse in Sweden and globally

In Sweden it is estimated that one out of twelve women has symptoms of uterine prolapse and each year some six thousand women undergo surgery. Out of these approximately 20% will have a relapse that requires an additional operation. If the patient feels that something bulges out of the vagina, has trouble emptying bladder, repeated urinary infections or if the symptoms of the prolapse affects the patients quality of life in a negative way she will be offered surgery (25). The global prevalence of genital prolapse among women under 45 years of age is estimated to 2-20% (19,26).

THE NURSING EDUCATION IN NEPAL

There are different lengths and forms of the nursing education in Nepal (K Bajracharya. Personal communication. 2012-02-01). Most of the students we met at Paropakar Maternity and Women's' Hospital studied a three year full time university education. The program is open to female student only. The six major themes of the education is development, communication, the nursing process, stress, teaching and learning and leadership. Three thirds of the last year is dedicated to theory and practical placements in midwifery and gynecology. A total of 23 weeks are dedicated to clinical placements in the field of midwifery and gynecology (27).

AIM

The aim of our study was to gain knowledge of how patients with uterine prolapse are cared for in a maternity hospital in Nepal.

Guiding questions were:

- What are the prerequisites for the care?
- How do the prerequisites impact the care of women with uterine prolapse?
- What consequences do the prerequisites mean for the caregivers?

METHOD

ETHNOGRAPHY

Ethnography is a method where the researcher studies cultural norms, rules and phenomena by observing human behavior in a specific context. The aim of an ethnographic study is to gain an understanding of a certain culture. Within ethnography, culture is considered to be created in all groups of people and forms the individuals' ideas of life, the world and their actions. To gain this understanding the researcher needs to do fieldwork, be in the context of the group studied, observing the everyday life. The researcher reveals everyday events that are natural to the members of the group by asking questions about what is happening, what is being done and why. The researcher can choose in what extent to participate in the life of the people observed, depending on what the researcher believes will be the best approach for the study. Ethnography is a method where you try to understand a culture from inside, the reality as seen from the members of the group members' perspective (28).

Ethnography is a "free" method where the researcher has to create the study by him or herself. There is no template to follow but only guidelines to guide the researcher in developing a study that will meet the aim of the study (28). According to Leininger the method of ethnography can be described as follows:

> *"the systematic process of observing, detailing, describing, documenting and analyzing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment"* (29, p35).

We decided to have an ethnographic approach since our aim was to get an understanding of behavior and perceptions in the environment we studied.

PARTICIPANT OBSERVATIONS

Participant observations are commonly viewed as a qualitative data collection method. The aim of the participant observations is to gain knowledge by getting intimately familiar with a group of individuals and study their context from inside. By participating in their everyday life the researcher receives information about values, norms and different patterns characterizing the social context studied. There are few formal rules on how to execute participant observations. The result comes down to for

instance what the group chooses to share and the researcher's capacity in presence of mind, creativity, sensitivity and patience. Participant observations usually extend over a long period of time resulting in detailed and carefully elaborated descriptions of human life and social contexts. The observations are always to be complemented by a variety of data, such as pictures, informal interviews and life-stories (30).

To meet the aim of our study we needed to get into the hospital environment and study the daily care from inside. Therefore we found participant observations a suitable research method. In the process of choosing a method we realized that not understanding Nepali or Nepalese minority languages would complicate the communication and make it difficult for us to get a result based on interviews and surveys only. Moreover we were not allowed to conduct formal interviews by the hospital management. These facts supported us further in choosing participant observations, since it is a suitable method when it is difficult to conduct interviews (31).

PRE-UNDERSTANDING

We had completed five out of six semesters at the nursing program at Sahlgrenska Academy at the University of Gothenburg Sweden when we left for Nepal. Our pre-understanding regarding nursing and caring is based on nursing theories studied at the university as well as experiences from internships and from working as nurses' assistants in Sweden. We had superficial knowledge about gynecology since the teaching in gynecology is very limited in the Swedish nursing program. We did not have any specific knowledge about the care of women with uterine prolapse. Therefore we visited a gynecological surgery ward in Gothenburg where we attended a uterine prolapse surgery. We also had the opportunity to talk to one of the patients about her situation and to one of the nurses about the care they provide to uterine prolapse patients.

We both had experience from staying longer periods of time in developing countries and one of us had visited Nepal before. None of us had experience of gynecological care or of participation in the care at hospitals abroad.

PREPERATIONS

While still in Sweden, planning our thesis we got in touch with Laxmi Tamang, founding member and joint-secretary of the organization Midwifery Society of Nepal (MIDSON). Laxmi Tamang connected us with her colleagues in Nepal. They recommended us to do our observational study at Paropakar Maternity & Women's Hospital where there is a steady case flow of patients with uterine prolapse. After our arrival in Kathmandu we met with Kiran Bajracharya, founding member and president of MIDSON. In cooperation with MIDSON we planned our study and they helped us in all the arrangements with the hospital. We decided to perform our study during a period of four weeks. To enrich our observations at Paropakar Maternity & Women's Hospital we planned to make one day visits to four other hospitals to get awareness of possible differences in the care provided. We wished to make these visits half way into our observational study. This was not accepted by the administrative staff of Paropakar Maternity & Women's Hospital so we made the visits after finishing our time at the hospital.

To be able to communicate with both staff and patients at the hospital we needed to work with the help of an interpreter. We found it important to use a female interpreter since the patients we observed were women suffering from gynecological problems. We also wished to find someone without professional experience of health care to make sure the interpreter would not be influenced by the health care system in her interpretation and to avoid missing out on things that might be taken for granted by someone familiar with health care. Laxmi Tamang connected us with Shabnam Samal, teacher and master student in sociology. After meeting her and introducing our study we agreed to work together. Her main task was to interpret in conversations and to translate some written material. She also functioned as a culture broker helping us understand situations and contexts that were unfamiliar to us.

SETTING

Paropakar Maternity & Women's Hospital is the only maternity hospital of Nepal and was established in the year of 1960. As the central referral hospital for maternal and neonatal care in Nepal the hospital receives patients from all over the country. The hospital is also a national and international center for educating health personnel in the field of reproductive health care of women. Each month nursing students from three different campuses are placed at the hospital for a month. The hospital is financed by the government of Nepal and by funds generated by the hospital itself. The hospital provides both indoor services and outpatient services. The services provided in the indoor department are among others obstetric service, gynecological service, neonatal intensive care and maternal intensive care. The Out Patient Department (OPD) is where the patients are referred for their first checkup. At the OPD they also do follow ups, counseling, teaching of pelvic exercise and change of ring pessary for the patients with uterine prolapse. Only the patients in need of surgery are admitted to the gynecological ward at the hospital. The hospital has 14 working units with 336 indoor beds and 79 service beds. Sixty one of the indoor beds are for gynecological patients and the rest are for obstetrics and special baby care unit. Last year a total of 29 361 patients were admitted to the hospital, 159 out of them suffered from utero-vaginal prolapse (32).

