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Treatment-Seeking Experiences of Ethiopian Women with Pelvic Organ Prolapse

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MSHEP, Walden University, 2017

BSN, Prairie View A&M University, 1990

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Health Education and Promotion—Global Health

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Abstract

Pelvic organ prolapse (POP) is a gynecological health issue that negatively affects women's lives globally and specifically in countries like Ethiopia where health care-related resources and infrastructures are limited. In remote areas of Ethiopia, women lack basic knowledge of POP and do not have the resources to access care and treatment that might be available. As a result, seeking treatment typically happens after years of suffering. Using a qualitative phenomenological method, this study addressed the treatment-seeking experiences for POP among women aged 30-60 in North Ethiopia. Fifteen women with POP were selected using purposive sampling at the University of Gondar referral hospital. Face-to-face interviews were completed and after being translated to English were transcribed. Data were then coded into categories and themes. Thirteen themes emerged via NVivo software. Ethiopian women with POP were motivated to seek treatment once symptoms became severe and impeded their lives physically, emotionally, or socially. Women also reported delaying treatment due to the embarrassment and fear associated with disclosing the disease as well as cultural and spiritual practices associated with seeking healing. Women who sought treatment early endured barriers including poor quality interactions with healthcare providers, financial strain, and long-distance traveling. The study sheds light on the importance of improving the quality of health care and health education relating to women's health in Ethiopia so that women will be supported in seeking treatment earlier for POP.

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Dedication

I want to dedicate my study to my late beloving father, Shambel Basha Derso Takele, and to my mother, Etalem Abebe, who taught me the value of God, education and hard work. Although you are not here to see the achievement, I remember the constant reminders you gave me to be a doctor and help others. You have been my example of working hard, faith in God, and how to be good to others.

I love you and miss you. Thank you for believing in me.

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I want to express my profound appreciation to my excellent study chair, Dr. Kimberly Brodie, for your valuable feedback and patience. You worked with me tirelessly, encouraging and uplifting me when the journey became tough. Many thanks to the second committee member, Dr. Nina Bell, for your constructive feedback and commitment to helping me to improve the quality of my work. Many thanks to Dr.Zelalem Mengistu for your guidance and everyone in the outpatient OB-GYN department at the UoG referral hospital for welcoming me and supporting me when I needed your support. Most importantly, I would like to thank the study participants who shared their treatment experiences with me despite their shame and embarrassment. I am so grateful to my lovely families, sisters and brother, and all priceless friends for your unconditional love, offering of help, encouraging words, and prayers throughout the years. I could not have completed the journey without your help. This has been an incredible journey, and I hold with me valuable lessons learned that will remain with me for the rest of my life.

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Chapter 1: Introduction to the Study

Pelvic organ prolapse (POP) is a serious and progressive women's reproductive health issue globally as well as in Ethiopia. The study focused on how women in a developing country such as Ethiopia understand the symptoms of POP, the challenges encountered while seeking treatment, and the driving forces for seeking treatment for POP. Research has indicated that Ethiopian women with POP lack knowledge about the disease and are unfamiliar with the symptoms and treatments available in the country (Gjerde et al., 2017). Moreover, women feel unable to share their health condition with others and seek treatment due to the stigma and feeling of shamefulness associated with reproductive health issues. The understanding of women's treatment seeking experiences, including management and treatment of their disease is very limited and requires further research to address the health condition properly (Abhyankar et al., 2019). The current study focused on learning their challenges and the characteristics associated with seeking treatment. The study may provide health care providers vital information needed to develop comprehensive health education and reproductive care services that will be accessible to all women in all regions of Ethiopia. Socially, such an inclusion could represent a dramatic change from the current process. Additionally, the study could enable policy makers and health officials to understand the significance of women's health issues and contribute to the development of national policies that focus on women's health, in particular POP.

The following sections of this chapter will include background information framing problems and the need to address the research problem and the study's purpose.

The chapter will also include an overview of the research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance. The chapter ends with a summary.

Background

POP is one of the most debilitating reproductive conditions affecting women during prime reproductive years. POP is a gynecological condition characterized by pelvic organ descent from natural positions as supportive pelvic structure weakens due to factors such as multiparity, obesity, and lifting and carrying heavy objects (Masenga et al., 2018; Smith et al., 2014). POP contributes to morbidity among women in both developed and developing countries as its symptoms impact social, physical, and economic function. One in nine American women go through gynecological surgery due to pelvic floor dysfunction like POP in their lifetime (Gedefaw & Demis, 2020). Hospital admission for POP surgery is also on the rise in other developed countries such as Germany and France. The prevalence rate of symptomatic POP globally is about 9% (Masenga et al., 2018).

Although POP risk factors are the same worldwide, rates of POP in developing countries are much higher. In sub-Saharan African countries like Ghana, Gambia, and Ethiopia, the rate of POP is as high as 55% (Masenga, et al., 2018). It is common for women in these areas to have limited understanding of the cause and symptoms of POP (Gjerde et al., 2018). In Ethiopia, awareness and subsequent care may be stifled by social context and normative beliefs. For example, most Ethiopians still believe that God causes illness for wrongdoing, and treatment in church or spiritual healing should be prioritized before seeking medical treatment (Anderson, 2007). These perceptions of care options, coupled with limited access to medical services, often frame how Ethiopian women seek treatment (Gjerde et al., 2018). It has been suggested that up to 67% of Ethiopian women with symptoms of POP experience depression, social isolation, and choose to care for themselves at home (Dheresa et al., 2018).

Although significant contributions have been made to POP research, Ethiopian women's treatment-seeking experiences and behaviors relative to POP have been minimally investigated (Gjerde et al., 2018). Specifically, there is limited research describing how Ethiopian women experience life with POP and minimal description of the driving forces and possible challenges related to seeking treatment for the condition (Gjerde et al., 2018). In times where the priority to address women's health needs more comprehensively is a global conversation, this research sought to add to the discussion by highlighting the necessity for these women's experiences to be detailed.

Problem Statement

POP is a serious and progressive women's reproductive health issue globally. POP is a progressive disease and advances in stage when women delay seeking treatment causing the uterus and cervix to protrude outside the introitus (Megabiaw et al., 2013). POP affects women's physical and emotional well-being as well as their quality of life (Asresie et al., 2016). High rates of POP persist in developing countries, including Ethiopia. One in five women affected by POP is experiencing an advanced stage and this condition impacts one in 10 women in the northern part of Ethiopia (Dheresa et al., 2018). This may be due in part to limited health education options to relay risk factors and prevention (Gjerde et al., 2018). It is suggested that some Ethiopian women perceived that POP is a part of healthy aging and it will heal on its own (Tinetti et al., 2018). Moreover, other women believe that POP is a spiritual curse to be dealt with in silence by seeking help from traditional healers (Dheresa et al., 2020; Gjerde et al., 2017). This coupled with the lack of social acknowledgement of women's reproductive health challenges and needs often inhibits women from sharing their physical discomfort or medical diagnosis with others and limits their treatment-seeking actions (Masenga et al.2018). Further, social context relays shame and stigma attached to this diagnosis, leading to diminished treatment-seeking behavior and limited willingness to share and or discuss their health condition. A study conducted in Northwest Ethiopia revealed that 83% of women with prolapse, delayed seeking treatment for about 7 years due to fear and stigma associated with POP, and only a third of the women in this area with the disease seek medical care (Adefris et al., 2017). Low levels of knowledge about POP and awareness of the disease symptoms persevere and interact with social context factors, thereby affecting treatment seeking and pursuit of care (Dheresa et al., .2020). As high rates of POP persist, further research is needed to describe the treatment seeking experiences of Ethiopian women including their hesitance to engage treatment and noted challenges.

Purpose of the Study

The purpose of this hermeneutic qualitative phenomenological study was to explore the treatment-seeking experiences for POP among Ethiopian women ages 30-60 in northwestern Ethiopia. I also aimed to understand the challenges Ethiopian women encountered while seeking treatment and the driving forces related to decision making to seek treatment for the disease. Women in this region are minimally proactive in seeking health care services at early stages of POP due to a lack of knowledge of the symptoms, shame, and stigma (Ghetti et al., 2015). Identifying the critical elements associated with their treatment-seeking experiences could help expose the needs of Ethiopian women in this area of health. This research sought to give voice to the lived experiences of these women with hopes in identifying why treatment is delayed or not sought.

Research Questions

RQ 1: What are the treatment-seeking experiences of Ethiopian women aged 30-60 diagnosed with POP?

SRQ 1: What driving forces influence decision making to seek or delay POP-related treatment among Ethiopian women aged 30-60?

SRQ 2: What role does social and cultural normative beliefs play in the decision seek or delay POP-related treatment among Ethiopian women aged 30-60?

SRQ 3: What are the challenges associated with daily life as a result POP diagnosis that interact with the decision to seek or delay treatment among Ethiopian women aged 30-60?

Conceptual Framework

The conceptual framework guides researchers to build a foundation and conceptualize the concepts relevant to the study (Green, 2014), which in phenomenological research is the design itself (Peoples, 2020). A phenomenological approach allows researchers to explore individuals' experiences with phenomena

(Cilesiz, 2011; Marshall & Rossman, 2014). It allows for rich exploration of personal experiences through the thematic description of thoughts and feelings of those who experience the phenomenon in question (Austin & Sutton, 2014). The hermeneutic phenomenological framework was chosen as the framework to explore how women make sense of their treatment-seeking experiences while framing the challenges and the driving forces to seek treatment for POP. The hermeneutic phenomenological approach provided an opportunity to understand Ethiopian women's experiences with a POP diagnosis and treatment. The emphasis is on understanding how the women construct their realities or worldview with this disease including how they choose to seek treatment. I aimed to understand women's perceptions, giving voice their lived experience without imposing on their perspectives.

Nature of the Study

The study approach was a qualitative hermeneutic phenomenological design consisting of individual structured and semi structured interviews with women affected by POP. The key phenomenon being investigated is the direct experience of living with POP in Ethiopia within a social context impacted by limited medical resources, social stigma, and cultural context minimizing the necessity for women's reproductive health care. The qualitative phenomenological framework supports the interview techniques to capture participants' treatment-seeking behaviors (Ghetti et al., 2015). As there is limited research that investigates the lived experiences of Ethiopian women with POP, this research design placed a specific focus on learning their challenges and characteristics associated with seeking treatment.

Definitions

Cultural influence: Factors that relate to “historical, geographical, and familial factors that affect assessment and intervention processes” (Minnesota Department of Human Services, 2017, p.1. Includes racial and/or ethnic identification, social orientation, communication style, locus of control relative to their environment, spiritual beliefs, and health beliefs due to culturally specific healing practices (Adefris et al., 2017; Minnesota Department of Human Services, 2017).

Driving forces: The “power or the energy behind something in motion” (Dictionary, n.d.). The motivator or factors to seek help or decisions to contact health care providers (Mc Sharry et al., 2014). For the purpose of this study, driving forces are the factors that motivate or encourage women to seek medical care for POP.

Pelvic organ dysfunction (POD): Pelvic organ dysfunction is the inability of the pelvic muscle to coordinate and relax. There are three types of pelvic organ dysfunction including urinary incontinence, inability to control bladder, fecal incontinence, and POP (Grimes & Stratton, 2020).

Pelvic organ prolapse (POP): POP is one of the most common pelvic organ dysfunctions in which the pelvic organ is bulging into or fallen out through the vagina due to the weakness of the pelvis floor structure muscles and tissues (American College of Obstetricians and Gynecologists [ACOG], 2017).

Treatment-seeking experience: Patients’ experiences in seeking treatment for POP that includes their interaction with doctors and nurses, their journey to obtain treatment, and their interactions with constraints (such as financial constraints, social context limitations, or transportation challenges due to long distances to the health care facility). Also includes surgical and/or medical treatment experience and the overall, experiences within the healthcare system (Oben, 2020).

Assumptions

It was assumed that qualitative phenomenological framework and methodology chosen supports an effective response to the research problem. As phenomenological research provides the opportunity to describe themes and details relative to a lived experience, it was assumed that the process as applied in this study yielded this result. It was also assumed that participants were honest in describing their experiences of living with POP. Finally, it was assumed that the participants were representative of all regions of Ethiopia, as their life experiences, cultural beliefs, and attitudes are similar in most regions. These assumptions related to the context of the study by effectively framed the population of focus and the necessity to uncover their experiences living with POP.

Scope and Delimitations

The scope of this study was to explore the lived experiences of Ethiopian women aged 30-60 with POP pertaining to the driving forces related to decision making for seeking treatment and the challenges faced while seeking treatment**.** Inclusion criteria for the study are women aged 30 to 60 years, diagnosed with POP, and seeking treatment in the UoG referral hospital. The exclusion criteria are women younger than 30, older than 60, women who sought treatment other than the noted hospital, and women not of Ethiopian descent.

Participants were selected using purposive sampling, which is useful when an in-depth detailed response was needed. Purposive sampling is widely recognized and used in qualitative research to support "the identification and selection of information-rich cases related to the phenomenon of interest" (Palinkas et al., 2015, p. 2). A small sample size (e.g., 5-25) was appropriate to gain in-depth information in this study (see Creswell 1998, 2014; Mapp, 2008). For this study, the sampling strategy was a purposive sample of 15 participants. The sample size, purposive sampling technique, and additional criteria were chosen to best relay details about the phenomenon in question among Ethiopian women and presented an effective response to the research questions.

Limitations

The potential challenges were that I may have needed adequate access to participants to achieve sufficient data. Choosing the UoG referral hospital as the site for participant recruitment relates to both access to participants and the likelihood that participants might be more of a representative sample of the general population of Ethiopian women. Additionally, securing a sample size that is too small could lead to ineffectual and less specific results. The other limitation was due to the topic's sensitive nature, participants may have hesitated to share the intimate details of their diagnosis and treatment experiences. As the researcher and an Ethiopian woman, my life experiences and opinions could have also posed a limitation to the study. However, as a trained nurse who has worked extensively with women on reproductive health issues, I have experience speaking with women objectively about sensitive topics. Moreover, I built trust and rapport early in the process and minimized the possible impacts assumed as limitations.

Significance

The impact of POP is significant in Ethiopian women's health and well-being, as some researchers have identified that approximately 80% of women with POP delayed seeking treatment (Adefris et al., 2017). Many women in Ethiopia diagnosed with POP have suffered for years and delayed seeking treatment due to financial constraints, fear of disclosure, and stigma (Adefris et al., 2017). This study sought to address the gap in understanding the treatment seeking experiences of Ethiopian women with POP. By investigating the treatment seeking experiences, the context Ethiopian women face while seeking treatment and the driving forces associated with seeking care could be better described. The study was aimed to bring voice to the lived experiences of Ethiopian women to address their unique issues.

Insights from the study may help practitioners understand how to educate women about the disease while developing effective medical and social services (Gjerde et al., 2017). Further, women may feel more empowered and supported by participating in the study and having a voice in their care and needs. The data collected may provide information to health care providers needed to develop a comprehensive health education and promotion services that will be accessible to all women in all regions of Ethiopia. For policymakers and health officials, the results of this study may enable them to understand the significance of this health issue and contribute to developing a national policy that focuses on women's health. This research aimed to bring about social change by improving the quality of life, improving health-seeking experiences, promoting health seeking behavior, and health-related experiences of Ethiopian women living with POP.

Summary

This study was conducted to explore and describe the treatment seeking experiences of Ethiopian women aged 30-60 living with POP including challenges associated and driving forces associated with treatment seeking choices. The aim of the study was to provide insight for health care providers in order to develop comprehensive health education and care services for women with POP in this part of the world. Chapter 2 will continue by providing a literature review to expose the problem further and support needed for this study. Chapter 2 also includes a more detailed overview of the conceptual framework, supporting the rationale for the study process and results.

Chapter 2: Literature Review

POP affects women’s physical and emotional well-being as well as their quality of life (Asresie et al., 2016). One in five women affected by POP is experiencing an advanced stage, and this condition impacts one in 10 women in the northern part of Ethiopia (Dheresa et al., 2018). But only a third of the women in this area with the disease seek medical care (Dheresa et al., 2018). High rates of POP persist in Ethiopia in part due to limited health education to relay risk factors and prevention (Adefris et al., 2018; Borsamo et al., 2021; Ghetti et al., 2015). Thus, there is a lack of knowledge about the illness in addition to lack of access to medical services and the stigma and shame attached to the disease. Women’s reproductive health challenges and needs are not acknowledged, often inhibiting women from sharing their physical discomfort or medical diagnosis with others, which limits their treatment-seeking actions (Masenga et al., 2018). Moreover, it is suggested that some Ethiopian women perceive that POP is a part of healthy aging and it will heal on its own (Tinetti et al., 2018).

As high rates of POP persist, further research is needed to describe the treatment seeking experiences of Ethiopian women including their hesitance to engage treatment. This qualitative inquiry was aimed to better understand the challenges Ethiopian women encounter while seeking treatment and the driving forces related to decision making to seek treatment for the disease. Giving voice to the lived experiences of the women in this area while identifying the elements associated with their treatment-seeking experiences will help expose the needs of Ethiopian women in this area of health.

This chapter will detail current literature relative to POP as a women’s health issue globally and specifically among women in Ethiopia. An overview of the chosen conceptual framework, evaluation of POP as a global women's health issue and in Ethiopia, social and cultural factors contributing to the delay in treatment seeking, and lack of knowledge associated with POP are detailed. A review of the available literature specific to reproductive health care in Ethiopia and the associated social and cultural dynamics will also be presented.

