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**Acting Responsibly in Nepal: Some Anthropological Remarks on Women's  
Experience of Pelvic Organ Prolapse**

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### Abstract

Often, it is taken for granted that individuals ‘act responsibly’ in their health-related behaviour. However, while minutely observing people’s behaviours and practices that directly and indirectly affect their health and well-being, it appears that such seemingly inherent ideas and practices do not always remain valid, and we can see individuals performing at par below rationality. In this article, I examine whether this notion is an innate quality of human beings and intrinsic to individuals or is it a socially constructed phenomenon? If so, this paper interrogates and highlights, in what kinds of cultural and social contexts individuals cannot act responsibly in a way that eventually promotes their health and well-being or reduces their vulnerability to problematic health situations. This paper is based on some ethnographic information generated through multiple research studies conducted in different periods in Nepal, aiming to understand women’s lived experiences of and the health care provisions regarding uterine prolapse in Nepal. Various forms of interactions and observations techniques were employed to generate information for these studies. Thematic analysis has been employed in the process of navigating through the qualitative information acquired through these studies.

*Keywords:* acting responsibly, medical anthropology, pelvic organ prolapse, ignorance, Nepal

### **Acting Responsibly in Nepal: Some Anthropological Remarks on Women's Experience of Pelvic Organ Prolapse**

The notion of health and responsibility has existed in human societies for centuries, in different forms and being addressed in various terms and ways, probably from the beginning of human history. It can be considered as among the preliminary steps for the survival of human beings. In fact, multiple components of cultural whole are meant to orient and regulate human behaviours, ideas, and practices, eventually, having crucial implications for the health and well-being of the individuals and the whole society. Human beings create their cultural milieu in their efforts to fulfill their basic needs such as nutrition, reproduction, bodily comfort, safety, relaxation, movement, and growth (Malinowski, 1988).

The cultural ways to meet these needs can be considered largely determined by the apprehension of maintaining good health, hygiene, and well-being motto of the respective community of people. However, analyzing the ideas and practices of hygiene in Europe, Elias (1978) critically stated that it is merely a fallacy to take that the changes in conduct such as body care, sleeping, drinking, and eating in the Middle Ages, mainly during 1500 to 1900, were driven by hygienic reasons. He firmly stated that it was only afterwards that such alterations were euphemized as hygienically motivated behaviours with the logic of medical knowledge.

Likewise, whether maintaining health is a responsibility of individuals or that of the collectivities including state and societal provisions has been a matter of debate in different societies. Such ideas and practices have passed through various upheavals. The obligation and the capability to shape one's health even during old age have become part of the scholarly debate and talk in the media and the people's concerns in their everyday conversations (Katz, 2000). With the development of the notion of the welfare state, the general understanding and

practices gradually evolved to embrace health and well-being provisions as part of the state machinery.

In modern societies, targeting the individuals, health education and information are disseminated directly through various means of communication, restrictions, rules and regulations- do not drink excessive alcohol, exercise regularly, consume less oily food, do not smoke, do not use drugs, do not involve in unhealthy sexual behaviours (signboards and leaflets on HIV/AIDS awareness raising), smoking prohibitions in the public space and so on. Such communications are meant to foster healthy behaviours or make people act responsibly to avoid risky behaviours that have detrimental effects on their health. The involvement of the state, public health experts, and medics, among others, can be seen in such promotional activities through various means of communication such as print media, social media, and audio/visual media.

The inability to maintain health is taken as the absence of responsibility of individuals to uphold health and hygiene. The 20th Century began and ended with many health policymakers and opinion shapers in the US blaming individuals for their ill health (Leichter, 2003). That is why it is believed that “most illness and premature death are caused by human habits of living that people choose for themselves” (Iglehart, 1990, p.4). The absence of prudent but avoidable lifestyle choices was taken as the main cause of Americans’ morbidity and premature mortality. In case of failure of the health of any individual, the person is made responsible for their health and hence liable as reckless even in old age (Featherstone, 1991).

Minkler (1999) has weighed and examined the contested meaning of “personal responsibility for health” in a recent historical context, on whether the main responsibility should reside with the individual for his or her health behaviour. He comes up with a more balanced approach that puts emphasis on

individual responsibility while fully acknowledging the larger picture of social obligation. Research taken forward with the inspiration of Foucauldian ideas focuses on individual responsibility for one's health as a method of discipline and bio-power (Jolanki, 2008; Minkler, 1999) enacted over the populace. Individual's choices in health ideas and behaviours are not merely based on their free will but rather several factors that limit individual influence.

