WOMEN’S EXPERIENCES OF UTERO-VAGINAL PROLAPSE: A QUALITATIVE STUDY FROM TAMIL NADU, INDIA

TK Sundari Ravindran, R Savitri and A Bhavani

Abstract

This paper reports on perceptions of causes of uterine prolapse of women suffering from this condition, and the problems they experience, based on information collected from 37 rural poor women in Tamil Nadu, India. Clinical examination confirmed a diagnosis of uterine prolapse in 32 women. All the women worked as wage labourers in agriculture. The mean age at which the women had developed symptoms of the condition was 26.2 yrs, and roughly 40 per cent of the women reported to be suffering from uterine prolapse after their very first or second deliveries. All but one had had all normal deliveries. According to the women, strenous manual work soon after delivery was an important factor associated with uterine prolapse, alongside factors such as frequent childbearing, or trauma to the pelvic floor following surgery. Uterine prolapse seriously compromises the quality of life of the women affected. It had far reaching consequences not only for their physical health, but also for their sexual lives, and their ability to work and earn a livelihood. There were a series of barriers to medical help for uterine prolapse, ranging from women’s reluctance to seek treatment and lack of familial support, to ineffective treatment and high monetary and opportunity costs.

Prolapse of the uterus is one of the most common sequela of a difficult childbirth. [1, 2] This condition is caused by the weakening of the pelvic muscles and ligaments that support the uterus, usually following damage after a difficult delivery, but sometimes, also following gynaecological surgery. The uterus sags down into the vagina, and may even protrude out between the vaginal lips. However, the symptoms may not appear till after menopause, when the damaged muscles lose tone and the ligaments atrophy. [3]

There are three degrees of utero-vaginal prolapse. In first-degree prolapse, the cervix appears at the vaginal opening only when the woman is asked to bear down. In second-degree prolapse, the cervix descends to the level of the vulva, and in third-degree prolapse, the cervix protrudes outside the vulva. The condition where the entire uterus may protrudes outside the vulva, bringing with it both the vaginal walls, is called procidentia.

A woman with prolapse may complain of a lump in the vagina or a feeling of “something is coming down”, back-ache and a bearing down sensation, abdominal pain, vaginal discharge, disturbances of micturition, frequency and dysuria, stress incontinence, difficulty in defecation, profuse periods, irregular bleeding and bleeding due to the protruding prolapse becoming ulcerated. If there is a large prolapse, the external swelling may inconvenience the woman in walking and carrying out her every day duties. [4]
This paper reports on perceptions of causes of uterine prolapse by women suffering from this condition, and the problems they experience, based on information collected from 37 rural poor women who had volunteered to have a clinical examination by a gynaecologist. Although based on a self-selected and small sample of women, the paper’s relevance lies in its focus on women’s perceptions of the causes of uterine prolapse and of its impact on their daily lives. Most published studies to date on uterine prolapse are hospital-based, clinical, and examine aspects such as incidence, characteristics of the women diagnosed with the condition, and prognosis following surgical repair. [ 5, 6, 7, 8, 9 ]

The setting
The women whose perceptions and experiences are reported in this paper belong to villages surrounding Chengalpattu town in Tamil Nadu, India. The clinical examination had been organised by Rural Women’s Social Education Centre (RUWSEC), a grassroots women’s organisation working in these villages. There had been a demand from the community for a clinical check-up, following the finding from a baseline survey that 106 women of the 4117 women between 15 and 50 years in the villages covered by the organisation’s community health project were suffering from second or third degree uterine prolapse (according to women’s self-reported morbidity). [ 10 ]

The clinical examination was organised in a community hall in Tirukkazhukundram town, located centrally to the villages from which the women came and well-connected by buses. The women came to the community hall from their villages in public buses. They were compensated for the busfare, and the clinical examination was held free of cost. Drugs were also dispensed free of cost following the clinical examination.