Literature Search Strategy

To learn more about POP, women's reproductive health, and Ethiopian women's experiences, articles were selected by performing a multi-database search using the keywords POP, women's experiences, treatment seeking, challenges, barriers, driving forces, Ethiopian women, and Ethiopian reproductive care. To further understand the concepts associated with the chosen conceptual framework, I performed searches using Google Scholar, SAGE, and EBSCO using the terms phenomenological research and phenomenological philosophy. As there are limited articles on the specific experiences of Ethiopian women, their POP diagnosis, and subsequent treatment seeking actions, some literature-based conclusions in this section relate to women in developing countries similar to Ethiopia in Africa and around the world.

Conceptual Framework

The conceptual framework guides researchers to build a foundation and conceptualize the concepts relevant to the study (Green, 2014). In phenomenological research, the framework is the approach itself (Peoples, 2020). Husserl introduced the concept of pure phenomenology that focuses on people's conscious experience from the individual’s point of view (Burkholder et al., 2016). Moreover, Husserl’s philosophy, transcendental phenomenology, was proposed to understand people’s thoughts and perceptions as they lived through their experiences. In terms of research, researchers must suspend their bias through reduction or bracketing. That is, the researcher’s preunderstanding of the experience must not influence the study and should be free from bias.

Heidegger, a student of Husserl, later developed hermeneutic phenomenology, which focuses on ontological assumption (People, 2020). Hermeneutic or interpretive phenomenology can be used to understand how different people’s lived experiences give meaning to the same phenomena. Furthermore, unlike Husserl’s philosophy, Heidegger’s hermeneutic approach allows other theories to be used with phenomenological research. In this approach, bias cannot be set aside or bracketed; instead, bias should be recognized and continuously revised.

In research, the phenomenological approach is used to understand people’s lived experiences based on how they express their feelings on the phenomena (Cilesiz, 2011; Marshall & Rossman 2014). Furthermore, the phenomenological framework helps researchers explore people’s experiences through thoughts and feelings of those who have direct experiences (Austin & Sutton 2014). The hermeneutic phenomenological framework was chosen as the theoretical framework to explore how Ethiopian women make sense of their treatment-seeking experiences while framing the challenges and the driving forces to seek treatment for POP. The hermeneutic phenomenological approach provided an opportunity to understand the deep layers of Ethiopian women’s experiences with POP diagnosis and treatment. The emphasis was on understanding how the women construct their realities or worldview with this disease. I aimed to understand women's perceptions by giving voice their lived experience and understanding without imposing on their perspectives. As all the women will have POP in common, this study was aimed to frame both their common or shared experiences while highlighting their unique treatment-seeking dynamics and characteristics.

The phenomenological framework has been used to study a variety of women's reproductive health issues including pregnancy, miscarriage, and childbirth (Meaney et al., 2017; Tebbet & Kennedy, 2012; Yang & Kim, 2021). The phenomenological framework along with ethnographic interview method has been used to explore the lived experiences of Ethiopian women with POP and other chronic diseases. For example, Gjerde (2018) uncovered how women suffered from POP for many years yet chose to be silent due to shame, embarrassment, fear of discrimination, and lack of knowledge of the disease. I found no additional studies using the phenomenological framework to explore lived experiences associated with POP or that describe treatment-seeking experiences among women with POP in Ethiopia. Thus, the purpose of this inquiry was to give voice to the lived experience of Ethiopian women dealing with the disease while describing the interactions of cultural influence and other driving forces associated with seeking treatment for POP.

Literature Review Related to Key Concepts

Pelvic Organ Dysfunction and Pelvic Organ Prolapse

Pelvic organ dysfunction or POD is a broad term for a group of conditions that affect the function of a woman's pelvic and reproductive organs and is associated with the inability of the pelvic muscles to coordinate and relax (Grimes & Stratton 2020). There are three types of pelvic organ dysfunction including urinary incontinence (or unable to control bladder), fecal incontinence, and POP (Grimes & Stratton, 2020). POP is considered a more severe dysfunction as it affects woman's physical, social, sexual, and psychological well-being (Verbeek & Hayward, 2019).

POP is described as a condition in which pelvic organs are bulging into or falling out through the vagina due to the weakness of pelvic floor muscles and tissues (ACOG, 2017). Pelvic organs are composed of tissues and ligaments that keep the bladder, vagina, uterus, and rectum within the pelvis (ACOG, 2017). There are multiple diagnoses of POP, and these are described in stages. Stage I is when the distal surface of the prolapse measures over one cm above the hymen, Stage II is when the hymen is one centimeter proximal to the leading edge of the prolapse, Stage III is when the distal portion of the prolapse is over one centimeter below the hymen, and the last stage, Stage IV, is where one of the pelvic organs is completely fallen out of the vagina (Gedefaw & Demis, 2020). For example, rectocele occurs when the rectum falls downward into the vagina causing women to suffer from urinary tract infections and inability to empty the bladder. Another example of Stage IV is uterine prolapse where the uterus pushes downward into the vagina opening those causes aching or pulling sensation (Henock, 2017).

POP symptoms range in severity. As the condition advances through stages, the symptoms become more severe. For example, in stage I, women are likely to report a heaviness in the lower pelvis (Haylen, et al.,2016). As the condition advances to stage III and stage IV, common physical symptoms include a ‘dropping’ sensation in the vagina, bowel and bladder incontinence, pain during sexual intercourse, and decreased vaginal sensation. Women also reported difficulty urinating when the uterus drops down and blocks the bladder as common in later stages (Gjerde et al., 2017). Additionally, women suffer emotionally and socially. Common emotional symptoms associated with stage III and stage IV POP include feeling ‘less than a woman’ due to negative body image, feeling embarrassed about their genital condition, shame over bowel and bladder incontinence (Jokhio et.al., 2020).

As a major gynecological and global health issue, POP is one of the most common pelvic organ dysfunctions with a global prevalence rate of approximately nine percent (Gedefaw, & Demis, 2020). POP diagnoses are responsible for over forty percent of gynecological surgical interventions (Asresie, Admassu, & Setegn 2016). Globally, almost 30 million of differing ages are affected by POP and its detrimental impact on quality of life (Gedefaw, & Demis, 2020). The occurrence of POP is particularly concerning for women who live in countries with limited medical and health promotion resources relative to maternal and reproductive health. These challenges are especially prominent in Sub-Saharan African countries (Gedefaw & Demis, 2020). Sub-Saharan African countries such as Ghana, Gambia, and Ethiopia, report POP rates between 20 and 55% (Masenga, Shayo, & Rasch, 2018). Prevalence is difficult to measure due to limited reproductive health outreach and minimal treatment seeking. Moreover, women in this region experience the confounding of multiple risk factors including high parity, high fertility rates, home births, early age of first birth, and prolonged heavy lifting (Gedefaw

& Demis, 2020).

Pelvic Organ Prolapse in Ethiopia

According to Dheresa et al., (2018), one in five women in Ethiopia are affected by pelvic floor disorders and POP is noted as one of the most common pelvic floor disorders in the eastern part of Ethiopia. Moreover, only a third of the women with the disease seek medical care due to the stigma attached to the disease and lack of medical service access. In Ethiopia, pelvic organ prolapse alarmingly affects both "women's health and quality of life" (Asresie, Admassu, & Setegn 2016). Sixty-seven percent of symptomatic Ethiopian women experience depression, social isolation, and confide at home after the onset of POP (Dheresa et al., 2018).

Several studies conducted in Ethiopia also report similar negative effects on women's psychological, physical, social, and economic well-being (Asresie et al., 2016, Dheresa et al., ,2018 & Dheresa et al.,2020). According to Gedefaw & Demis (2020), Ethiopian women in rural areas have higher POP cases than urban with similar risk factors.

Geographical variations for POP prevalence have been reported in the Northern part of Ethiopia where the burden of the disease related to symptomatic reduction on quality of life is much higher (Gedefaw & Demis 2020). A similar study conducted in Northwest Ethiopia revealed that symptomatic stage II-IV POP prevalence is nearly 46 percent (Belayneh et al.,2019).

Driving Forces Associated with Treatment-Seeking Behaviors

Ethiopian Healthcare System

The structure of the Ethiopian healthcare system may affect the prevention and treatment management strategy for women suffering with POP. Overall, the system has not focused on developing preventative, educational, or service-oriented mechanisms to tackle the health condition properly (Asresie, et al.,2016). This is common across Sub-Saharan Africa and therefore, the high prevalence of POP in these countries is supported by limited access to health care (Adefris, et al.,2018). The health care system in Ethiopia comprised of three tiers; primary, secondary, and tertiary. The primary tier is the primary care hospitals, health department, and rural health posts. The primary system is decentralized and allows trained health extension workers to provide basic health care services such as immunization, contraception, and sanitation care. Extension workers in rural areas often refer patients with serious illness to local hospitals and the health departments for further evaluation. The secondary and tertiary levels are the specialized hospitals that serve the general population. The coordination and management of the services are done by Weleda district offices and regional health Bureaus, whereas policy and decision makers are the Federal Ministry of Health (Argaw et al., 2019). This disconnects between service management and planning precedes care offerings including preventative education and effective on-site care.

The limitations posed when planning and services are disconnected lead to a lack of access to trained obstetric gynecologists. This is common across the country and there are few specialized health care facilities that provide surgical repair for POP. The financial burden for surgical follow-up limits care options (Adefris et al., 2017). Although the surgery at regional referral hospitals is free, the additional medication such as anti-pain and nausea medication is not affordable for most Ethiopian women who are not economically empowered. Additional expenses associated with transportation to and from medical facilities, food, and lodging while receiving treatment are also common reasons for delaying seeking treatment (Adefris et al., 2017).

Relative to reproductive health, the status of some Ethiopian women has improved over the last 20 years. For example, the maternal mortality rate has decreased from 708 per 100,000 live births in 1990 to 497 per 100,000 in 2013 (Tessema et al., 2017).

Although reductions in the rate are noted, the rate remains high comparatively when reviewing world standards (UNICEF, 2017).

Social and Cultural Factors and Treatment Delay

There are emerging social contexts within Ethiopian culture that contribute to the delay of POP treatment. Adefris et al (2017) evaluated 311 Ethiopian women with POP and noted 82 percent of women delayed treatment with the average length of delay of being seven years. According to Gjerde et al., (2018), Ethiopian women face challenges in seeking treatment for POP due to social factors associated with fear of disclosing the disease. Women report fear of losing family support, being chased away from home, feeling ‘less than a woman’, as well as discrimination and humiliation (Gjerde et al.,2018). Social humiliation and shame are implicitly tied to the diagnosis of POP as women express concerns about disclosing their health condition to their husbands. Fear of social and familial humiliation and increased divorce risk are mitigating factors in the delay of seeking treatment.

Cultural beliefs tied to the spiritual onset of illness may also delay treatment seeking. According to Gjerde et al., (2016), delay with seeking medical treatment is in part due to Ethiopian women's perception of the disease (POP) being caused by supernatural powers such as 'evil eyes' or a 'bad spirit'. In lieu of seeking professional care, cultural references affirm that women must conduct a ceremony to have mercy bestowed on them by responding to the spirits. It is also common for Ethiopian women to believe that the disease is caused by God's anger for doing something wrong. Therefore, treatment should start by seeking help from church leaders to pray and wash their bodies with holy water for several days (Gjerde et al.,2018). Most Ethiopians believe that God causes illness for wrongdoing, and treatment in church for spiritual healing should be prioritized before seeking medical treatment (Anderson, 2007). Furthermore, local traditional medicine or healers are considered the first choice to go to for any health condition in society. The complexities of social and cultural influence support questioning one's rationale for disclosing the condition and seeking treatment.

Lack of Knowledge Associated with POP Diagnosis

Healthcare Providers. A study conducted in the United Kingdom suggests that general health practitioner awareness of POP intervention may contribute to disease severity, how it is diagnosed, and their possible treatment options (Abhyankar et.al., 2019). Delayed referral to a POP specialist is also common in Ethiopia (Gjerde et al.,2018). This results from lack of knowledge on the part of general health practitioner about POP and its symptoms, treatment, and diagnosis. Instead of being referred to specialists immediately, women were more commonly instructed to manage their symptoms at home by taking pain medication and using incontinence pads until symptoms progressed to later stages of POP (Abhyankar et.al., 2019). Gjerde et al., (2018) noted that some of the Ethiopian women who seek treatment at local hospitals are instructed to take care of their POP symptoms with local remedies. And others who seek care in local private clinics are often told by private physicians unfamiliar with the disease that symptoms should be treated with pain relief injections and ointments (Gjerde et al.,2018).

Ethiopian Women. Ethiopian women who are diagnosed with POP are less likely to understand what the condition is, its progressive nature, or their treatment options (Abhyankar et.al., 2019). Ethiopian women lack knowledge of the symptoms of POP and are unaware of their treatment options Dheresa et al**., (**2018). The supporting factors for lack of knowledge include lower literacy levels and lower formal education levels. In areas where POP is most prevalent in Ethiopia, only about 40 percent of the women in the area are literate (Central Statistical Agency, 2014). Educational status significantly affects POP outcomes. Women who do not have formal education are 4.3 times more likely to have POP when compared to their formally educated counterparts (Asresie, Admassu, & Setegn (2016). Due to limited research, the connections between literacy levels and knowledge about POP symptoms and treatment are not yet addressed. However, research suggests that those with lower literacy levels receive less preventative care and have lower health-related knowledge (DeWalt, Berkman, Sheridan, Lohr, &

Pignone 2004).

Impact of Treatment Delay

The lack of professional assessment and support for disease prevention for POP among Ethiopian women supports limited motivation to disclose symptoms and impaired function (Adefris et al., 2017). As social and cultural norms converge, Ethiopian women may feel a lack of decision-making power to seek care for their POP related health condition. Cultural implications and experiences related to the lack of support from family, health caregivers, and community contribute to limited motivation among women to disclose and seek treatment (Adefris et al., 2017). Delaying treatment may have a psychological impact on women, including an increased risk of depression of sixty percent and self-isolation due to stigma (Zeleke et al.,2013).

Although there is no specific prevalence percentage of divorce due to POP, one study reports that divorce due to sexual impairment and inability to perform household duties among women with POP is incredibly significant (Gjerde et al., 2017). With 56 percent of women experiencing impaired sexual and reproductive health due to chronic pelvic pain and the dropping sensation as the uterus settles into the vagina, normal daily activities may be severely limited (Dheresa et al.,2018, Gjerde et al., 2017). Women choose to remain at home due to fear of the dropping sensation and injury while walking and working to take care of household duties such as cooking, fetching water, or hosting friends and families at home (Ghetti et al.,2015).

Experience of Ethiopian Women After Seeking Treatment for Pelvic Organ Prolapse

According to Belayneh et al. (2020), Ethiopian women reported improvement of their quality of life, sexual, and social health after surgical treatment for POP. Moreover, physical and emotional symptoms such as pain and depression subsided, whereas martial bonding, body image and social isolation improved. As women overcome the social, cultural, and health care related challenges in seeking help and received treatment for POP, knowledge about the disease increased, and discrimination and rejection stigma associated with the condition were alleviated or improved (Gjerde et al.,2018). Gjerde et al. (2018) also noted that Ethiopian women who received treatment for POP are more likely to openly disclose their health condition and thereby experience a sense of empowerment as they share their pathway to healing and recovery.

Phenomenological Studies and Pelvic Organ Prolapse

There are few qualitative studies on POP with focus on Ethiopian women. Gjerde et al. (2017) conducted qualitative exploratory research to explore how women with symptomatic POP in a low-income country such as Ethiopia deal with the experience and investigated social consequences caused by the disease. The authors concluded that women with POP lack knowledge about the disease and are unfamiliar with the signs and symptoms. Gjerde et al. (2018a) conducted another qualitative exploratory study of women's experience related to POP surgical treatment, recovery, and reintegration in the Amhara region of Ethiopia. In the study, twenty-five participants with POP who had surgical treatment were recruited using purposive sampling from University of Gondar

Hospital. In-depth interviews were conducted in the hospital and 5-9 month follow up interviews at home. The study revealed that women gradually regained physical and social confidence and normalcy after being isolated and discriminated against for many years. Additionally, women were willing to openly disclose their health condition after surgery.

The phenomenological approach, along with the ethnographic interview method, has been used to explore the lived experience of Ethiopian women with POP and other chronic diseases (Gjerde 2018b). The study revealed how women suffered from POP for many years yet chose to be silent and not disclose their condition due to shame, embarrassment, fear of discrimination**,** and lack of knowledge of the disease. Synthesis of these results and descriptions of the POP condition among women in Ethiopia necessitate further investigation of the factors contributing to limited treatment seeking behaviors. Moreover, as social and cultural influences converge, the context within which women make the decision to seek treatment becomes more complicated. Uncovering the details about which influences play a role in decision making to seek or delay care and how social and cultural influences frame those decisions could serve to expand the discussion on holistic women's reproductive health in Ethiopia. Specifically, this discussion must include the women, their voices, and their experiences. The phenomenological approach would allow the women living with POP in Ethiopia to become owners of the phenomenon. As a result, their verbalized descriptions of life with POP, their experiences, their context, and their needs would become an active part of this body of literature.

