

Research Article

Prevalence and Risk Factors of Pelvic Organ Prolapse in Rural Women

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ABSTRACT

Background: Pelvic organ prolapse (POP) is a common pelvic floor disorder that affects the quality of life of women through urinary, bowel, sexual, and psychosocial dysfunction.

Objective: This study aimed to determine the prevalence of pelvic organ prolapse and identify its associated risk factors among rural women.

Methodology: This hospital-based cross-sectional study was conducted at the Department of Gynaecology and Obstetrics, Saidu Group of Teaching Hospital, Swat, from 1st January 2025 to 31st December 2025 and included 190 rural women.

Results: The mean age of the participants was 46.7 ± 11.3 years, the mean BMI was 27.3 ± 4.2 kg/m², and the mean parity was 5.1 ± 2.3 deliveries. Pelvic organ prolapse was diagnosed in 68 (35.8%) women, with Stage II being the most common stage (41.2%). Anterior compartment prolapse was the predominant anatomical type (42.6%). The most frequent symptoms were vaginal bulge (86.8%), pelvic heaviness (77.9%), and lower back pain (64.7%). Women with prolapse were significantly older (53.2 ± 9.6 vs. 43.1 ± 10.8 years; $p < 0.001$), had higher BMI (28.8 ± 4.5 vs. 26.5 ± 3.8 kg/m²; $p = 0.001$), and greater parity (6.7 ± 2.1 vs. 4.2 ± 1.8 ; $p < 0.001$) than those without prolapse. Multivariable analysis identified multiparity (AOR=3.47, 95% CI: 1.82-6.62), age ≥ 50 years (AOR=2.84, 95% CI: 1.46-5.53), heavy lifting (AOR=2.67, 95% CI: 1.39-5.12), postmenopausal status (AOR=2.31, 95% CI: 1.18-4.51), home vaginal delivery (AOR=2.12, 95% CI: 1.09-4.11), and chronic constipation (AOR=1.94, 95% CI: 1.01-3.75) as independent risk factors.

Conclusion: It is concluded that pelvic organ prolapse is highly prevalent among rural women and is strongly associated with multiparity, advancing age, postmenopausal status, heavy lifting, home vaginal delivery, and chronic constipation.

Keywords: Pelvic Organ Prolapse, Rural Women, Prevalence, Risk Factors, POP-Q, Pelvic Floor Disorders.

INTRODUCTION

This is a pelvic floor disorder called pelvic organ prolapse (POP), which occurs when there is weakness in the muscles and connective tissue in the pelvis that support the uterus, bladder, rectum, or vaginal apex, causing them to descend from their normal position [1]. It is a major health issue affecting women that impacts on their physical, mental, social and sexual health. Pelvic organ prolapse is not typically a life-threatening condition, but it can be a significant impact on quality of life due to urinary, bowel, and sexual dysfunction and decreased functional abilities [2]. The incidence of pelvic organ prolapse ranges widely based on the criteria for diagnosis, study context and the demographic factors of those included in the study [3]. The prevalence of prolapsed uterus among women has been reported in community-based studies, ranging from 3-8%,

and in women in whom the degree of prolapse is determined by a pelvic examination, up to 50% [4]. In LMIC, women are often subjected to several obstetric and socioeconomic risk factors which make them more vulnerable to the deterioration of the integrity of the pelvic floor [5]. Pelvic organ prolapse is a complex condition. The well-recognized risk factors are pregnancy and vaginal childbirth, as the stretching and trauma that occurs during them can lead to a weakened pelvic floor from repeated trauma, which can result in a weakened pelvic support structure [6]. Other factors that contribute to the problem are advancing age, menopause, obesity, chronic constipation, chronic cough, heavy work, multiparity, long labor, instrumental deliveries and genetic predisposition [7]. These risk factors can manifest in rural women in combination, especially repeated pregnancies,

home deliveries, and physically strenuous agricultural or domestic work, and delayed access to obstetric services [8].

The most common symptoms of POP experienced by women include a feeling of fullness in the vagina, feeling heavy in the pelvis, lower back pain, urinary incontinence, urinary dysfunction, constipation, incomplete emptying of the bowel, and sexual dysfunction [9]. These symptoms tend to increase with prolonged standing, heavy lifting, or with physical activity, and can gradually result in emotional and social problems [10]. Unfortunately, many women put off getting medical attention due to embarrassment, cultural beliefs, ignorance about the disease, financial considerations, of the lack of specialist gynecological health services till it has progressed to the point of diagnosis [11]. In rural areas, there is a lack of maternal health services and preventive pelvic floor care, making pelvic organ prolapse a significant public health problem [12]. When a modifiable risk factor is identified, there is an opportunity to institute preventive interventions, better counselling in the antenatal and postnatal period, pelvic floor muscle training and appropriate referral in time [13]. Conservative management is an effective approach to relieve symptoms and delay disease progression for many women; therefore, early recognition is particularly important [14]. Others have shown that the factors of increasing parity, older maternal age, menopause, prolonged labor, home delivery, obesity, and heavy labor occupations are all consistent risk factors for POD [15]. These factors are, however, not equally important in all geographical areas due to differences in reproductive practices, health services, cultural norms and socioeconomic factors [16].

Objective

This study aimed to determine the prevalence of pelvic organ prolapse and identify its associated risk factors among rural women.