The hospital has very limited resources and much of the facilities are worn out. Our observations were carried out at ward 14, a gynecological pre- and postoperative ward, and at the gynecological room of the OPD. The ward has 28 beds. It is divided in two different rooms with the nurses' desk in between. Standing behind the nurses' desk it is not possible to see the patients. The gynecological room at the OPD is a small windowless room where both the examinations, history taking and giving of information is conducted.

DATA COLLECTION

Our data was collected during a period of four weeks at a gynecological ward and at the Out Patient Department of Paropakar Maternity & Women’s Hospital in Kathmandu, Nepal. Our participant observations were carried out by observing the staff in their daily work, making field notes of what we saw and experienced. Soon we realized that the general care was the same regardless of diagnosis. Still we kept our focus on the patients with uterine prolapse by paying extra attention to how they were cared for and

by posing specific questions. We spent half the day carrying out observations at the hospital, alternating between the morning and afternoon shift, and the rest of the day transcribing and discussing our field notes.

As a complement to our notes and to validate our observations we conducted informal interviews. All interview questions used were written in Nepal. They were continuously revised during the process of our observations to better meet the aim of our study. Four nurses and four nursing students were interviewed. These interviews were carried out either in the staffs changing room or when available in one of the private cabins at the ward were we could ask our questions in private. We also interviewed two relatives and six patients diagnosed with uterine prolapse. These interviews were held at the patient beds with no means of privacy since it was the only option. Some interviews with the students were held in English but most were held in Nepali with the help of our interpreter. We were not allowed to record the interviews. The interviews were documented in notes, one of us posed the questions and the other one took notes.

Furthermore we spoke to doctors working with uterine prolapse patients and a doctor working with developing national strategies for preventing and treating uterine prolapse. We also met with a Swedish midwife working for UNFPA building a cadre of midwifes in Nepal, discussing the national approach to the prevention and treatment of uterine prolapse.

DATA ANALYSIS

Following each day of observations and interviews at the hospital we transcribed and analyzed our field notes and interview material. The data was discussed thoroughly and divided into smaller units that were given different code names. At first we took notes on everything we observed out of our general question about the care of women suffering from uterine prolapse. As the data collection and parallel analysis proceeded, we could identify different categories in our material. A number of questions were raised, and based on these questions our observations turned more focused on specific areas of the care. Along the process we changed and added to the questions of our informal interviews to meet the new questions which arose out of our material. We chose to focus on what we found most striking in the material that emerged to us, namely resources and limitations. What were the prerequisites for the care and how did these affect the patients and nurses? The aim of our study was changes several times during the process.

ETHICAL CONSIDERATIONS

Before we left Sweden we were in touch with Nepal Health Research Council (NHRC). Given the fact that our study was not to be considered as research and is not going to be published NHRC gave us permission to perform our study without a formal ethical approval.

At Paropakar Maternity & Women's Hospital we were granted permission to perform our study by the administrative chief, the matron and the hospital director. We introduced ourselves to staff, students and patients as students doing an observational study collecting data for our bachelor thesis.

All individuals interviewed were asked for permission to use their answers in our thesis. They also received the information that our study was not going to be published, that their participation would be both voluntary, anonymous and that if there were any questions they did not want to answer they could refrain from answering without an explanation. Data obtained from the patients has been depersonalized due to the demand of confidentiality.

FINDINGS

The aim when we started our observational study at Paropakar Maternity & Women's hospital was to understand how the care of patients with uterine prolapse was performed and perceived by the nurses. During the course of our observations we realized two things: The main part of the care was not provided by nurses, but by students and relatives. Secondly we saw that the general care was the same regardless of diagnosis. The care of the patients with uterine prolapse did not differ much from the care of other patients. Hence, we observed all care performed, but still kept our focus on the patients with uterine prolapse. All active participants in our study were patients suffering from uterine prolapse.

At the end of our observations we had an extensive amount of material. We chose to focus on the part of the material we found most striking, the resources and limitations in the care given to the uterine prolapse patients. What were the prerequisites for the care and how did these affect the patients and nurses? Our findings will be presented in the following categories:
Prerequisites for caregiving; environment, equipment, hygiene facilities, staffing, unwritten rules.
Consequences for the patients; being embarrassed, involuntary sharing, power imbalance, lack of information, relatives as caregivers, increased risk of infections, compromised confidentiality.
Consequences for the caregivers; feeling of inadequacy, making the best they could, adjusting to the environment, not meeting the patient needs.

Introducing the uterine prolapse patient - a selection of patient stories
Many Nepalese women suffering from uterine prolapse have much in common in lifestyle and history. We have chosen to share two of their stories to set a picture of this group of individuals.

Rajuma
Rajuma was born in a rural mountain village of Nepal. Her father died when she was fifteen years old and at the age of twenty she married her cousin. Soon after marriage she got pregnant. She kept working in the home and on the fields until the day of delivery. She gave birth to her daughter alone in her house, sitting on her knees on the floor holding on to a chair to get strength. It was during delivery her uterus prolapsed. Soon after delivery she had to start working again. Her husband was mad at her because of her new condition. He scolded and hit her since he thought she would not be able to conceive any more children. She felt physically week and the prolapse made it difficult

for her to have sexual intercourse with her husband. One year after the delivery her husband left her. She and their daughter moved in with Rajuma's parents and brothers.

Rajuma suffered from her uterine prolapse for twenty two years before seeking help for the condition. She had only told a few close friends about her problem before she came to the hospital, she felt shy talking about it. She knew about the condition of uterine prolapse when it happened to her, but did not know that it was possible to get help until she saw an informational video on the television.

Even though Rajuma had a constant sensation of her prolapse it did not keep her from working. Instead she took breaks while working and when she needed to carry heavy loads she did it in batches. The prolapse was always outside her vaginal opening causing an uncomfortable feeling.

Sarasvati

Sarasvati is 45 years old and has four children. She lives in a very remote village in the mountains and works as a farmer. The soil where she lives is poor and it is difficult to get sufficient amounts of food for her and her family.

Ten years ago her uterus prolapsed. At first she did not know what had happened to her. She did not talk about it with anyone except her husband. Not until later they realized that other women in their village were suffering from the same condition.

She did not know why it happened to her, but she thinks it might have been because of the technique used during her last delivery. She delivered at a small hospital in the mountains where the birth assistants pulled out the baby with their hands as soon as the baby’s head was out. The fact that she worked hard soon after all of her deliveries might also be a reason.

The first time she sought medical help for her prolapse she got surgery. She did not get any information about not to work hard, carry heavy loads or to refrain from sexual intercourse the first months after surgery. Neither did she get a re-visit by any doctor. Three years later she had a relapse of her uterine prolapse. The prolapse made it difficult for her to work and has been painful. She has not been able to squat and has suffered from incontinence that is probably due to the uterine prolapse. When the condition got worse she and her husband travelled to Paropakar Maternity & Women's Hospital in Kathmandu to get help.