Summary

In summary, chapter two provided detailed information on the current status of POP in Ethiopia while highlighting many social and cultural context elements relating to this status. As current literature on Ethiopian women's lived experiences with POP is limited, further investigation of their decision-making processes associated with disclosure of their condition and treatment seeking behaviors was needed. This chapter also included a more detailed overview of the conceptual framework to support the rationale for the study process and intended methodology. Chapter three will include a detailed overview of the planned methodology chosen to respond to the noted research questions. This includes detailed descriptions of the research design rationale, the role of the researcher, participant selection logic, instrumentation, data collection and analysis plans, issues of trustworthiness, and ethical procedures.

Chapter 3: Research Method

The purpose of this hermeneutic qualitative phenomenological study was to explore the treatment-seeking experiences for POP among Ethiopian women 30-60 years old and to understand the challenges women encounter while seeking treatment and the driving forces related to decision making to seek treatment for the disease. Women in Ethiopia are minimally proactive in seeking health care services at early stages of POP due to a lack of knowledge of the symptoms, shame, and stigma (Ghetti et al., 2015). Identifying the elements associated with their treatment-seeking experiences will help expose the needs of Ethiopian women in this area of health. This research emphasizes the lived experiences of these women with hopes in identifying why treatment is delayed or not sought. This chapter will present the research design and rationale, an overview of the research questions and methodology, and a discussion of the role of researcher throughout the study. The data analysis plan, and procedures to maintain ethical and reasonable interactions with study participants are also addressed.

Research Design and Rationale

A qualitative hermeneutic phenomenological framework approach was chosen for this study to address Ethiopian women’s experiences with POP and answer the following research questions:

- RQ: What are the treatment-seeking experiences of Ethiopian women aged 30-60 diagnosed with POP?
- SRQ 1: What driving forces influence decision making to seek or delay POP-related treatment among Ethiopian women aged 30-60?

- SRQ 2: What role does social and cultural normative beliefs play in the decision seek or delay POP-related treatment among Ethiopian women aged 30-60?
- SRQ 3: What challenges are associated with daily life because of POP diagnosis that interact with the decision to seek or delay treatment among Ethiopian women?

The hermeneutic phenomenological approach provided an opportunity to understand Ethiopian women's experiences with POP diagnosis and treatment. Hermeneutic or interpretive phenomenology can be used to understand how different people's lived experiences give meaning to the same phenomena (Alase,_2017) through data collection and analysis (Guillen,_2019). In this study, the phenomenon of focus was the direct experience of seeking treatment while living with POP in Ethiopia within a social context impacted by limited medical resources, social stigma, and cultural context minimizing the necessity for women's health care. Resource constraints relative to social support, medical treatment, limited promotion of health-seeking behavior, and minimal advocacy for women's health constrain treatment-seeking behaviors (Bobo et al.,2017; Borsamo et al., 2021).

The phenomenological approach helped identify themes associated with women's treatment seeking experiences through an inquiry that exposes driving forces and associated challenges. The emphasis was on understanding how the women construct their realities or worldview while seeking treatment with this disease. The rationale for this approach stems from the need to have Ethiopian women state in their own words the challenges, driving forces, and other related characteristics associated with their care approach relative to POP. As there is limited research investigating Ethiopian women's lived experiences with POP, this research design focused on using interviewing techniques that exposed themes and key concepts associated with this phenomenon.

Role of the Researcher

As a qualitative phenomenological researcher, I was responsible for uncovering the characteristics and themes associated with the research questions posed for this study. I served as both an interviewer and observer while working to detail the elements of the participants' lived experiences. Qualitative researchers are "precisely interested in people's subjective interpretations of their experiences, events, and other inquiry domains" (Ravitch, & Carl, 2015). I was responsible for ensuring a conducive and safe environment for participants, with hopes of encouraging the freedom to express the rich context associated with their quality of life while living with and seeking treatment for POP.

As a young woman born and raised in Ethiopia, I know how it feels to be a young lady in an environment where the social requirement is to be submissive and quiet. I am familiar with the expectation to behave in a culturally appropriate manner as to be acceptable within society. As such, I understood common cultural standards such as the expectation to be married and live a life for others, not focusing on oneself and the impact that this could have on health-related decisions. Similarly, I understood that discussing sexuality and reproductive health issues within groups or among women and girls is not common. There is a cultural expectation that women do not share the details of their reproductive health challenges or illness with others. Knowledge of the cultural context of the phenomenon is advantageous in the study because I understand the common cultural standards that could impact how and if a woman seeks care.

Professionally, I am a registered nurse with a Bachelor of Science background, and I hold a master's degree in health education and promotion. I had the opportunity to visit Ethiopia in the summer of 2019 and met with an Ob-Gyn physician who treats patients with POP at a regional hospital. I served as a health educator for breast cancer and reproductive health care and general liaison for women being treated in the facility. During my time there, I became informed about the increased number of women being treated for POP and met women who had delayed treatment and denied their suffering. The opportunity to spend time with providers in Ethiopia and learn of women's experiences revealed a larger concern over the rise of POP in the region and whether the disease is given enough attention by the Ministry of Health. I listened as women verbalized frustration and feeling isolated from their community due to shame and embarrassment. Through these various interactions, I developed an interest in POP and the circumstances surrounding the women's treatment-seeking experiences.

As a qualitative researcher with this professional and personal history, the goal was not to separate myself from the experience, but rather to maximize transparency toward my preconceptions of their experience (Galdas, 2017). I consistently reflected on and documented all aspects of the research process. I minimized judgement of the participants' perspectives and was careful not to interject my own._I used a researcher identity journal to support self-awareness and reflection of feelings and beliefs that might potentially influence the study results. Conscious identification of presuppositions about the phenomenon is a common practice as a qualitative researcher. Identification of these presuppositions support the removal of preconceptions while seeking to understand the essence of the phenomenon in question. This journaling technique was used at each level of the inquiry including recruitment and interviewing of participants and analysis of data. Bracketing in phenomenological research is common and supports researcher engagement to separate preconceptions from the phenomenon and helped uncover one's evolving comprehension of the data (Fischer 2009)

Furthermore, to minimize personal biases, I used a record of the interviews to verify participants' responses, minimize engagement in social conversation to avoid influencing interview responses, and monitored the interview protocol carefully. Regarding professional biases, I did not have previous personal or professional relationships with the providers and nurse managers in the hospital. I am not currently volunteering or employed at the recruitment venue. Participants were considered if I have not had previous contact with them. It is very common for women to come to the hospital for treatment and not see them again; therefore, the chance to establish a long-term relationship was minimal.

A small stipend of 500 birr ($10) was provided to participants for their time after each interview. This small amount should not unjustly influence or coerce participation. As the researcher, I assured the confidentiality of the documentation collected, secured participant anonymity and carefully crafted informed consent.

Additional details are explained in the Data Collection section of this chapter.

Methodology

Participant Selection Logic

The study population were Ethiopian women aged 30-60 years old who have been diagnosed with POP and choose to seek treatment in the University of Gondar referral Hospital. This is a common service point for POP treatment and diagnosis in Northern Ethiopia and the POP prevalence rate is higher in the region of the country (Gedefaw & Demis 2020). This age range was appropriate because POP risk among people over forty years of age is higher due to the weak ligaments and pelvic structure. POP is responsible for over forty percent of gynecological surgery and age of forty and above, and delivering out of the institution is some of the determinant's factors for POP (Asresie et al.,2016). The potential among those aged less than 40 is still viable, specifically among rural women delivering at home and who have experienced prolonged labor (Akmel, & Segni, 2012).

In a phenomenological qualitative study, participants were selected based on their experience of the phenomenon and to maximize the sample's representation to the population (Salazar, Crosby, & DiClemente, 2015). Participants were selected using purposive sampling which is useful when an in-depth detailed response is needed. A small sample size (e.g., 5-25) is appropriate in order to gain in-depth information in this study (Creswell 2018, Creswell,1998, Creswell & Poth ,2016, Mapp,2008). Moreover, the sample size for a qualitative study depends on the nature of the topic, the structure of the questions, and the research design. Therefore, saturation was possible with smaller sample sizes in qualitative research. For this study the sampling strategy was a purposive sample of 15 participants identified.

Prior to conducting the research, a written agreement was obtained from the UoG referral hospital to serve as a recruitment site. Under the supervision of the UoG referral hospital site liaison, I was instructed to place the fliers in the hospital as a direct recruitment tool for the study. And the fliers placed in the areas where OB/GYN-related treatments are common. The fliers noted that interested parties are to contact the researcher directly and the contact information was written on the fliers.

The development of comprehensive research questions that yield “rich (high quality) and thick (sufficient quantity)” data from smaller groups is common as researcher aim for thematic saturation (Fusch and Ness, 2015). Once the eligible women were identified and agreed to be contacted, the researcher contacted them to further explain the purpose of the study, how and when data will be collected, and their rights as voluntary participants. Once a woman agreed to participate and meets all eligibility criteria, the researcher started the informed consent process to confirm participation.

The inclusion criteria are:

- women between 30 to 60 years of age
- women diagnosed with POP
- women currently seeking treatment at Gondar University Referral Hospital for POP

The exclusion criteria are:

- women younger than 30 years of age and older than 60 years of age

- women who are not diagnosed with POP
- women who are not of Ethiopian descent
- women who are not currently seeking treatment at Gondar University Referral Hospital for POP

Instrumentation

In this study, the qualitative explorative design was employed with semi-structured in-depth individual interviews. The interview protocol lasted approximately one hour and a half with an additional 30 minutes allotted for a follow-up interview. A series of open –ended and closed-ended questions were presented following a researcher-developed interview protocol. The interview questions developed based on the context of current literature describing Ethiopian women's experiences seeking treatment for POP. The researcher aimed to uncover the driving forces that influence their decisions to seek care and the challenges associated with seeking treatment. The interview questions are the result of an exhaustive review of research in this area and the researcher's professional understanding of this healthcare problem.

In a Phenomenological study, the aim was to explore participants' personal lived experiences and their meaning (Creswell, & Creswell, 2018). For this study, data collection included a semi-structured in-depth interview guide with open-ended questions performed. Unlike structured interviews, the semi-structured interview allowed the researcher flexibility and gave more opportunities for probing participants to provide additional detailed information (Guerrero-Castañeda et al., 2017).

To ensure content validity, the interview questions were submitted to the OBGYN

Doctor and Nurse manager who work closely with the women in the hospital. The purpose was to support a professional review to validate the content of the interview questions and to confirm the correctness of the translation of the local language (Amharic). Moreover, the researcher used field notes to monitor the effectiveness of the interview protocol, analysis of the data, and presentation of thematic results (Phillippi, & Lauderdale,2018).

All individual interviews were audio recorded. The interviews recorded in Amharic translated back to English for analysis. A thorough review of the transcriptions took place to help ensure that themes and responses are accurate. Confidentiality of the documentation included securing participants anonymity and making sure informed consent was crafted carefully, clearly, and per Walden University IRB standards. Further the details are explained in the data collection section of this chapter.

Procedures for Recruitment, Participation, and Data Collection

Recruitment took place at University of Gondar Referral Hospital for a period of four weeks. As not to interfere with treatment processes, women approached toward the end of their care. Women perceived eligible given a study flyer in Amharic language. The flier contained information relevant to the study process, participant criteria and requirements, and general protocol. Once eligible participants were identified and agreed to be contacted, I set up a time to formally introduce the study. A written informed consent translated to Amharic was provided to them and ample time given to read and ask questions. The informed consent contained information relevant to the study’s purpose, benefits and risks of participation, confidentiality procedures, and the right to withdraw from the study at any time. Use of this time with participants includes discussion of specific details about their privacy and answering any questions they had prior to participation.

The research took place in northern Ethiopia. Data for this study was collected using a semi-structured interview process (Jacob, & Furgeson, 2012, Creswell, 2018). The interviews were conducted in a private area within the Gondar University Referral Hospital (Rubin, & Rubin, 2012). The goal was first to capture demographic data then proceed with a series of open-ended questions. The initial interview lasted one hour and a half, and the follow-up interview lasted thirty minutes. Both sessions audio recorded to support clarifying and validating the data (Burkholder, et al., 2016). Field notes recorded throughout the interview process to annotate interactions with each participant.

Data Analysis Plan

The primary research question for this study was 'What are the treatment seeking experiences of Ethiopian women aged 30-60 diagnosed with POP?' An Interpretative phenomenological analysis (IPA) has been chosen to interpret the data. IPA strongly identifies with the hermeneutic approach recognizing Heidegger's ideal that understands and incorporates exploring and interpreting lived experiences (Tuffour, 2017). A thematic analysis process used to analyze and identify patterns and themes from data collected through individual interviews (Lainson, Braun, & Clarke, 2019; Maguire & Delahunt, 2017; Simmonds-Moore, Rice, & O'Gwin, 2019).

The inductive coding approach, also called open coding, was used for this study as this allows the researcher to create codes and themes from the data itself, not from preexisting frameworks (Ranney et al.,2015). Coding entailed reviewing all data collected from interview transcripts, field notes, audio records. According to Alease (2017), the first steps in the coding process was to read and reread data elements several times to familiarize myself with the content of responses. Then, transcribed the words, listened to the recorded response, and reread the transcripts for clarity. Data coded, analyzed and organized using NVIVO software. NVIVO is good for analysis of semi structured interview audio text and images (Zamawe,2015). Codes generated from the transcripts using line-by-line documentation of summaries. The summaries are used to develop themes. Initially, multiple open codes were used to identify emerging themes. The themes are then categorized to describe treatment seeking experiences and barriers to treatment. Collected data were read, reread, and separated by the transcribed themes until saturation was reached. To ensure the confidentiality of the documentation collected, data is contained in a secured file cabinet and backed by an extra hard drive.

Issues of Trustworthiness

As a qualitative researcher, I ensured trustworthiness by reviewing the qualities of the proposed study associated with credibility, transferability, dependability and confirmability.

Credibility achieved in order to promote the relevance and confidence of the study’s results (Connelly, 2016). Several strategies or techniques were employed to achieve credibility of the study findings. Member checking, where the participants assist with verifying data and correcting errors of study findings was one of the strategies used (Cypress,2017). Transcripts of each interview were reviewed and checked by participants for accuracy (Burkholder et al., 2016). Credibility established by asking effective follow up questions during the follow up interview (Morrow,2005). Additionally, triangulation took place to cross reference data from interviews and field notes (Korstjens & Moser, 2018).

Transferability is the idea of developing descriptive, contextual statements that can be transferable to another context or population for future research (Ravitch & Carl 2016). Furthermore, it is the ability to apply the results uncovered to another circumstance (Burkholder et al., 2016). The audio recordings were used to support rich and thick descriptions of the phenomenon. The fields note used throughout the study reveal detailed accounts about the settings, data collection experiences, and relevant cultural contexts (Hadi 2016). Detailed notations of cultural context inform other researchers of the transferability of the protocol.

Dependability is the consistency and transparency of the study process (Korstjens & Moser, 2018). To support dependability within the study, The Ob-Gyn department head at the University of Gondar. Zelalem Mengistu who signed a confidentiality agreement as part of the research protocol monitored protocol consistency during the data collection portion of the study Triangulation further support consistency between all aspects of data collection (Korstjens & Moser, 2018).

Confirmability is specific to shaping the findings to participant responses and limiting the researcher’s biases. Confirmability focuses on neutrality and the characteristics of the data (Korstjens & Moser, 2018). Establishing confirmability is achieved by focusing on what the data tells the researcher unbiasedly (Korstjens &

Moser, 2018). One of the strategies I used to ensure quality was personal reflexivity and end-user involvement, in which the researcher examined their awareness of their influence on the end-user research (Treharne & Riggs,2014). Also, I consistently monitored, acknowledged, and reflected on potential biases through journaling that supported an objective focused on the study's emerging themes.

Ethical Procedures

Sound research is a moral and ethical endeavor and should be foremost concerned with ensuring that participants are not harmed due to participation in research (Halai, 2006). Prior to conducting the study, I have obtained permission from the Walden University Institutional Review Board (IRB) in the United States followed by the Institutional Ethical Review Board of University of Gondar in Ethiopia. The recruiting materials were prepared in English and submitted to the Walden University IRB for approval. Once approval was received, the recruiting materials were translated into Amharic prior to being disseminated to the University of Gondar Hospital IRB. Recruiting materials included detailed descriptions of the purpose of the study, eligibility criteria, location of the study, study procedures, informed consent,_and actions to opt-out. The appropriate partner site and individual agreement forms obtained from the Walden University IRB resource and sent to the University of Gondar Hospital to the hospital CEO and participating members of the women's health unit.

This study took place in a hospital where participants receive treatment for POP. To ensure there is no coercion during the process, eligible participants were recruited toward the end of their treatment so as not to interfere with care. The informed consent written in Amharic given to women who meet the screening criteria. Ample time provided to read the informed consent and ask questions.

Participants were assured of the voluntary nature of this study, that they can withdraw from the study anytime and their care for POP will not be affected. A detailed informed consent process describing the voluntary nature of participation, why the research is being conducted, possible benefits and risks, and the role of the research team address multiple ethical of the study. The incentive of 500 birr and a small food refreshment were provided to thank participants for completing the study. This small monetary token was not used as persuasion or for coercion for participation. Participants exited from the study after receiving the 500 birr and refreshment at the end of the protocol.

