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A Study on Safe Motherhood: Causes Behind Uterus Prolapse Amongst Women In 3 VDCs Of Dadeldhura District

2004

A Report

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Submitted to:

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Table of Contents

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Call No.

1.	Background	1
2.	Objectives of Study	2
3.	Methodology	2
3.1	Central Level Planning and Search for Additional Resources	2
3.2	Information Campaign	3
3.3	Orientation to Motivators, Nurses and Health-workers	3
3.4	Organization of Two-day Health Camp	3
3.4.1	Registration and Watching Videos	3
3.4.2	Focus Group Discussion	3
3.4.3	Orientation, Check-up, Treatment and Referral	3
3.4.4	Interview of Patients	4
3.5	Data Tabulation, Key Findings and Analysis	4
4.	Key Findings	4
4.1	Estimated Prevalence Rate	4
4.2	Demographic Variables	5
4.2.1	Age	5
4.2.2	Marital Status	5
4.2.3	Caste and Ethnicity	5
4.2.4	Physical Characteristics	5
4.2.5	Education and Economic Variables	6
4.3	Menstruation: An Indicator of Reproductive Health	6
4.4	Child Birth Issues	6
4.4.1	Number of Children Birthed	6
4.4.2	Place of Childbirth	7
4.5	Attendance at Childbirth	7
4.5.1	Overall	7
4.5.2	Last Birth	7
4.5.3	Duration of Labour	7
4.6	Duration of Prolapse	8
4.7	Causes of Uterus Prolapse	8
4.8	Key Symptoms	9
4.9	Ways Identified to Prevent Uterus Prolapse	10
4.10	Sharing of Problem	11
4.11	Access to Treatment	11



NHRC Library
Accession No. 172
Call No.

4.12	Treatment Advice Given	11
4.13	Patient's Feelings and Reactions of Others	12
5.	Findings of Focus Group Discussions	13
6.	Analysis of Results	13
6.1	Uterus Prolapse: A Common Factor in Maternal Morbidity	13
6.2	Causes and Symptoms	14
6.3	Prevention and Cure	15
7.	Recommendations	16
	References	18

Annexure

- Annex 1: Services Provided in the Low Risk Birthing Centre
- Annex 2: Questionnaire
- Annex 3: Photos of Uterus Prolapse Research/Health Camp
- Annex 4: Map of Dadeldhura



NHRC
Accession No. 172
Call No.

4.12	Treatment Advice Given	11
4.13	Patient's Feelings and Reactions of Others	12
5.	Findings of Focus Group Discussions	13
6.	Analysis of Results	13
6.1	Uterus Prolapse: A Common Factor in Maternal Morbidity	13
6.2	Causes and Symptoms	14
6.3	Prevention and Cure	15
7.	Recommendations	16
	References	18

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Accession No. 172
Call No.

Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
ANM	-	Auxiliary Nurse Midwives
DFID	-	Development Fund for International Development
FCHV	-	Family Child Health Volunteer
FGD	-	Focus Group Discussion
IEC	-	Information, Education and Communication
LRBC	-	Low Risk Birthing Centre
MCH	-	Maternity Child Health
NHRC-		National Health Research Council
RUWDUC		Rural Women's Development & Unity Centre
SLC	-	School Leaving Certificate
USA	-	United States of America
VDC	-	Village Development Committee
CVAW-		Countering Violence Against Women

**A Study On Safe Motherhood
Causes Behind Uterus Prolapse Amongst Women
in
3 VDCs Of Dadeldhura District**

1. Background

The Far Western Development Region of Nepal is the remotest region of the country with low level of development in terms of social, infrastructure, health and economy. The traditional socio-cultural value system creates a disabling environment for the progress and development girls and women. As a result the life of women and girls is very difficult. The districts of this region are reported as having the lowest rank in the Gender Discrimination Indicators by a recent study by CBS/HMG, ICIMOD and SNV (2003).

District Ranks According to Gender Discrimination Index*

Lowest GDI**	
District	Rank
Kailali	44
Kanchanpur	51
Darchula	67
Baitadi	68
Dadeldhura	69
Doti	70
Bajura	71
Accham	73
Baglung	75

**Ranking is done on a 1 to 75 scale based on the 75 districts of Nepal
Source: Adapted from Map 10 as GDI/ICIMOD/CBS/HMG/SNV (2003)

Women's overall suffering is further aggravated by their poor health status due to traditional beliefs, lack of information and poor access to health services. WHO (1995) estimates that reproductive ill-health contributes to almost 33 per cent of the total disease burden of women. This figure can be estimated to be even higher in a region which is largely un-served and underserved by both health information and services. Women's burden of disease can be envisaged by Nepal's high maternal mortality ratio (539/100,000) and morbidity rate. The fact that for every mortality, six other women suffer morbidity must be taken into consideration while talking about women's health in Nepal. Traditional socio-cultural norms and mores further complicate this picture, as it does not sanction open discussion about sexual and reproductive health issues. Consequently, many women suffer in silence, since have been socialized to feel both embarrassed and ashamed to talk about their sexual and reproductive health problems.

In view of women's lack of information and access to reproductive health services in remote rural areas, the Rural Women's Development and Unity Centre (RUWDUC) has been running a Low Risk Birthing Centre (LRBC) in Dadeldhura district for the last 8 years. This centre has had positive impact in providing reproductive health and other health services to women of the

surrounding areas. (See Annex 1 for brief report on services provided). During this duration the nurses at the Centre have regularly apprised RUWDUC's board of the key health problems which women in the area face and its negative impacts on their personal lives.

One such reproductive health problem, which was identified as common amongst the women of this area, is uterus prolapse. This morbidity problem was seen to result in serious negative impacts, which ranged from physical and psychological to social and economic.

Since February 2003, RUWDUC has also been serving as the district coordinator of the Safe Motherhood Network of Nepal. This role has further added impetus to RUWDUC's commitment to improving reproductive health and safe motherhood in the area. Therefore, as part of this effort, RUWDUC has undertaken this study on uterus prolapse. RUWDUC hopes that with the findings and recommendations of this study will provide vital information regarding the issues behind uterus prolapse in Nepal.

The findings will be utilized to create awareness on prevention and cure of uterus prolapse in the country.

2. Objectives of Study

Overall Objective

To contribute to the improvement of the reproductive health of women of the of Far West Region of Nepal, with special focus on uterus prolapse.

Specific Objectives

- Determine causes behind uterus prolapse in Dadeldhura district.
- Raise awareness on safe motherhood in general and uterus prolapse in specific.
- Use the LRBC to promote the health of women and girls.

3. Methodology

3.1 Central Level Planning and Search for Additional Resources

The key researcher of this study assembled a team that comprised of senior researchers and a medical doctor. Based on their literature survey and in consultation with the medical doctor, a research tool was designed and pilot tested amongst some patients and ordinary people. Based on their feed back - the research tool was revised and finalized.

Discussions were also organized with the colleagues to ascertain the best way to execute the research given the resource constraints and security concerns. Based on discussion held with field staff of RUWDUC, it was decided to innovate and adopt an approach, which would enable the researchers to reach the target group in a short period of time. It was thus decided to organize a free health camp on uterus prolapse. As the resources from the NHRC would not be sufficient to cover the cost of the medical supplies, it was decided to explore other sources for support of medical supplies.

In this process, DFID Mid and Far-western Regional Office in Nepalgunj was successfully approached. This office provided the medical supplies required for the research camp.

3.2 Information Campaign

This study adopted a methodology where by the target of the research benefited during the course of the data collection. Due to meagre resources of the study as well the law and order situation of the country, it was decided to motivate local volunteers to gather the target group for the study. Pamphlets were printed and distributed through the volunteers to provide public information on the forth-coming camp in all the target areas. Information on the camp was also provided via word of mouth through the patients visiting the RUWDUC birthing centre and also through the participants attending training programmes organized by RUWDUC in the target VDCs.

