

KNOWLEDGE, ATTITUDE AND PREVENTIVE MEASURES AMONGST MARRIED WOMEN OF REPRODUCTIVE AGE TOWARDS UTERINE PROLAPSE IN THE EIGHT VILLAGES OF SURKHET DISTRICT OF NEPAL

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ABSTRACT: This article reports a cross sectional analytical community based study carried out amongst married women of reproductive age in the mid western region of eight village development committees (VDCs) of Surkhet district of Nepal. A total of 267 participants were selected by systematic random sampling. The prevalence of uterine prolapse was found to be 24.7%. Analysis of the data using chi square revealed that total pregnancies (p-value=0.005), delivery practice (p-value=.046), age (p value=.016), and knowledge level (p value<0.01) were found to be significantly associated with the status of uterine prolapse. First stage Binary logistic regression revealed that knowledge level (p-value=0.002) and total pregnancies (p value=.049) were significant at p value 0.25. In the final stage of binary logistic regression knowledge level (p value<0.01) and total pregnancies (p-value=.031) remained significant. However, attitude level which was not significant in the bivariate analysis, after controlling for other variables was found to be significant at the final stage of multivariate analysis at p value=.049. Two focus group discussions were carried amongst women with and without uterine prolapse to find out the factors influencing preventive behavior. It was found that though women had knowledge about the risk factors of uterine prolapse they were unable to practice risk prevention due to lack of support from family members. Gender discrimination, lack of education and awareness about one's health seems to be the root cause of it all. The result of the study can be used to address the concerned authorities and include prevention and management of uterine prolapse as a women's reproductive health right.

Keywords: uterine prolapse, knowledge, attitude, maternal health status

INTRODUCTION

Maternal morbidity is the unspeakable anguish undergone by millions of women in Nepal, which is not as focussed as much as the causes of maternal mortality [1]. Reproductive mortality and morbidity are one of the major problems for the women of Nepal. A study shows that out of 50 women reporting illness during a family planning camp, 96% were diagnosed with reproductive morbidity related illness [2]. Uterine prolapse is a significant health problem amongst women and has affected women all over, in the mountains, hills, plains and the valleys [3]. It is a condition in which women's uterus slips or sags out of its normal position. This is called incomplete prolapse. In a more severe case called complete prolapse, the uterus slips so far out of place that some of the tissue drops outside of the vagina [4].

Globally 30% women who have delivered a child are affected from uterine prolapsed [5]. A study carried out amongst Swedish women aged 20–59

years found the prevalence to be 30% [6]. In a 2000 study in northern India, of 2,990 married women surveyed for prolapse, 7.6% had prolapsed [7]. One study in the Terai districts, Siraha and Saptari found the prevalence at 30% and 42% respectively [3].

MATERIALS AND METHODS

Cross sectional study carried out amongst the married women of reproductive age in the Surkhet district of Nepal. Surkhet district which lies in the midwestern region of Nepal and is one of the poorly developed regions of the country. Eight VDCs of the Surkhet district were sampled during the survey namely Mehalkuna, Uttarganga, Chinchu, Lekhfarsa, Maintada, Gumi, Dahachour and Ghumkahare. Each VDC has 9 wards out of which three wards from each VDC were selected systematically. The total number of wards selected was 24. Systematic random sampling was done for the data collection. Using the voting data (household numbers) available from the election commission office, every 14th house ward was included in the study. The heads of households were also culled from the said list. A total of 24 data collectors were hired for the study.

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Table 1 Work post pregnancy

Observations(n=264)	Frequency	Percent
Light work		
1-7 days	84	31.8
8-14 days	51	19.3
15-21days	68	25.8
22-30days	42	15.9
>1 month	19	7.2
Mean± SD	17.3± 18.51	
Heavy work*		
1-7 days	21	8.0
8-14 days	20	7.6
15-21days	51	19.3
22-28days	11	4.2
29-35days	73	27.7
36-45days	3	1.1
>45 days	85	32.2
Mean± SD	44.29±48.89	

Table 2 Maternal Health

Variables	With prolapse N(%)	Without prolapse N(%)	χ^2	P- value
Total pregnancies				
1	4(10.5)	34(89.5)	14.921	.005
2	11(16.7)	55(83.3)		
3	13(23.6)	42(76.4)		
4	19(42.2)	26(57.8)		
>4	18(30.5)	41(69.5)		
Delivery Practice				
Own self	16(25.4)	47(74.6)	7.996	.046
Relatives/in laws	23(23.2)	76(76.8)		
TBA	11(47.8)	12(52.2)		
Health workers	15(19.2)	63(81.8)		