PREREQUISITES FOR CAREGIVING

Environment

At the ward studied, the patients were cared for in two big rooms, one with 18 beds and the other with ten beds. There were also a few private cabins. The rooms did not offer much privacy or seclusion for the patients or staff. The beds at the ward were placed close together and there was only one screen for shielding of the beds. Several examinations were performed at the same time making it impossible to screen off when needed. The nurses’ desk was placed in between the two rooms. While standing behind the desk it was not possible see the patients. Behind the desk there was a small dressing room for the staff.

The hospital had no central heating and the ward was very cold from time to time. There were a few small heaters made out of ceramics, but they were only enough for a few beds and were mostly used in the areas for staff. In daytime the sun shone in and raised the temperature, but still it was far from comfortable. There was no ventilation at the ward resulting in poor air.

The OPD had similar problems with privacy and seclusion as the ward had. In the small room there were two desks were the doctors and the nurse received the patients and took their medical history. Next to the desk was a green curtain that shielded off the area where the examinations took place. Behind the curtain there were three gurneys where three examinations could be performed at the same time. The windows of the room were sealed by cloth which resulted in poor air and no sunlight.

There was no room for private conversations neither at the ward nor at the OPD. All conversations, giving of information and discussions were held in the big rooms at the ward or in the only room at the OPD.

Equipment

There were a few chairs in the ward but visitors were most of the time sitting on the beds. Each patient bed at the ward had one blanket, one pillow and a nightstand were the patients kept their private belongings and medicine. The patient beds were made of iron with mattresses out of coconut hair. They were old and worn and many of the mattresses were broken, with hair sticking out causing itch to the patients. The bed linen used were often torn and stained.

The gurneys at the OPD were covered by a thick green fabric similar to oilcloth. The fabrics were worn out with holes in them and filled with stains of dry blood and other body fluids.

In both the OPD and the ward there were trolleys placed by the wall holding basic instruments, dressing equipment and buckets for collecting used gloves. The gloves were re-used due to the limited resources at the hospital. There was a small storage connected to the ward but equipment such as IV poles, suction apparatus and oxygen tubes were placed openly along the walls of the rooms.

There were no computers or typewriters at the ward and therefore all of the administrative work had to be done by hand. This required a vast system of different notebooks. Information was transferred between the different books and the charts.

Hygiene facilities

The hygiene facilities were sparse at the entire hospital. Inside the patient rooms there were no hand-basins. The patients' bathroom was placed outside the rooms. Inside the bathroom there were three squat toilets and one big sink along the wall. The toilets were unclean and sometimes you could find piles of bloody pads or bandages tucked away in the corners. Since the sink was not only used for washing hands but also for doing the dishes there were usually traces of food in the sink. There was only cold water in the patients' bathroom and nothing to dry your hands on.

The only sink for the staff to use was located at the staff toilet. The sink was old and the water tepid. There was a soap dish with a bar of soap and nothing to dry your hands on. Once during our observations the sink was out of function, meaning that the staff had to go to the next door ward to wash their hands.

At the OPD there was a sink inside the room but it was often without water. Due to this lack of running water the staff had to use a bucket and a can for washing hands. They used a bar of soap. There was no hand disinfectant at the ward or at the OPD.

Staffing

At each shift there was only one nurse on duty at the ward of about 30 patients. This nurse had the ultimate responsibility for the care of the patients. In the morning the nurse was supposed to make sure that basic morning care was provided to the patients and that the rooms were clean and tidy. The rest of the day care was given according to the patient needs. This care was mostly performed by the students. They were always under supervision of the nurse, though she was rarely present in the patient rooms. The nurse mainly entered the patient rooms when to administer medicines or to help the students with tasks they could not manage themselves. The nurse also carried out several tasks not directly related to the care such as placing a new soap at the staff toilet or putting the dressing kits in a place where the doctors could easily find them. A lot of the nurses' time was spent on doing administrative work, a time consuming activity as it was done by hand. They were also responsible for coordinating the care at the ward and for the communication with other units. The nurses were the ones making sure that the other staff and students executed their work properly.

Most of the daily care was performed by nursing students in the third year of their education. The students were doing their gynecological practice at the hospital and spent one month at the ward. During the day there were approximately ten to 15 students at the ward.

The students' tasks at the ward included bed making, checking of blood pressure and other vital signs, assisting the doctor while dressmaking and taking blood samples. However the majority of students spent most of their time doing their homework. During their practice they were to write a case study on a given diagnosis. This was done by reading about the diagnosis and talking to a patient suffering from the condition. The most common sight at the ward was the students standing together in groups reading, talking or writing their case study, not paying much attention to the patients. Some of the students, though a minority, spent much time caring for the patients, performing their tasks and talking to the patients.

At the ward there were one or two attendants at each shift. The attendants had a variety of duties but one of their main tasks was to keep the ward clean and tidy. They were also in responsibility of most of the patient transports within the hospital. Their level of education was low and they had no health care training.

Unwritten rules

The relatives of the patients were expected to be present at the ward to perform some of the tasks. They were expected to take care of the basic care of the patients, such as personal hygiene. The relatives were the ones supporting the patients if they were not

able to walk on their own. The relatives also carried out tasks such as taking blood samples to the lab and buying medicine and material necessary for the care of the patient. If the patient did not have any relatives around when these tasks were to be done, relatives of other patients usually helped them instead.

One of the nursing students told us that nursing used to be a low-status profession in Nepal as nurses frequently handled body fluids like urine and blood. Nowadays the profession has started to gain popularity and respect, partly because nurses deal as little as possible with body fluids. A few times we saw blood being spilled on the floor of the ward, accidentally and sometimes by purpose. Without communicating, the task of cleaning the floor was left to the relatives. At the OPD there could be fresh blood or other body fluids on the gurneys without anybody wiping it off between patients.

It was not a part of the care culture at the hospital to keep patients well informed about medical matters. Nursing activities such as checking of blood-pressure, temperature and pulse were sometimes performed without communicating with the patient. Most of the time limited information was given to the patient about what was being done and why. The students, who were usually the ones checking the vitals, often performed the task and went away without uttering a single word to the patient. Patients undergoing surgery were informed by the doctor about the nature of the operation and the preparations necessary, one day before the operation-date. Information and instructions were mostly given in order to make sure the care could be performed smoothly, rather than to make the patients understand their situation. Sometimes pre-operative information was not given at all.

There was an evident hierarchy at the hospital, with senior doctors at the top followed by doctors, nurses, interns, students and patients at the bottom of the scale. The staff showed much respect to the ones higher in the hierarchy and the staff was highly respected by the patients. The students did whatever the nurses told them to do. The doctors were rarely questioned by the nurses and almost never by the patients.