3.3 Orientation to Motivators, Nurses and Health-workers

An orientation was also organized for the health-workers, nurses, researchers and RUWDUC's programme motivators, who were to be involved in the research camp to the issue on hand such as objective of the camp, information on uterus prolapse, the procedure for health check up, focus group discussion and interviews of patients with uterus prolapse. Orientation and inputs on the questionnaire was provided to get a clear understanding of the forms. After the orientation a small pre testing was conducted in a CVAW women's group in the area for better understanding of the questionnaire.

3.4 Organization of Two-day Health Camp

3.4.1 Registration and Watching Videos

Based on prior information, patients came to attend the uterus prolapse (*aangh khasne*) camp on 27 and 28 of December 2003. A team of four people were assigned to register the patients and also take their weight and height. While the check-ups of some of the visitors to the camp were being carried on, the waiting patients were shown videos on women's issues (reproductive health and violence against women issues). Approximately 1,000 people (including students and children, guardians and spouses of the patients) who attended the camp watched these videos. Among them 588 were women who came for check-ups.

3.4.2 Focus Group Discussion

While some of those who came watched videos, focus group discussions were organized with 12 groups of 10 to 20 patients. These FGDs were centred on 3 queries: (i) What are the most common health problems during pregnancy? (ii) What do you know about uterus prolapse? (iii) What can you do for women who have uterus prolapse?

3.4.3 Orientation, Check-up, Treatment and Referral

The women who were registered were all provided health information on prolapse in groups. The information centred namely on nutrition, rest during childbirth and in the post-partum period, birth spacing, precautions to be taken not to get uterus prolapse, such as not carrying very heavy weights, taking care of personal hygiene. After these classes, the women called for check-up by the 3 nurses who were providing services.

The patients with prolapse had pessary rings inserted. They were also provided counselling regarding kegel exercises, as well as how to clean the ring regularly. They were also advised to return for follow-up check-up.

Out of the 588 women who had check-ups, 260 women were found to have prolapsed uteruses. Among them, 253 patients were provided with pessary rings and 7 taught appropriate exercises.

The check-ups also referred another 35 patients for operations for different complications related to reproductive health. One patient was found to have developed cancer due to constantly keeping a pessary inside her for 10 years. Few women also wanted to have abortions. Another patient came with third degree vaginal tear due to delivery of twins 17 days ago (both her babies died due to forcible extraction by the neighbour who was helping her). Around 30 patients came to ask for treatment of infertility. They were also referred to hospitals.

3.4.4 Interview of Patients

Only 150 patients out of the 260 were interviewed due to time constraints. Each interview took between 20 to 30 minutes. A team of 7 researchers interviewed the patients using the questionnaire developed. (See Annex 2)

3.5 Data Tabulation, Key Findings and Analysis

All the filled questionnaires were brought to Kathmandu, the answers tabulated and the key findings analyses.

4. Key Findings

4.1 Estimated Prevalence Rate

A total of 588 women attended the two-day camp-cum research programme. Out this group 260 women were found to be patients of uterine prolapse. However, the findings of this research are based on interviews with 150 women. Among these 150 women 53 per cent were from Jogbuda VDC, 35 per cent from neighbouring Sirsha VDC and 12 per cent from Alital VDC. The high incidence of uterus prolapse amongst rural women of Nepal certainly merits more attention than it is getting right now as an issue for creating awareness or even providing services.

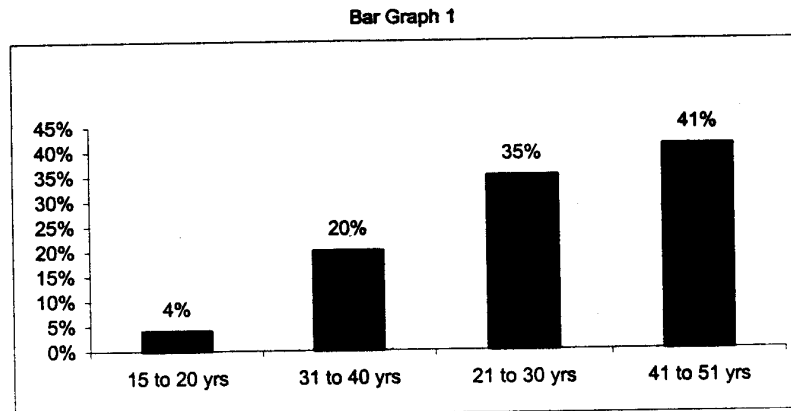
The number 260 representatives a very high occurrence of this condition among women, if one considers the fact that universe for this research is 15, 449 women (three VDCs included Jogbuda: 6,833; Sirsha 4,713; and Alital: 3,903) including young women who are not married. The prevalence rate calculated on this universe comes to 1.7 per cent. Lack of demographic information of each female member of this universe prevents us from actually stating the real incidence. If this 1.7 per cent occurrence in a universe of 15,499 gives us the figure of 260 women who are suffering from uterus prolapse for every unit of 15,499, and we scale this figure in a population of 100,000 women it comes to 1,677 patients ($100,000/15,499 = 6.45$ units * 260 = 1,677). This is a rough estimate as we cannot be sure that every woman in this universe of 15,499 received information about the camp or those women who were patients were able to attend. However, even this rough estimate rings a bell of alarm as to the prevalence of this condition amongst women of rural Nepal.

4.2 Demographic Variables

4.2.1 Age

This problem has been clearly seen to affect women of all ages in rural Nepal. The age range of the patients was as wide as 15 to more than 51 years of age. A large number of the patients (41%) were in the age group of between 41 to more than 51 years of age,

followed by patients in the age group of between 21 to 30 years of age (35%) followed by those in the between 31 to 40 age group (20%). Four per cent of the patients were even as young as between 15 to 20 years of age. (See Bar Graph 1).



4.2.2 Marital Status

The majority of all patients were married (89%) and the remaining 11 per cent were widows. The overwhelming majority (95%) of the women had been married before they were 19 years old, while only 5 per cent were married when they were between 20 to 24 years of age. The high prevalence of early marriage also has a significant bearing on uterus prolapse.

4.2.3 Caste and Ethnicity

The vast majority of the patients were chettri (61%), followed by 17 per cent brahmin, 13 per cent dalit and 9 per cent janajati. The occurrence rate in the different caste groups could be reflective of the caste representation in the population of the three VDCs.

4.2.4 Physical Characteristics

About 49 per cent of the patients were between 4'6" to 5' in height, followed by 37 per cent who were between 5' to 5'6". 14 per cent were between 4' to 4'6". The average height of the women in this area is comparable to the average Nepali height and in some cases even they are above average Nepali height. Findings about height seem to point towards adequate nutrition for girls during their childhood in this area. However, height could also be a factor of genetics. Men and women of the far-western region are generally found to be taller than Nepalis in eastern part of the country, even though people in eastern Nepal are generally better off.

The most common average weight of the patients was between 41 to 45 kgs (35%), followed by 36 to 40 kgs (27%) and between 46 to 50 kgs (19%). While 6 per cent of the patients were seen to be more than 50 kgs in weight, 13 per cent were found to be only between 25 to 35 kgs. However, as it is difficult to take out height and weight ratios for so many individual patients, the field research team were asked to report on the appearance of the patients. The research team reported the following based on the appearance of the patients: 67 per cent were seen as average for their weight, while 5 per cent were even seen to be on the fatter side, and 30 per cent perceived as thin for their height.

4.2.5 Education and Economic Variables

The majority of the patients were illiterate (75%), followed by 18 per cent who were just literate, 5 per cent who had studied up to class 5, and 1 per cent each who had studied up to class 8 or class 10 or had done their SLC. On the other hand, while 31 per cent of the patients' spouses were illiterate, followed by 22 per cent who were just literate, 26 per cent each who had either studied up to class 5 or up to class 8 and 21 per cent who had passed class 10 or done their SLC. The trend seen in the gap between the education level of men and women this research is very close to national statistics.