P value at 0.05

Table 3 Binary Logistic Regression

Variables	B	Odds Ratio	95% CI		P-value
			Lower	Upper	
Age	.027	1.027	.983	1.073	.227
Total Pregnancies	.296	1.344	1.027	1.759	.031
Knowledge Level	.869	2.385	1.473	3.860	<0.01
Attitude Level	.789	2.200	1.003	4.827	.049

P value at 0.05

A supervisor, including the researcher was present in each VDC to supervise the data collection. Data collection was done by creating a numbered list of the names of the househead and the house numbers of each ward. In case of any subject who was not present during the survey, the house beside the selected house was used as replacement. The confidentiality of the participant was maintained and participation was voluntary. The study was reviewed and approved by the National Health Research Council of Nepal.

RESULTS

Majority of the respondents were in the age group 30-34(20.6%), lacked formal education (47.2%) and more than three fourths (74.2%) were involved in farming. The prevalence of the uterine prolapse,

based on self report as well as diagnostic cases, was found to be 24.7%. Diagnostic here means women who have had own self diagnosed by the staff at the health center. Of this, nearly 50% had undergone treatment for the uterine prolapse.

The respondents were asked about the utilization of health services in the past 1 year. The respondents were allowed to answer more than one option. Around 38.3% of the participants had visited the private hospital while another 12.7% did not visit any health institution. Of 12.7%, 82.7% cited that the reason for not visiting was because they did not fall sick. The mode of payment for the respondents was out of pocket (82.9%).

Majority (76.7%) of women married between 15-20 years and the minority (6.0%) between 21-26 years. As for age at the birth of first child, 66.9% of the

women had their first baby between the ages 14-19 and only 3.45% had their first baby between the ages 26-30. Majority of the respondents were found to have three children (28.1%). The percentage of women who have four (16.3%) and more than four (14.1%) children makes up more than 30% of the total study subjects. Likewise for total number of pregnancies (includes live birth, still births and dead children), women who have had two or three pregnancies were found to be the highest with 25.5% and 20.9% respectively. The women who had been pregnant only once were found to be the least at 14.4%. For delivery practice, most births took place at home (72.7%). Of this, 37.5% had their baby delivered with the help of relatives and nearly 24% had it delivered alone without any aid. More than 34% of the respondents had not made any antenatal visits and those who had more than 4 visits were the least at 5.3%. Also the status of postnatal visits was very low with 17.4% of the women having made any post natal visits. The majority of the women (72.1%) did all kinds of work during pregnancy (cooking, washing dishes, getting wood from forest, water from far distance, taking animals out to graze). The scenario was almost the same for post pregnancy as 68.1% of them had started work immediately after delivery (less than 15 days). Women were asked the days since they started doing light work (cooking, taking care of child and old age) and heavy work (getting wood from forest, water from far distance, taking animals out to graze, foot milling). The result is shown in Table 1.

Analysis using chi square revealed that age was significantly associated to uterine prolapsed ($p=0.016$). Also, knowledge level was significantly associated ($p<0.01$) with uterine prolapse. Attitude level was not found to be significant. Few of the variables of maternal health found to be significant are shown in Table 2.

Analysis using the binary logistic regression revealed that knowledge level and total pregnancies were significantly associated with uterine prolapse. Attitude level which was not significant in the bivariate analysis, on controlling other variables became significant in the final model of logistic regression. The result is shown in Table 3.

Focus Group Discussion:

Focus group discussion was carried out amongst women with and without uterine prolapse. The survey on knowledge about uterine prolapse revealed that women had knowledge about risk factors, signs and symptom but had low knowledge about preventive measures. The aim of the discussion was to find out the factors influencing preventive behavior towards uterine prolapse amongst the women. The discussion was carried out for 40-45 minutes. Eight participants were recruited for each discussion.

When women with uterine prolapse were asked about risk factors of uterine prolapse, most of them said that carrying heavy load after delivery, not taking enough rest post delivery and poor delivery practice cause uterine prolapse. Women are generally considered impure after delivery and the family members and traditional birth attendants generally do not touch them so women resort to different means to take out the placenta.

"I took out my placenta by placing a bamboo over it so that it comes out due to the weight".

