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Barriers in Early Seeking a Diagnosis and Treatment among Women with Uterovaginal Prolapse, Gumer District, Central Ethiopia: A Qualitative Study

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ABSTRACT

Background: *Although early diagnosis and treatment options are available, many women arrive at health facilities late with an advanced stage of uterovaginal prolapse. This delay not only exacerbates physical discomfort but also their mental, emotional, and social life and the management of the case itself and its complications. However, research about their delaying factors in seeking is limited in the study district. Therefore, this study aimed to explore the barriers in early seeking of a diagnosis and treatment among women with uterovaginal prolapse, which can help in prevention interventions.*

Methods: *A qualitative study using a phenomenological study design was conducted between September 2025 and January 11, 2026, in Gumer District, Central Ethiopia. Twenty-seven participants with advanced uterovaginal prolapse were purposefully selected and interviewed in-depth until data saturation was achieved. Then the interviews were first transcribed and coded, and categories and themes were generated by applying thematic analysis.*

Findings: Three major themes, personal, clinical, and social, were identified as the barriers in early seeking of a diagnosis and treatment among women with uterovaginal prolapse.

Conclusion: *Barriers to early diagnosis and treatment of uterovaginal prolapse in women are systemic, linked to patients, community, and the respectful care behaviors of health professionals. Developing culturally sensitive and inclusive programs for patients, families, and health systems is essential to address these barriers. Furthermore, additional multi-perspective research involving spouses, families, communities, health professionals, and health service leaders is critical for effectively overcoming these challenges.*

Keywords

Fear, Uterovaginal prolapse, Gumer District.

Abbreviations

UVP: Uterovaginal prolapse (UVP), POP-Q: Quantitative Pelvic Organ Prolapse, HIV: Human Immunodeficiency Virus, SDGs: Sustainable Development Goals.

Introduction

Utero-vaginal prolapse (UVP) is a gynecological condition where the uterus and cervix sag or drop into the vagina, often due to weakening of pelvic floor muscles and ligaments [1,2]. It is more prevalent and severe in low-income countries, influenced by factors such as early marriage, multiple childbirths, limited obstetric care, aging, menopause, injury, chronic infections and malnutrition [3-7]. Its symptoms could include vaginal pressure, bulging, a sensation of organs descending, urinary incontinence or retention, and back pain [5,8]. UVP staged as mild (uterus drops into the upper vagina), moderate (uterus descends near the vaginal opening), advanced (uterus/cervix outside the vaginal opening),

and complete or procidentia (entire uterus outside the vaginal opening) [8]. Treatment options range from pelvic floor exercise (Kegels) and vaginal pessaries (support devices) for mild cases to surgery (hysterectomy) for severe cases, with early detection being key to effective management [6,9,10].

Uterovaginal prolapse (UVP) adversely affects women by causing discomfort, urinary incontinence, and decreased sexual function, leading to psychological distress and diminished quality of life [6,8]. As symptoms escalate, surgical intervention may become necessary, though these procedures carry their own risks [11]. UVP also restricts daily activities due to associated pain and anxiety about worsening conditions, impacting mobility and household tasks [7]. Furthermore, it is linked to various complications, including pelvic and lower back pain, urinary urgency, constipation, and challenges with prolonged standing or walking [7,8].

Early detection is crucial for managing UVP, yet many present with advanced stages due to delays in seeking treatment [6,8]. These delays aggravate physical and mental distress and complicate case management [7,8]. Research into the causes of these delays is scarce and predominantly quantitative [12,13].

The estimated global status of UVP is between 2 and 20% [14]. The estimated status of UVP in upper-middle- and high-income countries ranges from 9.23% to 53% [15]. The status of UVP in low- and lower-middle-income countries ranges from 10% to 93.4%, and the level of health-care-seeking behavior among women with UVP is low in low-income countries [16].