Almost all (99%) of the women worked within their households and most of the spouse looked after family farmlands. Only one woman reported being a daily wage earner.

4.3 Menstruation: An Indicator of Reproductive Health

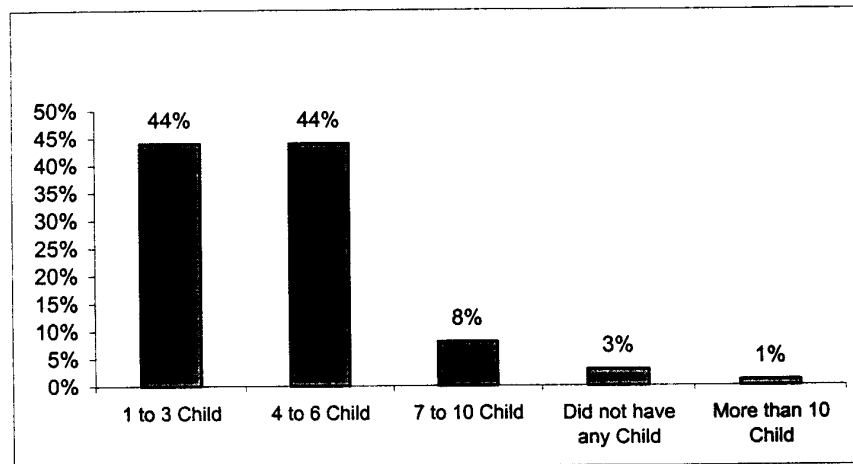
One of the queries put to the women was about her menstruation cycle. This was taken to also assess the state of the women's reproductive health. While 59 per cent of the women said they menstruated, 41 per cent said they did not. Among those who said they did not menstruate: the following reasons were given: age factor: 68 per cent; breast-feeding: 16 per cent; health problems: 8 per cent; pregnancy: 5 per cent; depo provera injection for family planning: 3 per cent.

4.4 Child Birth Issues

4.4.1 Number of Children Birthed

Forty-four per cent had given birth to between 1 to 3 and another 44 per cent to between 4 to 6 children. Around 8 per cent even reported having given birth to between 7 to 10 children. While 3 per cent did not have any children, 1 per cent had more than 10 children. (See Bar graph 2).

Bar Graph 2

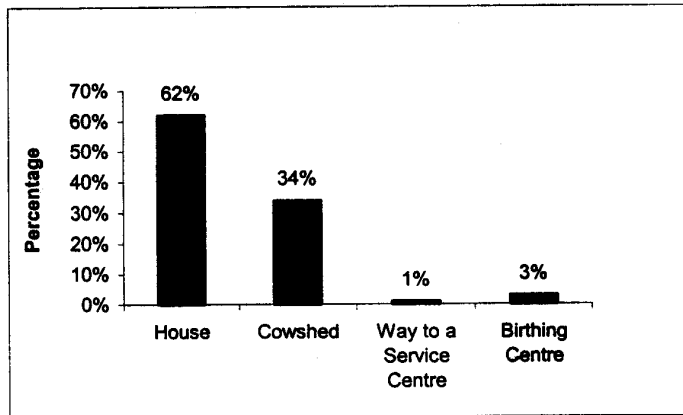


The total number of living children between 150 women was 563, among which were 53 per cent sons and 47 per cent daughters. The average number of children per woman was 3.75 or 4. Another factor which is observed that the survival rate of sons is higher than that of daughters in this population of women.

Bar Graph 3

4.4.2 Place of Childbirth

The majority of the children were born in the house (62%), followed by the cowshed (34%). While 1 per cent reported having given birth on the way to a service centre, only 3 per cent reported having given birth in a health facility (RUWDUC's birthing centre). (See Bar graph 3).

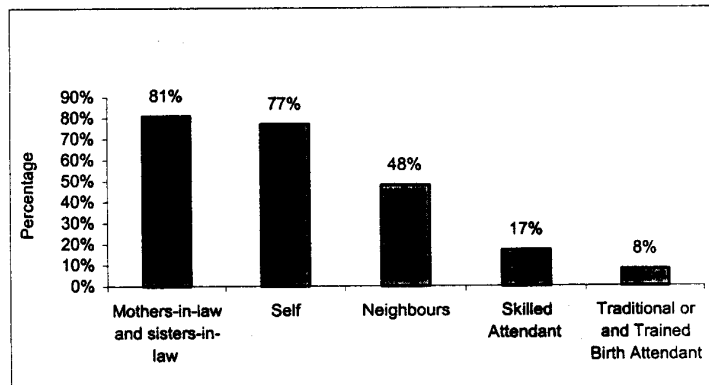


4.5 Attendance at Childbirth

4.5.1 Overall

Assistance at childbirth was provided by a number of individuals in the family or in the community. Mostly mothers-in-law and sisters-in-law (81%) were seen to provide assistance to women during delivery. At the final moment of birth the woman was seen to also birth the baby herself (77%). Neighbours seemed to be important in this community in providing some assistance for childbirth (48%).

Bar Graph 4



However, about 17 per cent also reported getting help from a skilled attendant (doctor, government nurse or ANM from RUWDUC's birthing centre) during at least one of their childbirths. In Bonetti et al (2002) only 5.6 per cent women in Achham and 8.1 per cent women in Doti reported being attended by a skilled medical person in their last labour and delivery. Another 8 per cent reported getting help from the traditional or and trained birth attendant. (See Bar Graph 4).

4.5.2 Last Birth

During the last birth 36 per cent of the women reported birthing the babies without any assistance. However, 30 per cent reported being provided assistance by mothers-in-law/sisters-in-law, followed by neighbours (19%). Some 10 per cent even reported being attended by a trained birth attendant (doctor, government nurse, LRBC's ANM). About 3 per cent reported that their husband assisted them and another 2 per cent said the traditional birth attendant helped them.

4.5.3 Duration of Labour

When queried about the duration of labour at the last birth before their uterus prolapsed, 56 per cent said that it took them between 1 to 3 days to give birth, while 29 per cent said they gave birth within 5 hours. While 7 per cent said it took them more than 4 days to give birth, another 7

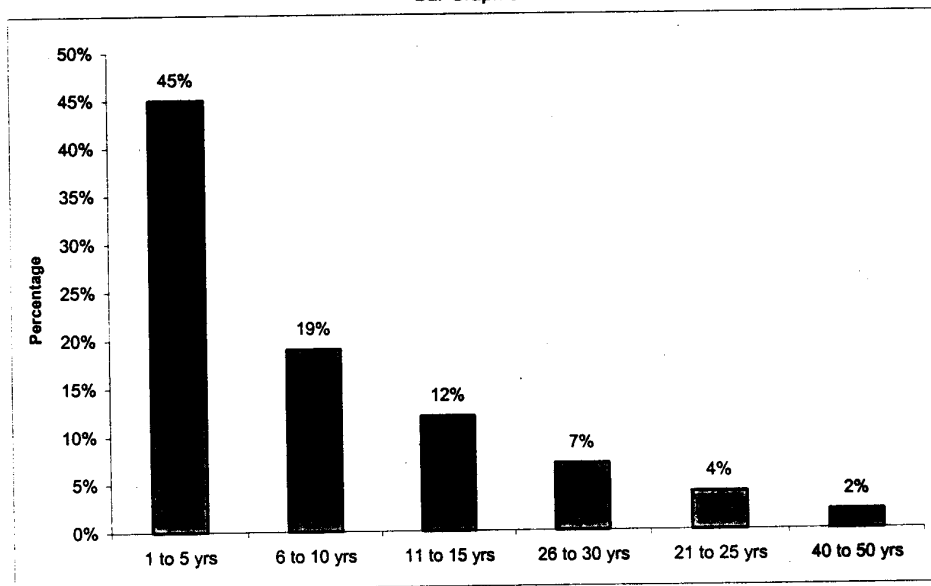
per cent said it took between 6 to 10 hours. One per cent, however, said it took them between 11 to 24 hours to give birth.

