

Prevalence of pelvic organ prolapse in women, associated factors and impact on quality of life in rural Pakistan: population-based study.

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Research article

Keywords: Community-based; Pelvic organ prolapse; Prevalence; Quality of life; Pakistan

Posted Date: July 24th, 2019

DOI: <https://doi.org/10.21203/rs.2.11882/v1>

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Version of Record: A version of this preprint was published at BMC Women's Health on April 28th, 2020.
See the published version at <https://doi.org/10.1186/s12905-020-00934-6>.

Abstract

Background Pelvic organ prolapse (POP) is a gynecological condition resulting from pelvic floor dysfunction in women. The objective of this study is to estimate the prevalence of pelvic organ prolapse associated factors, duration and impact on women's quality of life in rural Pakistan. Methods A large population-based cross-sectional study was conducted in which a three stage random sampling strategy was applied: randomly selected health centres and randomly selected Lady Health Workers from each health centre who then interviewed a random sample of women in their households. The interview used a structured questionnaire to collect symptom data. Female gynaecologists then conducted a clinical examination at the local health centres on women who reported symptoms of prolapse to verify and grade pelvic organ prolapse using Baden-Walker classification system. Results Among the 5064 women interviewed (95.8% response rate), 521 women had clinically confirmed POP, a prevalence of 10.3% (95% CI 9-11%). Among women with POP 37.8% had grade III or IV prolapse. The highest rate of POP (25%) was found in women aged 36-40 years and a rate of 77.2% was found in women of parity 4 or more. Among women with POP, 60.8% reported their quality of life as greatly or moderately affected; 44.3% had it for more than 5 years; and 78.7% never consulted a doctor. Conclusions Pelvic organ prolapse is highly prevalent in rural Pakistan and impacts on women's everyday lives and remains mainly untreated. Measures should be taken to provide health care services to reduce this burden of disease among women.

Background

Pelvic Organ Prolapse (POP) is a common gynecological condition related to pelvic floor dysfunction in women¹. It is the abnormal location of the pelvic organs, including the uterus, bladder, rectum or small intestine, into or outside the vagina². It results in one of the most common gynaecological surgical procedures performed: surgery for prolapse has a lifetime risk of 11–19% in the general female population based on data from High Income Countries (HIC)^{3,4}.

Much less is known about the prevalence and risk factors of POP from Low and Middle Income Countries (LMIC)⁵. A review of studies of pelvic floor disorders in LMICs published in 2011 found 13 studies with data on POP with prevalence estimates ranging from 3.4 to 56.4%, with a mean of 19.7%, however, most studies were small and not population based and had varying definitions and methods of ascertaining POP⁶. A population based study (n = 2070) not included in this review undertaken by UNFPA in Nepal found a prevalence of 10% based on asking the women if they had 'something coming down in the vaginal'⁷. More recent studies from Ethiopia⁸⁻⁹ and Tanzania¹⁰ showed prevalence ranging from 1% (based on symptoms included in general study of maternal health) up to 64.6% based on clinical examination.

Well established risk factors for POP, mainly based on data from HICs are older age, pregnancy and vaginal delivery, high parity and obesity, with others less consistently demonstrated including, early age at first delivery, forceps delivery, prolonged second stage labour, carrying heavy objects or doing heavy work

and high infant birthweight^{1, 8, 10-11}. The distribution of these various risk factors differs in low and middle relative to high income countries, for example, high parity and younger age at first delivery being generally more common, whilst forceps delivery and caesarean section less common. The rationale of our study was the lack of good data on POP and difficulties in assessing the burden of disease in women in LMIC's including Pakistan. Since the rural areas are most neglected hence studies from these areas warrants rigorous epidemiological investigation to assist in formulating strategies to provide appropriate services for treatment.

The objective of this study was to report the results of large community population-based study, including gynecological examination, investigating the prevalence of POP, risk factors and impact on women's quality of life, in rural Pakistan.