The status of UVP in Ethiopia shows 23.53%; women with UVP delay seeking care for an average of 50.6 months, and 78.7% never consult doctors about their condition [6,17]. A study in southern Ethiopia indicated that 82% of women facing UVP came for delayed treatment, and the reasons for the delay were feeling shameful to disclose, fear of stigma and cultural and spiritual beliefs [12]. Another study explored 84.6% of women with UVP treatment delayed to start the treatment, and their delay was associated with a lack of support, low income and fear of social stigma [13]. Of Ethiopian women with UVP, 52.07% have poor quality of life, highlighting a major health burden [18]. The common barriers are stigma, low awareness, and poor access, which hinder timely care and worsen UVP outcomes, and the common factors are age, parity, obesity, and mode of delivery [18,19]. Despite the availability of community health extension workers for local awareness, and early diagnosis and treatment of UVP in health centers, women in the study district often seek care at advanced stages of UVP. But the reasons for this delay are not well-explored, highlighting the need for qualitative research to explore these barriers. Understanding these factors is crucial for developing preventive interventions and improving service utilization, thereby reducing morbidity and mortality associated with UVP among women.

Methods

Study Area and Design

The study conducted in Gumer district, which is located in the central region of Ethiopia. It is 65 km from Wolkitie town, the capital of the Gurage zone (zones are a 2nd level subdivision of Ethiopia, below regions and above districts) and 220 km from the Ethiopian national capital, Addis Ababa. Most of the district lies in the Dega agroecology zone (72 %), whereas the rest is in the Woina Dega Zone.The district covers an area of 25,352 hectares and agriculture is the dominant land-use type and Ensete (Ensete ventricosum) is a dominant food crop with many types in the district (Gumer District Agriculture Office, 2025). There are 18 rural kebeles (the smallest political administration units in Ethiopia) with 10501 total population, with no hospitals, four public health centers, three Comprehensive band 15 basic health posts and 2 small urban towns(Bad and Bole) [13].

The study was conducted between September 2025 and January 11, 2026. The study design for this study was a qualitative, semi-structured interview with individual participants. This approach was chosen because this research method allows researchers to more fully understand the barriers of participants and because data analysis is more likely to remain true to participants' accounts and contribute to ensuring the researchers' own interpretations are transparent [20,21].

The semi-interviews were undertaken in the local language (Amharic and Guragigna) by two of the co-authors, who are from Numerous District, Ethiopia, and are familiar with the community of women. A thematic analysis was used to define themes using a six-step approach: 1) developing familiarity with the data through reading and reflection; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining themes; and 6) reporting themes [22,23]. The Standards for Reporting Qualitative Research check-list guided all components of the writing and reporting of this study.

Selection of Participants and Recruitment

The participants were recruited using a purposive sampling technique. Participants were identified through information taken from their registration (Gumer District Health office, which is collected all over 18 kebebeles through four health centers and covers their treatment cost making anual agreement with Atat Hospital) asked their volunterness before they enter treatment (either surgery or medication) while waiting their turn to get Obygyne OPD in Atat Hospital. Twenty-seven participants with UVP (3rd and 4th degree) were involved in the interview, because this was the point at which data saturation was reached. Participants in the all-rural districts were interviewed after obtaining their verbal informed consent and all information obtained was kept confidential during all stages of the study. The collected data were used only for the purpose of the study. Participants were eligible to participate in the study if they were 3rd and 4th degree UVP. However, those who were severely ill or non-volunteers for the interview were excluded.

Data Collection Methods

The qualitative data were collected by conducting an in-depth interview using a guide among purposively selected women who were delayed for at least 12 months before starting the treatment and diagnosed with an advanced stage of prolapse (3 and 4the degree UVP). The interview guide was adapted from works of literature [12,13] and voices were recorded during an interview and short notes were taken, when necessary, from the interviewees.

Data collection tools

A semi-structured interview guide, audio recording, and field notes were used to gather the data. An interview guide was used, translated into local language (Amharic), and designed by qualitative experts. The interview guide was unbiased and not a lead-in. The interview guides are available in the appendices (Appendices I and II).