While the majority (69%) said no one pressed their uterus during childbirth, 31 per cent did say their uterus was pressed to hasten the birthing process.

4.6 Duration of Prolapse

About 45 per cent of the patients had been suffering from this disease since the last 1 to 5 years, 19 per cent had been suffering from prolapse since the last 6 to 10 years. Similarly, 12 per cent had uterus prolapse between 11 to 15 years, while 11 per cent had uterus prolapse between 16 to 20 years, whereas 7 per cent had been suffering from this condition since the last 26 to 30 years. Meanwhile, 4 per cent reported having this problem since the last 21 to 25 years. Some 2 per cent even had this condition since the last 41 to 50 years. (See Bar Graph 5).

Bar Graph 5



Some of the patients (45%) reported they had uterus prolapse after the first child, while 17 per cent reported having this condition after the second baby. Around 19 per cent said they developed this condition after the fourth, fifth and seventh baby. Meanwhile 19 per cent of the patients said they had uterus prolapse after the last baby. In the study by Bonetti et al (2002) 40 per cent of women also reported uterus prolapse after the first child, while 58 per cent reported after completing two pregnancies or less and 2.3 per cent were nulliparous.

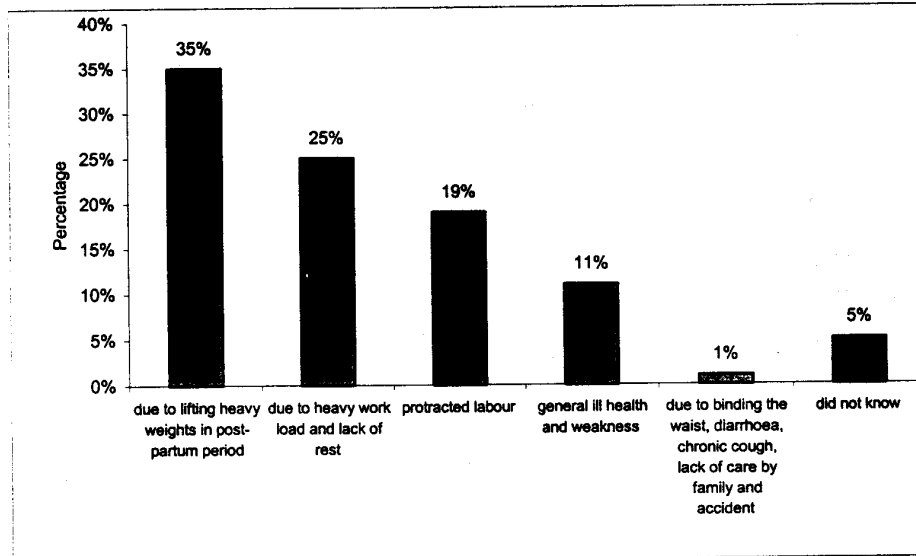
4.7 Causes of Uterus Prolapse

The majority (76%) of the women who were patients of uterus prolapse reported having to carry heavy loads as part of their routine housework. The remaining 24 per cent reported that they did not have to carry such heavy loads. However, 97 per cent said they did lift heavy objects within 45 days of childbirth. Only 3 per cent said they did not recall having carried anything heavy within that period.

The women's perceptions as to why their uterus prolapsed was as varied as due to lifting heavy weights within the post-partum period (35%), due to heavy work load and lack of rest in a unspecified time duration (25%), protracted labour (19%), general ill health and weakness (11%) due to binding the waist, diarrhoea, chronic cough, lack of care by family and accident (1% each). However, 5 per cent said they did not know why their uterus had prolapsed. (See Bar Graph 6).

In the study by Bonetti et al (2002) 20 per cent of the women stated that women identified heavy lifting heavy loads within the post-partum period as the reason for uterus prolapse, while 27.4 per cent identified lifting heavy loads without a specified time frame.

Bar Graph 6

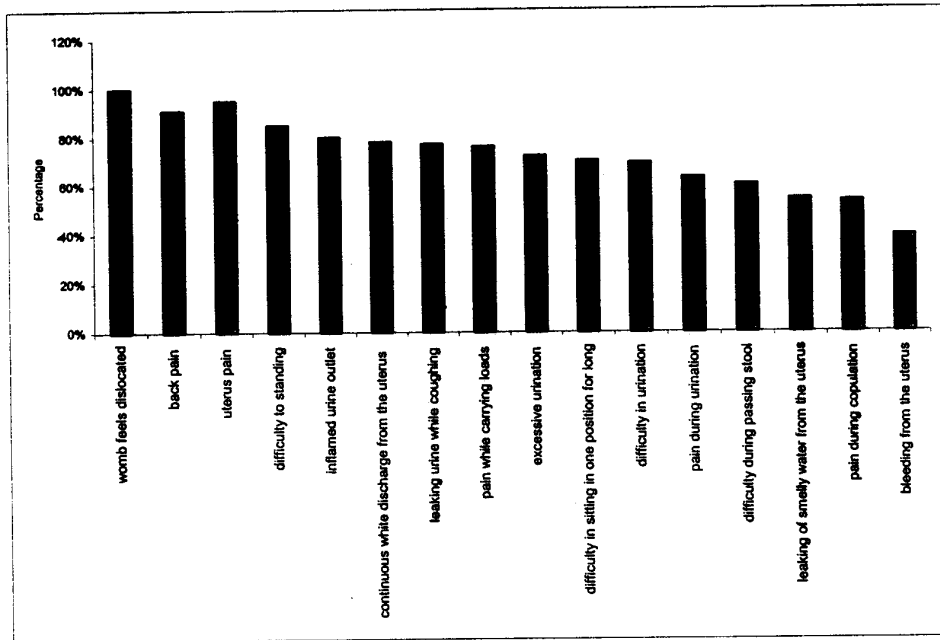


4.8 Key Symptoms

Among the key symptoms and problems reported by the patients were the following:

Womb feels dislocated (100%); back pain (91%); uterus pain (85%); difficulty to standing (85%); inflamed urine outlet (80%); continuous white discharge from the uterus (78%); leaking urine while coughing (77%); pain while carrying loads (76%); excessive urination (72%); difficulty in sitting in one position for long (70%); difficulty in urination (69%); pain during urination (63%); difficulty during passing stool (60%);leaking of smelly water from the uterus (54%); pain during copulation (53%); and bleeding from the uterus (39%). (See Bar Graph 7).

Bar Graph 7

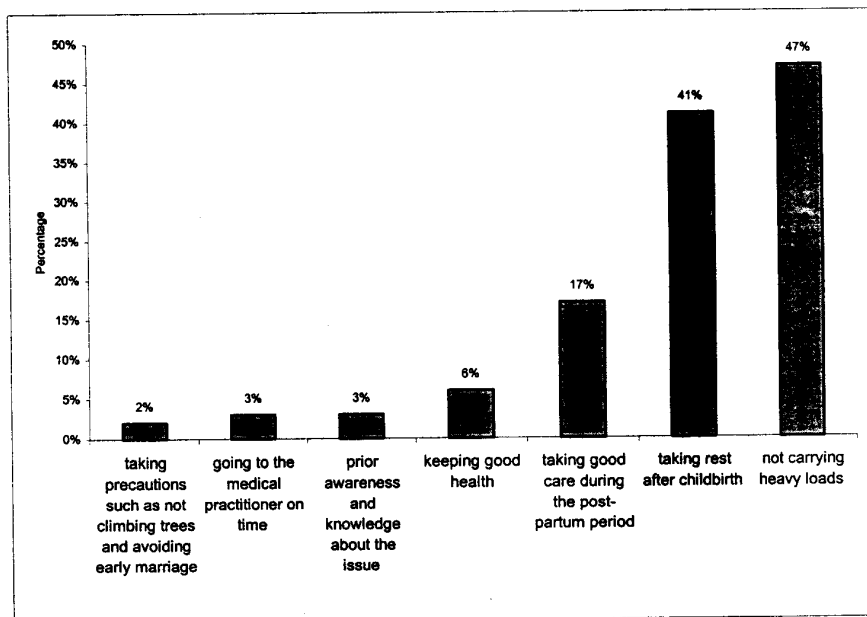


4.9 Ways Identified to Prevent Uterus Prolapse

In the perception of the patients the following was identified as ways to prevent prolapse:

By not carrying heavy loads (47%); by taking rest after childbirth for 45 days (41%); by taking good care during the post-partum period, including eating nutritious food (17%); keeping good health (no coughs, not being fat) (6%); going to the medical practitioner on time (3%); prior awareness and knowledge about the issue (3%); taking precautions such as not climbing trees and avoiding early marriage (2%).