Methods

The urinary and fecal incontinence and utero-vaginal prolapse (UFIUVP) study was a population based investigation of the prevalence of sub-types of pelvic floor disorders in women, their risk factors and impact on women's quality of life to assess the burden of these diseases in a rural population in Pakistan. The aim was to assess the prevalence of the different disorders in a rigorous manner, including pelvic organ prolapse symptoms reported by women with signs confirmed by clinical examination, as reported in this paper.

The detailed study design, subjects, sample size, settings, data collection and other methods are described elsewhere¹²⁻¹³. Briefly, all women aged 15 and above in the study areas were eligible and a structured questionnaire was administered by trained Lady Health Workers (LHWs) through face to face home based interviews. Getting consent from the study participant was paramount and it was obtained from the subject, or from her parent or guardian of any participants under the age of 18 years. Demographic, socio-economic and the obstetric characteristic details were also recorded. An appointment for a clinical examination was offered for symptomatic women.

The entry question to assess POP was; 'do you experience a feeling of bulging or protrusion coming down from or in the vaginal area?' (Yes/No). To enhance the understanding of the first question and likelihood of reporting, a second question was asked; 'do you experience bulging or protrusion or something you can see in the vaginal area?' (Yes/No). If the response to either question was positive the woman was asked for further information to assess the stage of bulging or protrusion (comes and goes back at strain; partially out but need to push it up back into vagina; or completely hanging out from the vagina), the duration of symptoms and when they first occurred? The women were asked "how much does bulging or protrusion bother you" to rate the impact of symptoms on their overall quality of life in general (not at all, slightly, moderately or greatly) (answer one only); and then they were asked "how much does bulging or protrusion interfere with your everyday life to rate the impact on specific aspects of their everyday: hygiene, home life, work life and social life (not at all, slightly, moderately or greatly) (answer one only). Finally, they were asked if they had ever consulted a doctor because of their symptoms (Yes/No).

A urogynaecologist, expert in pelvic floor disorders and part of the study team then reviewed all the questionnaires and from the responses, women were categorized as having POP (any of the symptoms of interest) or not. The women whose answers indicated the presence of POP symptoms were invited to attend the local health facilities to have a gynecological examination conducted by qualified local female gynecologists, expert and experienced in clinical practice to verify and assign the diagnosis. These gynecologists were provided training on how to examine and assess POP with Baden-Walker system of classification as they were not familiar with POP-Q staging system. The gynecologist took a standardized obstetric and gynecological history followed by clinical examination of the pelvic region and abdomen. A speculum and bimanual examination were performed with the patient in the left lateral position to assess the vaginal walls and cervix asking the patient to perform maximum straining or coughing. The Baden-walker classification system was used to grade POP considering posterior urethral descent, lowest part and other sites as: Grade 0 indicated normal position for each respective site, Grade I indicated descent halfway to hymen, Grade II indicated descent to the hymen, Grade III indicated descent half way past the hymen and Grade IV indicated maximum possible descent for each site. Women with POP were offered referral for clinical management.

Statistical analysis was conducted using SPSS software version 19.0 (IBM corporation Armonk, NY, USA). The prevalence estimates were calculated by considering those women in the numerator with POP verified by clinical examination as a proportion of all women interviewed. Summary statistics were calculated using frequencies, percentages for categorical variables like grades of POP and means, medians, standard deviations and ranges for continuous variables such as age. The chi-square test was used to evaluate relationship between the various categorical variables and continuous variables using the Student's t-test for the presence or absence of POP. The socio-demographic variables were then entered into logistic regression model to see statistical significance at $p < 0.05$. Odds ratios, p values and 95% confidence intervals were calculated for the relationships between the variables and the presence or absence of prolapse. No exposure was treated as main exposure for the POP (outcome) in this cross-sectional study so, we did not have any confounder and as well as any plausible interaction for the study.

Ethical approval:

Ethical approval was granted by the Ethical Review Committee of Aga Khan University, Karachi, Pakistan, (vide no. 741-CHS/ERC-07, dated 27 June 2007).