Data collectors

Data were collected through in-depth qualitative individual interviews by two trained interviewers who have training and experience with qualitative data collection and are fluent in local languages (Amharic and Guragigna).

Data collection procedure

At first, participants were informed of the purpose of the interview, field note, and audio recording and that every piece of information they gave would remain confidential (their identities and answers would remain confidential) and would be used for research purposes only. Participants were oriented to the study by interviewers who explained the aims and objectives in Amharic and Guragigna. Ethical clearances were obtained (from District Health office), and verbal informed consent was secured from individual participants. Interviews were conducted at the Atat Hospital compound, in a quiet place, individually. In-depth interviews were recorded using an audio recorder, and field notes were taken. A total of 14 eligible participants were interviewed. After completing the interviews, participants received no incentives. The interview (data collection) continued until it was adequate and complete, and little or no new information came from the interviewees (saturation). The interviews were then transcribed verbatim within a week and analyzed using an inductive thematic approach. Research teams aided the entire procedure; they supervised, facilitated the interviews, and worked on audio recording and field note-taking.

Operational definitions

Delay in seeking treatment for UVP: Seeking Diagnosis and treatment for a advanced stage UVP(3 and 4the degree) at 12 months or later after the onset of symptoms (for new patients) or recurrence of prolapse after prior intervention (for repeats) [12,13].

Advanced stage UVP: According to the Quantitative Pelvic Organ Prolapse (POP-Q) System, Stage III and IV pelvic organ prolapses are considered advanced stage UVP) [8].

Lack of psychosocial support: Those women who delayed seeking treatments because they do not have a person who supports them financially, materially and emotionally [12,13].

Lack of decision making power: Women who had willingness to get treatment but sought the permission of husbands to go to the treatment [12,13].

Availability of awareness

Women who know sign and symptoms, causes of UVP and availability of diagnosis and treatment [6,9,10].

Fear of stigma (families or social)

A woman with UVP who delayed seeking treatments due to perceived family or social discrimination [12,13].

Cultural influence

Feeling shameful to show their sexual body parts to others and looking for local traditional remedies for UVP [12,13].

Referred Staff attitude

A patient perception relating the perceived attitude of health care professionals in other medical condition times to the current one.

Data Management and Analysis

All interviews conducted in the local dialect were translated into English and transcribed verbatim. The data analysis method used in this study was Maguire and Delahunt's six-step approach [24]. The data were transcribed verbatim, and thematic analysis was used to code the data. During the data analysis, the PI read the transcripts line by line to identify codes. The codes were then collapsed into themes, and the themes were linked to literature, and finally, thematic analysis with open code software resulted in four main themes emerged from the data personal barriers, clinic barriers, social barriers, and approaches to overcome barriers.

Trustworthiness of the Data

Trustworthiness involves the following factors: 1) credibility (in preference to internal validity); 2) transferability (in preference to external validity or generalizability); 3) dependability (in preference to reliability); 4) confirmability (in preference to objectivity) [25,26]. Thus, in this study, to enhance trustworthiness, the pilot interview guide was tested two weeks before the actual interview with four participants. A day of training were provided to interviewers regarding procedures, how to approach participants, interviewing and discussing sensitive issues, and using voice recordings and field note-taking. The data collected were stored on a secured and password-protected computer of the PI and co-authors. All data were deidentified. No names or specific identifiers were used in the data processing, analysis, or dissemination of research results. Responses from the participants were anonymous on the tape.

Findings

Participants' Profile

Fourteen participants with advanced UVP (4 with stage 3 and 11 with stage 4 UVP) were involved in the study. The age of participants ranged from 42 to 53 years old and the majority (74%)

were married and had a health facility delivery history (89%) (Table 1).

Table 1: Participants' Demographic and obstetric characteristics, stage and awareness in UVP, Gumer District, Central Ethiopia, 2025.

