

Situation of Uterine Prolapse in Salyan, Mugu and Bajhang Districts of Nepal: A Clinic Based Study

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ABSTRACT

Introduction: Uterine prolapse is a major public health problem in rural Nepal. It is a medical and social problem, deeply rooted with poor health services and socio-cultural beliefs. Prevention and management is crucial for maternal health. This study aimed to explore the situation of uterine prolapse problems and attempts of health response through mobile camps.

Methodology: It is a mobile clinic based study of mobile reproductive health camps. Screening, laboratory investigation, treatment as well as preventive pressure were done at camps and screened cases were referred for hysterectomy. Follow up was done after three months of hysterectomy at respective camp sites.

Results: Prevalence of uterine prolapse is 15% among women attending in clinic in three districts; high number of women having first degree and third degree uterine prolapse.

Conclusion: There is urgent need of surgical treatment of UP. Promotive and preventive like behavior change communication interventions should focus to aware the people

Key words: mobile reproductive health camps, surgery, uterine prolapse

Introduction

Uterovaginal prolapse is the downward displacement of uterus from its normal anatomical position. The etiology is not known¹⁶. But Parity and obesity were strongly associated with increased risk for uterine prolapsed¹⁸. The loss of uterine support is resulting from early marriage, unassisted home delivery, lack of health facilities, social taboos, unbalanced and non-nutritious diet, multiple child birth, heavy manual work in the immediate puerperium in the majority of rural Nepalese women^{1,12,2}. Most of them do not attend a health facility for regular antenatal care or delivery. The recovery period after delivery is denoted by ethnic prescriptions and household needs that disregard the woman's physical readiness to resume work⁹. Especially extensive physical labor, smoking while having chronic obstructive pulmonary disease and low maternal weight due to lack of nutritious food are mainly responsible for this common disease³. Uterine prolapse (UP) can be viewed as a function of unequal gender relationships⁴.

Globally, 30% of all women who have delivered a child are affected. For every maternal death, an estimated six to 15

women face debilitating morbidity. The incidence in other countries is – 17% in Australia and U.S., 8.5% in France and 27% in Turkey. Global prevalence is quoted as 2 – 20 % under the age of 25 years¹⁴. In Nepal, 9-35% of Nepali women are suffering from uterine prolapsed, and at least 200,000 are in need of immediate surgical treatment⁵. Prolapse surgery is the 2nd in the operation list and 45% of cases appear after first delivery⁷. There is one in four women complained of UP, and one in four were diagnosed with UP. Over one fifth of women are reported the onset of prolapse before the age of 20 years⁸. Prolapse causes problems in performing daily activities. Women often complain of “something falling out” from genital area⁶. Surgical treatment is scarcely available and little is known of the results of UP surgery on women living under burdensome circumstances in Nepal¹³.

Methods

It is a out reach clinic based study. Mobile reproductive health (RH) camps were conducted in one hill (Salyan) and two mountainous (Mugu and Bajhang) districts of mid and far western Nepal from January 2010 to June 2010. Total 14 (five in Salyan and Bajhang district each and four in Mugu; three days for each camp) mobile RH camps were conducted. Camp sites were selected by the district reproductive health coordination committee (DRHCC) meeting conducted in the district. The basis of sites selections were previous morbidity pattern on RH problems, accessibility for service users, and unavailability of such service and geographical coverage of the district. Information was disseminated through formal letters to the health institutions form respective district health office. Local volunteers were mobilized for disseminating posters of conduction of RH Camp. Posters were also displayed in public place where peoples' gathering and movement took place. Public announcements were made through the local radio for one month before conducting camps in all districts.

Medical team focused on the three components during RH camps: first health service delivery, second capacity building of local stakeholders and third behavior change communication (BCC) activities for service users.

In the first components of camp, screenings of the uterine prolapse cases as well as treatment of reproductive health problems were done. Sexual and gender based counseling corners were the unit of the camp for those who felt difficulty in exploring the problems, counseling services were

provided for the respective gender. Investigation of the cases for treatment was supported by laboratory findings. Most of the reproductive health problems were treated in the camps. Drugs were provided with proper counseling for the compliance of drugs. Pelvic floor exercise and counseling was done for first degree prolapse and other non referred cases; ring pessaries were inserted. Those UP cases who were screened and supposed to refer for surgery consulted to female counseling corner. After individual counseling, they were called on the third day of the camps for group counseling and discussions were done in different aspects of hysterectomy. And last if they agreed voluntarily for hysterectomy; they were referred to Nepalgunj Medical College (NGMC), Kohalpur on free of cost.