The different preventive measures cited by the women.

"You should get married at the right age", "Rest for 2-3 months after pregnancy", "Have right age gap of about 5 years between two children", "Traditional herbs are the best as we can make them ourselves. And if we can't do that much for ourselves, we can't do anything else".

The different reasons for not practicing preventive measures were

"My man had gone to India to work and he came back six months after the birth so I got no help from anywhere", "People think women are iron made and that they can do anything".

Women without uterine prolapse also cited similar reasons for prolapse except for one

"If you touch food or eat food that is not allowed during menstruation".

Poor delivery practice was also seen amongst the group,

"I had my own pregnancy. I closed the doors and did it myself".

The different preventive measure for uterine prolapse was also similar amongst both the groups except for one peculiar measure cited by a woman.

"I heard that you cut a rooster, drip the blood on the uterus and then push the uterus inside, it works".

However, it was found that the women were taking certain preventive measure if not wholly.

"When lifting heavy loads, I bend down on my knees and lift it", "I eat well and started working only a month after pregnancy", "I have not gotten myself pregnant every year and I will make sure that there is a 2-3 years age gap".

FGD revealed that women had knowledge though partial about the risk factors of uterine prolapse but

were unable to take preventive measures due to lack of support from family, lack of manpower in the family. Poverty and gender discrimination was found to be the underlying factor for women not being able to practice preventive measures.

DISCUSSION

The prevalence of uterine prolapse in the study was found to be 24.7% amongst a total of 266 women. The finding is consistent with the other studies that have been carried out in the various districts of Nepal. A clinic based study carried out in the districts of Doti, Achham which share borders with Surkhet district found the prevalence to be 20% [8]. The prevalence of 24.7% has been obtained on the basis of self report as well as women who found it diagnostically. The Achham and Doti study found that of the total women who self reported uterine prolapse, 95.1% and 98.1% of them were found to be suffering from prolapse on clinical examination [9]. Similar findings were also presented in studies carried out in Asia, Africa and some parts of Europe. For example in Iran amongst women 18-68 years of age, the overall rate of prolapse was found to be 53% and in Sweden amongst women aged 20-59 years, the prevalence was 30% [6]. However, having said that, this study while cannot be generalized to the whole population, also may not be able to pin point the exact figures for cases of uterine prolapse due to self reported cases. But on the other hand, actual cases could have been hidden due to taboo issues by the women resulting in the figures being underreported.

Legal age of marriage in Nepal is 18 years. However, the result shows the mean age of marriage for women to be 16.8 years. The result was congruent with the national data for age of women at marriage which is 17.2 [8] and Nepal Safer Motherhood Project put the age as 16. The young age of marriage can be attributed to the practices of arranged marriages in Nepal [9]. But the finding does not coincide with studies carried internationally as tradition, culture and norms are different [6]. The study revealed that 37.2% of the women delivered their last baby with the help of relatives and mother in law. A government hospital based study found that the majority of the deliveries (68.18%) in the rural area were done by mother in laws or neighbors. This could be for the reason that health centers are mostly ill equipped so women prefer to have delivery at home where accessibility to warm water and food is easy. Also modesty reasons come into play [10]. Parity which is considered to be one of the risk factors of uterine prolapse was found to be significant. The fertility rate in Nepal is high because the children are considered blessings and the longing for a male child results in women being pregnant number of times. And having a male child also gives the guarantee that their paternal line continues and the sense of financial security for

future [11]. However, very few studies have been done on the subject and the researcher found no study that discusses the significance of knowledge level with uterine prolapse [12].

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RECOMMENDATION AND CONCLUSION

The study found that the prevalence of uterine prolapse is alarming and there is a wide gap in the knowledge level. The maternal health status of the women is quite low and it is one of the underlying factors for uterine prolapse. This shows that there is a lack of awareness amongst women about their health in general. At the policy level, prevention and management of uterine prolapse should be included as women's reproductive right. Government should provide primary health care centers with educational materials for awareness programs. The government should include uterine prolapse in school education for higher grades. Though, the government of Nepal has provided incentives to women who deliver their baby at health institutions, the figures are still low. So, the government should increase access to health care services by building strong coordination between the government and the various NGO and INGOS working in the field. The health workers should be provided with training so that they can detect uterine prolapse in the earlier stages. The government and the various organizations should involve mass media in order to spread awareness about preventive and curative aspects of uterine prolapse.

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