Results

Of the 5284 women in the study areas approached to take part, 5064 were interviewed, a 95.8% response rate (Figure 1). Of the 220 women not interviewed, 110 declined to take part and for 78 the LHW was unable to make an appointment after several attempts. There were 613 women who reported positively for POP in the questionnaire with different degrees of symptoms (see Table-1). Of these 613 women, 551 (89.9%) attended for clinical examination (Figure 1). On clinical examination 30 (5.4%) women were

not considered to have POP and 521 (94.5%) were verified as POP cases. These 521 were included as POP cases in the subsequent analysis.

The prevalence of clinically verified POP in the sample, therefore was 10.3% (521/5064; 95% CI 9–11%). The grades of POP observed were: 188 (36.1%) grade-I; 136 (26.1%) grade II; 89 (17.1%) grade III; and 108 (20.7%) grade IV, (see Table 1). The type of POP within each grade is shown in Table 2, the most common being the cystocele grade I (n = 129, 24.8%). Anterior only genital prolapse occurred in 129 (24.8%) women; anterior and posterior in 131 (25.1%); posterior only in 48 (9.2%); and anterior, posterior and uterine in 213 (40.9%): there were no cases of anterior and uterine or posterior and uterine prolapse.

Multivariable analysis showed that the only socio-demographic factors found to be significantly associated with increased likelihood of POP were: increasing age (OR 1.05, CI 1.04–1.06) and higher parity (OR 1.18, 95% CI 1.15–1.21). Table 3 shows the individual age and parity groups, indicating a clear gradient for both but no significant association between earlier age at marriage and POP. No significant association found with education, occupation, language spoken, religion and social class and POP.

The duration of POP, its impact on the women's overall quality of life, and consultation with a doctor about it are shown in Table 4. Among the women with POP, duration was long, with 44.3% reporting having had it for more than 5 years. In terms of their overall quality of life, 60.8% said it moderately or greatly impact on this, and 47.8% reported that it moderately or greatly impacted on their everyday life, including hygiene, home/work life and social life. Only 111 (21.3%) reported ever consulting any doctor about their POP. Among all women with POP, 91 (17.5%) also reported some form of urinary incontinence.

Discussion

In this population-based study in rural Pakistan the prevalence of POP based on clinical examination of symptomatic women was found to be 10.3% (95% CI 9–11%) among women aged 15 years or older. This prevalence is consistent with a population based study in Nepal⁷ in which the prevalence of POP was 10% and a study of 174 women in rural Ghana¹⁴. where it was 12.1%. A previous study in Pakistan of 717 women in an urban squatter settlement reported a prevalence of 19.1%¹⁵. However, a community based survey of 1034 women in rural Gambia, reported a much higher rate of 46%¹⁶. A much higher prevalence of POP 64.6% was reported from the most recent study on this topic in LMICs from rural Tanzania¹⁰. Two other recent studies both from Ethiopia reported differing prevalence. One included 395 women who completed a questionnaire then 294 of these women had a clinical examination: in the questionnaire symptomatic pelvic organ prolapse (do you have a feeling of bulging/pressure or something seems to be coming down through the vagina or do you have a visible mass protruding via the vagina) was 6.3% but when women were examined 55.1% had anatomical prolapse stage II-IV⁸. The other reported a much lesser symptomatic prevalence (experienced a prolapse uterus where you can feel part of the womb protruding outside of the vagina) of POP of 1% in a very large study of general maternal health experiences⁹. This overall shows a variation from 1% to 64.6% in the prevalence of POP due to applying different definitions used in the diagnosis of POP⁶, different methods of POP classification, inclusion of