Bar Graph 8



(3%); taking precautions such as not climbing trees and avoiding early marriage (2%). (Bar Graph 8)

4.10 Sharing of Problem

Most women were found to share about the problem with their spouse (41%). Others in whom she confided were friend (11%), sister-in-law (11%), sister (7%), mother-in-law (6%), daughter-in-law (2%), brother-in-law and mother (1% each). Almost 21 per cent reported that she had not shared about the issue with anybody.

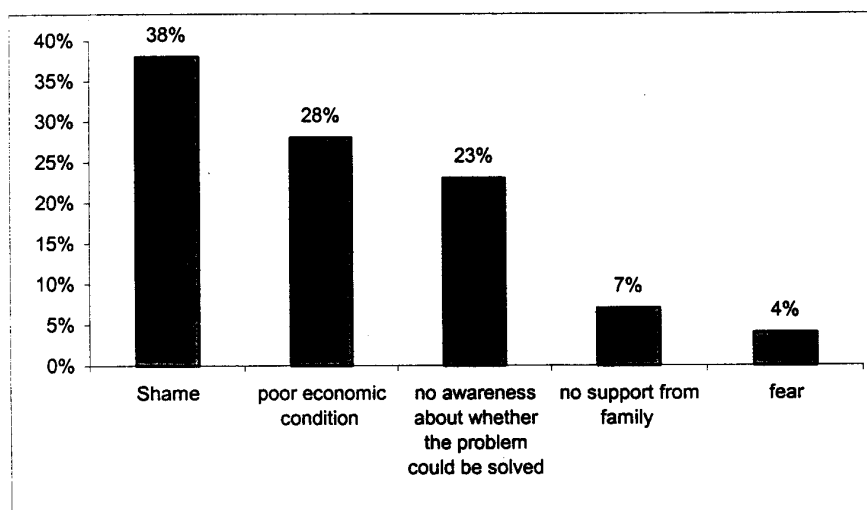
The main cause given for not sharing her problem was shame (68%), fear (29%) and lack of money for treatment (3%).

4.11 Access to Treatment

Prior to attending the camp organized during the course of this research, 71 per cent had not accessed any treatment for her problem. The remaining 29 per cent (n=44) who had accessed treatment had gone to the local hospital (32%) or gone to a hospital in India (32%). While others had gone to the health post (21%), visited the sub-health post or RUWDUC's birthing centre (7% each). About 3 per cent reported having gone to the local shaman for treatment.

The majority (71%, n= 106) who had not accessed any treatment gave the following reasons for not having done so: shame (38%), poor economic condition (28%), no awareness about whether the problem could be solved (23%), no support from family (7%) and fear (4%). (Bar Graph 9).

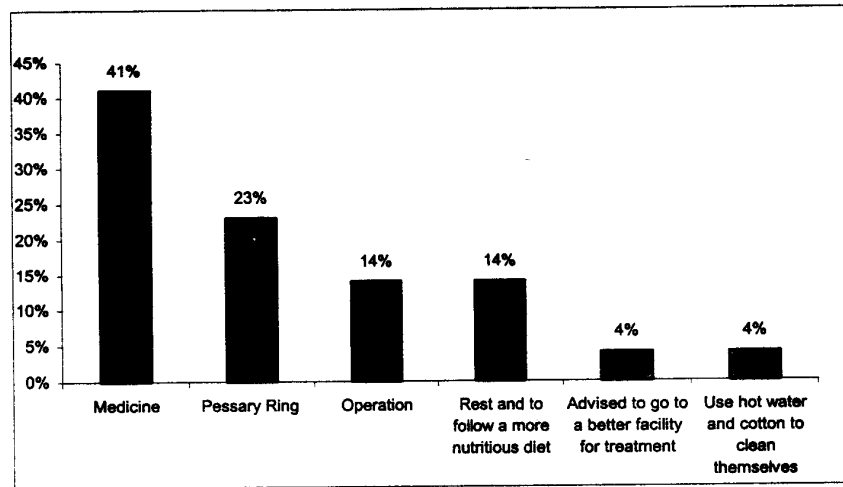
Bar Graph 9



4.12 Treatment Advice Given

The majority said they were prescribed medicines (41%). While others (23%) said the pessary ring was fit in them and 14 per cent were advised operation. Another 14 per cent were recommended rest and to follow a more nutritious diet. 4 per cent were advised to go to a better facility for treatment, while another 4 per cent were told to use hot water and cotton to clean themselves. (Bar Graph 10).

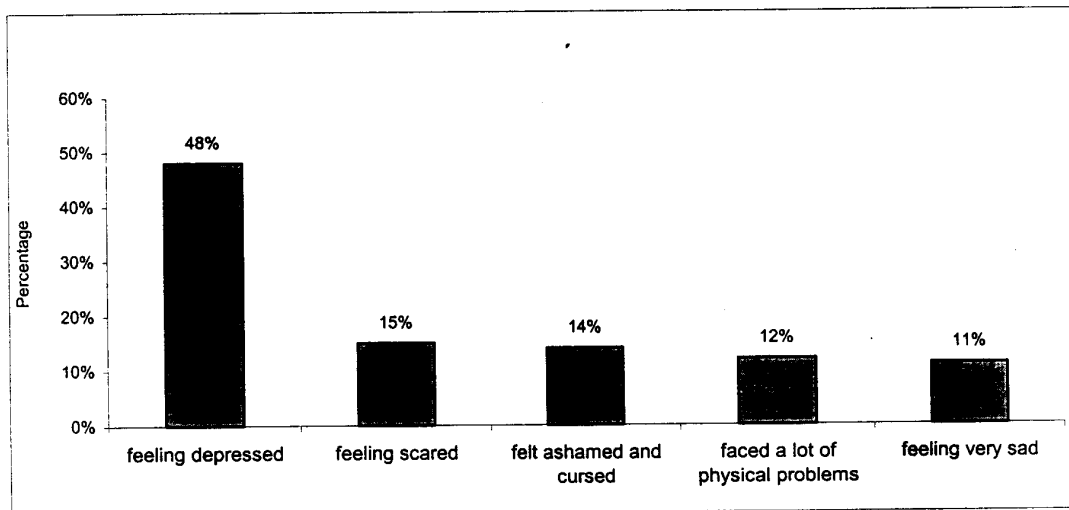
Bar Graph 10



4.13 Patient's Feelings and Reactions of Others

All the patients (100%) expressed feeling very worried about their physical condition. The majority (48%) of them reported feeling depressed after developing this condition. While 15 per cent reported feeling scared, 14 per cent said they felt ashamed and cursed. Another 12 per cent said they faced a lot of physical problems, 11 per cent reported feeling very sad. (Bar Graph 11)

Bar Graph 11



However, only 20 per cent said their spouse treated them differently as compared to before. The majority (80%) said there was no difference in their relationship. Those who felt their spouse behaved differently, reported difference in mostly verbal behaviour (90%), while 10 per cent said there was a difference in their physical relationship as well.

Other members of the family were seen to suggest that the patient go for treatment (51%). While another 21 per cent did not show any reaction, 15 per cent showed sympathy and 13 per cent disgust. If the patient's condition came to be known to community members, they were also seen to show sympathy (41%) and suggest the patient go for treatment (23%). Another 21 per cent did not show any reaction, while 10 per cent displayed disgust for the patient's condition.