All data collected remain confidential. Participants consented to use audio recordings from the interview as part of the informed consent process. Participants de-identified and assigned a number linking them to their interview data. The sensitive nature of this reproductive health topic could cause women to become hesitant during the interview. Providing a secluded and quiet interview environment promoted safety and the reduction of fear of physical or emotional risk (Bahramnezhad & Cheraghi,2014).

To ensure confidentiality, participants' identifying information were not placed on the audio recordings or the interview transcriptions. Instead, a code number used to identify the participants and access to data linking the code to the participants' identifying information will be limited to the researcher. Post data analysis, study materials relevant to procedures instruments locked in a safe place for up to 5

(Creswell,2018). Once the study is completed and the results are published, all data retrieved will be destroyed.

Adhering to the Walden University Internal Review Board (IRB) standards and procedures is critical to protect the rights of the participants to prevent the possibility of having an ethical issue in planning and conducting research.

Summary

In summary, chapter three outlined the methodology chosen to respond to the note research questions. A phenomenological qualitative study was proposed to explore the lived experiences of Ethiopian women aged 30-60 relative to living with and seeking treatment for POP. This chapter presented detailed descriptions of the research design rationale, role of the researcher, participant selection logic, instrumentation, data collection and analysis plans, issues of trustworthiness, and ethical procedures. Chapter 4 will provide more detail about data collection and analysis, the participant group, and study results.

Chapter 4: Results

The purpose of this hermeneutic qualitative phenomenological study was to explore the treatment-seeking experiences of women with POP aged 30-60 years old in Ethiopia and to understand the challenges women encounter while seeking treatment and the driving forces related to decision making when deciding to seek treatment for the disease. The hermeneutic phenomenological approach was used to address the research question directly related to the purpose of the study as well as three sub questions on what driving forces influence decision making to seek or delay POP treatment, what role social and cultural normative beliefs play in decisions to seek treatment, and the challenges that are associated with POP that interact with the decision to seek or delay treatment.

This chapter presents the summarized results of the data collected through the conduction of semi structured, in-depth participant interviews. I was able to find themes and associated characteristics to better understand treatment-seeking experiences. The data collected also allowed me to identify and the challenges associated with the participants' daily life because of the POP diagnosis. I was also able to better understand the driving forces that influence decision making to seek or delay treatment. The results are explained with respect to each of the three sub research questions with associated themes organized to relate to each.

Data Setting

The study took place in the UoG referral hospital outpatient gynecology floor in a quiet isolated room. The data for this study were collected between June 2022 to August 2022. Fifteen women answered open and close-ended, semi structured, exploratory questions about their lived treatment experiences, challenges, and motivational factors associated with seeking or delaying treatment for POP. Before the interview recording, I asked each participant to confirm their permission to be recorded. To maintain the confidentiality of each participant, interview data were coded using a number and letters and in order of the interview.

Demographics

The 15 participants were Ethiopian women 30-60 years old who live in the northern part of Ethiopia and seek treatment in the UoG referral hospital. This is a common service point for POP treatment and diagnosis in northern Ethiopia and the POP prevalence rate is higher in the region of the country (Gedefaw & Demis 2020). The age range is relevant because POP risk among women over 40 years of age is higher due to the weak ligaments and pelvic structure. Additionally, the risk for POP increases when women deliver outside of a medical institution, which is common in this reason. As a result, POP- related symptoms contribute to over 40% of gynecological surgery procedures in this population (Asresie et al., 2016). The potential among those aged less than 40 is still viable, specifically among rural women delivering at home and who have experienced prolonged labor (Akmel & Segni, 2012)

Data Collection

Approval and Consent

Once the IRB approvals were granted and the eligible participants identified, the informed consent process began. The consent was read to each possible participant to explain the study's purpose, the process, the right to withdraw their consent anytime without affecting their care, and to ensure them of the interview's confidentiality. The consent was written in English and was translated to Amharic, the language of the participants. All study participants were presented the Amharic version of the informed consent, which outlined the interviewing and recording policies and procedures. Only women who signed the consent were moved forward in the study process.

Instrumentation

Interview questions were developed based on the context of current literature describing Ethiopian women's experiences seeking treatment for POP. I aimed to uncover the driving forces that influence their decisions to seek care and the challenges associated with seeking treatment. The interview questions are the result of an exhaustive review of research in this area and my professional understanding of this health care problem. A series of open and close-ended questions were presented following a researcher-developed interview protocol. For this study, data collection included a semi structured, in-depth interview guide with open-ended questions. Unlike structured interviews, semi structured interviews allow the researcher flexibility and gives more opportunities to probe participants to provide additional detailed information (Guerrero-Castañeda et al., 2017).

To ensure content validity, the interview questions were submitted to the OBGYN doctor and nurse manager, employees of the UoG who work closely with the women seeking treatment at the UoG referral hospital. The purpose was to support a professional review to validate the interview questions' content and to confirm the correctness of the local language (Amharic). Moreover, I used field notes to check the effectiveness of the interview protocol, analysis of the data, and presentation of thematic results (see Phillippi, & Lauderdale, 2018).

Data Collection

Participants were recruited as explained in Chapter 3. In a phenomenological qualitative study, participants should be selected based on their experience of the phenomenon and to maximize the sample's representation to the population (Salazar, Crosby, & DiClemente, 2015). Participants were selected using purposive sampling, which is useful when an in-depth detailed response is needed. Flyers were prepared in Amharic, the local language, and posted in the hospital and left in the out-patient ob-gyn clinic where patients were seen.

The recruitment protocols yielded 15 participants. A small sample size (e.g., 5-25) is appropriate to gain in-depth information in this study (Creswell 1998, 2014; Mapp, 2008). Only those who met the eligibility criteria were contacted and met face to face in the quiet and isolated room near to the outpatient clinic. I explained to each participant the parameters of the study, the consent and interview process, and how long it takes to complete the interview. The participants were also informed of a small incentive of 500 Ethiopian birr that is equivalent to $10 after the completion of the interview. The interview guide supplied a structure for the interview process (see Appendix). The interview was conducted in Amharic using the recorder and transcribed in Amharic and later translated to English. Each interview was reviewed with participants for confirmation of details.

The interview lasted approximately 1 hour-and-a-half with an added 30 minutes allotted for a follow-up interview. The 15 participants were allowed ample time to reflect at length with minimum interruption. Moreover, to clarify and to allow for more in-depth information, follow-up questions were asked. The first three interviews were conducted on the first week of June 2022 and continued daily for 2 weeks.

Data Analysis

All individual interviews were audio recorded. A thorough review of the transcriptions took place to help ensure that themes and responses are accurate. NVivo 20 software was used to aid in data analysis. The data analysis method chosen for the study was an interpretative phenomenological analysis (IPA). A thematic analysis process, which aligns well with IPA, was used to analyze and identify patterns and themes from data collected through individual interviews (Lainson et al., 2019; Maguire & Delahunt, 2017; Simmonds-Moore et al., 2019).

The inductive coding approach, also called open coding, was used for this study as this allows a researcher to create codes and themes from the data itself, not from preexisting frameworks (Ranney et al., 2015). The coding process involved reviewing all data collected from interview transcripts, field notes, audio records. The first steps in the coding process are to read and reread data elements several times to become familiar with the content of responses then transcribing the words, listening to the recorded response, and rereading the transcripts for clarity (Alease, 2017). To familiarize myself with the data, I read and reread the data and listened to the audio recordings**.** The data were coded, analyzed, and organized using NVivo software. NVivo is good for analysis of semi structured interview audio text and images (Zamawe, 2015). The codes were generated from the transcripts using line-by-line summaries and documentation. Then, the summaries were used to develop themes. Initially, multiple open codes were generated and used to find emerging themes. The themes were categorized to describe treatment seeking experiences and barriers to treatment. The collected data were read, reread, and separated by the transcribed themes until saturation was reached.

All data collected and study materials were locked in a secured cabinet in my office near the referral hospital. To ensure the confidentiality of the documentation collected, data was backed up by an extra hard drive. To ensure privacy the participants' identities were not revealed. Each participant was given a unique ID used for the duration of the study.

Results

SRQ 1: What Driving Forces Influence Decision Making to Seek or Delay Pelvic Organ Prolapse-Related Treatment Among Ethiopian Women Aged 30–60?

Through the interviews, I identified a series of themes related to treatment-seeking experiences and the challenges associated with participants' daily life because of the POP diagnosis. I was also able to understand the driving forces that influence decision making to seek or delay treatment. The codes generated from this data were reviewed and confirmed from the transcribed interviews. Major themes and subthemes were identified from the interviews and each one of them is addressed in the following sections.

Category 1: Factors Influencing Seeking or Delaying Treatment

Factors for Seeking Treatment.

Theme 1: Disease Progression. Some participants stated that the progression of the disease and severity of symptoms, such as pain around their waist and inability to walk due to dropping of the womb, forced them to seek treatment. As some of the participants stated, they decided to seek medical help when the symptoms got worse. Participant 8 stated, “I was in pain, could not walk, urinated completely, my bladder feels full, my womb feels heavy. And unable to have sexual activity without pain.” Participant 2 responded what motivated her to seek treatment saying, “I have decided to seek treatment because of the severeness of the illness. I want to heal and feel better.” Participant 13 stated, “The disease worsened. After multiple visits to the local doctor, he referred me to the referral hospital. Participant 12 stated “I came to this hospital because I can’t eat, my stomach is sore, and severe pain around my waist, especially my lower back pain, worsened over the last eight months.” Participant 14 stated, “I was motivated to seek medical care because of my symptoms, such as my womb came out and remained out for many years.”

High rates of POP persist in developing countries, including Ethiopia in part due to limited health education options to relay risk factors and prevention behaviors (Adefris et al., 2018; Borsamo et al., 2021; Ghetti et al., 2015). Most participants reported that the local doctors treated them with medicine that did not cure the illness. For example, Participant 9 stated, “I went to a local doctor when my symptoms worsened, and my womb stayed out almost for one year. The drainage got heavier. The local doctor treated me with tablets but did not cure me. Finally, he referred me.” Participant 8 stated,

> I was very ill and told to get health insurance, so I went to see a local doctor who gave me tablets without examining me but did not help me. It made me sicker. I asked him to refer me to the hospital, but the doctor refused three times.

Theme 2: Family Influence. Some of the participants were brought to the hospital by a family member due to increased severity of the symptoms. For example, Participant 2 said,” I am here in the referral hospital for two weeks with my father, but he went back to his farm work and my son is here with me.” Participant 14 stated, “My husband brought me to the referral hospital after I told him about my illness, and my children also encouraged my husband to bring me to the hospital.” Participant 15 responded that her sister encouraged her to the hospital saying, “I got very sick and decided to come to the hospital. However about ten years ago my sister brought me to the hospital for vaginal drainage even though my husband did not approve it.” Participant 8 stated, “One of my relatives who saw me in pain told me that it was hypertension and that I should see a doctor for hypertension before it got worse.”

Factors Influencing Delaying Seeking Treatment.

Theme 3: Fear of Losing Family Connection That Delays Seeking Treatment. Women hide their disease for many years and delay treatment due to fear of losing family connections. For example, some women noted a fear of divorce and being discouraged by their husbands to seek treatment. Participant 11 explained, “I did not know what kind of illness I had and thought it would get better. And I hid it from my husband for about eighteen years because of fear of divorce.” Participant 4 stated,

> About six years ago I told my husband when the first symptoms appeared, but he kept saying that you will be okay just focus on your work, it could be the heavy work you do, just do light work until you feel better. So, I believed him and tried to do the light work.

Participant 14 added,

> my husband, whom I told at the beginning, said he knew about the disease and there was a treatment for it, but he did not take me to the hospital to see the doctor because he wanted me to do the house and farm work. So, he decided to ignore my illness and left me to suffer for a long time.

As most of the participants mentioned, separation from the family, being viewed as less than responsible over home actions and work-related tasks, along with concerns of spending long times in the hospital caused stress and the women felt forced to delay seeking treatment.

Theme 4: Lack of Experience of the Local Providers. The local doctors' lack of experience and knowledge of the disease also contributed to the delay in seeking treatment. Many participants said that the doctors treated them with medication that did not help them with their disease. The medications temporarily eased their pain but did not cure the larger symptoms. As a result of this cycle of misunderstanding, physicians often waited many years before referring them to a specialized hospital. For example, Participant 13, "Every time I visited the doctor, they gave me medicine for hypertension and told me it will get better if I take the tablets they prescribed. But did not cure my real illness." Participant 8 stated,

> [I was not] able to get a referral sooner, and the local doctor did not know the disease and wasted my time seeing him repeatedly. He gives the same tablets to all patients; even when my husband went to see him, he gave my husband the same tablets he gave me, so we thought my husband had the same health issue I had, until I came to his hospital, and they told me the actual disease I have.

Participant 6 reported,

> I have seen doctors because of my pain and dropping of my womb, But the medicines they gave me were for kidneys that I do not have a problem with. I even told them that a woman with a similar health issue told me to go to the referral hospital, but they did not listen. Finally, they got tired of me and referred me to this hospital.

Participant 12 said,

> the local doctor who I visited for three years advised me to rest and eat healthy food and take tablets to get cured of this illness. So, I did as he advised me and finally when I did not get cured, he referred me to UoG referral hospital.

A study conducted in the United Kingdom suggests that general health practitioner awareness of POP intervention may contribute to disease severity, how it is diagnosed, and their possible treatment options (Abhyankar et al., 2019). Delayed referral to a POP specialist is also common in Ethiopia (Gjerde et al., 2018). This results from lack of knowledge on the part of general health practitioner about POP and its symptoms, treatment, and diagnosis.

Theme 5: Lack of Awareness of the Disease in the Community. Some women reported living with the disease for some time because other women were not discussing the disease or, other women were living with the symptoms of the disease without treatment. One participant lived with the disease for over eleven years due to lack of knowledge of the disease and believed that God gave it to punish her for wrongdoing and must wait until God forgives her sin. For example, participant 7 said, “First, I thought it is given by God and left it alone, but later on I went to see a local doctor who referred me to this hospital.” Participant 9 said, “I did not understand and waited about four years before I went back to the clinic.” Participant 4 explained, “I was just focused on my daily duties and thought the disease is not that bad and will get cured on its own.” Participant 2 added “I hid my symptoms for thirteen years thinking that it will get better soon with holy water. I did not think they would have a treatment for it.” Only a third of the women in this area with the disease seek medical care (Dheresa et al.,2018). This small number is related to a lack of knowledge about the illness, lack of access to medical services, and the stigma and shame attached to the disease. And some respondents expressed their fear that the POP might change to cancer. Some participants responded that they did not disclose their disease to anyone in the community because they did not think it was a serious disease and would heal soon. Ethiopian women who are diagnosed with POP are less likely to understand what the condition is, its progressive nature, or their treatment options (Abhyankar et.al., 2019).

Participant 3 mentioned “I waited for ten years because I did not know about the severity of the disease.” Participant 14 also added “I have wasted over seven years because of my lack of knowledge of the disease and I do not know who else has the disease like me. Nobody knows about my disease, and I was not sure how they would react if they knew about it. There might be women in our community who has the disease and hide it like me." Low levels of knowledge about POP and awareness of the disease symptoms interact with social contexts and other factors, thereby affecting treatment seeking and pursuit of care (Dheresa et al., .2020).

Category 2: Negative and Positive Treatment-Seeking Experiences—Positive Treatment-Seeking Experiences

Negative Treatment-Seeking Experiences.

Theme 6: Long-Distance Traveling. Accessing health care eservices for women who live in the remote areas are difficult as it requires long distance travelling. The negative treatment-seeking experiences most mentioned by participants are the long and multiple appointments before seeing the senior doctors to get treatment. Also, the long-distance traveling to the hospital as most of them live in remote areas and women cannot travel alone. Participant 10 mentioned "The hardest part is the long-distance traveling to the hospital" Participant 14 added, "I don't like the long waiting period to see a doctor and long multiple appointments to return to the hospital for evaluation and starting the treatment. I am getting old and tired of walking to the hospital back and forth. This referral hospital is very far from where I live. My womb comes out during the walk and remains out. It has been three years since I started coming here and I still did not get treatment yet." Participant 1 said, "I can't go to the hospital by myself as it is too far from my house." Participant 4, "When they give me multiple appointments the traveling alone is difficult." Participant 15 added the financial constraints in addition to long distance travelling “the long distance travelling to the hospital, not having enough money for food transportation and lodge is the hardest part of seeking care.” The long-distance of the hospitals is a significant obstacle among other challenges identified by participants, such as financial strains that need to be addressed by the Ministry of Health and policymakers.

Moreover, separation from family and children due to multiple appointments is considered as negative treatment experiences by many of the participants “Participant 4 mentioned “I don’t like the separation from my family and children especially my baby I left him home with my children.” Participant 11 added “I am not with my children and cannot feed them and take care of them due to my Illness.” Participant 12 also added her worries about blind son leaving him behind “taking care of my son, who got blind at the age of seven for an unknown reason. And I don’t have anyone to keep him when I come to the hospital.” Participant 13 mentioned “The hardest part of seeking care is the multiple appointments, the separation from my children. I have not breast fed for three days since I came to the hospital and my breast is full of milk and painful.” The long-distance of the hospitals is a significant obstacle among other challenges identified by participants, such as financial strains that need to be addressed by the Ministry of Health and policymakers.