Characteristics	Category	Frequency (percentage)
Age (in completed years)	<50	5(36%)
	50 and above	9(64%)
Residence	Urban	1(7%)
	Rural	13(93%)
Marital status	Married	10(72%)
	Widowed	3(21%)
	Divorced	1(7%)
Education level	No formal education	9(64%)
	Primary level (1-8)	5(36%)
Occupation	Housewife	9((64%)
	Merchant	5(36%)
Religion	Muslim	2(14%)
	Orthodox	7(50%)
	Protestant	3(22%)
	Catholic	2(14%)
Parity	<5	3(21%)
	5 and more	11(9%)
Place of past child deliveries	Home	0(0%)
	Health facility	9(100%)
Stage of UVP	3rd	3(21%
	4th	11(79%)
Availability of awareness	Know causes of UVP	12(86%)
	Know sign and symptoms of UVP	14(100%)
	Availability of diagnosis and treatment/Source of information	13(93%)/ 14 (100%)

Themes

Four main themes and many more sub-themes emerged from the data: personal barriers, clinical barriers, and social barriers.

Theme 1: Personal barriers

Level of education

As per the finding, women's education level was the barrier to seeking early diagnosis and treatment for UVP. Among the interviewed participants, 9/14 (64%) had no formal education. A participant said, "Those educated women listen and understand during counseling, media, and other information or readings, but I cannot…"

Another one said, “You know, illiterates like me lack many things to understand from what we hear and observe. And those who lack education ignore medical treatments or even prefer traditional healers”.

A participant also narrated that "I don’t understand what doctors tell me while I go to healthcare centers for other medical issues, and they also do not consider my understanding level; they tell everything on their own level. So, I ignore going there for tests and treatment. As per the finding, women's education level was the barrier to seeking early diagnosis and treatment for UVP. Among the interviewed participants, 9/14 (64%) had no formal education. A participant said, Those educated women listen and understand during counseling, media, and other information or readings, but I cannot…"

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Low income

Even though women have access to UVP diagnosis and treatment services, there are some expenses associated with receiving services, such as the means of transport and food in the town, especially for those who come from rural areas and are poor. A participant narrated, "For those who come from rural areas, transportation costs are a barrier." A participant narrated, "Although I know the benefit, since my home is rural, that is why I avoided it and hid disclosing my case for more than a year; transport costs are expensive, and I am poor, have no supporter, and cannot afford it."

Perceived diagnosis or treatment costs

The perceived cost of further screening or treatment is a barrier to seeking early UVP diagnosis and treatment. A participant narrated, "I feared there may be further screening and expensive costs associated with it, so I avoided it and hid for the last two years".

Perception of no medical cure

Many women (6/14) had the perception that 'no medical cure' and 'traditional healers are better'. A participant said, “Why am I having trouble? Is there a cure for private part prolapse? If that's the case, let me know”.

Similarly, another participant stated, “Many women in my village told me that such prolapses in the vagina are cured by traditional healers; modern doctors give you antipyretics only. Then, I decided to avoid disclosing to health extensions and others, and I took traditional medicine from elsewhere that is better for me than modern medicine…”

Another participant also described, "Many women, including me, accept the advice of traditional healers rather than modern health professionals. We perceive modern health professionals as recent, but traditional healers are long-experienced, and God has gifted miracles to cure such problems".

Fear of disclosure

Among the interviewed participants, 11/14 (79%) mentioned that the main reason for their delay was fear of disclosure to their spouses, family members, and neighbors. This is because such prolapses are considered a social taboo in their community, and it was thought to be a shame not only to disclose it but also to discuss it with anyone else.

The participant stated, “It is hard and just a difficult thing to explain to people most of the time, even to my husband, sisters, and daughters. I become worried and depressed about myself and about this condition and even cry for long times in a hidden place”.

The other one stated that "…for me, it is sad to disclose such secrets…it is a shame". Sometimes, I ask myself, what is the importance of telling other people rather than exposing my secret? I would hardly talk to anyone about it. I feel ashamed to talk about it”.