After visiting the camp organized in the course of this research, 85 per cent said they were hopeful of recovery. However, 15 per cent were still not sure whether they could ever recover. The majority (71%) were also hopeful of support from family members if they had to do surgery, while 29 per cent were not confident. While 40 per cent were confident that their families could provide some economic support if required, 40 per cent said they would be cared for after surgery and 20 per cent said they would be provided morale support.

5. Findings of Focus Group Discussions

The women who participated in the focus groups were not necessarily patients of uterus prolapse. They were women who had come to attend the research camp with various other gynaecological ailments. These focus groups were conducted to assess the degree to which there was awareness about uterus prolapse, its causes, its prevention and cure.

Most of the women who participated in the FGDs knew what uterus prolapse was. The reasons identified for this condition varied from climbing trees while pregnant, to sexual intercourse right after childbirth, heavy work and lack of rest during pregnancy and the post-partum period. Similarly, other reasons cited were given birth at an early age, miscarriage, dysentery, frequent pregnancies, and extra pressure put during labour to hasten childbirth.

Sympathy was seen as the only thing that women as a community could offer to each other, coupled with advice to seek medical help. They said they would advise women to rest and not carry heavy loads.

6. Analysis of Results

6.1 Uterus Prolapse: A Common Factor in Maternal Morbidity

The high frequency of cases of uterus prolapse in the context of Nepal makes it a serious women's reproductive health issue, which requires urgent attention of policy makers and service providers. The estimated figure of 1,677 cases of uterus prolapse per 100,000 live births does fall within the estimated 6 cases of maternal morbidity for every case of maternal death. Nepal's current rate of maternal mortality is 539 per 100,000 live births. Calculated on the basis of these estimates there would be an estimated 3,234 cases of maternal morbidity per 100,000 live births in Nepal. Based on this calculation, one could surmise that a slightly more than 50 per cent cases of morbidity results in uterus prolapse.

The age range of uterus prolapse found by this study amongst Nepali women (15 years to more than 51 years) also makes it a serious reproductive health issue. Unlike in the developed world, where menopausal and post menopausal women are found to suffer from uterus prolapse due to reduced oestrogen levels, which lead to the ligaments losing elasticity and strength, in Nepal this

condition has been found in girls as young as in their teens. The seriousness of this condition is compounded by the fact that it has a progressive nature.

A study done by Bonetti et al (2002) in Accham and Doti districts of this region has also shown a very high prevalence of uterus prolapse among women of this area.

6.2 Causes and Symptoms

The causes identified by the patients who took part in this study are corroborated by medical research. Medical research identifies the following as the key causes of uterine prolapse:

Pregnancy and childbirth: The weight of the pregnant uterus on the pelvic floor and abdominal straining during vaginal delivery can cause muscle, connective tissue and nerve damage. The risk increases with multiple pregnancies and/or high birth weight babies. The factor of multiple births applies very well to the patients of this study. On average they had more delivered more than 3.75 children. Forty four percent reported having had between 4 to 6 babies. Very rapid labour and delivery is also reported as one of the causes of uterine prolapse. This could also be a significant reason amongst our sample as 29 per cent reported giving birth within 5 hours.

Raised intra-abdominal pressure: Chronic coughing, straining caused by constipation, heavy lifting, and obesity can place pressure on the internal organs and cause uterine prolapse. The correlation between the high occurrences of uterus prolapse in Nepali women and their poor quality of life can be easily identified. Their health and life is not only marred by cooking in poorly ventilated spaces, leading to chronic cough, but also by having to constantly carry heavy loads of fuel wood, fodder and farm produce.

Menopause: Reduced oestrogen levels can cause ligaments holding the uterus in place to lose some of its elasticity and strength. This factor is also seen to hold true for our research sample as 68 per cent of those who reported not having their menstruation (n=62) were already into their menopause. Hormone replacement therapy is not easily available in Nepal, even to women who have access to hospitals; it is therefore, very far from the reach of this rural sample.

Fibroid tumours: Has been reported, as a contributing factor, but this research could not assess as to whether this was a factor amongst Nepali women for uterus prolapse.

Congenital factors: Women born with collagen defects are at higher risk of developing pelvic organ prolapse including uterine prolapse. However, this factor also could not be determined in this research.

Race is a factor in risk for uterus prolapse, though reasons for it are as yet undetermined. For example, a study in the USA showed that Hispanic women are more at risk than white women, and also that Afro-American women have a lower risk (Hendrix et al, 2002, Brown et al, 1997). Whether Nepali women as a race are more prone to uterus prolapse also cannot be determined by this study. This study's sample was purposive to the extent that it took patients of uterus prolapse as its key target group. However, on the lines of race as a factor, the sampling was random. Also the race of the women who were a part of this study cannot be categorised as two different races. Only the caste groupings have been identified. The relatively high frequency of

occurrence seen amongst the chettri women could only be due to their larger representation in the population of this area.

The women who reported about their cases in this study displayed all the classic symptoms of uterus prolapse. All three degrees of uterus prolapse were also found among the patients, namely:

First degree: where the cervix droops into the vagina.

Second degree: where the cervix sticks out beyond the opening of the vagina (the introitus).

Third degree: where the entire uterus is outside the vagina, also called procidentia. This is caused by weakness in all of the supporting muscles. Chronic irritation and dryness causes a thickening of the outside layer of the cervical and vaginal tissue, which leads to lesions and bleeding.

Besides, these symptoms reported by the patients of this study also tally with the following associated conditions, namely:

Cystocele: A herniation of the upper front vaginal wall where a part of bladder bulges in to the vagina, which leads to urinary frequency, urgency, retention, and incontinence.

Enterocoele: The herniation of the upper rear vaginal wall where a small bowel portion bulges in to the vagina. Standing leads to a pulling sensation and backache and is relieved by lying down.

Rectocele: The herniation of the lower rear vaginal wall where the rectum bulges into the vagina. This makes bowel movements difficult to the point that one may need to push on the inside of the vagina to empty one's bowel.

6.3 Prevention and Cure

This study also clearly revealed that there has been /is no serious attempt on the part of the government health service delivery system to even remotely address this problem. One key cause of the lack of attention could be the fact that relatively little is known about on the degree of occurrence of uterus prolapse amongst Nepali women. As seen in the study the majority of women are silent about the issue due to shame and fear. Research on this topic has also been scant; maybe this research is one of the few done on this issue in Nepal.

Other reasons for the government's relative silence on this issue is also the donor-driven syndrome that the entire health sector is prone to. As also reported in Himal South Asia (April 2002), while USD 400,000 were spend on a AIDS awareness campaign, while the disease only affects 58,000 Nepalis who have tested positive. A health issue, which by the estimates of this research affects as many as 1,677 women in every 100,000 women, receive little attention. It is hoped that this study will serve the purpose of bringing this reproductive health issue of women to the forefront.

Awareness about how to prevent this condition does not require very complicated messages and can be easily taken forward through the government's own system and by networks such as the Safe Motherhood Network of Nepal. However, IEC materials on this issue are yet to be designed

or disseminated widely by the government. FCHVs, MCH workers can also be trained to provide information and referrals about uterus prolapse. The fact that none of the women participating in the FGDs or those who were patients had any idea about possible prevention through exercises and other non-surgical methods during the early stages reveals a need for an aggressive information campaign on the issue.

The other issue, which needs to be addressed, is providing morale support to the patient. Husbands were found to be quite supportive of their wife's suffering. Even in an area as remote as these three sample villages, 29 per cent of the patients had already visited a health facility at least once. However, it also must be kept in mind that 71 per cent had not had any access to treatment. The majority of the patients also reported that the husband's behaviour towards her had not changed. Whether this was the truth or the patient did not confide otherwise for fear of retribution from the husband cannot be stated based on just one interview. The family was also seen to be a strong support system that empathised with the patient and suggested she go to a health facility. However, shame, fear, lack of knowledge and resources were seen as big obstacles to accessing services. Therefore, creating an environment for the patient to be able to talk about it is the first step towards curing prolapse. Women's groups, which already exist for different purposes could be included to initiate awareness about this issues amongst women.