different age groups, in and undertaken in rural and urban areas with different cultures and perceptions. For example, the study in Gambia, was based on interview and examination of women randomly selected from a rural community but criteria for the diagnosis of POP used was categories of cases such as mild-uterine prolapse into vagina; moderate-cervix visible at introitus; and severe-uterine descent outside of introitus without using a validated classification system¹⁶. In an earlier Pakistan study the sample was from urban squatter settlements and was based only on women's reported symptom of "a feeling something coming down or out of vagina specially during walking, coughing or sneezing" which has a weaker relation to actual POP¹, with no further clinical examination conducted for confirmation of the condition. In the Tanzanian study¹⁰ the median age of the women was 46 years' which is higher than our study of 37.6 years¹². In the smaller Ethiopian study the median age was 35 years, similar to our study age group but a different questionnaire was used on the basis of the questionnaire that was used in a HIC country USA⁹. Their clinical examination prevalence was much higher than ours at 55% though all women were offered clinical examination in this study compared with only symptomatic women in our study.

In our study we used a clear definition of POP verified by physical examination using the Baden-walker method of classification of grades and we found that 94.5% of women were verified as POP cases on gynaecological examination. There were a further 62 women among those who declined clinical examination and we don't know what proportion of these would have had diagnosed POP. We found that 37.8% of women with POP had grade III or IV prolapse extended beyond the hymen, the generally acceptable landmark found in most of the classifications^{1,6}. As POP cases of grade III or IV generally require surgical management the results in our study, where 38% were at these grades, are consistent with the population based study conducted in Nepal where a third of the total POP cases identified required urgent operative management⁷.

The mean age of the women with POP in this study was 37.6 years with a mean parity of 5.5 births. Increasing age and parity were identified as risk factors for POP in our study and this is consistent with other studies in LMICs^{11,14,16-18} as well as in developed countries^{1,19-20}.

Almost half of the women had a duration of POP of more than 5 years and 6% of women had POP for more than 20 years. Overall more than 60% of women reported symptoms as greatly or moderately impacting their overall quality of life and almost half reported that their everyday life activities were also affected greatly or moderately. However, despite the long duration of POP and its effect on women's lives, only 111 (21.3%) women had consulted a doctor about their condition. A study from rural Ghana showed that 35.3% of women with prolapse had sought treatment¹⁴. There are numerous possible reasons for this low rate of consultation in LMICs, including shyness, social stigma, lack of resources and high cost of care and accepting that prolapse is "normal"^{6,14,16}.

The strengths of this study are its sampling method, the very high response rate, and the robust method of data collection along with clinical verification and applying a well-defined Baden-Walker classification

system. However, there are some limitations. We did not use a specific questionnaire to evaluate 'impact on quality of life'; however, we developed our questionnaire based on different available and validated instruments (e.g., PFD120) and this was pretested in a pilot study¹². POP associated factors were assessed only for demographic/socio-economic and the obstetric variables and we did not assess other risk factors such as women's height, weight, body mass index or any heavy work or carrying heavy objects. The women who did not report symptoms were not invited for gynaecological examination and they may have had POP but not reported symptoms. There were also 62 women who had reported POP but did not attend for examination, and we do not know if the prevalence of diagnosed cases would be the same in this group.

Conclusions

This large population-based study with high response rate and robust sampling and data collection methods has shown that POP was highly prevalent in a Pakistan rural population and the data on effect on quality of life showed that this is a substantial problem for the women affected. Yet the majority of affected women did not seek medical care. Attention is required at the population level to improve the awareness and knowledge of the problem and efforts made to minimize the social stigma by women reporting and provision of appropriate services and surgical management.

List Of Abbreviations

POP = Pelvic Organ Prolapse.

HIC = High Income Countries.

LMIC = Low and Middle Income Countries.

UFIUVP = Urinary and Fecal Incontinence and Utero-Vaginal Prolapse.

UNFPA = United Nations Population Fund (United Nations Fund for Population Activities-An Organization).

Declarations

Ethics approval and consent to participate:

Ethical approval was granted by the Ethical Review Committee(ERC) of Aga Khan University, Karachi, Pakistan, (vide no. 741-CHS/ERC-07, dated 27 June 2007).A consent form was developed both in English and local language and after informed consent women were asked to participate in cross sectional survey.