CONCEQUENSES FOR THE PATIENTS

Being embarrassed

Close to daily several examinations were performed at the same time making it impossible to screen of every bed to shield off the women examined. During rounds examinations were performed in the patient beds with the women's genitals exposed, making the patients feel embarrassed. Most of the time the women had to spread their legs, facing the room with no means of covering themselves. With doctors, interns, nursing students and nurses there were sometimes more than ten people surrounding the patient examined.

Many of the women suffering from uterine prolapse had ulcers and were in need of daily dressing. Because of this, they were affected by the lack of privacy during procedures more often than other patients. We observed that two of the patients with uterine prolapse pulled their shawls over their heads to hide their faces, as soon as the examinations were over. They shared their experience of being ashamed, telling us that they felt exposed during examinations when the screen was not used. This was why they wanted to hide their faces after the examinations. Even though being ashamed they accepted the situation:

”I needed to digest it. I was ashamed, but what to do when you are in the hospital? I want to get well. Everybody told me that I will be fine again so that made me happy.”

One of the nurses answered our question about her thoughts regarding the lack of privacy during examinations as follows:

“It is difficult, embarrassing. I would feel shy. But almost everybody here are women, there are almost no men, so that is better. ”

At the OPD all the conversations with the patients took place in a room full of people. The problems that the patients at the OPD needed help with were gynecological and intimate. Since there was no space for private conversations the women had to tell about their problems in a room with many ears to listen, making some of them feel embarrassed to talk. When we asked the nurse about this she commented on the problem as follows:

”When I take the history of the patients many of them tell me they have problems such as stomachache. But when we get behind the curtain it is revealed that they have other intimate problems as well, such as prolapse or bleeding.”

Involuntary sharing

Due to the lack of secluded spaces conversations were held in the rooms for others than the concerned to hear. At the ward discussions with and about the patients occurred by the patient beds, often very loud and clear. These conversations could be long and detailed and include more than ten doctors and students standing around the bed, listening and taking part of the cases. Anyone in the room could join the circle to listen to the things being said, just out of curiosity. It happened that relatives or patients not concerned interfered and shared their thoughts and views on the case. Sometimes when this occurred the patients of focus looked uncomfortable and frightened.

All patients were affected by the fact that conversations about their situation and disease were held for others to hear. Though the patients with uterine prolapse were a particularly vulnerable group of patients. The nurse who worked at the OPD described the situation of the uterine prolapse patients as a group:

“They are different from other patients because they are shy and ashamed. Even if they have lived with this condition for 25 years they are still hiding it. They don’t want anybody to see and they don´t seek help until they suffer from infections, ulcers or other problems. They don´t want to talk about it, maybe because they are afraid of what the society, their friends and family will think and say. It´s taboo to talk about the genitals in the Nepalese culture.”

Both at the ward and the OPD sensitive information was given to the patients openly. An example of this was when a patient was informed about the death of her new born child in front of everybody in the 18 bedded room. She burst out in a heart-rending cry and the whole ward got silent. First everybody turned and watched the woman, then

they tried to mind their own business again with the cries not ceasing. The woman got into a state of shock and the feeling at the ward got extremely tense.

Power imbalance

The hierarchy had a significant impact on the care and was particularly obvious in the relationship between the patients, nurses and doctors. The staff sometimes talked about the patients in third person while standing next to them and they were often referred to as cases, rather than individuals.

The educational needs of the staff were many times given priority even when it affected the patients in a negative way. The patients integrity was consequently set aside for the benefit of educational needs. As an example of this the students performed full body examinations on patients that were in no need of them. The patients seemed to have no saying in if they approved of being an object of teaching or case studies. Their low standing in the hierarchy was never a topic of discussion among the staff.

The high respect for the doctors and nurses made some of the patients scared of asking questions that were of importance for their well-being. One relative explained that she did not dare to ask about her mother's diet. Her mother was recently diagnosed with diabetes and the daughter was afraid that she had given her food when she was not supposed to. She thought the doctor would be angry with her if she told. Some patients asked us to be present when asking the doctors for information since they were afraid of being scolded.

Lack of information

The patients often received short instructive information about what medicine to take and how to prepare before surgery and examinations. It was often a one-way communication without any explanations following the instructions. Many patients expressed a fear of asking for information even though they wanted to know what was going to happen with them or how the outlook was on their disease or progress. This made participation and understanding of the care difficult for the patients.

Most of the patients we talked to had received information about what kind of surgery they were about to undergo, but did not always understand what was really going to be done or what the consequences would be. Two patients we interviewed days after their operation told us that they did not know what kind of surgery had been performed until after the operation was done.

The patients with uterine prolapse that suffered from ulcers needed daily dressings. At the first occasion the doctor informed them about how the dressing was to be done and what material they would use. But at the following daily dressings the doctors usually came to the patient, asked her to spread her legs, did the dressing and went away without telling the patient about how the treatment was proceeding or what they were doing. This left the patient unknowing of their current situation and without any perception of how long they would need to stay at the hospital.

Information was also lacking in situations when patients might have been in need of comfort and clarity to make it easier to put up with pain and anxiety. One woman suffering from severe pain was left without information about her ongoing and planned

treatment. Neither had she received any information on what kind of medicine that was being administered to her or when relieved suffering could be expected.

The lack of information was not always perceived as a problem by the patients concerned. One woman with uterine prolapse said that she had received information about the dressing of her ulcer and about necessary lifestyle changes after the surgery. She had not received information about the surgery, but added that she did not think she would be able to understand more information anyway, since she was a farmer and had no education.

Relatives as caregivers

The relatives had an important role in caring for the patients. They were the ones helping the patients when there was no staff around. Even when staff was present some tasks were expected to be performed by relatives. There were occasions when relatives were concerned that their family member would not receive the help needed if they were left alone at the ward. As an example of this the husband of a patient suffering from uterine prolapse refused to leave his wife during the morning round, even though he was told repeatedly to leave the room. He explained to us that his wife had just received laxatives and would soon have to visit the toilet. She was week and needed support. He was deeply worried that she would not get the help she needed from any of the staff at the ward. He stayed with his wife and a few minutes later he was the one supporting her to the toilet.

Some patients were questioned when having no relatives around at the ward. This happened both in situations when relatives were needed for performing different tasks and when patients were sad or worried, in need of comfort. Practical problems were sometimes solved by the relatives of other patients who did errands and performed tasks for the patient in need. Patients who were sad and worried, but did not have any relatives present, were usually left alone.

Increased risk of infections

The environment and the lack of resources at the hospital created an increased risk of infections for the patients. The limited hygiene facilities made it almost impossible for the staff to keep proper hand hygiene. The doctors performing the examinations rarely washed their hands, instead they just changed gloves between patients. Sometimes gloves were not used at all while dressing wounds. Gloves were in general used sparsely since the hospital had no budget to buy disposable gloves. They were not used when inserting peripheral venous lines and not always when performing body examinations. When making the beds, the nursing students only used one pair of gloves each for all of the beds at the ward. In addition to this, the bed linens were not changed in between each patient.