Nepal has a separate entity, The National Health Education, Information and Communication Center (NHEICC) under the Ministry of Health and Population, Nepal, established in 1993, to look after health education and promotion (MoHP, 2024). It aims to make people aware of health education and raise awareness in different critical areas including nutrition, habits, physical activities, weight and stress management and other dimensions of preventive care. All these efforts also imply that it is the responsibility of the individuals and families to take care of their health and well-being.

Scholarly debates are going on globally about whose responsibility it is to ensure people's health. However, I have realized that this issue has not acquired adequate attention from the scholarly community, including anthropologists and other social scientists, in Nepal. For the analytical convenience of the transformation in different notions and aspects of health/illness, methods of prevention and process of remedies, the health care system in Nepal could grossly be divided into three different phases. Considering the social nature of factors affecting the healthcare domain, I have taken some broadly accepted and explicit demarcation points for the division of different epochs. Nevertheless, it does not mean that overlapping ideas and practices are absent in these phases. This kind of categorization simply helps to understand the diverse dimensions and notions which were dominant in these stages.

The traditional phase can be considered as lasting up to 1950 when traditional and indigenous healing methods were in dominant forms. Ayurveda and various forms of shamanism among different caste and ethnic groups were in practice in this phase. The presence of biomedicine, which entered Nepal during the first half of the 19th century (Streefland, 1985), was very thin and limited only in Kathmandu and other urban areas. In this period, primarily the individuals and families were responsible for the maintenance of their health. The end of World War II opened the door for modernity in different parts of the world. Among others, medical technologies and Western healthcare ideas and practices were expanded in this period during this phase as part of the larger developmental package. Nepal also witnessed the expansion of biomedicine in this era in the form of national development and modernity (Dahal, 2022). State involvement in public health promotion, planned health promotion, and taking health as a development program are some of the features of this period.

Later on, the wider realization of community participation in the development sectors was also realized in the Nepali health care domain as well to bring development closer to the people. With the neoliberal influence in development sectors and limiting state involvement in the health sectors, private sector involvement flourished in the Nepali health care industry in the post-1990 liberal democratic environment. Health policies and practices have witnessed several implications and direct influence of upheavals in the national political landscape. Along with the political departure through the promulgation of a federal republican constitution, free basic health services have been explicitly enshrined as health rights in the new constitution of Nepal (The Constitution of Nepal, 2015).

### **Research Questions and Objectives**

The general inquisitive query that made me develop this article is to examine Nepal's healthcare landscape about how people understand their responsibility as individuals to deal with their health concerns and challenges. The overarching guiding orientation in this paper is to comprehend whether health is considered conditioned or made in the Nepali context.

The following are the specific objectives of this paper:

1. To analyze women's experience of uterine prolapse through the lens of acting responsibly and interrogate how the research participants present them, and
2. To examine the factors that influence people's notion and practices of acting responsibly

### **Research Methods**

Multiple ethnographic and qualitative research studies conducted at different times in various parts of Nepal aiming to seek explicitly focused research mainly around the health, gender and women have provided the foundation for the development of this article. Studies on uterine prolapse conducted from 2012 to 2022 in multiple sites in Nepal's middle hills in Gorkha, Parbat, Kabhre, Dhading, and Sindhupalchowk are the main sources of these data. I was involved in each of these medical anthropological studies as a principal investigator. The study designs employed in these research were exclusively qualitative and ethnographic with my involvement as a medical anthropologist in each of the studies and at least a female field researcher was also involved to have conversations with the patients—the women research participants.

Observations and interactions were the main techniques of data collection employed in these different researches. In-depth interviews with the research participants, key informant interviews, and observation of mobile health camps

were the main techniques employed to generate information from the field. The informants were sought from adult people comprising of both rural and urban areas, men and women, and health care seekers and service providers. The thematic analysis was adopted in generating themes from the data acquired from these field studies after revisiting the field data in consideration of the objectives of this paper. The utmost ethical considerations have been upheld while acquiring and processing information and dissemination of the knowledge afterwards. Throughout the process, I have paid adequate attention to the safety, dignity and confidentiality of the information acquired from different organizations and individuals. Whenever the informants are quoted here, pseudonym has been used to refer to both the individual and organization to anonymize their identity.