It must also be kept in mind that even among those who accessed services only 23 per cent were provided the pessary rings, while other were treated, maybe only symptomatically. There seems to be a gap in the training provided to medical practitioners about treatment of uterus prolapse, both in Nepal and in India.

During the course of this research, the patients were prescribed non-surgical treatment options, while the majority (253) were provided with vaginal pessary, which is a device similar to a diaphragm, which can be inserted into the vagina to help support a prolapsed uterus. Patients were also taught how to manage the device including insertion, removal and cleaning, periodically. The remaining 7 patients were prescribed pelvic floor exercises. These kegel exercises may limit the progression of the prolapse and alleviate symptoms such as low back pain and pelvic pressure. However, once the prolapse has progressed, the exercises are no longer useful. These two relatively simple cures can be widely practised in the context of Nepal.

In addition, surgical cures should also be made available and accessible to rural women.

7. Recommendations

The following are recommended on the basis of this study.

- The results of this research in conjunction with the study by Bonetti et al (2002) should be considered to form a basis to design a national programme on prevention of uterus prolapse in Nepal. Especially, in view of its progressive nature.
- The NHRC take this issue up as a key reproductive health issue for Nepali women and encourage follow-up studies in other parts of the country to corroborate these findings.

- The issue of uterus prolapse be considered a key reproductive and human rights issue of Nepali women and that both the governmental and non-governmental sectors focus to prevent it by initiating a mass awareness campaign.
- The government should make non-surgical remedies for uterus prolapse available at the health post and sub-health post level. The technical expertise required for this sector should be developed through a comprehensive human resources development programme.
- The government should make this issue part of its safe motherhood campaign and direct all partners to also take it up in their bi-lateral and multi-lateral programmes.
- The government should also make surgical options available at regional hospitals and develop the required essential expertise.
- Efforts to improve the overall status of women should be further strengthened.
- Male involvement in women's empowerment and reproductive health issues should be made a norm in all programmes.

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Annexure

Services Provided in the Low Risk Birthing Centre

The Low Risk Birthing Centre has provided services to a total of 9,522 women and children of Jogbuda, Alital and Sirsha VDCs since its establishment. Following is the data:

Total number of services provided from 1997 to September 2003	
Total number of Ante Natal Patients	6,402
Total number of Post Natal Patients	150
Total number of Gynaecological Patients	434
Total number of General Patients	1,694
Total number of check-ups provided for children under 5 years	564
Total number of deliveries conducted in the Low Risk Birthing Centre	278

पाठेघर खस्नु (पोल्याप्स) सम्बन्धी अन्तरवार्ता

प्रश्नावली

नाम:
ठेगाना: जिल्ला..... मा.वि.स. बार्ड नं..... गार्ड.....
अन्तरवार्ता लिनेको नाम
मिति.....

१०१. जात
- | | | | |
|-------------|--------------------------|-----------|--------------------------|
| १) ब्राम्हण | <input type="checkbox"/> | ४) दलित | <input type="checkbox"/> |
| २) क्षेत्री | <input type="checkbox"/> | ५) जनजाती | <input type="checkbox"/> |
| ३) ठकुरी | <input type="checkbox"/> | ६) अन्य | <input type="checkbox"/> |
१०२. उमेर:
- | | | | |
|----------|--------------------------|------------------|--------------------------|
| १) १५-२० | <input type="checkbox"/> | ५) ३५-४० | <input type="checkbox"/> |
| २) २१-२५ | <input type="checkbox"/> | ६) ४०-४५ | <input type="checkbox"/> |
| ३) २६-३० | <input type="checkbox"/> | ७) ४५-५० | <input type="checkbox"/> |
| ४) ३१-३५ | <input type="checkbox"/> | ८) ५० भन्दा माथि | <input type="checkbox"/> |
१०३. वैवाहिक स्थिति:
- | | | | | | |
|---------------|--------------------------|---------------|--------------------------|-----------|--------------------------|
| (१) विवाहित | <input type="checkbox"/> | (२) अविवाहित | <input type="checkbox"/> | (३) विधवा | <input type="checkbox"/> |
| (४) पारपाचुके | <input type="checkbox"/> | (५) छुट्टिएको | <input type="checkbox"/> | | |

१०४. १) वजन:केजी २) लम्बाई: फिटइन्च (अन्दाजी)

३) Respondent (अन्तवार्ता दिने) हेर्दा:

(१) मोटो छ (२) ठिकै छ (३) दुब्लो छ

१०५. तपाईंको महिनावारी हुँदै छ ?

१) छ २) छैन

यदि छैन भने किन ?

- | | |
|-------------------------|--------------------------|
| १) उमेरको कारणले सुकेको | <input type="checkbox"/> |
| २) गर्भवती | <input type="checkbox"/> |
| ३) अस्वस्थ भएर अनियमित | <input type="checkbox"/> |

१०६. विवाह हुँदा तपाईंको उमेर कति वर्ष थियो ?

- १) १९ वर्ष भन्दा कम
२) २० - २४ वर्ष
३) २५ - ३४ वर्ष
४) ३५ वर्ष भन्दा माथि

१०७. पेशा: (के काम गर्नु हुन्छ ?)

- १) घर भित्रको काम
२) ज्यालादारी
३) मजदुरी
४) शिक्षिका
५) अन्य खुलाउने _____

१०८. शैक्षिक स्तर:

- १) प्राथमिक स्तरसम्म (कक्षा ५)
२) कक्षा ६ देखि ८
३) १० पास वा एस.एल.सी
४) साक्षर
५) अशिक्षित

१०९. श्रीमानको शैक्षिक स्तर:

- १) प्राथमिक स्तरसम्म (कक्षा ५)
२) कक्षा ६ देखि ८
३) १० पास वा एस.एल.सी
४) साक्षर
५) अशिक्षित

११०. कति वटा सन्तान जिवितै जन्माउनु मयो ?

- १) १ - ३
२) ४ - ६
३) ६ - १०
४) १० भन्दा माथि

१११. कति वटा सन्तान जिवित छन् ? जन्मा..... छोरा..... छोरी

११२. सन्तान जन्माएको ठाँउ र सहयोग गरेको व्यक्ति/हरुबारे जानकारी दिनुहोस् ।

१) ठाउँ - कति कहाँ जमिए ?

- क) गोठ _____ जना
ख) घर _____ जना
ग) प्राथमिक स्वास्थ्य चौकी _____ जना
घ) रुडुकको प्रसुती गृह _____ जना
ङ) अस्पताल: (१) टिम अस्पताल _____ जना (२) जिल्ला/अञ्चल अस्पताल _____ जना
च) भारतको अस्पताल _____ जना

२) व्यक्ति - कसले कति पटक सहयोग गरयो ?

- (क) सुडेनी (ख) सासु (ग) छिमेकी (घ) तालिम प्राप्त सुडेनी
(ङ) सरकारी नर्स (च) डाक्टर (छ) रुडुकको अ.न.मी. (ज) आफै

११३. सबैभन्दा पछिल्लो बच्चा जन्मदा कसले सहयोग गरेको थियो ?

- १) (क) सुडेनी (ख) सासु (ग) छिमेकी (घ) तालिम प्राप्त सुडेनी
(ङ) सरकारी नर्स (च) डाक्टर (छ) रुडुकको अ.न.मी. (ज) आफै

२) बच्चा जन्मदा सहयोग गर्ने मानिसले घेट/पाठेघर थिचेको थियो?

- (क) थियो (ख) थिएन

३) बच्चा जन्मन कति समय लाग्यो ? (पहिले वेथा लागे देखि बच्चा जन्माए सम्मको अवधि)

- (क)घण्टा (ख)..... दिन

8) के तपाईं भारी घेरे बोग्गु हुन्छ ?