The day’s events comprised of a workshop in the morning on utero-vaginal prolapse and its management and treatment, followed in the afternoon by clinical examination of the women by a senior gynaecologist. The workshop session had built in a lot of discussion-time for women to ask questions and clarify their doubts.

Information on women’s perceptions and experiences on uterine prolapse was collected with the help of a check-list by the NGO’s senior community workers in one of the rooms, at the same time as the gynaecologist performed clinical examination on women in another room. Interviews with women were carried out in complete privacy, with the informed consent of the women. The primary purpose of the data collection was to help the organisation with suitable follow-up activities.

Profile of the women
All 37 women who came for the workshop and clinical examination were from landless agricultural labouring households, and belonged to the Scheduled Castes. All the women worked as manual wage labourers in agriculture. Nearly all (34 out of 37) were illiterate.

Thirty two of the 37 women (87 per cent) were found to be suffering from utero-vaginal prolapse on clinical examination, while five did not have any apparent gynaecological problem. The mean age of women suffering from prolapse was 37.5 years. [ 11 ]
However, many women had been suffering from the condition for more than ten years (mean 12.3 yrs). The mean age at which the women had developed symptoms of the condition was 26.2 yrs.

Roughly forty per cent of the women (13 of 32) reported to be suffering from uterine prolapse after their very first (10 women) or second deliveries (3 women), 11 women after their third delivery, 9 women after their fourth to sixth deliveries and two, after their ninth delivery.

All but two women had experienced only normal deliveries. There was one instance of a forceps assisted delivery, and one stillbirth. About forty per cent of the women (13 of 32) had delivered all their babies at home, twenty eight per cent (9 women) had had all their deliveries in public hospitals, and the remaining ten had delivered some babies at home and some - usually the first and the last - in hospital. Twenty two of the thirty two women had undergone tubal ligation in hospital - the nineteen who had hospital deliveries and three others.

The profile of the women with prolapse in this instance appears to vary from that commonly found in medical text books. For example, one text book describes the typical patient who complains of prolapse as “the woman aged about 50 years, who has given birth to several children and who usually gives the history of a difficult confinement or of the birth of large children.” [4] Studies from industrialised countries have also reported age, parity and weight of the woman to be significantly associated with the risk of uterine prolapse. [6, 8]

However, some developing country studies indicate that uterine prolapse may occur in a relatively young population. For example, a study from two hospitals in Kenya during 1989-93 of 156 and 195 patients with uterine prolapse respectively, illustrated that this is mainly a rural problem of a relatively younger population. [12] In another study from Dakar of 104 cases of genital prolapses, the average age of the women was 30 years and 64 per cent were between the ages of 20 and 39 years. [13] An early study from India confirms the same. A study of 214 women admitted to the gynaecological ward of Osmania hospital, Hyderabad during 1951-54, observed that uterine prolapse was not necessarily the outcome of repeated childbirth but often followed damage to the pelvic floor after the very first delivery. [14]

Perceived causes
Women were asked what they thought had caused the uterine prolapse. Heavy manual labour within a week to a fortnight following delivery was perceived to be the cause by 18 of the 32 women.

“I had delivered my first child in my husband’s home, because my mother was too poor to bring me home for delivery. I had no rest even for a week. One day, I had to carry a huge basket of cow dung. As I bent down and lifted it up from the floor to put it on my head, I felt something give way inside.” [30 yr old woman with 3 children]
“After my third delivery, I had to do all the household work from the very next day. I had to boil the paddy to dehusk it (to make rice). After sitting next to the fire for many hours, when I lifted the large vessel up to drain the water, I blacked out and fainted. After this, I have had the prolapse.” [42 yr old woman with 3 children]

“ We are very poor. My husband and I were both bonded labourers those days. It was soon after my first delivery, I had to carry a heavy bundle of firewood on my head. That’s when it happened”. [45 yr old woman with 9 children]

The stories (of the 18 women) were very similar - of having lifted up water pots, or the heavy pounding instrument to pound the rice or millet, and sensing a protrusion soon after. All but two of those who developed prolapse after their first or second deliveries reported such incidents.