The material used for dressing was not kept in an ultra-pure way. The tape used was kept in pre-cut pieces, attached to an old x-ray plate, hanging behind the nurses' desk. Dressing material was sometimes touched by the hands of the staff before applied to wounds, including open operation wounds.

Compromised confidentiality

The confidentiality of the patients was compromised by deficiencies in the physical environment and the care culture at the hospital. The lack of space for private conversations resulted in many people hearing the discussions about the patients. Sometimes the students did their handover in the room by the patient beds. At the OPD the doctors only had one table for taking the history of the patients. With a high number of patients to tend to, this resulted in that three patients at a time could be talking to their respective doctor about their situation and problems next to each other. Usually the room was filled with staff, relatives and patients waiting for their turn, close enough to hear the conversations between the doctor and patient.

The charts of the patients were usually kept in places within reach for unauthorized people. They were often placed at the nurses' desk, on trolleys in the patient rooms or on the foot of the beds. Staff, patients and relatives could easily access them. Patients looked in the charts and at several occasions we saw relatives reading in the charts of their own family member and other patients. Only the staff was allowed to read the charts, but nobody reacted on the fact that anyone could take part of the information in the charts.

If someone came to the ward looking for a person, they sometimes got to look in the round-book were all the patients names and diagnoses were listed. This occurred even when they were not able to tell the full name of the person they were looking for. One man who did not find the name of his relative or friend in the round-book was let into the patient room to look for the person on his own, but he did not find her.

CONSEQUENCES FOR THE CAREGIVERS

Feeling of inadequacy

The nurses found it hard to give the best care possible with the lack of manpower at the ward. Being only one nurse at the ward having the responsibility for 30 patients was a big restraint. The nurses also had to keep track of everyone and everything. They were always wanted by doctors, attendants, other hospital staff, students, relatives and patients, answering questions and instructing who ever needed help understanding or finding someone or something. Most of the nurses' time was spent behind the nurses' desk coordinating and doing administrative work, and not out with the patients. Almost all of the nurses we interviewed stressed the problem with the lack of manpower. They said it was not possible to provide good care when they had thirty patients to care for:

> *"It is difficult. Sometimes three or four patients get into a state of shock at the same time and it´s very hard to take care of them at the same time. Sometimes the patients are bleeding and I have to check their vitals, it´s difficult to make it."*

> *"I don´t have as much time as the students to interact with the patients, there is no time."*

When we asked one of the nurses what kind of staff she wanted at the ward to improve the care she answered:

> *"Same as me, senior nurses. Then nobody would have to fear that the patients would not get the care or medicine in time, which is the situation today. I would like to have at least two more senior nurses working here."*

In the interviews the nurses also talked about how the lack of material resources compromised their possibility of giving proper care to the patients. They experienced the lack of equipment and dressing material as a problem since it was not sufficient for the number of patients. One of the nurses was concerned about the inadequate ventilation, telling us that the patients felt suffocated in the summertime.

Many of the nurses were frustrated over the fact that the care was not free of charge for patients with other diagnoses than uterine prolapse. They wished that they could provide free health care and medicine to the poor patients. One of the nurses said:

> *"Compared to other hospitals this hospital is cheap and many things are free of cost. But I wish that the Ministry of Health provided free medicine to the poor patients. The poor are suffering and sometimes dying."*

The situation of Nepalese women made the nurses feel frustrated in the caring of women with uterine prolapse. After a uterine prolapse surgery the patients need to make big life style changes. They are not allowed to squat, carry heavy loads or have sexual intercourse for a period of six months after surgery. They need to eat a nutritious diet and keep a good personal hygiene. These restrictions and recommendations are often difficult for a Nepalese woman to incorporate in everyday life. Most of the women are poor and live in the rural areas. Their families are dependent on their ability to work in the household and in the fields, which means heavy physical work. Most of the tasks they perform are done while squatting since that is the custom in Nepal. It is not possible for the nurses to change these conditions which do increase the risk of relapse.

Making the best they could

The nurses and nursing students tried to limit the amount of people present in the room during rounds and examinations by making everybody not working at the hospital leave the room. They told the relatives to stay outside until rounds were over. They often closed the door to the room and sometimes the nurses scolded the doctors if they performed examinations without using the screen and not emptying the room of unauthorized people first.

At the end of each shift the nurse gave an oral handover to the nurse getting on her shift. To be able to do this in private the nurses used the dressing room, the only place where it was possible to close the door. It was a very small room behind the nurses' desk where nobody except the nurses and attendants were allowed. This place made it possible for the nurses to talk about the condition of the patients without anybody listening in on them.

Due to the lack of manpower the nurses had to delegate most of the caring tasks to the students. Still some of them tried to stay in control of everything to ensure the patients received a proper care. To make sure the students performed their tasks in a good way some of the nurses spent a lot of time on checking the students' documentation.

Adjusting to the environment

The nurses at the hospital had to adjust their way of working to an environment with a lot of limitations. At many times they were forced to perform their tasks in a way they knew compromised the quality of the care. Sometimes they were so used to the hospital care culture and the insufficient resources that they seemed to have become blind to it. This resulted in them not always making the best they could with the resources available.

The lack of privacy during examination was something the nurses were aware of caused embarrassment for the patients. They said it was a problem that the screen was not used and that they themselves would feel embarrassed being examined openly. Still they did rarely use the screen to shield off the patient beds, even when it was available. Neither did they ask permission from the patients for our presence during the examinations, even though we repeatedly asked them to.

With only one nurse at each shift it was hard to find the time to support patients that had to go through straining or embarrassing examinations. Though there were times when the nurse was present during examinations, but still did not give her support to the patient. Sometimes when there were already lots of interns and doctors involved in an examination and no screen being used, both the nurse and nursing students could join the circle observing, instead of supporting the patient or getting the screen. When asked about this behavior, the nurses stressed the interns and doctors need to learn and practice.

Many limitations in the environment were difficult or impossible for the nurses to do anything about. They had to find a way to make things work with the prerequisites given. One example was the temperature at the ward which was very low during winter time. With no ventilation the staff sometimes had to open the windows to get fresh air into the ward. This made the temperature drop to an even lower degree. To stay warm the staff wore their own long sleeved sweaters under their scrubs. This meant an increased risk of infection to the patients, but the staff had to do this to put up with the cold.

Another example was the gloves, they could only be used sparsely due to lack of resources. This was a fact the nurses could not change. The gloves were mostly used by the doctors performing the examinations which were the only occasions when gloves were used consistently. The nurses sometimes complained about the doctors using the gloves in a careless manner, not considering that they were to be re-used. The nursing students mostly used gloves to protect themselves, for instance while making the beds. The bed linen at the ward were often torn and worn out. They were not washed or replaced frequently. When a new patient was admitted, a bed was prepared by simply correcting the sheets and brushing them off by hand.