Positive Treatment-Seeking Experiences.

Theme 7: Knowing Other Women with Similar Disease. The positive seeking treatment experiences were associated with knowing other women who have similar experiences and sharing their journey with others in the hospital. For example, Participant 2 stated, “I feel good about seeking medical treatment because I have met several women who are suffering from the same health issues and am able to talk with them without feeling shame and fear." Most participants also revealed that hearing from other women in the clinic about the disease and the treatment cures makes them feel hopeful as well as knowing that they are not alone suffering with POP. Participant 3 mentioned, "knowing that I will be cured makes me feel good I have hope and faith in God that I will heal and feel better."

Theme 8: Patient–Healthcare Providers Relationship and Interaction. Having a good and trusting Patient -provider relationship is important for women within this culture especially when discussing sensitive issues related to reproductive health, like POP. As the women described the contexts under which treatment was delayed, they also described their perceptions of ideal conditions under which to seek treatment.

Participant 10 said, "I like being here and being seen by the doctor who examined me and talked to me about the disease and the doctors are polite except for the long waiting to see them."

Participant 4 said, "Doctors in the referral hospital are helpful, not like the local doctors who mistreat and misdiagnosed." Overall, while sharing their positive treatment-seeking experiences, participants' interviews also shed light on the need for more empathy and accuracy in care.

For example, participant 2 stated "I feel good about seeking medical treatment because Doctors are polite and respectful." Participant 4 confirmed that "I like getting better the doctors talk to me with respect and assisted me to get health insurance to get the treatment free."

SRQ 2: What Role Do Social and Cultural Normative Beliefs Play in the Decision to Seek or Delay Pelvic Organ Prolapse-Related Treatment Among Ethiopian Women Aged 30–60?

Category 3: Cultural and Social Belief Systems

Theme 9: Trusting God and Traditional Spiritual Remedies. The normative cultural beliefs that play in the decision to delay treatment for POP among the participants are extensive. Several participants revealed that they had sought spiritual solutions for their disease, such as washing the disease with using holy water for several days traveling to many places and praying by the priests and elders for healing before seeking medical care. For example, participant 12 stated, “I went to the holy place many times and did the body washing with holy water is called (Tsebel) and I trust God will heal me.” Participant 2 added, “I hid my symptoms for thirteen years, thinking it would get better soon with holy water.” Others used leaves to cleanse the womb, which they revealed helped with the pain for a few days but not curing the disease. For example, participant 11 said “We use some leaves when we have sickness, so I use that to cleanse my womb.” Some participants regretted delaying seeking treatment during the early stage of their illness as participant 8 said, “I started going to the holy place and washing my body to cleanse the sickness in the last three years. I have wasted my time.” In Ethiopia, awareness and subsequent care may be stifled by cultural context and spiritual beliefs. For example, most Ethiopians still believe that God causes illness for wrongdoing, and treatment in church or spiritual healing should be prioritized before seeking medical treatment (Anderson, 2007).

Subtheme 9:1: Rejection. Hiding a disease is a common social and spiritual practice in Ethiopia as there is a belief that sickness comes from God for doing poorly in life (Gjerde et al.,2018). Because of this normative belief, women hide their illnesses and suffer from the disease. Most participants revealed that withholding their illness was due to the complicated relationship between understanding the condition as spiritual punishment and the necessity to isolate oneself. Moreover, they expressed afear of disclosure related to the socio-spiritual stigma attached to being sick. For example, participant 10 said, "In our community, we do not share information about this illness, so I did not tell anyone." Participant 15 stated, "I have never heard about this disease in the community before. And I did not disclose it to anyone in the community." Participant 7 said "First, I thought it is given by God and left it alone for ten years only going to the holy place but later on I went to see a local doctor when the disease got worst."

Women in this region are minimally proactive in seeking healthcare services at preliminary stages of POP and report social and spiritual stigma as one of the causes (Ghetti et al., 2015, Borsamo et al.,2021).

This socio-spiritual stigma is compounded by the result of lack of disclosure among women which is suffering alone. Several women expressed fear and self-isolation related to being the only woman who suffers from the disease in their community. Participant 4 said, "I pray women will not be quiet in fear and shame like I did for many years." The other respondents expressed fear of the community's reaction if they disclosed the disease. Participant 13 noted, "Since I did not know anyone with the disease, I did not disclose it to anybody. I do not know what it is like to live in the community if they know about my disease." Participant 14 confirmed the possibility of negative community reaction about living with POP saying, "nobody knows about my disease, and I am not sure how they will react if they know about it. There might be women in our community who have the disease and hide it like me." A study done by Shitu et al., (2023), also revealed that fear of rejection and discrimination from the community contributes for hiding the disease for long time until it is progressed into later stages

Theme 10: Social Expectation to Hide the Disease. The social normative beliefs that delay seeking treatment revealed by many participants relate to embarrassment at discussing and disclosing the symptoms of POP. As a result, women live in hiding or isolated from the community and close family members. For example, participant 10 said, "We hide the disease to prevent embarrassment and shame and if people know about it, they will be talking about us, because it has odorous drainage. We do not want to be around people." Participant 11 added, "I am uncomfortable discussing my real diagnosis." Several women reported a fear of losing family support, being chased away from home, feeling 'less than a woman', as well as discrimination and humiliation. Social humiliation and shame are tied to the diagnosis of POP as women express concerns about disclosing their health condition to their husbands. Fear of social and familial humiliation and increased divorce risk are mitigating factors in the delay of seeking treatment. Participant 5 said, "The last person I told was my husband because I was unsure how he would react when he heard about womb disease." Participant 3 explained, "The first person I disclosed to be my mother, then later on, I told my husband that my womb is big and coming outside, you can’t do anything it is closed.” Most of them disclosed to their husband last when they did not have another person to take them to the hospital. For example, participant 9 said, “I told my husband after I got sicker because he is the only person to bring me to the hospital.”

Over all the respondents shed light on the social and cultural normative beliefs play in the decision seeking treatment for POP. Participant 10 said, “I told my mother first because she is my trusted confidant. She had a womb illness before, and she got cured after the doctor cleaned her, so she told me to see a doctor to get cleaned.” Participant 3 said, “I disclosed my diagnosis to my youngest daughter about two years ago because she is my confidant and helper. I hid my illness for eighteen years from her to avoid her being worried about me.” Social expectation to hide the disease Some of the participants said their families were unhappy and embarrassed after they disclosed the illness to someone outside of the immediate family. Participant 15 stated “My husband and children are unhappy about my disclosure to others.”

Overall, the choice to hide the disease is the product of a complicated relationship between social expectations to limit shame on the family, fear of rejection by husbands, losing family and social support.

SRQ 3: What Are the Challenges Associated with Daily Life Because of Pelvic Organ Prolapse Diagnosis That Interacts with the Decision to Seek or Delay Treatment Among Ethiopian Women Aged 30-60?

Category 4: Burden of Disease

Theme 11: Physical Burden. The physical burden associated with POP symptoms has greatly affected women's daily activities. Almost all participants reported that POP caused them to stay home in isolation, being unable to walk, stop community activities, attend church services, cook, and entertain guests at home as they used to do prior to their illness. For example, Participant 11 stated, "My life has changed for the worse physically and emotionally; having this disease affected my life in many ways. I stopped working and cannot walk because of the pain and the womb coming out and staying out. I am in constant pain and do not like being around people."

Almost all participants said they bend leaning forward when walking to ease the Pain**.** For example, participant 2 stated, **"**It affected my activities badly and I stopped going outside completely after a lady insulted me called me (Gobata) because of how I walk bending forward." Participant 5 added, "It affected my daily life and social activities greatly; I don't go to church, weddings, and all other community activities. I cannot cook or do farm and housework and can't walk long distance. Every time I walk the drainage starts pouring and the pain around my waist is unbearable."

Theme 12: Psychosocial Burden. The psychosocial burden is unbearable for women affected by POP. As Degefae &Demis (2020 pg.2) stated, in Ethiopia, "pelvic floor disorders have a negative impact on women's lives, emotional stability and quality of life." The majority of the respondents explained that sharing information about a reproductive system illness is not common among women in their culture; as a result, they isolate themselves from the extended family and community. They are ashamed and feel less than women. Participant 11 stated, "My life has changed from good to worse because of my illness. I feel sorry for myself and sad. I am lonely and isolated from all community activities. Praying that I will get cured and things will get better." Participant 6 added, "My life has changed entirely for the worse ever since I had the first symptoms. I feel like I'm not a complete human being. My self-esteem is low." The participant said that, due to staying home and being unable to work on the farm, her marital relationship suffered. Participant 13 confirmed, "It affected my daily work. I cannot do the farm work to help my husband. Just sit at home and have been isolated for the last three years."

Participant 9 mentioned "Yes, my life is bad now; I do not feel like a complete woman; I am isolated from everyone...and my last four years have been bad for me." Other women said the POP illness and the emotional strain is so bad, they wished not to see other women suffering from this illness and it's better to die in peace than to live with the condition. Participant 6 stated "When the illness gets worse, I ask God why me? Why do I have the disease?"

Participant 4 added "I am ashamed to tell people it is a sensitive matter and personal. I just wish not to see any women suffering from this disease like me; I wish the disease just kills without suffering."

Participant 15 mentioned "My husband nagged me and made me feel less than a woman." As the women talked about how POP changed their lives for the worse, some of them were regretful for delaying treatment, however the lack of emotional support from their husbands prevented them feeling safe disclosing the illness.

Theme 13: Financial Burden. Participants also expressed how having POP affects their work and earning potential. This problem is compounded by the extended time associated with multiple visits to the hospital and long-distance traveling. Many of these visits require staying in a hotel which costs lots of money and causes financial constraints. Participant 15 said, “The disease made me poor and made my relationship with my husband bad and he blamed me for the financial restrain and mad at me for seeking medical help.” Participant 10 added, “I do not have enough money for food or transportation, and the lodging is the hardest part of seeking care.” Participants11 added, “It affected me financially as I stopped working and earning money to seek care.” Participant 5 said, “The hardest part is not able to do the work as I used to. The financial burden is bad.”

Overall, the participants’ interviews shed light on the treatment-seeking experiences of women with POP, lack of knowledge of the disease among patients and local physicians, lack of awareness of the disease in the community, and the long-distance traveling to the hospitals, the significant obstacles among other challenges identified by participants, such as financial strains that need to be addressed by the ministry of health and policymakers.

Figure 1

Category 1: Factors Influencing Seeking Treatment or Delaying Treatment—Factors

Influencing Seeking Treatment

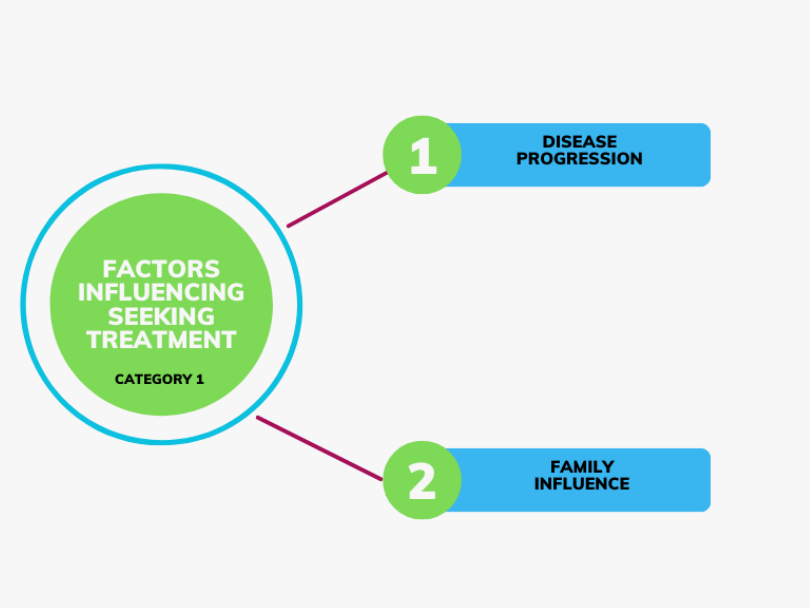


Figure 2

Category 1: Factors Influencing Seeking Treatment or Delaying Treatment—Factors Influencing Delaying Treatment

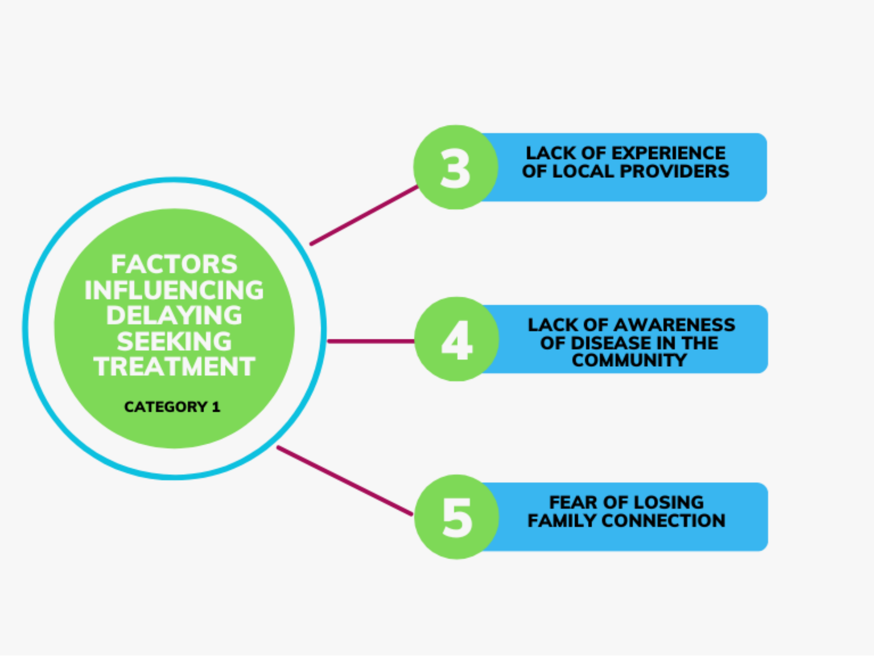


Figure 3

Category 2: Negative and Positive Treatment-Seeking Experiences—Negative Treatment-Seeking Experiences

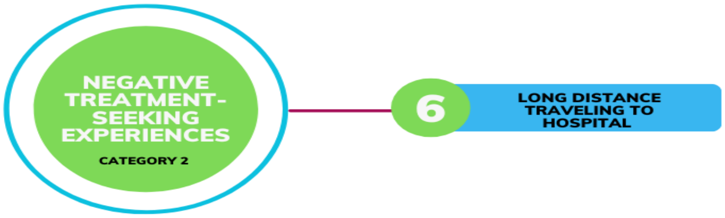


Figure 4

Category 2: Negative and Positive Treatment-Seeking Experiences—Positive Treatment-Seeking Experiences