One woman reported violence as the cause. L- had returned to hospital for resuturing of her tubectomy incision. Her husband was very angry that she had gone away yet again, leaving him to manage everything at home. Finding her lying down after her return from hospital, he physically assaulted her. She believes that the prolapse followed this.

In the case of N-, the prolapse was the result of an unfortunate accident. She was returning home to her village from hospital after her first delivery. The child was stillborn. She was travelling by a three wheeler taxi (auto rickshaw). The vehicle met with an accident and she was flung out of it. She suffered serious injury and uterine prolapse as a consequence.

First birth at a young age (between 15 and 18 years) followed by frequent childbearing was mentioned as responsible for the uterine prolapse by four women. Four women mentioned that the prolapse had followed a surgery - sterilisation in three cases, and surgery for fibroids in the fourth case. Two had developed symptoms of uterine prolapse following abortions - induced in hospital in one instance, and spontaneous in the second. Only two women mentioned a difficult first delivery as having caused the prolapse.

Particularly heartrending is the story of 26 year old K-. Both K-‘s babies died in infancy. She has a second degree prolapse, and is afraid of another birth, but also badly wants to have a baby.
Her husband is contemplating remarriage.

Associated health problems
Sixteen of the 32 women (50 per cent) had been living with uterine prolapse for more than ten years, while 10 had developed it within the last five years. Six had been suffering from it for between 6 and 10 years. Those who have had it for many years reported that the degree of prolapse had been increasing over time, and that it was becoming more and more difficult to live with this condition.
The women were suffering from a number of health problems associated with uterine prolapse.
The most common problems were difficulty in standing and sitting because of the prolapse and an obstructed and blocking feeling (16 women), and back ache (14 women). Obstruction while passing urine and motion (7 women) was next most common problem. Four women had acute lower abdominal pain, and six others complained of profuse and smelly or itchy white discharge. Other problems included recurrent episodes of urinary tract infections (4 women) and heavy menstrual bleeding (3 women). Some women suffered from more than one problem simultaneously.

Three women with a third degree uterine prolapse said they had ulcers on the ‘protruding part’ and five women (including these three) complained of their protrusion “getting caught” in their sarees when they worked, often causing ulceration with blood oozing out.

“The saree gets caught when I get up, and water starts oozing out of the wound. I have heavy bleeding during periods”

“The pain in my genital region is unbearable”

“I am unable to do any work, and feel very depressed. Very often I get acute pain and burning sensation during urination. There is also profuse and smelly white discharge on many days”

While only 8 women reported problems related to ulceration, 16 women were found to have cervical erosion and/or ulcerated cervix on clinical examination, and were referred for biopsy (for cervical cancer).

Living with uterine prolapse
Living with uterine prolapse is far more than a health problem for poor women dependent on heavy manual labour to earn their livelihood. Twenty one of the thirty two women talked about the problems they faced because of their ‘inability to lift heavy objects’ (7 women) and ‘difficulty in working in the farm’ (14 women).

“I have been unable to go for harvesting for the past two years, because I am not able to carry the bundles of harvested paddy, or remove the chaff from the grain (which involves lifting up the basket of grain and chaff above one’s head) ..And you know that the highest wages are earned during harvest!”

All the women with third degree prolapse and 10 of the 13 women with second degree prolapse said that as they grew older, they were finding it increasingly difficult to do even routine domestic tasks such as fetching water, carrying firewood and lifting pots up from the fire while cooking:

“When I carry something heavy, it comes down more. I can hardly walk then.”