Consent for publication:

Not applicable

Availability of data and material:

Yes it can be provided by corresponding author as soft copy on request.

Competing interests:

None

Funding:

Funding for this study was provided by the University Grants Commission of Aga Khan University, Karachi, Pakistan. Funding was approved to cover multistage sampling from three different districts of rural Pakistan. This involved frequent traveling budget, incentive for participating women and salary for research coordinators.

Authors' contributions:

AHJ, the principle investigator, was involved in all aspects of the study, original conception, design and implementation, quality assurance, acquisition of data, management, analysis, interpretation of data and drafting the article for intellectual content. RMR was involved in the original conception from a clinical perspective, helping in questionnaire design, assessment of completed questionnaires, training of health workers for data collection, clinical examinations and expertise in the clinical aspects of the manuscript. RMR updated all the references for discussion based on recent literature search. CMA was involved in the original conception and design of the study from a women's health perspective, helped in questionnaire design, analysis and in interpretation of findings. She was involved in critically reviewing the article for intellectual content and language. All authors approved the final article.

Acknowledgements:

We are indebted to: the health department of the Sindh government; the Executive District Officers Health district Mirpurkhas and Matyari for their logistic support through those in charge of primary health centers; the Lady Health Workers; and all of the women who took part in the study

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Tables

Table-1 Symptoms of prolapse reported by women and grades of POP found on clinical examination

Degree of prolapse/bulging		N	%
		613*	
1	Comes and goes back at the strain	261	42.6
2	Partially out but need to push it up back in vagina	188	30.7
3	Completely hanging out from vagina	164	26.8
Women on which clinical examination conducted			
Baden-Walker system for evaluation of POP grade by clinical examination		N	%
		521**	
1	Grade I (Descent halfway to hymen)	188	36.1
2	Grade II (Descent to the hymen)	136	26.1
3	Grade III (Descent halfway past the hymen)	89	17.1
4	Grade IV (Maximum possible descent for each site)	108	20.7

*All women who reported bulging/protrusion.

**All women on which clinical examination conducted and found as POP cases.

Table-2 Different types of pelvic organs prolapse according to grade of prolapse

Baden-Walker system for the evaluation of POP findings by clinical examination	N	%
	521	
Grade-I of prolapse		
Cystocele	129	24.8
Cystocele and Rectocele	59	11.3
Entrocele	0	-
Grade-II of prolapse		
Entrocele and Rectocele	28	5.3
Rectocele and Cystocele	41	7.9
Cystocele, Rectocele and Uterine	67	12.9
Grade-III of prolapse		
Cystocele and Rectocele	31	6.0
Cystocele, Rectocele and Uterine	38	7.3
Rectocele and Entrocele	20	3.8
Grade-IV of prolapse		
Cystocele, Rectocele and Uterine	69	13.2
Cystocele, Rectocele, Entrocele and Uterine	39	7.5

Table-3 Odds ratios (95% Confidence Intervals) for selected socio-demographic associated factors with POP

Associated factor	Total women in group	Number with POP	Prevalence within group	Odds Ratio	(95% C.I)	P-value
POP by age (in years)						
15-20 yrs.	838	11	1.3	1.00	-	
21-25 yrs.	705	36	5.1	4.05	2.0, 8.0	<0.001
26-30 yrs.	921	73	7.9	6.47	3.4, 12.3	<0.001
31-35 yrs.	803	116	14.4	12.69	6.8,23.7	<0.001
36-40 yrs.	814	130	16.0	14.29	7.7, 26.7	<0.001
41-45 yrs.	414	56	13.5	11.76	6.1, 22.7	<0.001
46-50 yrs.	286	48	16.8	15.16	7.7, 29.6	<0.001
51 &>yrs.	283	51	18.0	16.53	8.5, 32.2	<0.001
POP by parity						
Para Nil	621	11	1.8	1.00	-	
Para 1-3	1861	108	5.8	3.42	1.8, 6.4	<0.001
Para 4-6	1534	218	14.2	9.18	5.0, 16.9	<0.001
Para 7 and more	1048	184	17.6	11.81	6.47, 21.9	<0.001
POP by age at the time of marriage (only married women included)						
14 years or less.	337	43	12.8	1.00	-	
15-20 years.	3469	371	10.7	0.82	0.58, 1.15	0.24
21-25 years.	746	74	9.9	0.75	0.50, 1.12	0.16
26-30 years.	189	29	15.3	1.24	0.74, 2.06	0.41
31 years or more.	30	2	6.7	0.49	0.11, 2.12	0.34