Perceived stigma

Among the interviewed participants, 9/14 (64%) explained that their delay in getting treatment was directly or indirectly related to fear of stigma from their family members, particularly husbands, neighbors, and other community members. They were not only worrying about the future but also facing stigma due to disclosing their status, which is unusual in the community culture. A participant explained, “I think that husbands hate a wife having such reproductive organ problems. Besides, most of the time, I see women who get divorced without any tangible reason…. When I realize the reason, it might be because of conditions like this. So, I was very concerned that one day my husband might know or suspect that I had this problem and hate me or divorce me”.

Another participant described, "I had the decision to tell my neighbor about the condition and need some information regarding treatment options. But I worry that she might discriminate against me and talk about me behind my back because I know that many women are victims of gossip". The other one said, "My husband is not concerned about my health even though he is currently living with me, and in case he may marry a second wife. So, I preferred to stay hidden rather than disclosing such secrets for more than a year".

A participant narrated, “My husband insulted me badly and left me alone, and he stayed with his second wife after seeing my private part. After that, I had hidden my case and decided not to tell anyone for more than two years. But now, after I discussed it with the health extension worker, she convinced me to be screened at a health center and treated at the hospital. I would like to thank her".

A hopeless feeling

A few participants’ personal feelings about UVP, such as considering UVP as a punishment from God or perceiving a hidden evil act, having no medical treatment or cure, and having other medical cases like being HIV/AIDS positive, were explored, making some women feel helpless. This hopeless feeling discouraged them from seeking UVP early diagnosis and treatment, being a barrier to their early seeking of diagnosis and treatment.

A participant narrated, “Although I know the presence of tests, I feel hopeless going anywhere. I am suffering with such prolapse and AIDS ….”

Another one also said, “I lack hope for life, and I ignore seeking tests or treatment for both the prolapse and AIDS, but the health extension worker advised me to go to the hospital”.

Theme 2: Clinical barriers

Referred healthcare staff attitude (both medical and non-medical in health facilities)

Three out of fourteen (21%) participants stated healthcare staff attitudes, which were exemplified as a lack of respectful care, insulting, or breaking privacy during previous times for participants' other medical conditions, were the stated barriers to seeking UVP diagnosis and treatment on time.

A participant narrated, "Health professionals’ disrespect and security guards insult me while I went to the health center for typhoid treatment; I do not want to be insulted, and it is that that makes me not seek early tests or treatment services for my private prolapse".

"You know, nurses used abusive words during my back pain treatment. The nurse girls exposed my body as they wanted and even insulted me. Due to this, I avoided coming to health centers and disclosing my security”.

A participant said, “Some health professionals lack concern and ethics. They really are careless of patients' worry. This surely makes me hide my problem and seek early treatment”.

Healthcare staff communication

The ability to seek UVP diagnosis and treatment for UVP is influenced by the quality of communication between healthcare workers and clients.

A participant stated, "I visited a health center and disclosed my issue (prolapse), but after they checked their fingers, they didn't explain my problem or what to do, except when they ordered me to come back when they phoned me, but no one called me".

The other one stated, “I went to the nearest health center in my village, but nobody gave me a good response. They looked down on me, and also others laughed at me since I do not speak their language well. Seeing these, I stay silent with my prolapse at home for a long time".

Another participant said, “Doctors do not explain what to do after finger check procedures; I really feel pain when I have a dry cough and ask them to consult. They ignore me. After that time, I preferred to hide my such secret cases to expose and seek treatment”.

UVP medical treatment availability (surgery)

Although the diagnosis of UVP is accessible at health centers, if the treatment is not available there, particularly UVP surgery, some women avoid seeking both early UVP diagnosis and treatment, like if there are referral methods after the women are diagnosed at a health center. So, this referral system influences women to stay silent or delay in seeking diagnosis and treatment of their UVP early. Besides, they complain about the quality of the appropriate referral service for UVP.

A participant stated that "I decided to avoid disclosing to healthcare workers at the health center about my prolapse case because service is not there; I know they refer to hospitals because they cannot do surgery, so why did I expose my secrets to them?"