Not meeting the patient needs

The caring needs of the patients were not always met. Sometimes the students did not take notice on patients in pain or with a reduced general condition. With the nurse rarely in the rooms the patients were reliant on the skills of the students. The students on the other hand, were putting a lot of focus on their case studies and less on observing the state of the patients. When the students talked to the patients in order to collect data for

their case studies, they sometimes found out about caring needs that were not known up until then. Any new information of importance was supposed to be forwarded to the nurse. What was important or not was left to the students to decide. A woman suffering from uterine prolapse told a student that she had difficulties urinating, with pain and a burning sensation. She also had problems with her vision, dizziness and was afraid to walk on her own. Later on we spoke to the student about her conversation to the patient and about what information she had forwarded to the nurse. It turned out that she did not find the information important enough to tell the nurse. The students we talked to felt that the responsibility laid upon them was reasonable, but that the reality did not cohere with what they learned in school.

The respect for persons higher in the hierarchy had a negative impact on the care of the patients. An example of this was when a patient with a vaginal bleeding was very pale, breathed heavily and sat with her arms around her belly, showing she was in pain. A student talked to her and was about to get the doctor when her teacher showed up. The teacher started talking to the student who let the conversation go on until the teacher was satisfied. During their conversation the student repeatedly looked worriedly at the patient but did not dare to interrupt the teacher. As soon as the teacher stopped talking to her the student went to get the doctor.

DISCUSSION

METHODOLOGY

Using participant observations as our method enabled us to get close to the nurses and the women treated at Paropakar Maternity & Women's Hospital. By observing the nurses in their daily work we had the opportunity to discover behaviors, routines and attitudes that might have been hard to capture by interviews only. Usually research within this methodology extends over a longer period of time than we had the possibility to spend in Nepal (30). We had to limit our observations to four weeks. With more time we could have become a more natural element in the nurses' daily context, which probably would have affected their way of approaching us and what they chose to share with us. It is likely that we would have gotten more of an inside perspective and a deeper understanding of the care and culture, with other conclusions as a result. Still we did get more data than we had expected during our four weeks at the hospital. We were able to get an understanding of the care given to the patients with uterine prolapse, the prerequisites for the care and how the patients and nurses perceived the care.

Since we found the nurses and nursing students to spend quite little time on performing caring tasks, we made the decision not to take part in the care. We prioritized to observe the caring tasks performed, having as little impact on the work as possible. We were aware that this put us in the position of being outsiders rather than insiders. Our presence at the ward probably affected both the staff, patients and relatives behavior. Having two foreign students observing and taking notes on everything you do will surely have an impact on how you act and behave.

Most of the nurses seemed nervous about being interviewed by us. We explained to them that our questions were meant to give us a better understanding about the care provided. Not to put their knowledge to the test. Despite this there is a risk that some of

the answers were affected by the nurses' sense of needing to perform and deliver good answers to us. Some of the answers might be telling what they wished to be true rather than a description of the reality. Still the interviews gave us a lot of information about the routines and prerequisites at the ward and it was a good opportunity to get to know the nurses better. In the interviews the nurses told us about their feelings and thoughts about the care, the hospital and the situation for the patients with uterine prolapse. Since we were able to do the interviews in private, the nurses could tell us the negative sides of the working situation as well as the good things.

Conducting participant observations in an environment where we did not understand the language had clear disadvantages. Not being able to understand the patients' and nurses' own words was a weakness in our data collection. To be able to communicate with staff and patients we were dependent on our interpreter. In translating conversations that we were not participating in, it was sometimes difficult for the interpreter to keep up with everything being said. When we were not in control of the conversations, it was off coarse not possible to press the pause button in order to give the interpreter time to translate.

We made the decision to work with an interpreter without health care experience. We reasoned that this would limit the risk of missing out on things in the care that a health care professional might have taken for granted. Using an interpreter with no experience of hospitals or health care sometimes complicated our observations. Not knowing the language of medicine or the caring processes it was not easy for her to translate what was being said. On the other hand, her interpretation was without the ideas and values that a health care professional might have put into what was being said and done. We also found it very meaningful to work with an interpreter as she functioned as a culture broker, giving us a better understanding of different situations in a context that was unfamiliar to us. Overall our interpreter did a great job and without her it would have been impossible for us to get as much information out of our observations as we did.

Doing an observational study in a culture that we were not familiar with made it difficult to read between the lines. We sometimes found it hard to understand what words, actions and expressions really meant since this was a culture foreign to us. We often felt like we missed out on the finer points in conversations and actions. Our result is based on our reflections, interpretations and selection of data of the material collected. Our Swedish perspective did of course have an impact on what we saw and chose to focus on. Some things we found essential, might have meant less to the people concerned. In the same way we are likely to have missed out on things that were of great importance to the ones involved.

One of the strengths in the data collection and analysis of our study was that we always had two sets of eyes and ears in every situation. We were able to see different things in the same situation, which gave us a richer picture of what we had observed.

We used a variety of data to validate and better understand what we observed in the ward and the OPD. Our interpreter translated the informational brochures given to the patients and a magazine about Paropakar Maternity & Women's Hospital, giving us formal and statistical information. We also took pictures in the hospital. Although we were not allowed to use the pictures in our thesis, they helped us to view the condition

of environment and equipment with more distanced and neutral eyes than when being in the middle of everything.

We complemented our observations by speaking to both the nurses, nursing students, patients and relatives. Sometimes their answers confirmed our interpretations and when they did not, we tried to look further into the matter of question to get a deeper understanding. We also spoke to several doctors and a Swedish midwife working for UNFPA. These conversations gave us a better overall picture of the situation in the country and a better understanding for the treatments and approaches to the problem. This gave us a better ability to look critically at the care provided.

The four visits to other hospitals in Kathmandu gave us a picture of the care at Paropakar Maternity & Women's Hospital in comparison to the care at other Nepalese hospitals. This we feel enriched our study since we had more to compare with than the Swedish care and care facilities.

FINDINGS

According to the definition of WHO reproductive health means among other things to have the freedom to decide about when and how often to reproduce, as well as getting information about and the possibility to use different fertility regulations. WHO points out women's right to safe pregnancies and deliveries by stressing their right to accessible and appropriate health care services (15). The literature states that Nepalese women's reproductive health rights are being violated in several ways. Many women are deprived of the right of decision-making concerning timing and spacing of pregnancies. Usually the men are the ones deciding about health care expenses. The access to health care services is restricted due to the remoteness of many areas of Nepal and often women are not allowed to travel alone. This makes it hard for women to access health care when needed (2, 3). Our findings correspond to the literature describing these violations of the women's reproductive rights.