For capacity building of local health service providers, key person and school adolescents; it is necessary to strengthen the capacity of local HWs. Master of trainer of trainee was given to the district supervisor on minimum initial service package (MISP) on reproductive health. Onsite coaching for local health workers for identification, classification and management of the RH problems in the local level was done for local health facilities' staffs. They were oriented about how uterine prolapse and GBV is linked and approaches to overcome this problems. Community key persons, school teachers, female community health volunteers (FCHVs), local leaders, dhama/jhankri were oriented on problems of UP, GBV and MISP on RH. Secondary/higher secondary schools' adolescents were also oriented on these issues at the school of each camp. Such orientation programs were conducted one day before the camp started.

On part of BCC activities , youth friendly health education corner, video shows corner were also established and preventive measures like public health education through video shows, group discussion, dissemination of IEC materials, counseling, street drama, quiz contests and radio programs were also done. Many people benefited from these activities

All the information was recorded in forms and register which were developed as per government standards. Data were entered in daily in excel sheet then analyzed. Analyzed copy of data was submitted DHO and concerned local health institutions where camps were held for health management information system (HMIS). The quality of all activities was monitored by district health office (DHO), donor and implementing agency.

After three months, all post hysterectomy cases, UP cases and rest of the cases were followed up in the respective camp sites (two days each camp sites).

Results

Camps were conducted in planned date and time. Medical team spent whole 6 months.

Daily attendance of patients in the outpatient department (OPD) was 212 per camp. Total service users were 8,892 including male 1085 (12%) and female 7872 (88%). Out of total service users; 36% were from Salyan district, 32% were from Bajhang and Mugu each. Regarding ethnicity; 23.46% were from dalit, nearly eight percent were hill janajati and 68.87% were other hill ethnic group.

Table 1: Sex and ethnic distribution service users

Ethnicity	Male	Female	Total	Percentage
Dalit	320	1766	2086	23.46
Janajati	70	612	682	7.67
Others (B/C)	695	5429	6124	68.87
Total	1085	7807	8892	100.00

Health problems

Nearly 60% of the patients who came in the camps were diagnosed having RH problems. Categorically, 24% were gynecological cases (including male sub-fertility); nearly 23.5% were cases having sexually transmitted infections/reproductive tract infections (STI/RTI), seven percents for

obstetric services. RH camps provided temporary family planning services (implant and intrauterine contraceptive device with technical support of DHO Salyan, 3% of total women received FP services. 1.45% of total women got sexual and gender based violence counseling service through the GBV counselor. Rests of the cases (40.71%) were having non-RH problems cases.

Table 2: Disease category

Disease category	Male	Female	Total	Percentage
Gynecological cases (including male sub-fertility)	115	2046	2161	24.30
STI/RTI	83	2005	2088	23.48
Family planning (Implant/ or IUCD)	0	272	272	3.06
Obstetric cases	0	622	622	7.00
Non RH cases (general)	887	2733	3620	40.71
GBV cases	0	129	129	1.45
Total	1085	7807	8892	100.00

Age distribution and UP

Women aged 20-24 years had found high UP problems; out of total 1343 women of aged 20-24 years, nearly 10 percents women were suffering from uterine prolapse. UP is also prevalent in adolescent age group (15-19 years), where more

than two percents. Women aged more than 50 and over years, more than 28% of that aged women were suffering. The scenario indicates that women are suffering from long time to at this age. Regarding the ethnicity and uterine prolapse conditions.

