Married Women's Knowledge, Attitude, and Practice Regarding Uterine Prolapse in Morang District of Nepal

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ABSTRACT: Uterine prolapse is a common health problem, particularly among adults and old women in Nepal. This study aims to assess the level of knowledge on uterine prolapse among currently married women aged 15 to 49 years and assess their attitude and practice. Researchers used a descriptive research approach in this study. Participants were selected from simple random sampling, and the study area was selected from purposive sampling. There were 140 respondents aged 15 to 49 years currently married women. If there are two respondents in a single family, then the researcher has picked only one respondent for the interview. Semi-structured interview schedules have been used as a tool for the study. Research has identified various factors for uterine prolapse like age at first marriage, place of delivery, and history of abortion. Nearly one in two women had average knowledge of uterine prolapse, and one in four women had never heard of uterine prolapse. There are good practices (90 percent) for getting health facilities for uterine prolapse checkups. However, many of them are unaware of the Kegel exercise. Very few women (one in ten women) had a positive attitude towards uterine prolapse. To promote knowledge, attitudes, and practices of uterine prolapse, health promotion programs should target women from all caste/ethnic groups, age groups, and education levels, including urban and rural communities.

Introduction

Uterine prolapse is a very common condition, particularly among adults and old women in developing countries. It is a debilitating condition in which the supportive pelvic structures of muscles, tissue, and ligaments give away, and the uterine drops into or out of the vagina (UNFPA, 2011).

Uterine prolapse is a condition in which muscle and supporting ligaments holding the uterine in place get too weak to keep the uterine in position (Manandhar & Rai, 2022). It is the most common gynecological health problem of women. There are several degrees to determine

the severity of uterine prolapse in a woman. When the uterine cervix protrudes into the lower third of the vagina, the condition is called a first-degree of uterine prolapse. It is called the second degree when the cervix protrudes past the vaginal opening, and while the entire uterine protrudes past the vaginal opening is referred to third degree (Bhurtel et al., 2019). Uterine prolapse may cause maternal morbidity and mortality in women of reproductive age in developing countries (Badacho et al., 2022).

Uterine prolapse is a condition where the muscles and supporting ligaments are too weak to hold the uterine in a normal position. Uterine prolapse is a major public health problem of reproductive-age women in Nepal and awareness of uterine prolapse can prevent a huge number of Uterine Prolapse cases. The actual number of uterine prolapse-affected women is unknown because many women don't seek medical help due to shame from the condition which affects a private part of the women's body (Singh, 2016).

According to UNFPA (2011), uterine prolapse is a significant public health issue. Uterine prolapse was found between 2 percent to 20 percent at the global level in 2006 and it was approximately 10 percent for Nepal. The estimation of uterine prolapse is 5.2 percent and they have a high unmet need for evaluation and possible surgery (Groen, 2015). Uterine prolapse rates in Morang district have decreased during the last three years. According to the Department of Health and Services (DoHS) (2077), there has been a declining pattern of uterine prolapse in Nepal for three years. At the national level, it decreased from 19,925 in 2074 to 15,828. In Koshi province, it decreased from 5043 to 3055 in 2077, and in the Morang district level, it decreased from 3630 to 2993 in 2077 during the last three years (DoHS, 2077).

The Nepal government has made many efforts to address Pelvic organ prolapse problems on various levels. To identify the causes and consequences of uterine prolapse many INGOs and NGOs have made significant financial investments. In addition, the general health and practices of women are strongly affected by a large number of precautionary measures. According to Aryal (2017), the prevention of pelvic organ prolapse involves care of the entire body.

However, the government of Nepal and Sundarharaicha Municipality have launched several programs in ward number 5. Women have been lacking good health facilities for uterine prolapse at study area. Their knowledge, attitude, and practice on uterine prolapse is poor. This study has focused on knowledge, attitude, and practice of uterine prolapse among married women aged 15-49 years of the Sundarharaicha Municipality ward number five.

The researcher has found fewer studies on this issue. This study has provided baseline information on women's knowledge, attitude, and practice of uterine prolapse issues. Further, it provides the change that occurs in women's health and their perspective on uterine prolapse. The researcher hopes that this study will be helpful to policymakers, researchers, and students who are interested in the field of uterine prolapse in women.