(क) घेरे भारी (ख) थोरै भारी (ग) ठिकै भारी

9) के तपाईंले बच्चा जन्माउनु भएको 84 दिन भित्र भारी बोग्गु भएको कियो ?

(क) थियो (ख) थिएन

998. तपाईंलाई पाठेघर सम्बन्धी अफठ्यारा कहिले देखि भयो ?

999. के कस्ता लक्षणहरू देखा परे ?

- १) कम्मर दुख्ने
- २) पिसाब फेर्दा: (क) दुख्ने (ख) पोल्ने , (ग) गाह्रो हुने
- ३) घेरे पिसाब लाग्ने/हुने
- ४) दिसा गर्दा गाह्रो हुने
- ५) पाठेघर भरेको जस्तो लाग्ने
- ६) योनीबाट सेतो पदार्थ आइराख्ने
- ७) योनीबाट रगत बगिरहने
- ८) योनीबाट गन्हाउने पदार्थ आइराख्ने
- ९) पाठेघर दुख्ने
- १०) सहवास गर्दा दुख्ने
- ११) भारी बोक्दा दुख्ने
- १२) खोक्दा पिसाब चुइने
- १३) उभिरहन गाह्रो हुने
- १४) बसिरहन अफठ्यारो हुने

996. तपाईंको पाठेघर किन भरेको जस्तो लाग्छ ? उल्लेख गर्नुहोस्

११७. तपाईंको पाठेघर के मर्दा नमर्ला अस्तो लाम्ख ? उल्लेख गर्नुहोस्

११८. तपाईंको पाठेघर मरेपछि त्यस बारेमा सबै भन्दा पहिला कोसँग सल्लाह गर्नु भएको थियो। किन ?

- १) साथी
- २) श्रीमान्
- ३) सासु
- ४) जेठानी, देउरानी,
- ५) दिदी बहिनी
- ६) दाजुभाइ
- ७) अन्य

११९. यदि छैन भने किन सल्लाह नमरेको ?

- १) डरले
- २) लाजले
- ३) इज्जत जाला भनेर
- ४) औषधी गर्न पैसाको अभाव भएर
- ५) अन्य

१२०. पाठेघर खसेपछि तपाईंले केहि उपचार मराउनु भयो ?

१) (क) भयो ? (ख) भएन ?

२) यदि मराउनु भयो भने, कसबाट मराउनु भयो ?

- (क) उप स्वास्थ्य चौकी
- (ख) स्वास्थ्य चौकी
- (ग) प्राथमिक स्वास्थ्य सेवा केन्द्र
- (घ) नीजि स्वास्थ्य क्लिनिक
- (ङ) अस्पताल
- (च) सुडेनी
- (छ) धामी वा भक्त्री
- (ज) भारतमा गएर उपचार गरेको
- (झ) अन्य

३) यदि उपचार मराउनु भएन भने किन मराउनु भएन ?

४) सल्लाह वा औषधी दिएको भए, के कस्तो उपचार वा सल्लाह पाउनु भएको थियो ?

१२१. पहिला पाठेघर सम्बन्धि अरु केहि परीक्षण मराउनु भएको थियो ?

१) थियो

२) थिएन

१२२. पाठेघरको स्वास्थ्य परिक्षण कहाँ मराउनु भयो ?

१) प्राथमिक स्वास्थ्य चौकी

२) स्वास्थ्य चौकी

३) रुडुक प्रसुतीगृह

४) जिल्ला अस्पताल

५) अञ्चल अस्पताल

६) भारतको अस्पताल

१२३. पाठेघर भरेपछि तपाईं आफुलाई कस्तो महशुस भयो ?

१२४. पाठेवर मन्नेपसि तपाईं र त्रीमन्त्रको सम्बन्ध मिला केहि विनमता आस्ता अस्ता भान्छ ?

- १) मान्छ
- २) मान्छैन

यदि तपाईं मने.

- (क) मौखिक हिंसा
- (ख) शारीरिक हिंसा
- (ग) बेइज्जत गरेको
- (घ) अन्य

१२५. तपाईंलाई करिवाको अन्य सदस्यहरूको कस्तो व्यवहार मरे

- १) सहानुभूति देखाए
- २) हेसा गरे
- ३) घृणा गरे
- ४) उपचार गर्न सल्लाह दिए
- ५) उपचार गर्न लिएर गए
- ६) अन्य

१२६. तपाईंलाई समुदायका अन्य सदस्यहरूको कस्तो व्यवहार मरे

- १) सहानुभूति देखाए
- २) हेसा गरे
- ३) घृणा गरे
- ४) उपचार गर्न सल्लाह दिए
- ५) उपचार गर्न लिएर गए
- ६) अन्य

१२७. तपाईंलाई आफ्नो शरिरबारे कति चिन्ता लाग्छ ?

- १) धेरै
- २) थोरै
- ३) लागेन
- २) अन्य

१२८. तपाईंलाई यस शिविरमा आउनको लागि कसले सल्लाह दियो ?

- १) आफै निर्णय गरेर
- २) श्रीमानले सल्लाह दिएर
- ३) परिवारका अन्य सदस्यले सल्लाह दिएर नाता खुलाउनुहोस् _____
- ४) छिमेकीले सल्लाह दिएर
- ५) साथीहरूले
- ६) अन्य

१२९. के गर्दा तपाईं फेरि पूर्णरूपले स्वास्थ्य हुन सक्नु हुन्छ होला जस्तो लाग्छ ?

- १) लाग्छ
- २) लाग्दैन

१३०. के शल्यक्रिया गर्नु पर्छो भने श्रीमान/परिवारले सहयोग मर्छर्न होला जस्तो लाग्छ?

- १) गर्छर्न
- २) गर्दैनन्

१३१. यदि सहयोग मर्छ भने के कस्तो किसिमको सहयोग मर्छ होला ?

- १) आर्थिक
- २) मानसिक
- ३) स्याहार सुसार
- २) अन्य

Photos of Uterus Prolapse Research/Health Camp



Video Presentation on Women's Issues



Focus Group Discussion



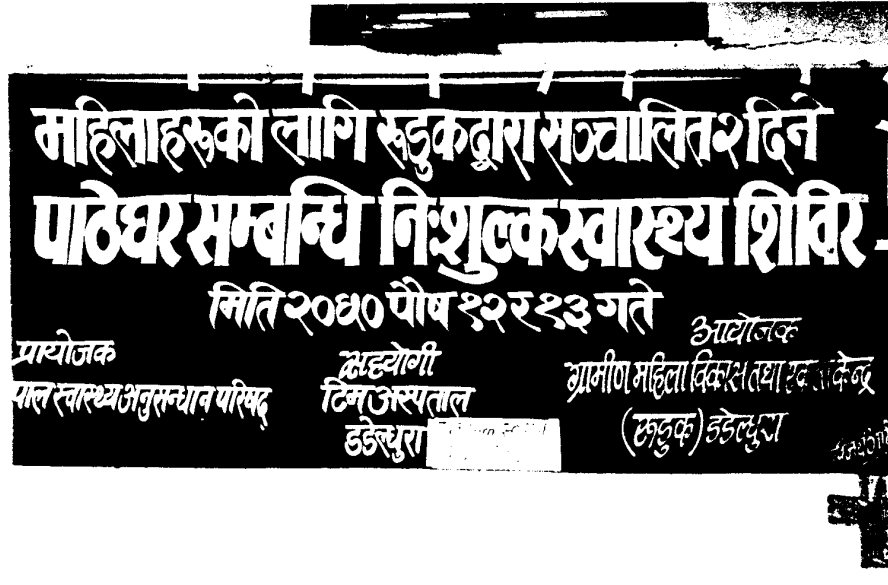
Interview of Prolapse Patient



Women Queuing for Check-up



Treatment of Uterus Prolapse Patient by Nurse



Health Camp Banner

Dadeldhura District

Annex 4