Another one said, "My home is in a remote rural area, very far from town. No surgery, no other treatments in health centers, so they simply refer to other places. How can I seek their healthcare services?

The other participant said, "There is nothing to be done in health centers around me. They refer to other health facilities. I heard this, although I know my case needs a diagnosis early, fearing the referral cost of being kept silent for a long duration because I lacked money and supporters. They also refer without checking for other problems except for prolapse, but there are many things tested before surgery; these are expensive and, due to this, I avoided going there".

Theme 3: Social barriers

Distance

Some women come from remote rural areas; transport facilities and cost are the other barriers to women seeking early UVP diagnosis and treatment. A participant said, "I am a rural woman, and the road is difficult; cars are not accessible. As a result, I delayed going to any health facilities". Similarly, the other participant narrated, "Although I may have interest, distance and transportation issues made me delay seeking early tests and treatment".

Husbands' less involvement

Some husbands are less involved in their spouse's UVP issue and provide less support for early diagnosis and treatment. Participants also suggested that their spouses lack awareness about UVP, although UVP awareness for every woman is provided through health extension workers to women.

A participant described, "Some women, including me, would like to inform their spouses or get their consent before they receive treatment. If the husband does not support us psychologically and economically, we stay home without going for diagnosis or treatment".

A participant said, "Sometimes, husbands support less because they do not know about prolapses of women. That is a secret".

Influence of cultural beliefs and some religious fathers

Six out of fourteen participants explained similar concepts. Cultural beliefs and community practices prevented them from seeking a medical diagnosis and receiving timely treatment of their UVP. The community's traditional practices, like local remedies, massaging the abdomen, and drinking the juice of unknown herbal plants as treatment for UVP, are commonly recommended by either traditional healers or some religious fathers. All these collectively are barriers to women seeking early medical diagnosis and treatment for UVP.

A woman described that "I delayed seeking treatment since my husband refused to give money for transport, saying it was useless to go there".

Another woman narrated, "My husband does not allow me to go for modern treatment; he recommends that I take advice from religious fathers. Fearing breaking his command, I lost to seeking doctor's treatment".

As per this study, family, friends, neighbors, and societal cultural issues affect the early medical diagnosis and treatment of women with UVP. This means that those societal beliefs, for instance, that UVP issues have no modern cure, influence women to engage in either religious practices or traditional practices.

A participant described, "In my village, women, including me, believe that vaginal prolapses are not cured by modern treatments but rather by religious or traditional healers with special miraculous ones. They are not considered as a disease". So, my friends and family said, "Go to church and ask religious fathers for advice on what to do…"

Similarly, another one said, "Such prolapses are not medical issues in my kebele, and my neighbor advised me not to expose my secrets, rather to go to a traditional healer who is popular in his cure".

Some religious fathers do not encourage UVP cases to be seen by health professionals and take modern treatment, and this is suggested as one of the hidden barriers for delaying some women's diagnosis and treatment for UVP.

A participant stated that "I needed to go to health centers to be tested for my prolapse because I attend religious practices, and my pastor advised me of some of GOD's curing mechanisms and warned me not to tell such a secret to doctors. The other person said, "As my prolapse became enlarged, I told my religious father, and then he recommended me to take some herbal drugs and pray regularly as he ordered me. That is why I went to the hospital".

Discussion

This study examined barriers in early seeking of a diagnosis and treatment among women with uterovaginal prolapse in the Gumer District, Central Ethiopia, using a qualitative approach. The findings identified three main themes: issues related to personal,

clinical, and social. The research findings are significant in the context of global and national efforts to combat and reduce UVP-related maternal morbidity and deaths, particularly in low-resource settings. Understanding these barriers is essential for developing effective interventions to support women with UVP for awareness creation, screening and treatment in the region of Ethiopia and other similar settings.