Pregnancy and delivery are the two main risk factors for uterine prolapse. The risk increases when deliveries are conducted without professional assistance and delivery complications such as perineal injuries are not repaired properly or neglected. Giving birth to many children, malnutrition and heavy lifting are other risk factors (19-21,23). All of these risk factors are common among Nepalese women, consequently uterine prolapse is one of the main causes for ill-health among Nepalese women (23,24). We were able to identify many of the risk factors mentioned in the literature among the patients with uterine prolapse at Paropakar Maternity & Women's Hospital.

To help Nepalese women suffering from uterine prolapse we found many different needs that had to be fulfilled. All women with uterine prolapse needed high quality physical care. We observed many limitations in the hospital that compromised the quality of the care, among others a lack of manpower, confidentiality and material resources. In our opinion the women were also in a great need of information to get the best out of their treatment and recovery. Overall we got the impression that big societal changes improving the conditions of Nepalese women would be necessary for a long-term effect on the issue with uterine prolapse. This fact also showed in the nurses' frustration over not always being able to provide a sustainable care for this group of women.

The common thread we found in all patient stories told to us at the hospital was their subordinate position to their husbands and their vulnerability in the status as women. They were all hard working and several of them talked about the lack of food, either due to poverty or because they were denied a nutritious diet by their husbands' families. Most of them had either gotten their prolapse during delivery without proper delivery techniques or while carrying heavy loads. The treatment for a stage three uterine prolapse was surgery, which required a long period of physical restrictions such as refraining from sexual intercourse, squatting, heavy lifting and other risk factors. If these restrictions are not followed there is a risk of relapse. To us the necessary lifestyle changes after uterine prolapse surgery seem to be very hard to achieve for many Nepalese women. Being the only maternity hospital in Nepal Paropakar Maternity & Women's Hospital received patients from all over Nepal making it difficult to do follow-ups on all patients. Instead they were referred to seeking help at health posts close to their homes. In our opinion the sustainability of the care was damaged by the fact that the hospital staff was not able to change the conditions under which many Nepalese women live and work. Neither could they provide a consistency in the post-operative care since most of the women returned to their home villages after surgery. We figure this might have increased the risk of getting a relapse for the women living far away from the hospital. This fact was out of the hands of the nurses to change. The nurses expressed a frustration over this and over the state of their country. They wished that the government would do more for these women.

Most of the nurses we spoke to agreed that the lack of manpower was a great issue in the care of the patients with uterine prolapse. Our observations confirmed this further. There were not enough nurses to care for the patients properly. The amount of staff was not sufficient, thus the work performed by students and relatives was essential for the care. Though many relatives spent a lot of time at the ward their effort was not enough to secure the quality of the care. We found that the shortcomings in competence of the relatives and students affected the care in a negative way.

Relatives functioning as caregivers were many times an upsetting phenomena to us. We found it hard to observe relatives performing tasks that in our opinion should be performed by professionals. From our perspective it was of course positive to engage the relatives in the care, though we found them to be helpers in the care more than being just relatives. Some of the tasks laid upon the relatives seemed to adventure the patient safety to us. As an example the relatives were sometimes sent to take blood samples to the lab. Often they were also the ones that had the most regular contact with the patients. This sometimes put them in the position to observe and report eventual changes in the status of the patients, a task we do not find suitable for someone without a health care education.

There were a lot of positive aspects for the patients in having their relatives close to them at the hospital. According to our observations and experiences from the stay in Nepal the Nepalese and Swedish culture differs a lot when it comes to family and individuality. In Sweden we find people to have a great need of privacy and spending time on their own. In Nepal the family is of great importance, living your whole life together and it is common that you spend most of the time with your family. Many people are not used to being alone, especially not when they are ill. Based on these

observations we reasoned that the relatives were a great source of safety and comfort to the patients.

The care of the patients at Paropakar Maternity & Women's Hospital was mostly done by the nursing students, supervised by one professional nurse. Speaking to the nursing students we perceived them to have an excellent theoretical competence. Most of them studied in their last year of the three year university education. They told us about holistic care and about how to observe the patient needs and give care accordingly. Though we did not experience that this competence was transferred into practice. Many times we felt that the patients suffered unnecessarily because of nursing students not taking notice on or not doing anything about patients being in pain, feeling nauseous and so on. Many of the students were young and some of them seemed nervous and insecure in the contact with the patients. We think their insecurity to be an eventual reason to why they did not step into situations when patients were in need of help. The students did tell us that the reality at the hospital did not cohere with what they learned in school. The gap between theory and reality is something that we recognize from our Swedish nursing education. Still we could not help but wonder why the students' theoretical knowledge showed so little in their practical work. When speaking to them about this matter we got the impression that they had to learn a lot by heart without reflecting about the deeper meaning of it or how to use it. From our point of view this way of teaching must make it hard to use your knowledge in practice. We believe that reflecting and analyzing is a very important part of the daily care which anchors the theoretical knowledge in practice, making you more secure in your actions as a nurse. The nursing students at Paropakar Maternity & Women's Hospital found the responsibility given to them reasonable. We question this as we found that their knowledge and experience was not always enough to meet the needs of the patients.

The gap between the students' theoretical knowledge and work in practice also showed in the physical care. The students told us about aseptic technique and how to avoid infections, but in practice they did not work with this technique. One reason to this might be the fact that neither doctors nor nurses did consistently work within the rules of aseptic technique. The students told us that they sometimes found it hard discovering that caring tasks were performed in a completely other way in reality than how they learned in school. They found that all equipment they learned how to use in school was not always available at the hospital. Sometimes this made it hard to work in a proper way. From our own experience we know that it can be hard to make demands on the care as students. We figure that this must be even harder for the Nepalese students because of the strong hierarchy at the hospital. The students were not in a position to question the nurses or doctors. This makes it difficult for them to change the methods of working at the hospital, even if they know that the routines at the ward were not always right.

The care at Paropakar Maternity & Women's Hospital was clearly affected by the lack of resources, but even when resources were there we found that they were not always used. The nurses knew that lack of seclusion during examinations created embarrassment for the patients. Still they rarely used the screen when it was available. Both nurses and students performed tasks such as dressings and inserting peripheral venous lines without using gloves, even when gloves were there to use. We figure that this behavior is partly born out of the lack of resources. When there is only one screen that is often occupied when needed the normal way of doing an examination will be

without using the screen. Eventually this becomes the way to work and therefore the screen will not be used even when available. We think that the same theory probably goes for the gloves or aseptic technique that was not always used. The lack of proper hygiene facilities was a challenge for the staff and resulted in them not washing hands between patients and care tasks.