### **Vulnerability to Pelvic Organ Prolapse: Embedded in the Ignorance**

Ethnographic information acquired from two different genres of studies, which commonly fall within the broader umbrella of medical anthropology, provides the foundation for this part of the paper. The lived experience of the patients, the experience and observation of the health care providers, family members' observations and interrelationships as well as some data acquired through the ethnographic observations are employed in weaving this chunk of the article.

Many women are suffering from pelvic organ prolapse (POP) in Nepal. The unique aspect of POP's situation in Nepal is that women in the relatively younger age of early twenties are also suffering from this ailment (Dahal, 2017). Living in a harsh socio-ecological environment dominated by patriarchal values and norms, these women have realized that women's bodies are more vulnerable to disease than that of their male counterparts. "Since flesh and blood are similar in all human body, so all of them become sick", is very rarely heard in the field, as a Chhetri woman in her mid-thirties from Gorkha stated.



Likewise, people have realized that being ill is inherently natural to the human body, “to be ill or to have disease is like a law of nature”, as an elderly Tamang woman from Kabre had stated. Upholding this kind of idea relieves people from taking the responsibility of getting ill. When we look at the finitude of human beings amidst the infinite capability of nature, getting ill is indeed part of being human.

Many women in the early years of POP studies around 2008/09 used to express their situation of helplessness because of a lack of awareness among themselves. Lack of appropriate knowledge and consciousness of health care has been pointed out by both the health workers and the patients themselves as the leading cause of POP among rural women in rural Nepal.

For the child delivery, village people put hair inside the mouth of a woman thinking that she feels vomiting which will create stress in her stomach leading to a comfortable delivery. And another is to let the woman hang in the rope to have stress in the stomach. She said both these are very dangerous and they are the main reason for prolapse. Additionally, they also have negligence of post-delivery and pregnancy care, which further increases the chances of having uterine prolapse. (Health Post In-charge, Kabhre)

Diseases come from illiteracy and negligence to sanitation. We were not aware of care in the post-partum period. We did not know that we did have not to lift weights in this period, avoiding early resumption of early sexual relations, not only my husband but I am also responsible for this. (44, Chhetri, Kabhre)

Women had taken responsibility for the ailment that affected their body parts due to their fault of lacking consciousness. Their confession shows that knowledge comes from literacy, mainly formal education. The widespread understanding of being literate in contemporary Nepal implies that people become

aware of new ways of carrying on life appropriate to the changing and challenging times (Fujikura, 2001). Not having such a life mantra makes these women feel lacking consciousness and being excluded as well as ironically it provides even a sanctuary to what they regard as inappropriate behaviours.

Realization of the inability to act responsibly which results in a problematic health situation leads to the feeling of guilt and shame. The sense of guilt and shame is manifested in different forms among the women.

Now my youngest daughter is 24 years old and I had this problem since her birth. I had not disclosed about this ailment over the years. It is a hidden disease (*lukewarm rog*), and women in our locality feel shame to expose this. (Woman, 49, Dhading)

I feel shame about which part of my body I got such an ailment. At the age of 35, my menstruation did not stop for 15 days and my eldest son took me to Nardevi Ayurvedic Hospital in Kathmandu. The doctors advised me to keep the ring pessary. (Women, 54, Sindhupalchowk)

#### **Acting Responsibly: Deserves External Support**

Looking for causation of the ailment at the structural level is significantly available in these field sites in the middle hills of Nepal. Some of the women regard poverty as the main culprit of the ailment- every problem and disease happens only to the poor. Sometimes, people make use of the discourse that shifts the responsibility of getting ailment towards her natal family and the prevalence of inadequate care during childhood. Bishnu Katuwal (53) from Kabhre regards, “his wife had to face a lot of problems since her childhood that her mother died when she was one year old so she did not get enough care (from childhood) and got weak body”.

Women also pointed out that their inferior power relationship with their husbands had also constrained their ability to act rationally. These women have considered an excessive share of the burden of work on their part as natural. They

do not question it unless it goes beyond their physical capability to handle that. Moreover, sometimes their lower saying in the intimate relationship becomes unmanageable for them.