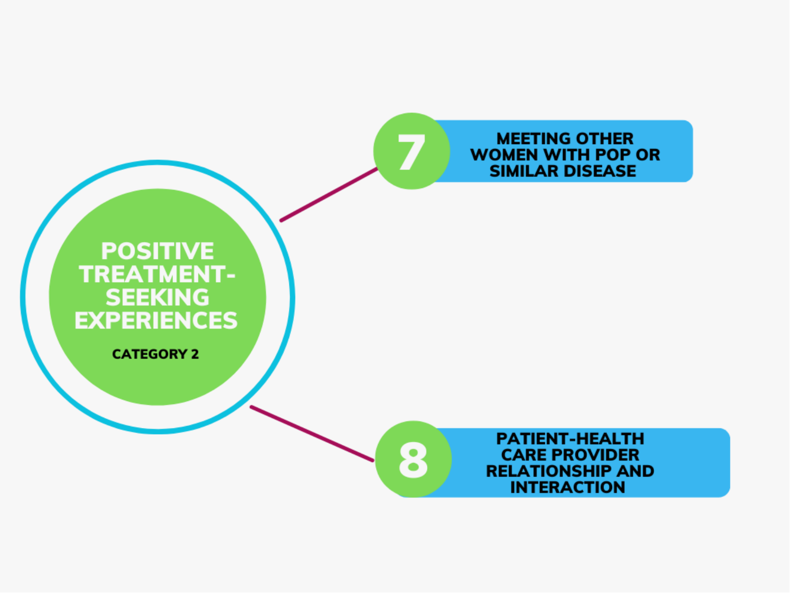


Figure 5

Category 3: Cultural and Social Belief System

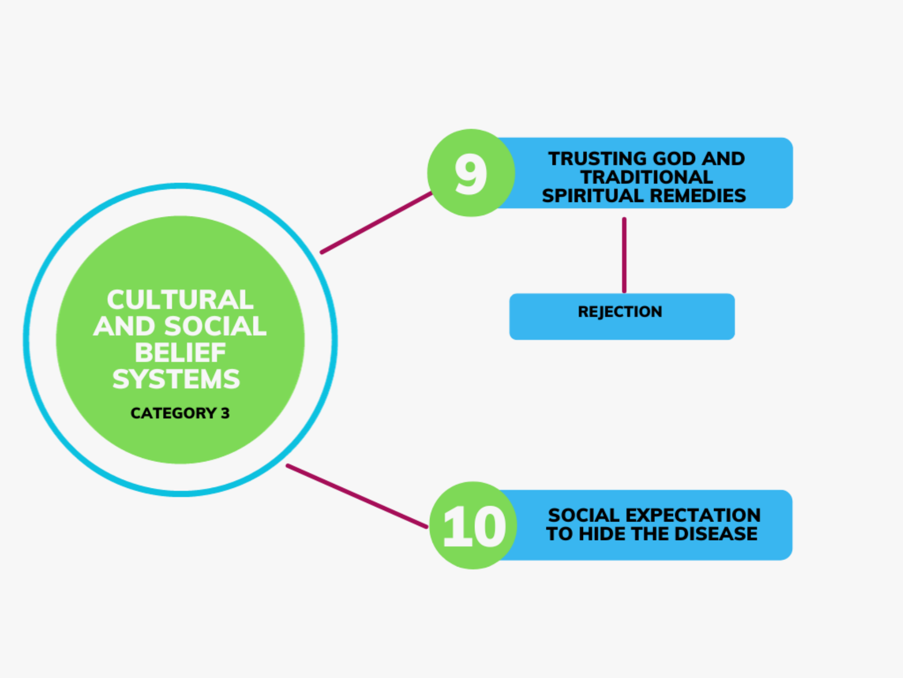
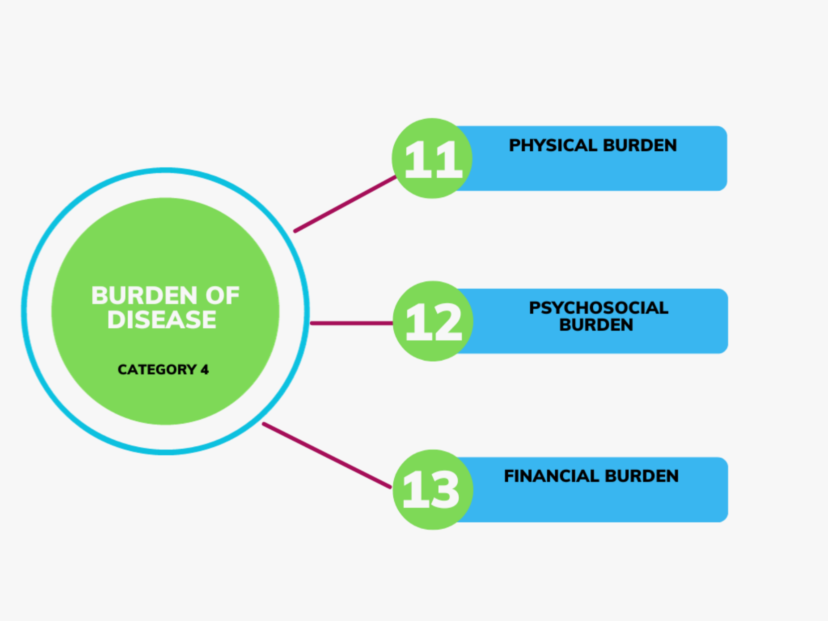


Figure 6

Category 4: Burden of Disease



Evidence of Trustworthiness

As a qualitative researcher, I ensure trustworthiness by reviewing the qualities of the proposed study associated with credibility, transferability, dependability, and confirmability. The specific plans to address trustworthiness were described in detail in Chapter 3.

Credibility

Credibility should be achieved to promote the relevance and confidence of the study's results (Connelly, 2016). For this study, several strategies, or techniques were employed to achieve credibility of the study findings. Member checking was used, where the participants aided with verifying data. (Cypress,2017). Transcripts of each interview were reviewed and checked by participants for accuracy as common with phenomenological protocols (Burkholder et al., 2016). The research questions posed were organized and presented in the same sequence with each participant. The questions were developed and presented in three sections, each designed to align with a research question. Therefore, specific interview questions were aimed at gathering data that would help respond to a research question. Credibility was also established by asking effective follow up questions to participants during the follow up interview protocol (also described in Chapter 3) (Morrow, 2005). Additionally, triangulation took place to cross reference data from interviews and field notes taken by the researcher (Korstjens & Moser, 2018)

Transferability

Transferability is the idea of developing descriptive, contextual statements that can be transferable to another context or population for future research (Ravitch & Carl, 2016). Furthermore, it is the ability to apply the results uncovered to another circumstance (Burkholder et al., 2016). The methodology outlined in Chapter 3 and the expression of that protocol in this chapter express a specific and detailed explanation of the context under which this study took place. Moreover, an emphasis was placed on the development of sound research questions that could be reproduced within the framework of future research protocols.

Dependability

Dependability is the consistency and transparency of the study process (Korstjens & Moser, 2018). The Ob-Gyn department head at the Uof G. Zelalem Mengistu who signed a confidentiality agreement as part of the research protocol monitored protocol consistency during the data collection portion of the study, Triangulation and review of the data and field notes taken support consistency between all aspects of data collection (Korstjens & Moser, 2018). To strengthen the study validity and trustworthiness I used member checking, a process where participants had time to review their responses and confirm accuracy of what was recorded.

Confirmability

Confirmability is specific to shaping the findings to participant responses and limiting the researcher's biases. Confirmability focuses on neutrality and characteristics of the data (Korstjens and Moser, 2018). Establishing confirmability can be achieved by focusing on what the data tells the researcher in an unbiased way (Korstjens and Moser, 2018). Although I was familiar with the geographic region in Ethiopia, I did not facilitate research within a workplace of familiarity. I have no previous contact with the participants, and they were made aware of their rights as participants prior to agreeing to participate. Participants were also informed of how their confidentiality would be protected, namely by removing identifying characteristics associated with the data. In this study, audio recordings of the interviews allowed me to evaluate the data carefully and to identify categories, themes and subthemes where appropriate. The data support rich descriptions of the phenomenon as described by the women experiencing it.

In order to reduce bias and to ensure quality, I practiced personal reflexivity in which the researcher examines their awareness of their influence on the end user research (Treharne, & Riggs,2014). I consistently monitored, acknowledged, and reflected on potential biases through reflexive journaling documenting my observations during the interviews.

Summary

In this chapter I have provided more details about data collection and analysis, the participant group, and study results. This phenomenological qualitative study explored the lived experiences of Ethiopian women aged 30-60 relative to living with and seeking treatment for POP. The aim was to uncover the driving forces influencing their decisions to seek care and the challenges associated with seeking treatment. Fifteen eligible women were interviewed. The findings provide insight into what factors influenced women's choice to seek or delay treatment for POP. The analysis revealed that almost all women lack basic knowledge of the disease and possible treatment options. Lack of social support from family and community, and the lack of positive experiences or limited expertise of local health care providers are the main factors in delaying seeking treatment. Factors including progression of the disease, severity of the symptoms, and family influence were most related to seeking treatment.

The study also revealed that cultural and spiritual practice plays a significant role in delaying treatment. Women sought spiritual remedies before seeking treatment with healthcare professionals. The socio-spiritual expectation to hide the disease led women to suffer from the disease alone and isolated at home for many years. Women experienced many challenges in daily life associated with POP including physical, psychosocial, and financial suffering.

However, women also expressed that once they sought treatment in the hospital, they met other women who had suffered from POP or a similar reproductive disease for many years and connecting with other women helped them to open up and share their experiences. The data collected may provide vital information to health care providers needed to develop comprehensive health education and promotion services that will be accessible to all women in all regions of Ethiopia. For policymakers and health officials, the results of this study may enable them to understand the significance of this health issue and contribute to developing a national policy that focuses on women’s reproductive health needs. In chapter 5, I will discuss the study interpretation, study limitations, recommendations for future study, and the implication of social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The aim of this phenomenological qualitative study was to explore the experiences of Ethiopian women living with POP. I explored and describes the treatment-seeking experiences of Ethiopian women aged 30-60 living with POP, including challenges and driving forces associated with treatment-seeking choices. The study provides insight for health care providers to develop comprehensive health education and care services for women with POP in this part of the world. The main findings from this study included four categories and 13 themes to address the three main research questions as discussed in Chapter 4:

- Research Question 1
  - Category 1: Factors Influencing Seeking or Delaying Treatment
    - Theme 1: Disease progression
    - Theme 2: Family influence
    - Theme 3: Fear of losing family connection
    - Theme 4: Lack of experience of the local providers
    - Theme 5: Lack of awareness of the disease in the community
  - Category 2. Negative and Positive Treatment-Seeking Experiences
    - Theme 6: Long-distance traveling
    - Theme 7: Meeting other women with POP or similar disease
    - Theme 8: Patient–healthcare providers relationship and interaction
- Research Question 2
  - Category 3: Cultural and Social Belief Systems

    - Theme 9: Trusting God and traditional spiritual remedies
    - Subtheme 9:1: Fear of rejection
    - Theme 10. Social expectation to hide the disease
- Research Question 3
  - Category 4: Burden of Disease
    - Theme 11: Physical burden
    - Theme 12: Psychosocial burden
    - Theme 13: Financial burden

The findings of this qualitative research revealed essential themes of addressing each research question. The key elements identified and learned from each research question highlight delayed treatment-seeking actions among Ethiopian women with context to physical, social, and geographical challenges. Moreover, women perceived a lack of support from their families, communities, and health care providers when discussing their challenges or seeking treatment. The women resorted to isolation and muting themselves while suffering the symptoms of progressive POP to avoid rejection, shame, and embarrassment due to the stigma attached to POP. These individual struggles are compounded when health care providers often cannot address their needs or diagnose them accurately. This lack of knowledge and delay in accurate diagnosis leads to severe symptoms due to advanced progression. As a result of poor care, and advanced disease, some women take the risk of disclosing the disease to close family members, at which time they are often encouraged to seek care. These themes indicate the struggle as women face diminished physical and emotional capacity while trying to determine how to help themselves. Moreover, the themes imply gaps in the health care system, namely, health education relative to women's reproductive health needs in this part of the world.

Chapter 5 continues this discussion in four major sections. The first section summarizes the overall research and summarizes the study findings (themes) and conclusions. The last sections are the study's implications and recommendations for future research.

Interpretation of the Findings

This hermeneutic qualitative phenomenological study addressed the treatment-seeking experiences for POP among Ethiopian women aged 30-60 in northwestern Ethiopia. Thirteen themes emerged from the data analysis and relate to gaps revealed in the literature review. The themes provide insight into the experiences explored in the primary research questions, namely the treatment-seeking experiences of women living with POP. The following sections highlight the themes, and the corresponding discussion suggests how this data could inform health promotion practices for this underserved population. Specifically, the study findings extend knowledge for this population related to health behavior needs in relationship to reproductive health. The aim of the discussion is to help practitioners understand how to educate women about the disease so that their suffering is limited, to normalize care and treatment of POP in Ethiopian communities, and to examine the most appropriate and effective medical and social services to balance professional competency and quality of care (see Gjerde et al., 2017). The key findings from this study are organized into categories: (a) factors influencing seeking or delaying treatment, (b)treatment experiences negative-positive, (c) cultural and social belief systems, and (d) burden of the illness**.**

Research Question 1

Category 1: Factors Influencing Seeking or Delaying Treatment

Theme 1: Disease Progression. The progression of the disease and severity of symptoms such as having a heavy foul-smelling drainage, difficulty of walking, dropping of the "womb," and pain around the waist are the main factors relating to disease progression. Most of the women suffered from POP for more than 8 years and chose to isolate from their community due to embarrassment and fear of rejection. The progression of these symptoms influenced women to seek treatment although they did not know what they were seeking treatment for. Many of the participants revealed that as they sought treatment for these POP symptoms, they were not properly diagnosed until much later. Some women reported visiting the doctor several times without an accurate diagnosis, delaying a referral to the women's hospital for effective treatment. Advanced disease progression without proper treatment as experienced by the women in this study aligns with current literature that highlights a lack of awareness of POP in these Ethiopian communities despite women's relatively high risk. High rates of POP persist in developing countries, including Ethiopia in part due to limited health education options to relay risk factors and prevention behaviors (Adefris et al., 2018; Borsamo et al., 2021; Ghetti et al., 2015).

Theme 2: Family Influence. Most of the women stated that after many years of suffering physically and emotionally due to the severity of symptoms of the disease, they disclosed the symptoms to their closest family members such as a mother or siblings.

Many women saw these family members as confidants and people who were most likely to be supportive. Moreover, these are also the people in their lives who were the first to notice women’s loss of productivity (e.g., when daily activities at home and out on the farm became difficult or an impossibility). Although children were reported to offer support their ill mothers, most women said they did not tell them first to prevent them from being worried and stressed. The husband is typically the last person a woman with POP symptoms would disclose to as they suffered severe embarrassment and fear of divorce. However, several women reported that once the husband and other family members learned about their symptoms and disease, they encouraged them to seek care and treatment. They also highlighted that their husband’s approval of seeking care is vital for financial support. Since women cannot travel long distances alone, the husband must become aware of the disease for the woman to begin the journey to the referral hospital.

Theme 3: Fear of Losing Family Connection. Many of the women felt forced to delay seeking treatment due to fear of diminished family connections while away at the referral hospital. As most of the participants mentioned separation from the family, being viewed as less than responsible for home actions and work-related tasks, along with concerns about spending long times in the hospital caused great stress. Fear of losing family connection was also tied to uncertainty of responses from family members after disclosing the disease. Several women explained their concerns associated with having a reproductive health issue and how it could bring shame on the family. Suffering with POP was considered a sensitive and private issue. Women reported fear of losing family support and connection, being chased away from home, feeling “less than a woman,” as well as discrimination and humiliation. There are similar findings in the literature on POP as women expressed fear of stigma and discrimination from their family and community members (Shistu et al., 2023). This fear prevented them from disclosing their health condition and seeking treatment.

Theme 4: Lack of Experience of the Local Providers. The local doctors' lack of experience of POP is also associated with the delay in seeking treatment. Many participants mentioned that local doctors were focused on the presented symptoms, but not the disease as the source of the symptoms. Therefore, doctors gave poor medical advice focused on pain relief and subsequently treated several women with medication to manage pain only. The negligence to the source of the symptoms prolonged effective diagnosis and treatment. Some women stated the medicine reduced the pain for short period of time, whereas others said they continued to suffer with the other symptoms including drainage, dropping of the uterus, and poor mobility. A study conducted in the United Kingdom suggests that lack of awareness of POP among health practitioners may contribute to disease severity, late diagnosis, and limitations of women's possible treatment options (Abhyankar et al., 2019). Whether being treated in local clinics or by private physicians, it is common practice in this region for women to be treated with pain relief injections and ointments which is not a long-term care plan (Gjerde et al., 2018). Feeling discouraged after several attempts at treatment, some chose alternative care or no care due to refusal of the referral to the hospital where they receive appropriate care for POP.

Theme 5: Lack of Awareness of the Disease in the Community. In this region of Ethiopia, discussing private health matters in public is considered shameful and not a common practice in the community. Several participants shared sentiments noting the desire to relate and express their pain and interact with other women in the community suffering with POP. However, since reproductive health matters are not discussed, they did not have the opportunity to share their pain and journey without fear of being judged and humiliated by their neighbors and friends. As some of the women stated they believed the disease is given from God for wrongdoing and should be managed in private by praying or other home remedies. Therefore, due to the lack of awareness of POP as a reproductive health issue that requires medical treatment, non-discussion or talk of holy remedies are commonplace.

The literature on the nature of social awareness of POP supports the idea that treatment often starts by seeking help from church leaders. Specifically, women seek prayer and wash the body with holy water for several days (Gjerde et al., 2018). This social and cultural belief, along with the community not knowing about the disease and women not talking about the disease, renders POP a non-medical matter. Moreover, this lack of awareness supports a thought process that the disease will heal on its own or with the aid of only spiritual remedies. As a result, women delay or do not seek medical treatment for their condition. The evidence of this theme aligns with the study conducted by Dheresa et al. (2018), explaining that only one-third of the women in the region with POP seek medical treatment with an understanding that their condition requires medical care.

The challenge presented by the lack of knowledge is compounded by women being unaware of treatment availability (Shitu et al., 2023). As most women stated, if their POP symptoms remained tolerable as it was during the first few years, they would have kept their symptoms secret is due to the stigma attached to the health condition. Women in this region are minimally proactive in seeking health care services at early stages of POP due to a lack of knowledge of the symptoms, shame, stigma due to cultural influences (Borsamo et al., 2021; Ghetti et al., 2015).

Category 2: Negative–Positive Treatment-Seeking Experiences

Theme 6: Long-Distance Traveling and Multiple Appointments. To understand the women's treatment-seeking experiences, I asked what they encountered that could explain both positive and negative experiences while seeking care. Most participants live in remote areas far away from the referral hospital and lack access to public transportation. As a result, they travel on foot for more than a day when seeking care at the referral hospital. The lack of transportation and the long-distance walk on foot aggravates the pain around the waist experienced with POP and accelerates the odorous drainage. These circumstances make the women feel embarrassed to be around people while traveling. The other challenge is that women cannot travel alone without being accompanied by someone, preferably their husband or relatives, which would require disclosure of the disease. Furthermore, women are responsible for taking care of the children and family, as well as helping their husbands with farming. The women perceived leaving home and needing to travel and be away for long periods of time and inconvenience. Therefore, women delayed seeking treatment to avoid leaving their children behind and interrupting their day today activities and responsibilities. They deferred seeking medical care which often requires multiple appointments and long stays in the hospital.