From our point of view the confidentiality of the patients was very poor at Paropakar Maternity & Women's Hospital. Anybody could read the charts and the patients were discussed loudly for others to hear. To us this seemed like a big violation of the patients' integrity. But during our period of observations at the hospital nobody talked about the compromised confidentiality as a problem, not the patients nor the staff. We sometimes saw relatives looking in other patients charts discussing the information with the patient. It seemed to us like the patients felt no need to keep the information about them secret while in the hospital. They only seemed to mind when there was a lot of people talking about them and standing around them. At these occasions it felt like the issue was not that people heard about their condition but that they felt exposed and scared about what was being said. Confidentiality was never a topic of discussion, neither among the staff nor the patients. We reason that this was partly a consequence of the wards' lack of space for privacy and the Nepalese culture of living very close to family and relatives. Nepalese people often live very close with their families and are not used to being alone. This might affect their view upon confidentiality. Sharing with other people in the same situation might feel natural to them in a way that is hard for us to understand. At the same time many of the patients had been ashamed talking about their situation before they were admitted to the hospital. When we asked the women about their situation, medical and personal history many of the women shared freely. It felt like they had a great need of telling their story. We reason that finally being at the hospital getting care and being surrounded by others suffering from the same condition might have eased the feeling of shame. At the hospital they were in a context were it was accepted to talk about their prolapse. Also we believe that the lack of privacy created a sharing environment. Since anybody could hear the conversations of the staff about the patients most people in the ward knew what the other patients suffered from. Even if someone would have liked to keep information secret it would not be possible. We perceived the lack of seclusion a problem even if it seemed to have positive as well as negative consequences for the patients. It is difficult to know what the patients would have shared to the hospital staff if they had gotten the opportunity to talk to them in privacy. There were times when we really felt the need of spaces for patients and staff to speak in privacy. Sensitive information was given openly in the ward, which we experienced most of the time made everyone present feel uncomfortable.

According to us the giving of information was lacking at the hospital. The women got little information about their condition, the planned treatment and outlook. Many of them were scared of asking the staff for more information and some did not think they would be able to understand more information anyway. This we think is an example of how the low social position of women can affect the care. Illiteracy is a common issue among Nepalese women (3). With a lacking knowledge of how the body functions and about health care it will be difficult to understand your own condition and the information given by care providers. We think this makes the women dependent on others and puts them in a position where it is hard to question the care or the absence of care. When a majority of the patients are uneducated we think it should be of greatest interest to the care providers to make the information as accessible as possible and

given in a form customized for the receiver. Instead the information was very limited. We were under the impression that the doctors did not value the importance of the patients being well informed about their treatment. Maybe they shared the same view as some of the patients, that they were uneducated and therefore there was no point in trying to explain medical matters to them. Even though both patients and care providers maybe agreed on the fact that information was not possible or necessary because of the women's educational level, we found this a great problem for the sustainability of the care. Many of the women did not even know what kind of surgeries they had undergone. Giving the women that little information truly compromised the possibility of participation for the patients in making decisions regarding the care. Several women were admitted to the hospital due to relapse of their uterine prolapse. Based on our knowledge about the women's position in the Nepalese society we realize that it was a hard task for the hospital staff to prevent relapses from happening. Improved conditions of Nepalese women by big societal changes would be necessary for a long-term effect. Though we believe that the hospital staff would be able to improve the conditions for the women by providing adequate information. If the women were provided thorough information on their condition, treatment and were motivated to follow post-operative restrictions, we believe that they would get more knowledge hence gain power of their situation.

IMPLICATIONS

To improve the situation for women in Nepal suffering from uterine prolapse, we believe there is a need of major societal changes. We found many aspects working against this group of women and their ability to stay in good health. Their subordinate position in the family and the society as a whole creates difficulties in treating and preventing uterine prolapse. As long as women do not have the right to make decisions regarding their own health and body, such as when to get pregnant and when to seek health care, it will be difficult for the caregivers to help them in an efficient way. When uterine prolapse is regarded as something shameful, women will keep refraining from seeking health care. Being a poor country, many women need to do heavy physical work to be able to provide for their family. If the monetary situation in the country does not change, many women will have to keep working with farming that wears out their bodies.

Paropakar Maternity & Women's Hospital is a hospital with very limited resources, both concerning material and staffing. The nurses have an unreasonable work load being only one nurse on duty at the ward, caring for almost thirty patients. Consequently the patients were dependent on the care given by relatives and nursing students. The whole hospital is in a need of a renovation. The building is not insulated and the temperature inside is dependent on the outside temperature. This, combined with a lack of fans and heaters, made it very difficult to manipulate the temperature to a comfortable level for the patients. There is not enough equipment and material for securing a good care and the lack of hygiene facilities is an obvious problem. The prerequisites for providing care of good quality that is safe for the patients are simply not there. Considering this reality, we still think the care at Paropakar Maternity & Women's Hospital can be improved by making better use of available resources. The material resources available at the hospital should be utilized fully. All staff at the ward ought to make it a habit to use the screen whenever available and needed. It would be

desirable that it was the common way of working, making sure not to compromise the integrity of the patients when it is possible to avoid. Gloves should be used not only during examinations but also when dressing wounds and performing other tasks meaning a risk of infection to the patients.

Improved patient information could lead to increased patient satisfaction and treatment results. Through accessible information customized for each individual the patients would gain necessary knowledge, enabling them to regain power and understanding of their situation. The patients would benefit from receiving more extensive information, they would be left with fewer unanswered questions and less worry. Furthermore we figure that thorough information given to the women with uterine prolapse before being discharged would decrease the risk of relapses. Improved information to the patients would mean a major change for the better. The women would have a greater chance of staying healthy after hospital treatment and surgery and that would probably save the nurses a lot of frustration. Providing information does not take much material resources and does not have to be very time-consuming. Better informed patients may also help the hospital to save a lot of money by reducing complications, shortening the amount of days patients are admitted at the hospital and even avoiding operations of relapses. We believe that it would be a win-win situation for patients and staff to keep the patients well informed.

We believe that an open and more active communication between staff and patients would improve the care. Opening up for dialogue would create a more allowing atmosphere where patients could feel comfortable to ask about their thoughts and concerns. It would open up for the patients to become more involved in decisions regarding their care and create a possibility to question the care. A continuous dialogue between staff and patients would make it easier for the staff to give a proper care since they would get more information about the patients, both as individuals and about symptoms and feelings. We believe that this would save the patients from unnecessary suffering by easing anxiety and reducing the risk of information about patients' status being neglected or never told to the nurses.

To have a more open dialogue between the nurses and students would also benefit the care. Due to the lack of communication between nurses and students, important information regarding the patients was sometimes lost. The current habits and hierarchy prevent the nurses from getting vital information only told to the students. The students carried much theoretical knowledge about nursing and caring and the nurses possessed valuable experience of practice. We believe that the students' low hierarchical standing towards the nurses made it difficult for them to question the established routines as well as asking the nurses for help and guidance. If the relationship between students and nurses was characterized by an openness and curiosity towards each other's knowledge, it is possible the nursing theories could be implemented in the care in a better way. The hospital staff would benefit from using the students' knowledge to improve the care instead of forcing the students into a way of working that all felt was not satisfactory.

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