I think my husband is another reason for my disease (uterus prolapse). He used to force me for sexual intercourse after 25 days of the delivery. As a woman, weakened by the delivery I could not do anything against his desire. (Woman, 63, Sindhupalchowk)

Both my husband and I were unaware that the resumption of early intercourse could lead to this kind of problem; otherwise, I would have avoided him. (Woman, 44, Kabhre)

The dynamics of the interplay between different social, cultural and economic factors make women vulnerable to multiple morbidities.

We do not have access to health care services, we have to do heavy work, and often we experience a lack of sufficient rest after delivery. Likewise, neither we have time to care for ourselves nor do we have ideas and knowledge to make us healthy. So far as I have heard, uterine prolapse occurs only among the women of the village and not in the city. (Woman, 38, Gorkha)

With the internalization of the need for external support in bodily care, responsibility goes beyond the level of individual and family. Women have also realized that their existing knowledge is insufficient to take care of themselves. That is why they approach the medics and health facilities. Sometimes, they also participate in awareness-raising programs conducted by the local health facilities in collaboration with other NGOs and development partners.

I have taken two days of training about uterus care and prolapse. One of my neighbors called me for the two days of training. I went immediately as I was eager to learn some more things about delivery care. I would also like

to request you (the researcher) to arrange high-level training). From that training she knew that a woman has to keep herself clean; otherwise, she has to suffer from various diseases. (Woman, 42, Dhading)

Women have also stated that once they learn about the need for hygiene, maintain decent and healthy behaviour, reduce the workload, and need medical consultation, some of them have begun to alter their health ideas and practices.

Realizing the pains and suffering in my life after this ailment, I think our body is most important. Nothing is more important than our body. Our life resides in our body. If we cannot take care of our body, if there is no body, then what else do we need? (Woman, 53, Kabhre)

### **Conclusions**

The debate about acting responsibly in the healthcare sector has not attracted sufficient discussion in Nepali academia yet. This notion is in line with the idea of survival of the fittest, an evolutionary mantra. In the absence of adequate debates, often, either an individual's agentive capacities are downplayed, or the power of the structural forces overemphasized. The ethnographic data on uterine prolapse in Nepal suggests that women's way of acting responsibly is socially mediated and conditioned by much more powerful exogenous forces. It will not do justice to these women to simply label them as not acting responsibly. Such judgment, without understanding their social, cultural, and economic context and constraints, will be merely another form of victim blaming for finding their fault for not being able to come out of the structural traps.

Even if women are living in poverty, misery, and suppression, they still have shown their capability to be 'both the subject and object of their knowledge' (Foucault, 2002), knowing their situations by themselves. As a subject, they are capable of comprehending their conditions and the body, the object. Then, why

not expect them to act responsibly about their bodies and health? Not doing that, in principle, would be an injustice and even downplay their knowledge and capacity. Nevertheless, considering they are situated in typical conditions, they do need to be facilitated by the external agencies of medicine in a broader sense and the state machinery.

Acting responsibly involves a differential degree of involvement in some or all of these aspects of vulnerability and social mediation of acting. On top of this, it also evolves as per the need and may not be sufficient to maintain health, hygiene, and well-being over the period in a linear way. Lack of adequate knowledge, in light of the omnipresence of modern and formal education, seems to be a dominating phenomenon in the study areas. To make the women not feel humiliated for their lack of knowledge, their knowledge base must be expanded, and that should not be interpreted as a lack of acting responsibly.

One more important point, in light with the increasing number of mobile medical camps in different parts of rural areas, and government attention to surgical solutions to prolapse, it is imperative to be cautious that the medicalization (Dahal, 2022; Frawley, 2015) of uterine prolapse is not expanding. In this case, acting responsibly may become equivalent to the enhancement of passivity of the individual actant, to depend upon resolution in the sanctuary of the medical domain, instead of enhancing one's capacity, raising confidence, improving resilience, and elevating immunity.

Further critical research and scholarly contributions are needed in the field of how patients and health seekers' acting responsibly is influenced and mediated by the broader cultural context. How do different actors in the health care domain view such a notion, how do the contemporary global health practices and ideologies come into play in the process of acting individuals in Nepal through which channels and mediations their influence is exerted and at which degree

needs further explorations? Instead of considering the notion of health, healing and health care provisions as exclusively evolving within a country context, they have to be sufficiently dealt in light with and as part of the global health development process. These aspects have not been sufficiently dealt with in this paper and these issues deserve further research and scholarly engagements in the broader anthropological arena.

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