The present study gives insight into some of the major barriers women and men face in seeking diagnosis and treatment of UVP on time. This study reveals women's education significantly impacts their likelihood of seeking early diagnosis and treatment for UVP, as educated women better understand counseling and media information. Consistent with other research, illiterate individuals often struggle to comprehend health information and may ignore medical treatments [27,28]. This implies a need for continuous interventions for women and men at the community level, improving awareness to tackle the gap and achieve SDG on maternal health issues, including UVP. Educating women and the community to make them aware that it is a treatable condition and encouraging life. Women's independence in decision-making on health care services in the family will improve their quality of life [29,30].

The findings explored some husbands are less supportive of their spouses with UVP, resulting in delayed diagnosis and treatment. The present study gives insight into the fact that men's support is such an important factor affecting reproductive health service utilization, including UVP and This stems from a lack of awareness about UVP among husbands, even though health extension workers are educating women on the topic. Other studies congruently revealed lack of support associated with UVP treatment delay, personal or familial factors like lack of support, neglect, and prioritizing children/family needs over self-care [27,29].

The findings showed low-income women in rural areas facing additional challenges, which is in line with a study that states low income is a barrier for women's UVP treatment-seeking behavior [31].

The present study explored that fear of disclosure negatively impacts UVP tests and treatment in women, driven by societal taboos and concerns about judgment and stigma from family and friends. Besides, some cultural beliefs and societal norms hinder timely medical diagnosis and treatment of UVP in women, with traditional healers and spiritual leaders promoting prayer and herbal remedies over medical intervention. Other studies revealed a congruent concept: women with UVP failed to seek healthcare advice mainly due to shyness and embarrassment [31,32]. Psychological or cultural barriers like shame, taboo, and stigma associated with speaking about genital problems affect women with UVP who fail to seek healthcare or treatments [29].

Healthcare staff attitudes, including disrespectful care, insults, and privacy breaches, hinder timely diagnosis and treatment for UVP. Healthcare staff communication quality affects timely seeking of UVP diagnosis and treatment, serving as a barrier for clients. Congruently, studies show insight that increased focus on person-centered care, particularly emotional support, information, and education, may improve women's experiences when seeking care for UVPUVP [30].

Healthcare system issues like distance, poor accessibility, and transportation costs impede women's access to early UVP diagnosis and treatment. Despite the accessibility of UVP diagnosis at health centers, the lack of available treatment, specifically UVP surgery, leads some women to forgo early diagnosis and treatment, particularly if referral methods are unclear post-diagnosis. A study shows congruent exploration, poor accessibility, high costs, and negative experiences with previous treatments [29]. A study explored that more than half of women with UVP failed to seek healthcare advice, a determinant mainly due to shyness and embarrassment and lack of proper knowledge about the condition. Interference of symptoms with physical activities was the main significant determinant of healthcare-seeking behaviors [32]. This implies a need of additional teaching campaigns designed according to cultural backgrounds in each society to address these sensitive issues.

Moreover, the present study identified three new significant personal, clinical, and societal contributing factors that affect UVP tests and treatment in women. These were the perceived cost of additional screening or treatment, perceptions that women have "no medical cure", and a sense of hopelessness related to UVP along with the presence of other medical issues like HIV/AIDS. for additional the perceived cost of additional screening or treatment hinders the pursuit of early diagnosis and treatment for UVP. Perceptions that women have "no medical cure" impede efforts for early diagnosis and treatment of UVP. A sense of hopelessness related to UVP, perceived as a divine punishment or a hidden maleficence, along with the presence of other medical issues like HIV/AIDS, contributes to feelings of helplessness in some women. This discourages them from seeking early diagnosis and treatment for UVP.

The findings of this study have implications for society, healthcare practice, and research. The social implications include the need to consider rural societies, traditional healers, religious healers, and men's awareness, status, and perceptions during the planning and application of UVP screening programs. There is a need for community awareness to clear misconceptions and men's participation in community women's reproductive education to achieve SDGs by the year 2030.