Objectives
- To assess the level of knowledge on uterine prolapse among currently married women of age 15 to 49 years
- To assess the attitude and practice regarding preventive measures and treatment of Uterine prolapse

Review of Literature

There is no specific theory to show the relationship between government support for women's health and their knowledge, attitude, and practices of uterine prolapse. Various social theories help to link government support for women and their health perceptions. Some social models have explained women's health-seeking behavior. The Trans Theoretical Model (TTM) proposes behavior change in various stages. These stages include pre-contemplation, contemplation, preparation, action, and maintenance. According to the Health Belief Model (HBM), a person's perceived susceptibility to a health threat, perceived severity of the threat, perceived benefits of acting, perceived barriers to action, and cues to act all influence behavior change. The Theory of Planned Behavior (TPB) suggests that behavior is determined by a person's attitudes, subjective norms, and perceived behavioral control. The motivational interviewing (MI) model focuses on resolving ambivalence about behavior change, building motivation, and enhancing self-efficacy.

The Social Cognitive Theory (SCT), explains that behavior is shaped by a combination of personal, behavioral, and environmental factors, and these factors interact and influence each other. SCT explains learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior. Bandura (2001) explained that self-efficiency, the confidence of a person or his/her ability to perform a behavior has a significant influence on behavior change https://www.ruralhealthinfo.org. It can be useful for explaining the understanding of how these factors interact and how to improve the personal health of women.

Some empirical studies have outlined that socio-economic and demographics have a major role in determining the health status of women, especially in uterine prolapse. Manadhar and Rai (20220) have outlined various factors to increase uterine prolapse in rural women in Nepal. They are early marriage, childbirth before the age of 20 years, very low space for pregnancies, and unskilled birth attendants. About 46 percent of women have sufficient knowledge of uterine prolapse. The antenatal and postnatal visits for uterine prolapse are significantly correlated with ethnic group, level of education, and family income (Bhurtel et al., 2019).

According to Elsayed (2016), the knowledge and practices of women are associated with the socio-economic status of women. He showed that half of the studied women (56.5 percent) didn't hear about uterine prolapse. A vast majority of women (95 percent) exhibit poor knowledge regarding uterine prolapse. The majority of the studied women (81 percent) seek medical advice, for those who are from poor socio-economic status and are suffering from uterine prolapse. Also, the vast majority of women (93 percent) didn't know preventive measures of uterine prolapse (Elsayed, 2016).

Vasconcelos et al. (2020) show that patients' poor knowledge of the use of pessaries and a higher level of educational attainment are associated with improvements in pessary knowledge. Fear of vaginal discharge, irritation, bleeding, and pain were factors that supported the decision not to use a pessary. One factor that has contributed to a more positive attitude toward pessaries by health professionals is the experience of specialist and veterinary management training.

Gender discrimination against women in society as social, economic, and cultural are major factors for uterine prolapse. Uterine prolapse is primarily caused by factors like

adolescent pregnancy, heavy loads, inadequate nutrition, multiple pregnancies, unsafe abortion, and limited access to contraception (Amnesty International, 2014)

Subedi (2011) found that due to traditional gender roles, lack of knowledge, and the stigma about uterine prolapse, most Nepalese women do not seek health care for their condition. They often keep the condition a secret, being afraid of society and ashamed. Women who are suffering from uterine prolapse might be at risk of rejection by their husbands, family, and even the community. It is a common condition and treatable but very few women know about it.

Research on uterine prolapse shows that it also affects women's mental health. It was taken as a stigma in low-income countries. Most of the women have hidden their condition, neglected to seek help and live with the disease, they suffer from its complications for long periods (Thapa et al., 2014; Badacho et al., 2022). The rate of prevalence ranges from 4-40 percent globally, and 19.7 percent in low- and middle-income countries. About 200000 women in Nepal have suffered from uterine prolapse (Walker & Gunasekera, 2011; Manandhar & Rai, 2022).

Methodology

This is a cross-sectional study on uterine prolapse of women aged 15-49 years from Sundarcharaich-5, Morang. It has used descriptive research design. The study area was selected purposively, and respondents were selected from random sampling methods. In Sundarharaicha Municipality, there are 80562 population in 12 wards, among them researcher has selected ward number 5 for the study. The ward number 5 has 6255 population and 1442 households (NCO, 2022). By using the sample size calculator (online), 137 or more samples are needed to have a confidence level of 95 percent that the real value is within ±8% of the measured/surveyed value. In the case of 2 respondents in one household, only one respondent was selected for the interview.