“Squatting down to wash clothes and vessels is becoming excruciating”
Relations with spouses were strained because of the problems women had in engaging in sexual intercourse. Twenty two women said that they avoided sex, and this was a source of constant friction between them and their husbands. In the case of twelve women, sexual intercourse was an ordeal to be endured once in two weeks (at the most) or even less frequently - once in several months. The remaining ten said that their husbands forced themselves on them, despite it being not at all enjoyable and indeed, extremely painful to the women. Violence and battering associated with forced sexual intercourse was reported by eight of these ten.

“This year I could not go to the fields to work due to this problem (prolapse). My husband beats me daily as I am neither able to go to work nor willing to sleep with him.”

“He refuses to believe that I am in pain. He says, what’s wrong with you, you look healthy and robust, who are you waiting for, if not me.”

“When he is drunk, there is no reasoning with him. If he is sobre, he is considerate”

Barriers to medical help
Twenty of the 32 women suffering from uterine prolapse had not sought any medical help for their condition. Most of them did not give any reasons why. The five women who gave reasons mentioned fear of surgery (2), lack of time (1), and not being permitted by her husband to seek medical help for this condition (1).

Four women had sought treatment and had been on medications for some time. They felt no better, and had stopped.

“I went to the hospital more than ten years ago. They said I would get better with drugs and no surgery was required. I did not get any better. So I stopped taking the drugs, and did not go again.”

One woman said, however, that although she had gone to the hospital several times, she had never been able to tell the doctor the actual reason for her visit - the prolapse. She had complained of breathlessness, difficulty walking, aches and pains, and had hoped the doctor would probe further. They never did, and she was usually given pills for “strength”.

Another had gone to the hospital a number of times only to be told to come back again after a month or two for admission for surgery, because there was a long waiting list for gynaecological surgeries. She had given up after four such visits.

Six women had been admitted in the hospital for tests and surgery, but had left hospital without any treatment, for a variety of reasons.
“I went to Egmore hospital (specialist hospital in the capital city of Chennai) for treatment. But my infant girl who I had left behind at home, died all of a sudden. I left hospital immediately.

I haven’t gone back. I have had no free time ” [50 yr old woman with five children, prolapse after aborting the sixth pregnancy]

There was another woman who also left hospital because of an emergency at home - the death of her father-in-law. In two (of the six) instances the women had stayed in government hospital for over a month, waiting for surgery. They left against medical advice, because they could not stay any longer. Two others had been refused surgery because they were acutely anaemic, and a surgical risk.

Most of the women interviewed (29) wanted medical help from Rural Women’s Social Education Centre, the NGO which organised the clinical examination. All the women who had been recommended surgical correction (11) or biopsy (16) were keen on going through the procedures. However, cost of treatment was a major worry for all of them. Although treatment provided at RUWSEC’s hospital is subsidised to the extent of 50 per cent of actual cost, the women were not in a position to afford this and requested that they be charged a flat rate of Rs 500/- (US$12.5) This represented 80 per cent of their monthly earnings, but would cover only 10 per cent of the costs incurred by the hospital. [15]

Removal of the cost barrier alone would not make treatment accessible for all women. Four of them were afraid their husbands would not permit them to go in for a surgery even at the reduced cost of Rs 500/- because there would be other expenses involved - for visiting the women, towards food costs for a companion who would have to stay with them in hospital, and so on. Moreover, the women’s absence from home would inconvenience their husbands. Two women worried about lack of social support to take care of their children when they were away in hospital, and also to help them with domestic tasks after the surgery.

Conclusions
Literature on obstetric morbidities such as uterine prolapse rarely give us a glimpse of what it means to women to live with the condition for years together, without support from the immediate family, and without access to appropriate medical help, in the way that the stories of the few women who speak above, does.