Theme 7: Meeting Other Women with POP or Similar Disease. A few women noted positive treatment seeking experiences. Several women reported feeling empowered when they shared their experiences with other women, specifically women experiencing a similar illness. Most participants reported fearing judgment, but experienced a sense of belonging and relief when they met another woman with POP. The feeling of not being alone supported a sense of belonging and empowerment to share their illness and seek treatment in the future (Gjerde et al., 2018). The other positive treatment-seeking experiences are related to discussing and hearing about POP treatment. Almost all participants were relieved to meet with other women in the clinic waiting room, hearing about their health condition and how they were silenced for many years. This proved to be a dramatic dichotomy; thinking that they were alone, and it was shameful to disclose to other people, while reconciling connection among other women who are on their healing journey.

Theme 8: Patient–Healthcare Providers Relationship and Interaction. Establishing a caring and trusting relationship between patients and providers is crucial in caring for women with POP disease. This sensitive private matter requires precise and respectful communication for women to understand the disease and open to share about their illness. Women who were treated in the referral hospital expressed a positive experience as the doctors were helpful and knowledgeable, talked to them with respect without judging, and gave them great advice. Furthermore, the providers assured them that the disease was treatable, and they would not give up hope of helping them find relief.

Overall, while sharing their positive treatment-seeking experiences, participants' interviews also shed light on the importance knowing others have similar health issues

Research Question 2

Category 3: Cultural and Social Belief Systems

Theme 9: Trusting God and Traditional Spiritual Remedies. Traditional normative and cultural beliefs that play in the decision to delay treatment for POP among women are far-reaching. Most of the women confirmed that they sought spiritual healing and prayer from priests and elders individually and in groups. Spiritual practices also included washing the body with holy water also called "Tsebel" and washing with leaves to wash out the disease for several days. As women explained, spiritual solutions for the problem are considered a best first step and supersedes seeking medical advice. Seeking spiritual solutions is a widespread practice in rural areas. This study's findings extend the previous research that, women believe POP is a spiritual curse to be dealt with in silence by seeking help from traditional healers (Gjerde et al., 2017; & Theresa et al., .2020). Prayer is common when suffering from POP. Some participants clarified that prayer is sought to ask God that one would be cured rather than needing to seek treatment.

Subtheme 9:1: Rejection. A subtheme of rejection emerged from the main theme Trusting God and Spiritual Remedies. The fear of rejection played a role in women hiding their disease for many years in silence. As hiding a disease is a common social and spiritual practice in Ethiopia, there is a belief that sickness comes from God for doing poorly in life (Gjerde et al.,2018). Most women mentioned that since they do not know about the disease and have not met anyone with the disease in the community, they are not sure how the people in the community will react if they disclose the illness. This theme is noted in the literature as reported by Shitu et al., (2023), fear of rejection and discrimination from the community contributes to hiding the disease for longer times until it has progressed into later stages. Overall, the fear of rejection interacts with "cultural beliefs and community practices..." that prevent women with POP from seeking treatment and receiving care in a timely fashion (Shitu et al. 2023, pg.5).

Theme 10: Social Expectation to Hide the Disease. The choice to hide the disease results from a complicated relationship between social expectations to limit shame on the family, fear of rejection by husbands, losing family, and minimal social support. Masenga, Shayo, & Rasch (2018), reported similar findings that women refrained from sharing reproductive health challenges and discomfort with others due to the shame and stigma attached to POP. The current study extends the current literature existing knowledge confirming that women with POP delay seeking treatment due to social expectation and discrimination. (Shistu et al., 2023). Moreover, Community normative beliefs make it uncommon for women to discuss reproductive health issues publicly. As a result, women isolate themselves from family, friends, and community to avoid embarrassment and humiliation. They are also concerned about the loss of womanhood or being "less than a woman," meaning not being physically able to engage in intercourse when choosing. This limitation also contributes to a fear of divorce and rejection from their husbands.

Research Question 3

Category 4: Burden of Disease

Theme 11: Physical Burden. When asked about the burden of POP in their daily life, most respondents perceived that the physical, psychosocial, and financial burdens are significantly associated with having POP**.** Almost all participants reported that because of severe symptoms of POP, they lost community connection and chose to stay home in isolation, affecting their daily activities. Several women reported missing community activities, not attending church services, and refusing to entertain guests at home as they used to do before their illness**.** The constant pain that gets worse during ambulation and the womb dropping out and staying out for long periods of time inhibits them from doing any physical activities outside, like helping their husbands with farming. Moreover, some women were forced to walk bending forward because of the pain. This is an example of how the physical pain forced visual acknowledgement and exposure to illness and several women noted embarrassment as others gawked or stared at them. As these physical burdens compound, women endure a loss of identity and normalcy. (Toye et al., 2020).
A study by Wang et al. (2022) reported similar findings about the disruption of quality of life and how POP affects women's social and personal activities. In general, this study gave insight into the gravity of physical symptoms, related to both pain and physical appearance, that causes embarrassment, shame and feelings of the need to isolate.

Theme 12: Psychosocial Burden. The psychosocial burden is unbearable for women affected by POP. As stated by Teal (2020), "in Ethiopia, pelvic floor disorders have a negative impact on women, emotional stability and quality of life (p.2).” As the women talked about how POP changed their lives for the worse, some regretted delaying treatment; however, the lack of emotional support from their husbands prevented them from feeling safe disclosing the illness. Some expressed feeling “less than a woman” as their husbands disparage them for being sick and always staying home. Others said the POP illness and the emotional strain are so bad that they wished not to see other women suffering from this illness. Specifically, they stated it is better to die in peace than to live with the condition. This dramatic and devastating emotional reality emerges from a loss of identity, not feeling like a woman due to reproductive health challenges, and loss of intimate relationships with husbands. Women are left feeling emotionally vulnerable resulting in loneliness and low self-esteem.

Theme 13. Financial Burden. The financial burden of POP is a theme that emerged and has ties to =delayed treatment and care. diagnosing POP is one of the few reasons affecting participants’ relationship with their husband. Living with POP affects women’s ability to work and reduces their earning potential. This problem is compounded by the extended time associated with multiple visits to the hospital and long-distance traveling. Long-distance traveling to referral hospitals for multiple appointments takes women and families away from work. Moreover. Many of these visits require staying in a hotel, which increases the financial burden. These findings are supported by another study in southern Ethiopia (Shitu et al.,2023), which reported that women with financial constraints are six times more likely to delay treatment. Overall, the financial burden is experienced mostly due to travel and disruption from daily work activities, rather than the actual treatment itself.

Connection With the Theoretical Framework

The hermeneutic phenomenological framework has been chosen as the theoretical framework to explore how Ethiopian women make sense of their treatment-seeking experiences while framing the challenges and the driving forces to seek treatment for POP.

This study's findings revealed that women with POP suffered physically and emotionally for many years in silence without seeking treatment because of many factors or challenges, such as stigma and shame associated with the disease, lack of knowledge, diagnosis, and treatment of POP. Other challenges revealed in this study are the delayed referral to referral hospitals by the local doctors due to lack of experience with POP and minimal skills of the local doctors in clinics from remote areas. The phenomenological framework guided me as a researcher to explore women's direct experiences of seeking treatment for POP through their thoughts and feelings and understand how these women construct their realities or worldview with the disease (Burkholder et al., 2016). Also help us understand how and what these women experienced while seeking treatment for this disease (Neubauer et al., 2019). Although all women have POP in common, this study framed their shared experiences while highlighting their individual treatment-seeking dynamics and characteristics.

Extension of Knowledge

Although significant contributions have been made to POP research, Ethiopian women's treatment-seeking experiences and behaviors relative to POP have been minimally investigated (Gjerde et al., 2018). Specifically, there is limited research describing how Ethiopian women experience life with POP and minimal description of the driving forces and possible challenges related to seeking treatment for the condition. In times where the priority to address women's health needs more comprehensively is a global conversation, this research seeks to add to the discussion by highlighting the necessity for these women's experiences to be detailed.

Insights from this study revealed factors such as the lack of knowledge of the disease, lack of support from the spouse, fear of financial constraint associated with treatment-seeking, and lack of knowledge and experience with POP among local health providers contributing to delaying seeking treatment. The study also identified the factors associated with positive treatment-seeking experiences such as the hope of knowing that POP is treatable, feeling relieved that they are not alone in suffering from POP, and fostering good communication and relationship with the healthcare providers at referral hospitals.

As there is limited research investigating the lived experiences of Ethiopian women with POP, this research design specifically focused on learning the challenges and characteristics associated with seeking treatment. Women who suffered from POP for many years were significantly negatively affected by severe pain and foul, odorous drainage and yet chose to be silent due to shame and stigma associated with the sensitive nature of the disease. The characteristics of suffering in this study relate to extended physical discomfort due to living with advanced stages of the disease. The findings paint a picture of desperate choices women are making while living with this disease and in many cases, women are choosing to suffer in silence. Therefore, women's stories are a pathway for understanding the depth of their suffering and, therefore, the depth of the response required by health educators and health care professionals.

The findings affirm the need to develop comprehensive, culturally competent health education programs about POP for women living in this area of Ethiopia. Professional development focused on POP care for health educators and health care professionals in this region would allow them to better manage the cultural, social, and spiritual elements that interact with a woman's actions related to acknowledgement of and treatment for POP. This study's findings support the need to increase accessibility and availability of healthcare facilities equipped with the proper diagnostic and treatment modalities for POP. Moreover, improving referral systems between local doctors and referral hospitals, while considering the impact of support groups in the referral hospital would allow the women to share their experiences, encounter health educators who can clearly explain treatment options and become more autonomous in their treatment choices.

This study seeks to contribute to the well-being of Ethiopian women by way of reducing suffering from the disease. At the root of suffering is the necessity to hide symptoms and illness progressions. Specifically, the data offers a deeper understanding of how the stigma associated with reproductive health issues influence treatment seeking at an early stage of the disease. The goal is for women to be able to openly express their symptoms without fear of shame or embarrassment, seek care in areas where providers are knowledgeable of POP, and to suffer less physically, emotionally, and financially as a result of earlier treatment. facilitate open conversations about POP and treatment availabilities in the area.

Study Limitations

A potential limitation of this study is the age of the participants, which may or may not represent fully the intended age range of 30-60. For this study, the average age is 44, with 3 participants in their 30's, most participants between 40 to 50 years of age, and one 60 years of age. It is possible that different themes could have emerged if more participants in the sample were in their 30s or 60s. Also, purposive sampling was employed as part of the recruitment process. This could present a limitation when considering the collective voice of women in the region, many of whom had yet to make it to the referral hospital for treatment. Anticipated constraints associated with accessibility and hiding the disease informed my choice to recruit participants at the referral hospital. Future studies should focus on expanding the age range to hear from women in their 30's and to consider expanding recruitment into areas away from medical facilities.

Recommendations for Future Research

As there is limited research that investigates the lived experiences of Ethiopian women with POP, this phenomenological study's findings added to the existing literature by expressing participants' personal lived experiences with POP, the challenges encountered while seeking treatment and the driving forces related to decision making when deciding to seek treatment for POP. Several important themes were identified, and gave voice to women living with the shame, embarrassment, and the physical and psycho-social ramifications of progressed POP. Future studies should continue asking critical questions related to social and cultural context and reproductive illness to better understand the interactions between community expectations and treatment seeking decisions. While this study revealed some of those challenges, it does not explore the root causes and the scope of the study does not imply a resolution to mitigate them. Recruitment of available participants resulted in a narrow age range with the average age of 44 years. There were limited participants representing the 30s and 60s age group. Phenomenological studies focus mostly on whether the participant is a representative of the phenomenon in question. To that end, the sample is representative. .To encourage more voices to be heard, future studies should focus on expanding the age range to hear from women in their 30s and 60s and to consider expanding recruitment into areas away from medical facilities.

Accessibility to culturally competent healthcare services with experienced and knowledgeable providers is also needed for women living in this part of Ethiopia. Future research should consider the knowledge and professional development needs of the healthcare community in these Ethiopian communities. Culturally skilled and educated community health educators must be available to educate and be a resource for women needing support. Health educators can act as advocates to encourage women to learn the symptoms of POP, know the treatment options, and to seek treatment earlier. Given the cultural and spiritual constraints associated with seeking medical care noted in this study, future research should look to determine best practices associated with health education in these communities. This could lead to earlier intervention, which could help alleviate the financial constraints noted in the study population.

Implications for Positive Social Change

Social change is an ongoing process that happens in every society. Only a few studies have endeavored to give Ethiopian women suffering with POP a voice to express their experiences. Therefore, this study supports social change by continuing the conversation on behalf of marginalized women in Ethiopia. Specifically, the hope is that this study will contribute to how women will speak about their experiences with POP to reduce shame and hiding the disease. Only a few studies have endeavored to give Ethiopian women suffering from POP a voice to express their treatment experiences. This study affirms the social pathways for women to share their positive and negative experiences without feeling embarrassment and shame.

Additionally, women are affirmed by the acknowledgment of their symptoms. This study offered a space for such acknowledgment. Therefore, the study supports the empowerment of these women to continue the conversations about their experiences with the disease and how it has impacted their lives. This empowerment could lead to greater acceptance and disclosure among women in their communities.

This study further supports social change by promoting a shift in healthcare service expectations in this region of Ethiopia. This study affirmed the need for improved professionalism and practical knowledge about POP among healthcare professionals in Ethiopia. The data implied the need for increased training and delivery of comprehensive reproductive health care for women in this area. Social expectations of improvements in health care are emerging and will continue to rise as more women understand the value of this level of care. Overall, the knowledge gained from this study will enable health educators to advocate for establishing a national policy to develop comprehensive and culturally appropriate health education about POP and women's reproductive health in Ethiopia.

Conclusion

My ultimate goal is that the findings of this research study will contribute to the knowledge that exists and provide enlightenment about the journey of Ethiopian women dealing with POP and their challenges while seeking treatment. The study findings highlight how POP affects quality of life, and how factors related to culture, family, social awareness and normative beliefs, and health care quality interact with their treatment seeking processes. This research served to give voice to women who were living in silence and some in shame with an illness that is treatable. The research process resulted in crucial information that health educators can use to advocate for better training for healthcare providers and widespread improvements to health education processes in critical areas. Furthermore, the voices of the women in this study present a call to action to policymakers, spiritual leaders, community leaders, and key agencies to understand POP and its impact on health and wellbeing to examine national health policy to improve the quality of women's lives by addressing the factors associated with delaying treatment in this region of Ethiopia.

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Appendix: Interview Guide

Hello, my name is Frehiwot Derso and I am a Ph.D. student from the USA. Before we begin the interview, thank you for giving me permission to interview you. As mentioned earlier, the purpose of my study is to explore and understand the treatment-seeking experiences of Ethiopian women aged 30-60 diagnosed with Pelvic Organ Prolapse. I hope to learn as much as I can so that I can provide information to care providers in this area to better assist women like you. I will be asking you a series of questions and you are free to answer in any way you wish. Please feel free to elaborate as much as you like when answering the questions. If a question is unclear to you, please ask me to explain it further. The length of this initial interview will be up to 90 minutes (about 1 and a half hours) followed by a 20-minute refreshment break. The follow-up member check interview will take up to 30 minutes and during this time you will be asked to add any additional information you might have and to confirm the completeness of certain responses. I will audio record the interviews so that I do not miss anything you say. I also will be taking some notes during the interview session to make sure I capture all your responses. Your name will not be included on any of these recordings or writings and all information will be kept confidential. If at any time you feel uncomfortable, we can stop the interview. Also, a staff nurse is on standby just in case you feel uncomfortable and need further assistance.

You have signed the informed consent which relays your willingness to complete the following interview. As a reminder, your care and treatment here at the referral hospital will not be affected by your participation in this study. Do you have any questions about informed consent? If you do not have questions let us begin. May I start the recording now?

Step 1- Initial Interview (90-minutes)

Questions Related to Demographic Data;

1. Age
2. Educational status--

   What is the highest level of education obtained?
3. Occupational status

   How do you describe your occupational or work status?
4. Marital status-

   Are you currently married/single/divorced/widow?
5. Reproductive Health Questions

   Do you have children? How many?

   Number of pregnancies?

   Age at first delivery?

   Delivery place-- home or hospital?

   Distance to your home from the hospital?

   Age and date of diagnosis for POP?

   Age and date of first symptoms of POP?

(Follow-up; note the amount of time between age/date of first symptoms and age/date of diagnosis and confirm this amount of time with the participant).

Are other reproductive health issues other than POP?

Semi structured Interview Questions

SRQ1. What driving forces influence decision-making to seek or delay POP-related treatment among Ethiopian women aged 30-60?

1. What motivated you to seek medical care for POP?
2. Why do you think you developed POP?
3. Of the times you have sought treatment, what did you like most about your experience of seeking care?
4. Of the times you have sought treatment, what do you like least about your experience of seeking care?
5. What made you decide to seek treatment at the referral hospital?
6. Describe your understanding of your POP?
7. I see that there was ______ (weeks, months, years) between the onset of your symptoms and your first attempt to seek treatment. Why did you wait to seek treatment?
8. How did you manage or choose to care for any reproductive illness before being diagnosed with POP?

SRQ2. What role do social and cultural normative beliefs play in the decision to seek or delay POP-related treatment among Ethiopian women aged 30-60?