This study has used primary as well as secondary information where primary data were collected from the household surveys, and secondary data was obtained from published literature such as books, journals, articles, and research papers. This study has used a semi-structured interview schedule to collect the information. Data were entered and analyzed by using the SPSS 20th version. The findings were analyzed using descriptive statistics.

Results and Discussion

Uterine prolapse has a significant association with the socio-demographic status of respondents like age of respondents, caste and, religion (Bhurtel, Mandal & Shah, 2019). It also varies with rural and urban residences. There were various factors for uterine prolapse in rural women. Early marriage and childbirth before the age of 20 years, a higher number of pregnancies are more responsible for uterine prolapse (Manandhar & Rai, 2022).

Table (1) shows majority 85 percent of the respondents were 25-49 years. Among them, the majority belonged to Janjati and Brahmin/Chettri ethnicity i.e. 46.4 percent were of Janjati caste, especially Chaudhary, Rai Limbu and Newar, and 41.4 percent were from Brahmin / Chhetri community. As well most of the respondents follow the Hindu religion which is 78.6 percent.

Table 1. *Socio-demographic characteristics of respondents n=140*

Characteristics	Category	Frequency	Percentage
	15-19	3	2.1
	20-24	18	12.9
	25-29	25	17.9
	30-34	27	19.3
	35-39	27	19.3
	40-44	17	12.1
Age	45-49	23	16.4
	Brahmin/Chhetri	58	41.4
	Janjati	65	46.4
	Dalit	16	11.4
Caste	Others	1	.7
	Hindu	110	78.6
	Buddhist	12	8.6
	Kirat	16	11.4
Religion	Christian	2	1.4
	Illiterate	2	1.4
	Literate	8	5.7
	Primary	22	15.7
	Secondary	44	31.4
	Higher Secondary	36	25.7
	Bachelor	18	12.9
Education Level	Master's degree	10	7.1
	Single	76	54.3
Type of Family	Joint	64	45.7

Age Mean: 34.12±8.53 SD, Median: 34, Range: 17-49

The majority 31 percent of respondents completed the secondary level of education, 7 percent completed their master's level education, 1.4 percent were illiterate, and 5.7 percent of respondents were literate (Can read and write). 54 percent of respondents live in single-family and 46 percent live with a joint family.

There is an indirect relationship between parity and women's empowerment. More Hindu extended families share their household resources with the families of siblings and their children (Shrestha et al., 2015). Effective family planning programs could avoid uterine prolapse. It is hypothesized that upper caste Hindu families are more health concerned than the high parity of women on the condition.

Table 2. *Respondents by occupation, age of first marriage, and age of first pregnancy*

Characteristics	Category	Frequency	Percentage
Occupation of respondent	Agriculture	2	1.4
	Business	26	18.6
	Service	30	21.4
	daily wages	1	.7
	Housewife	80	57.1
	Study	1	0.7
Age of first marriage	15-19	52	37.1

	20-24	57	40.7
	25-29	29	20.7
	30-34	1	0.7
	35-39	1	0.7
Age of first pregnancy	15-19	39	27.9
	20-24	60	42.9
	25-29	36	25.7
	30-34	4	2.9
	35-39	1	0.7

Table (2) shows that more than half 57 percent of respondents were housewives, 21 percent were in services, and 18.6 percent were engaged in business. 40.7 percent of respondents' age of first marriage is 20-24 years, and 37 percent of respondents married before 20 years. The majority of the respondents 42.9 percent of the age of first pregnancy is 20-24 years. According to Badacho et al. (2022), the predictor of uterine prolapse in women of reproductive age is age at first marriage, place of delivery, birth attendant assistance, and history of abortion.

Knowledge of Uterine Prolapse

Shrestha et al., (2015) expressed women's knowledge of uterine prolapse was related to their education, residence of women, and reproductive age groups. About fifty-three percent of respondents had never heard about uterine prolapse, and of those who had heard 37.5 percent had satisfactory knowledge. The knowledge about uterine prolapse was associated with urban/rural settings, age groups, and education levels. The satisfactory level of knowledge was associated with geography, caste/ethnic group, and age group of women. It is suggested that uterine prolapse-related health promotion initiatives target women from all caste/ethnic groups, age groups, and education levels, as well as urban and rural population