Implications for health care practices include the need for health professionals to consider rural women and their husbands, who may have awareness gaps and misconceptions about UVP. The findings of this study also indicate the key implication of the need to understand how barriers affect the success of screening and treatment programs. Therefore, health care programmers might need to consider root barriers to overcome them.

The research implications of healthcare include the need for future research to conduct research on cross-checking multiple perspectives, like those of both spouses, family, community, health professionals, and health service leaders, to dig up further evidence about UVP screening and treatment barriers.

Study's strengths

To our knowledge, this study is the first to explore the personal, health system, and sociocultural factors that hinder the pursuit of early diagnosis and treatment for UVP using a qualitative approach in the study district. The study design enabled in-depth data collection about barriers to the pursuit of early diagnosis and treatment for UVP. The study used a diverse sample (the study purposively included participants from rural and urban areas and sociodemographic characteristics (age, marital status, religion, and UVP stages), which increased its representativeness. The accuracy of the data was improved by the use of primary data (individual in-depth interviews) supported by voice recordings, field notes, and experienced data collectors.

Study Limitation

The study only included women's perspectives and did not assess the perspectives of health professionals, husbands, family, or community. Since this study was facility-based (hospital-based), it might miss the women who had no access to treatment, mainly in remote rural areas with long delays and advanced stages of prolapse. The time from the onset of the symptom until starting the treatment was self-reported; there might be miscounting of duration in old interpreting (old women count durations relative to events) that might exaggerate the delay time to start treatment; therefore, precaution is needed when interpreting.

Conclusion

Barriers to early diagnosis and treatment of uterovaginal prolapse in women are systemic, linked to patients, community, and the respectful care behaviors of health professionals. Developing culturally sensitive and inclusive programs for patients, families, and health systems is essential to address these barriers. Furthermore, additional multi-perspective research involving spouses, families, communities, health professionals, and health service leaders is critical for effectively overcoming these challenges. To reduce the time between the onset of symptoms and receiving UVP treatment among the women with the problem, improving awareness among women, early case finding, psycho-social support, involving religious and influential people, and economic empowerment are all recommended.

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Appendix

Appendix I: Preamble

Thank you so much for meeting with me today and agreeing to participate in this interview. I want to remind you that what you say here is confidential and will not be linked back to you or your family or identify you in any way. I am recording this interview so that I can transcribe it. This means I will type out the words said in this interview into a secure document for analysis. There will be no identifiers on the transcripts. The purpose of this interview is to explore your opinions and perceptions about our study topic. We are here to learn from you, so anything you have to share is welcome. Nothing you say here will affect me or you in any way. There are no right or wrong answers, so be free.

Appendix II: Interview Guideline

Interviewer: ... Demographic and obstetric characteristics (age, residence, occupation, religion, parity, place of past child deliveries) and availability of awareness (cause, sign and symptoms, availability of UVP diagnosis and treatment)

I have heard people say they had uterovaginal prolapse before. Have you ever heard? From whom/where?

"What do they mean when they say uterovaginal prolapse?" ---------- ---------- (cause, sign and symptoms, availability of UVP diagnosis and treatment, duration)

What do you know about uterovaginal prolapse? ----------All perception towards uterovaginal prolapse

Interviewer: ... I heard in this area that some married men encourage or support their wives to go for uterovaginal prolapse screening or treatment. But some others do not, am I correct? What's your opinion, please? ---------- ----------

How do they encourage or support their wives to undergo uterovaginal prolapse? ----------

Those married men who do not support their wives—what prevents married men from supporting their wives from going for the screening?

Does your husband allow you to have uterovaginal prolapse screening?

Who makes decisions? ----------

Who told you, or who did you confirm with, that you have uterovaginal prolapse?

What have you done so far to manage your case (uterovaginal prolapse)?

If screening is free and causes no harm, will you be free to be screened? ----------

We really appreciate your time and insight. Thank you once again.

Before we wrap up, is there anything that you think is important for us?

If I missed anything when I reviewed our conversation,

Really, to the last, anything you want to say... ----------

Thank you very much!