9. Have you sought traditional medicine for POP? If yes, what did that include?
10. Could you tell me about your feelings about seeking medical treatment for POP?

11. Have you sought help anywhere else before you came to the hospital? If yes, where, and how often? Describe those experiences.
12. To whom have you disclosed your diagnosis of POP? (Follow-up; Is there a reason person “A” and no person “B” ？）
13. Have you disclosed your diagnosis with other women in the community? (Follow up; What made you feel comfortable or uncomfortable with disclosing diagnosis or discussing the condition with other women?)
14. Describe how you are being treated by your family and friends since disclosing your diagnosis?

SRQ3. What are the challenges associated with daily life because of POP diagnosis that interacts with the decision to seek or delay treatment among Ethiopian women aged 30-60?

15. How has your daily life been affected by your POP diagnosis? (Follow-up; family responsibilities, work responsibilities, community responsibilities)
16. How does having POP affect your relationship with your family, friends, and other people close to you? (Follow-up; husband [if married], children)
17. How has seeking care affected your daily life? (Follow-up; What has gone well? What was the hardest part of seeking care as it relates to your daily life?)
18. How has your life changed since you were diagnosed with POP?
19. Describe what it is like to live with POP in your community?

20. Is there anything else you would like to tell me about your experience of seeking care before we close the interview?

End of Initial Interview

We have now concluded the initial interview. I would like to thank you again for allowing me to interview you. Just to remind you, as we discussed during the written consent process the information shared with me is confidential. Please call me on my personal phone number with any questions you might have.

You will now be provided with a 20-minute refreshment break. Feel free to walk about, have refreshments, and I will call you back when it is time to finish the last phase of the interview.

Phase 2- Break (20 minutes)

Begin 20-minute break

The researcher reviews field notes to determine additional questioning for the 30-minute follow-up.

Phase 3- Follow-Up (30 minutes)

Welcome back to the interview room. The next 30 minutes are designed to allow us to review your interview responses. The purpose is to make sure I have accurately recorded your replies and for you to ask any questions you might have. Are you ready to start the 30-minute follow-up?

Phase 4- Conclusion and Exit the Study

Thank you for completing the interview process for this study. Your participation is appreciated. Do you have any questions for me? If you have any questions after today, please contact me on 94 435 2074.

Follow-Up Interview Protocol

Hello, thank you for returning to our follow up interview session today. This follow-up interview clarifies some of your responses from our first interview. Also, to confirm your responses to the initial interview is recorded accurately. As we disused during the initial interview. I will audio record the interviews so that I do not miss anything you say. I also will be taking some notes during the interview session to make sure I capture all your responses. The length of this follows up interview will be 30 minutes. Do you have any questions about the information you have just received? If you do not have questions let us begin. May I start the recording now?

We now have concluded the follow-up interview. I would like to thank you again for allowing me to interview you. Just to remind you, as we discussed during the written consent process the information shared with me is confidential. Please call me on my personal phone number with any questions you might have.

የቃለ መጠይቅ መመሪያ (Interview Guide)

ጤና ይስጥልኝ፡፡ ፍሬህይወት ደርሶ እባላለሁ፡፡ ለዶክትሬት ዲግሪዩ እየተማርኩ ሲሆን ነዋሪነቴም አሜሪካ ነው፡፡ ቃለ ምልልሱን ከመጀመሬ በፊት፣ ሊተባበሩኝ ስለፈለጉ ላመሰግን ፈልጋለሁ፡፡ ቀደም ሲል እንደገለጽኩት፣ የጥናቴ ዓላማ፣ በፔልቪክ ኦርጋን ፕሮላፕስ በተባለው በሽታ የተጠቁ፣ እድሜያቸው ከ30-60 የሚሆኑ ኢትዮጵያውያን ሴቶችን በማናገር፣ የምርምር ስራ ማካሄድና ለበሽታው መፍትሄ መፈለግ ነው፡፡ በዚህ ሂደት ብዙ ትምህርት ቀስማለሁ ብዬ ተስፋ የማደርግ ሲሆን፣ ትምህርቱና መረጃው ላይ በመመስረት በየአካባቢያችሁ የሚገኙ ባለሙያዎች፣ ለእናንተ ለሴቶች የተሻለ እርዳታ ሊያደርጉላችሁ ይችላሉ፡፡ በርከት ያሉ ጥያቄዎች የምጠይቃችሁ ሲሆን፣ በመሰላችሁ መንገድ ልትመልሷቸውና ነፃ ሆናችሁ መመለስና ማብራራት ትችላላችሁ፡፡ ጥያቄዎቹ ግልጽ ካልሆኑ፣ እንዳብራራላችሁ ጠይቁኝ፡፡ የመጀመሪያው ቃለ ምልልስ 90 ደቂቃ የሚፈጅ ሲሆን፣ የ20 ደቂቃ መዝናኛ ጊዜ ይኖራል፡፡ በቀጣዩ የ30 ደቂቃ ቃለ ምልልስ፣ የተረሱ፣ የሚጨመሩ፣ ልክ ያልሆኑ ወይም ይበልጥ መብራራት ያለባቸው ጥያቄዎች ላይ ትኩረት ይደረጋል፡፡ ምንም ነገር እንዳይረሳ፣ ቃለ ምልልሶቹ ይቀረጻሉ፣ ማስታወሻም እወስዳለሁ፡፡ በቀረፃው ላይ ስማችሁ አይካተተም፣ የሰጣችሁኝ ማስረጃዎች ምስጢርነትም የተጠበቀ ይሆናል፡፡ ተጨማሪ እርዳታ ስትፈልጉ፣ መልስ ለመስጠት የምትችል ነርስ አጠገባችሁ ሆና መልስ ልትሰጣችሁ ትችላለች፡፡ ቀጣዩ ቃለ ምልልስን በፈቃዳችሁ እንዳደረጋችሁ የሚገልጸው የስምምነት ሰነድ ላይ ፊርማችሁን ታሰፍራላችሁ፡፡ ላስታውስ የምፈልገው፣ በዚህ ቃለ ምልልስ ምክንያት በሀኪም ቤቱ የምታርጉት ህክምና አይስተጓጎልም፡፡ ወዳችሁ በምታደርጉት ቃለ ምልልስ ላይ ጥያቄ አላችሁ? ካልሆነም፣ ስራችንን እንጀምር፡፡ ድምጻችሁን መቅረጽ ልጀምር?ከማንነት ጋር የተያያዙ መረጃዎች፤

1. እድሜ?
2. የትምህርት ደረጃ፤ የደረስሽበት ከፍተኛ የትምህርት ደረጃ?
3. ስራ፣ ምን ዓይነት ደረጃ እንደሆነ ማብራራት ይቻላል?
4. ትዳር፣ ባለትዳር ነሽ/አላገባሽም/ፈት/ነሽ?
5. ከቤተሰብ ግንባታ ጋር የተያያዙ ጉዳዮች፤
    a. ልጆች አሉሽ? ስንት ልጆች?

b. ስንት ጊ\ዜ አርግዘሻል?

c. በስንት አመትሽ የመጀመሪያውን ልጅሽን ተገላገልሽ?

d. የት ወለድሽ? ቤት ወይስ ሀኪም ቤት?

e. በሀኪም ቤቱና በቤትሽ መሀል ያለው ርቀት ምን ያህል ነው?

f. ፒኦፒ የተባለው በሽታ እንዳለብሽ መቼ ታወቀ?

g. የፒኦፒ የመጀመሪያው ስሜትሰ? (ተከታይ ጥያቄ፤ የፒኦፒ የመጀመሪያው ስሜትና በሽታው እንዳለባት መቼ እንደታወቀ ማገናዘብ)

ከወሊድ ጋር የተያያዙ ጥያቄዎች

1. ልጆች አሉሽ? ስንት?
2. ስንት ጊዜ አርግዘሻል?
3. ስንት አመትሽ ነበር የመጀመሪያ ልጅሽን ስትገላገይ?
4. የት ተወለደ/ች? ቤት ወይስ ሀኪም ቤት?
5. በቤትሽና በሀኪም ቤቱ መሀል ምን ያህል ርቀት አለ?
6. ፒኦፒ እንዳለብሽ መቼ ታወቀ?
7. ምልክቱ መቼ ታየ? (ተከታይ ጥያቄ፣ ምልክቱ መጀመሪያ ላይ በታየበትና ምርመራ በተደረገበት ጊዜ ያለውን ማገናዘብና ከተሳታፊው ማረጋገጥ)

ከፒኦፒ ሌላ፣ ከወሊድ ጋር የተያያዙ ጥያቄዎች

ከፊል-ቅርጽ የያዙ የቃለ ምልልስ ጥያቄዎች

ከቅ1. ከ30-60 እድሜ ክልል ውስጥ ያሉ ኢትዮጵያውያን ሴቶችን፣ ከፒኦፒ ጋር የተያያዙ በሽታዎች ላይ እንዲወስኑ ሊገፉፉ የሚችሉ ምን ምክንያቶች ሊኖሩ ይችላሉ?

1. ፒኦፒን በተመለከተ ህክምና ለመውሰድ ምን ሊገፋፋሽ ቻለ?
2. ፒኦፒ እንዴት ሊይዝሽ የቻለ ይመስልሻል?
3. አርዳታ ከፈለግሽበት ጊዜ አንስቶ፣ ከተከታተልሻቸው ህክምናዎች የትኛውን ነበር የወደድሽው?
4. አርዳታ ከፈለግሽበት ጊዜ አንስቶ፣ ያልወደድሽው የትኛውን ህክምና ነው?
5. ሀኪም ቤቱ በመሄድ ህክምና እንድትከታተይና ውሳኔ ላይ እንድትደርሺ የረዳሽ ምን ነበር?
6. ስለ ፒኦፒ ያለሽን ግንዛቤ ንገሪኝ እስቲ?
7. የመጀመሪያውን ምልክት ባየሽበት ጊዜና ህክምና በጀመርሽበት ጊዜ መሀል......... (ሳምንታት፣ ወራት፣ አመታት) አልፈዋል፡፡ ለምን ያን ያህል ጊዜ አባከንሽ?
8. ፒኦፒ እንዳለብሽ ከመታወቁ በፊት፣ ከወሊድ ጋር የተያያዙ ህመሞችን እንዴት ልትቋቋም ቻልሽ?

ከቅ2. እድሜያቸው ከ30-60 የሚሆኑ የፒኦፒ በሽታ ያለባቸው ኢትዮጵያውያን ሴቶች ውሳኔ ላይ ለመድረስ፣ ተጽእኖ ሊያሳድሩ የሚችሉ ማህበረሰባዊም ሆነ ባህላዊ እምነቶች ምን ሚና አላቸው?

1. ከፒኦፒ ለመፈወስ ባህላዊ መድኃኒት ሞክረሻል? ከሆነም ምን ዓይነት መድኃኒት ነበር?
2. ፒኦፒን በተመለከተ ህክምና ለማድረግ ስታስቢ ምን ስሜት ተሰማሽ?
3. ወደ ሀኪም ቤቱ ከመሄድሽ በፊት ሌላ ህክምና ለማድረግ ጥረት አድርገሽ ነበር? እስቲ ግለጪያቸው፣
4. ፒኦፒ እንዳለብሽ የነገርሽው ሰው አለ? ለምን እሱን/እስዋን መረጥሽ?
5. ስለበሽታሽ በአካባቢሽ ለሚኖሩ ሴቶች ገልጠሻል ወይስ አልገለጥሽም? (ለምን እንደዚያ ልትወስኚ ቻልሽ?)
6. ስለበሽታሽ ከገለጽሽላቸው በኋላ፣ ቤተሰቦችሽም ሆነ ጓደኞችሽ እንዴት ተንከባከቡሽ?

ከቅ3. እድሜያቸው ከ30-60 የሚሆኑ የፒኦፒ በሽታ ያለባቸው ኢትዮጵያውያን ሴቶች ህክምና ለማድረግም ሆነ ለማዘግይት ምን የህይወት ተግዳሮቶች ገጠሟቸው?

1. የፒኦፒ በሽታ እንዳለብሽ መታወቁ የዕለት ከዕለት ህይወትሽ ላይ ምን ተጽእኖ አሳድሯል? (የቤተሰብ፣ የስራ፣ የማህበረሰብ ኃላፊነቶች)
2. የፒኦፒ በሽታ እንዳለብሽ መታወቁ ከቤተሰብሽ፣ ከጓደኞችሽና ከሌሎች ሰዎች ጋር ያለሽ ግንኙነት ላይ ምን ተጽእኖ አሳድሯል? (ባለቤት [ባለትዳር ከሆንሽ [፣ ልጆች)
3. እርዳታ መሻትሽ ህይወትሽ ላይ ምን ተጽእኖ አሳድሯል? (ምን ደህና ነገር ተፈጠረ፣ የዕለት ከዕለት ኑሮሽን በተመለከተ ከባዱ ነገር ምን ነበር?)
4. የፒኦፒ በሽተኛ መሆንሽን ካወቅሽ በኋላ ህይወትሽ ተቀይሯል?
5. በማህበረሰቡ ውስጥ የፒኦፒ በሽተኛ ሆኖ መኖር ምን ሊመስል እንደሚችል ግለጪልኝ እስቲ?
6. ቃለ ምልልሱን ከመቋጨታችን በፊት ልምድሽን በተመለከተ ልትነግሪኝ የምትፈልጊው ተጨማሪ ሃሳብ አለሽ?

ቃለ ምልልሱ አበቃ

የመጀመሪያው ክፍል ተጠናቋል፡፡ ስለተባበርሺኝ አመሰግናለሁ፡፡ ቀደም ሲል እንደገለጽኩት፣ ይህ ቃለ ምልልስ ምስጢር ሆኖ ይቆያል፡፡ ጥያቄ ካለሽ፣ በግል ስልኬ ደውይልኝ፡፡ የ 20 ደቂቃ ቡና ና ሻይ እረፍት አለ

ደረጃ 2 (20 ደቂቃ) እረፍት

**(20 ደቂቃ) እረፍት ተጀመረ **

ተመራማሪዋ ለ 30 ደቂቃ ክትትል ተጨማሪ ጥያቂዎችን ለመወሰን የመስከ ማስታወሻዎችን ትገመግማለች፡

ደረጃ 3- ክትትል (30 ደቂቃዎች)

እንኮን ወደ ቃለመጠይቁ ክፍሉ ተመልሰሽ በደህና መጣሽ፡ የሚቀጥሉት 30 ደቂቃዎች የቃለ መጠይቅ ምላሾችን ለመገምገም የሚያስችሉ እኛን ለመፍቀድ የተነደፉ ናቸው. ዓላማው ትክክለኛነትሽን በትክክል መመዝገብሽን ማረጋገጥ እና ሊኖርሽ የሚችሏቸውን ማንኛውንም ጥያቄዎች መጠየቅን ማረጋገጥ ነው. የ 30 ደቂቃ ክትትል ለመጀመር ዝግጁ ነሽ?

ደረጃ 4- ማጠቃለያ እና ከጥናቱ መውጫ

ለዚህ ጥናት ቃለ መጠይቅ ሂደቱን ስለጨረሽ አመሰግናለሁ。 የአንች ተሳትፎ በእጅጉ አድናቆት አለው。 ለእኔ ጥያቄዎች አለሽ？

ከዛሬ በኋላ ማንኛውም ጥያቄ ካለሽ እባክሽን በ 94 43 535 2074 ላይ አነጋግሪኝ.

<u>የተከታታይ - ቃለ መጠይቅ ፕሮቶኮል</u>

ሰላም ዛሬ ወደ ተከታያችን ቃለ መጠይቅ ስብሰባው ስለተመለሽ አመሰግናለሁ፤ የዚህ ቃለ ምልልስ ዓላማ ከቃለ መጠይቅዎቻችን የተወሰኑትን አንዳንድ ምላሽዎን ለማብራራት ነው. ደግሞም, ስለነበሩት የመጀመሪያ ቃለመጠይቅ ምላሽዎን በትክክል ማረጋገጥና በትክክል መመዝገቡን ለማረጋገጥ ነው፡፡

በመጀመሪያ ቃለ ምልልስ ወቅት እንደተነጋገርነው የምትሉት ነገር እንዳያመልጥ ድምፃዊ ቀይሶችን እወስዳለሁ。 እኔ ሁሉንም ምላሾችሽ መያዙን ለማረጋገጥ በቃለ መጠይቅ ስብሰባ ላይ እኔ የተወሰኑ ማስታወሻዎችን እወስዳለሁ。 የዚህ ቃለ ምልልስ ርዝመት30ደቂቃ ይሆናል。 አሁን ስላገሽው መረጃ ጥያቄዎች አለሽ？ ጥያቄዎች ከሌለሽ እንጀምር。 ፡ ቀረፃውን አሁን መጀመር እችላለሁ？

እኛ አሁን ተከታዩን ቃለ መጠይቅ አደረግነው. ቃለ-መጠይቅ እንድሰጥ በመፍቀድሽ እንደገና አመሰግናለሁ. በጽሑፍ ስምምነት በተደረገበት ጊዜ እንደተነጋገርነው ለማስታወስ ብቻ በቃሌ የተካተተ መረጃ ሚስጥራዊ ነው. ሊኖርሽ ከሚችሉት ጥያቄዎች ጋር እባክሽን በግል የስልክ ቁጥር ደውይልኝ.