Results from binary logistic regression analysis

Table-4 Duration, impact on women's overall quality of life and specific aspects of life of POP and consultation with a doctor.

Variable	N	(%)
Duration of POP: first began		
3 to 6 months ago	28	5.4
7 months to 1 year ago	62	11.9
> 1yr to 2 yrs ago	68	13.1
> 2 yrs to 5 yrs ago	132	25.3
> 5 yrs to10 yrs ago	118	22.6
>10 yrs to 20 yrs ago	80	15.4
> 20 yrs ago	33	6.3
Impact of POP on women's overall quality of life		
Not at all	80	15.4
Slightly	124	23.8
Moderately	149	28.6
Greatly	168	32.2
Impact of pop on specific aspect of everyday life including hygiene, home life, work life and social life:		
Not at all	74	14.2
Slightly	198	38.0
Moderately	130	25.0
Greatly	119	22.8
Ever consulted any doctor because of POP		
Yes	111	21.3
No	410	78.7

Figures

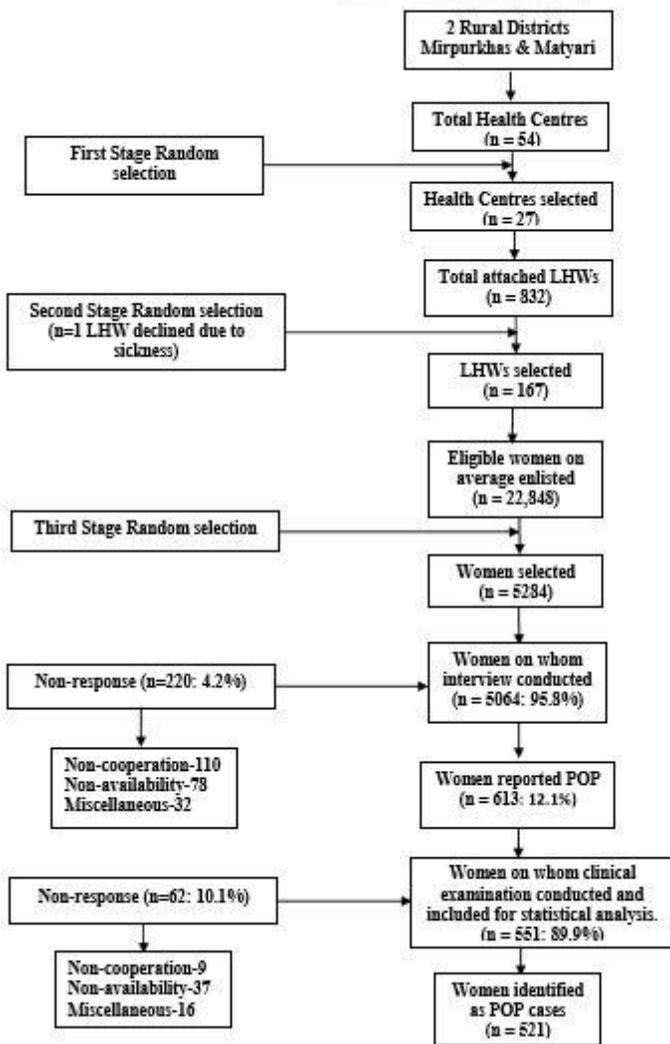


Figure 1

Diagram showing flow through the study