For poor women who may not be in a state of good general health, strenous manual work soon after delivery seems to be an important factor associated with uterine prolapse, alongside factors such as frequent childbearing, or trauma to the pelvic floor following surgery. In many instances symptoms begin to appear at an early age, after the first or second deliveries. Uterine prolapse seriously compromises the quality of life of the women affected. It has far reaching consequences not only for their physical health, but also for their sexual lives, and their ability to work and earn a livelihood. There are a series of barriers to medical help for uterine prolapse, ranging from women’s reluctance
to seek treatment, to lack of familial support, ineffective treatment and high monetary and opportunity costs.

It is worth noting the high level of correspondance between women’s reporting and medical diagnosis of utero-vaginal prolapse (32 out of 37, or 86.5 per cent). A study in Istanbul reported a similarly high level of specificity - 95.7 per cent when women’s reporting of pelvic relaxation was compared to medical diagnosis. [16] Community-based surveys with well constructed questionnaires could therefore be recommended as a reliable means to identify women suffering from utero-vaginal prolapse. Perceptions of women in the present study on the causes of prolapse were also remarkable in being medically valid and justifiable as possible causes.

Some degree of relaxation of pelvic muscles, and consequently, genital prolapse of a mild degree, may not be totally preventable especially as women grow older. However, there is no justification on the part of those working in the area of women’s health for not initiating action to
- limit women’s exposure to risk of uterine prolapse at an early age
- minimise and alleviate problems in day-to-day life faced by women affected; and
- make appropriate medical help accessible to women.

In the short-run, some possible interventions that a community based organisation (such as RUWSEC) may be able to undertake would be
- arranging for subsidised treatment including surgery
- counselling the husbands and families of the women to ensure that women are able to receive treatment, and to help them appreciate the nature of the problem and on ways in which they could be supportive
- organising support networks of women in the community, to help women affected in various ways: accompanying them to the hospital, helping them with domestic tasks etc.
- educating pregnant women on preventing uterine prolapse through avoiding strenuous work immediately after delivery, and through pelvic-floor exercises in the post-natal period
- making birth spacing and birth control methods more accessible to all women

In the long-run, however, alleviation of poverty and improvement in women’s overall health status would alone reduce the incidence of uterine prolapse and alleviate the needless suffering of poor women with this condition.

Communication: TK Sundari Ravindran, Rural Women’s Social Education Centre, Nehru Nagar, Vallam Post, Chengalpattu-603 002, Tamil Nadu, India. Phone and Fax:91-4114-30682

Notes and References
1. Satur DM and Chakraverti J, 1955. A statistical survey of prolapse of the uterus with respect to age and parity. Journal of Obstetrics and Gynaecology of India, 6:147-150. This study found in that among 5494 women with gynecological complaints visiting
private clinics in Bengal, Delhi, Punjab and Uttar Pradesh in India during 1952-54 that one out of every five women examined suffered from uterine prolapse.


11. A comparison of the characteristics of the 37 women who volunteered for the clinical examination with that of the 106 women who had reported suffering from utero-vaginal prolapse in the base-line survey shows that the latter were a much younger group (mean age 31. 9 yrs). This is possibly a reflection on the women’s health seeking behaviour - they wait till the problem becomes very difficult to cope with.

Nearly sixty per cent of them had delivered their first babies in a hospital, and fifty per cent of all deliveries had taken place in hospital. Ninety eight per cent of the deliveries
were normal and full-term, and about one per cent each were pre-term and forceps deliveries respectively.


15. The NGO (Rural Women’s Social Education Centre) decided to raise funds to make treatment available at a price affordable to the women, and even perform surgeries free of cost to those who could not afford to pay at all.


ABOUT THE AUTHORS
TK Sundari Ravindran is an activist-researcher on women’s health and reproductive health and rights. She is honorary executive director of Rural Women’s Social Education Centre, (RUWSEC) Chengalpattu, India.

R. Savitri is a statistician-demographer, and deputy director in the Department of Health and Family Welfare, Government of India, New Delhi.

A. Bhavani is the Co-ordinator of RUWSEC’s Community-based women’s health programme.