Table 3. *Distribution of respondents by knowledge of uterine prolapse n=140*

Characteristics	Category	Frequency	Percentage
Heard about uterine prolapse	No	5	3.6
	Yes	135	96.4
Uterine Prolapse means	Infection	6	4.3
	Uterine come outside	134	95.7
Causes of uterine prolapse	<3= Poor knowledge	57	40.7
	3-5= Average knowledge	76	54.3
	6-8= Good knowledge	7	5
Uterine prolapse effects on women's health	1= Poor Knowledge	56	40
	2-3= Average Knowledge	71	50.7
	4-5= Good knowledge	13	9.3
Is uterine prolapse preventable?	No	4	2.9
	Yes	136	97.1
Methods of prevention	<3= poor knowledge	74	52.9
	3-5= average knowledge	62	44.3
	6-7= good knowledge	4	2.9

The quality of life of women is connected with different phases of uterine prolapse which has negative effects on social mobility, emotional stress, and physical health. It was also associated with women's parity, education level, age, and family structure of women (Shrestha et al., 2015).

Table (3) shows that about 96.4 percent of respondents have heard about uterine prolapse and they said *"Aang khaseko"* is a popular name for uterine prolapse in the community. About 97 percent of women have accepted that uterine prolapse is a preventable disease. On the other hand, 4 percent of women said uterine prolapse means infection of organs and 95.7 percent of women said uterine prolapse means the uterine come outside. Only 9.3 percent of women have good knowledge of uterine prolapse whereas 48 percent of respondents have average knowledge. Out of six right answers on causes of uterine prolapse, 54.3 percent of women have average knowledge, 40.7 percent of women have poor knowledge and only 5 percent of respondents have good knowledge.

Attitude towards uterine prolapse of respondents

Table (4) shows that 75.7 percent of women didn't discuss with friends, and 81.4 percent of women did not discuss with family and neighbors about the uterine problem of women. There are very few women (18.6 percent with friends and 24.3 percent with family and neighbors) had discussed uterine prolapse.

Table 4. *Respondent's attitude towards uterine prolapse n=140*

Characteristics	Category	Frequency	Percentage
Ever discussion with friends	No	106	75.7
	Yes	34	24.3
Ever discussion with family members and neighbors	No	114	81.4
	Yes	26	18.6
Behavior toward uterine prolapse-affected women	1= Poor attitude	99	70.7
	2= Average attitude	24	17.1
	3= Good attitude	17	12.1
Visit health facility after delivery	No	125	89.3
	Yes	15	10.7
willingness to visit health facilities when screening camps are available	No	114	81.4
	Yes	26	18.6

There was only 12.1 percent of women had a positive attitude and 70.7 percent of women had poor attitudes toward uterine prolapse-affected women. About 89.3 percent of respondents did not visit the hospital after delivery whereas only 10.7 percent of women visited the hospital after delivery. About 18.6 percent of respondents had the willingness to visit a health facility whereas 81.4 percent of women were not willing to visit a health facility for screening the uterine prolapse at a government health facility.

Table 5. *Respondent's practices on preventing uterine prolapse*   n=140

Characteristics	Category	Frequency	Percent
Use of FP for birth spacing	No	14	10.0
	Yes	126	90.0
Heavy work during the postpartum period	No	127	90.7
	Yes	13	9.3
Having nutritious food during pregnancy/postpartum period	No	15	10.7
	Yes	125	89.3
Doing Kegel exercises during the postpartum period	No	133	95.0
	Yes	7	5.0

Table (5) shows that the majority of women (90 percent) use family planning for birth spacing, and 9.3 percent do heavy work during the postpartum period which is a risk factor for uterine prolapse. There was good practice (89.3 percent) of having nutritious food during and after delivery. But, a large number of women (95 percent) didn't know about the Kegel exercise.

Conclusion

There were various factors for uterine prolapse, like early marriage, a higher number of pregnancies, and traditional practices. Women's healthcare decision-making and purchase costs have an indirect relationship with gender parity and empowerment. uterine prolapse also depends on the age at first marriage of women, place of delivery, and history of abortion. Knowledge of uterine prolapse is influenced by women's place of residence, reproductive age, and education levels. The majority of women have good practices for getting health facilities and nutritious food. However, some of them are unaware of the Kegel exercise. Nine of ten women have good practice of health checkups for uterine prolapse at health institutions. They do not work heavily during the postpartum period. Therefore, it is suggested that uterine prolapse-related health promotion programs should target women from all caste and ethnic groups, age groups, and education levels, including urban and rural communities.

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