Table 3: Ethnicity and age wise distribution of UP

Ethnicity	15-19 year (568)	20-24 year (1343)	25-49 year (4428)	50 and over (1101)	Total (%)
Dalit (1776)	6	30	173	62	271(15.26)
Janajati (612)	2	4	62	37	105(17.16)
Others (5429)	5	96	482	225	808 (14.88)
Total (%)	13(2.29)	130 (9.68)	717 (16.19)	324 (28.16)	1184 (100)

Regarding ethnicity, 15% of the dalit women were found UP problem, 17% from the janajati and 15% of other hill Bramin and Chhetri (B/C) women. Out of total (5074) women who were attended in the camp with RH problems, 23.33% of were there to get rid of uterine prolapse problems

Degree of UP

Among women attending the camp, 15% of them were to

found have uterovaginal propalse conditions. It was highest in Salyan district (19.66%) followed by Mugu district (12.89%) and Bajhang (11.86%). Of total uteroveginal cases, 40% cases were of I degree and required perennial exercise, 17% of cases were of II degree and required ring pessary insertion and 43% cases were III degree UP and procedentria.

Table 4: Degree of UP

Category/District	Salyan (3006)	Bajhang (2496)	Mugu (2305)	Total (7807)
1 st degree UP	221	102	151	474
2 nd degree UP	86	60	49	195
3 rd degree UP	284	134	97	515
Total (District wise Prevalence %)	591(19.66)	296 (11.86)	297(12.89)	1,184 (15.17)

Hysterectomy status

Total 407 third degree UP and procedentia cases (34.37%, N=1184) were refereed for free hysterectomy in Nepalgunj medical college and teaching hospital (NGMC) at Kohalpur. All the cost (transportation, lodging, fooding) of UP cases

including care taker was free. 322 UP cases (72%, N=407) arrived at NGMC out of which hyterectomy was done for 277 cases.(82%, N=322). 43 cases were cancelled due to underlying medical causes. Total 272 cases were inserted with ring pesseary (23%, N=1184) at the camp.

Table 5: Summery of hysterectomy

District	Referred cases	Arrival cases	Hysterecto my cases	Cancelled cases	Ring pessary insertion cases
Salyan	233	192	164	26	130
Bajhang	101	69	60	9	84
Mugu	73	61	53	8	58
Total	407	322	277	43	272

Discussion

Uterine prolapse is a major reproductive problem of Nepalese women. In 2002, in a clinic based study, undertaken jointly by GTZ, UNFPA in far western Nepal (Accham and Doti) 25.1% women were reported with different degrees of UP⁸. Another study undertaken by the Safe Motherhood Network Federation-Nepal in 10 districts, where prevalence of UP was found to average 9%. Among

hill women this was 15% compared with 5% amongst terai women. This essentially clinic based study was undertaken in gynecological camps organized in different districts¹⁰. Study conducted in three eastern districts found 20.1% morbidity of UP¹⁵. A hospital based study from the Maternity Hospital in Kathmandu, which reports that, out of the total 1,147 gynecological patients, 9.6% were found to have uterine prolapse⁴. A outreach clinic based study conducted by Adventist Development and Relief Agency

(ADRA) in three hill district of mid western Nepal (Dailekh, Jajarkot and Rukum), 1,362 (8.77%, N=15,529) were found having UP problems¹¹. This study found average 15% UP cases ranging from 12% in Bajhang to 19.66% in Salyan. Among UP cases, 43 % were third degree and procedentia cases which reveal women were suffering from long time. . Research documents mentioned that prolapse is a leading cause of ill health and suffering among women of all ages from different social groups and geographical areas. Non-surgical treatment arrests the condition early, when UP is both less painful and less expensive to treat. Interventions such as pelvic floor strengthening exercises and pessary rings are inexpensive and low-tech, lending themselves to sustainable, local level implementation¹⁶.

Conclusion

UP condition is a major public health issue in Nepal with little attention given. Women lack knowledge about UP and seek care at hospital only during the late stage. They have poor access to medical treatments. Along with surgical treatment, preventive measure should be focused to raise awareness and to address this "culture of silence". Health service delivery at peripheral level should be strengthened for access to quality reproductive health services. Socio-cultural discrimination like early marriage, lack of education, lack of equal opportunity for girls, weak decision making and lack of male participations need to be reduced. Emphasis should be given on delaying ones first pregnancy, planning a good gap between pregnancies, and delaying first pregnancy together with the use of contraceptives in the targeted population.

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