METHODOLOGY

This hospital-based cross-sectional study was conducted at the Department of Gynaecology and Obstetrics, Saidu Group of Teaching Hospital, Swat, from 1st January 2025 to 31st December 2025 and included 190 rural women. Participants were women of reproductive age (18 years and older) who lived in rural areas and visited the Department of Gynaecology and Obstetrics during the study period and who signed informed consent forms. Women with

symptoms suggestive of pelvic organ prolapse had a detailed pelvic examination and women without symptoms were examined as well to assess the prevalence. The exclusion criteria included women who had previously had a pelvic reconstructive surgery, congenital abnormalities of the pelvis, a gynecological malignancy or possible pregnancy, acute pelvic inflammatory disease, severe medical illness that prevented a pelvic examination, or refusal to participate.

Data Collection

All the eligible participants were enrolled by using non-probability consecutive sampling after obtaining approval and informed written consent from Institutional Ethical Review Committee. The demographic and clinical data, such as age, BMI, educational level, occupation, marital status, menopausal status, number of children, gravidity, age of first childbirth, place of delivery, mode of delivery, birth interval, history of prolonged labor, instrumental delivery, chronic cough, chronic constipation, heavy lifting, smoking status, and family history of pelvic organ prolapse were obtained through a structured questionnaire. A standard gynecological examination was done by the consultant obstetricians and gynecologists for all participants. Pelvic organs prolapse was evaluated by the Pelvic Organ Prolapse Quantification (POP-Q) system, and classified as Stage 0, I, II, III, or IV. Vaginal bulge, pelvic pressure, urinary incontinence, difficulty voiding, constipation, incomplete bowel evacuation and sexual dysfunction symptoms were documented, along with the compartment involved (anterior, apical, posterior, or multicompartament prolapse). The main outcome was the occurrence of pelvic organ prolapse among rural women. Secondary outcomes were the distribution of POP-Q stages, involvement of any anatomical compartments, clinical presentation of symptoms, and demographics, obstetric, lifestyle and medical risk factors for pelvic organ prolapse.

Statistical Analysis

Data was analysed with SPSS version 26.0. The continuous variables were reported as mean $\pm$ standard deviation and categorical variables were reported as frequencies and percentages. Independent t-test for continuous variables and Chi-square test for categorical variables were used for comparing pelvic organ prolapse positive and negative women. Univariate

analyses were used to identify variables that were significantly associated with the presence of pelvic organ prolapse and subsequently were entered into a multivariable logistic regression. Odds ratios (ORs) were adjusted and presented with 95% confidence intervals (CIs) and a p-value of < 0.05 was set as the statistical significance criteria.

RESULTS

The study included 190 rural women with a mean age of 46.7 ± 11.3 years and a mean BMI of 27.3 ± 4.2 kg/m². Most participants were

aged 50 years or older, accounting for 69 (36.3%), followed by 61 (32.1%) aged 40–49 years, 42 (22.1%) aged 30–39 years, and 18 (9.5%) younger than 30 years. A total of 117 (61.6%) women had no formal education, while 73 (38.4%) had primary or higher education. Most were housewives, comprising 145 (76.3%), whereas 45 (23.7%) worked as farmers or laborers. Premenopausal and postmenopausal women accounted for 98 (51.6%) and 92 (48.4%), respectively. The mean parity was 5.1 ± 2.3 deliveries.

Table 1. Demographic and Reproductive Characteristics of the Study Participants (N=190)

Characteristic	Category	N (%) / Mean $\pm$ SD
Age (Years)	Mean $\pm$ SD	46.7 $\pm$ 11.3
Age Group	<30 Years	18 (9.5)
	30–39 Years	42 (22.1)
	40–49 Years	61 (32.1)
	≥ 50 Years	69 (36.3)
Body Mass Index (Kg/M ²)	Mean $\pm$ SD	27.3 $\pm$ 4.2
Educational Status	No Formal Education	117 (61.6)
	Primary Or Above	73 (38.4)
Occupation	Housewife	145 (76.3)
	Farmer/Laborer	45 (23.7)
Menopausal Status	Premenopausal	98 (51.6)
	Postmenopausal	92 (48.4)
Parity	Mean $\pm$ SD	5.1 $\pm$ 2.3

Pelvic organ prolapse was identified in 68 (35.8%) women, while 122 (64.2%) had no prolapse. Among affected women, Stage II was the most common, occurring in 28 (41.2%), followed by Stage III in 19 (27.9%), Stage I in 15 (22.1%), and Stage IV in 6 (8.8%). Anterior

compartment prolapse was the most frequent anatomical type, affecting 29 (42.6%) women, followed by multicompartiment prolapse in 20 (29.4%), posterior compartment prolapses in 11 (16.2%), and apical prolapse in 8 (11.8%).

Table 2. Prevalence, Stage and Anatomical Distribution of Pelvic Organ Prolapse (N=190)

Variable	Category	N (%)
Pelvic Organ Prolapse	Present	68 (35.8)
	Absent	122 (64.2)
POP-Q Stage (N=68)	Stage I	15 (22.1)
	Stage II	28 (41.2)
	Stage III	19 (27.9)
	Stage IV	6 (8.8)
Anatomical Compartment	Anterior Compartment	29 (42.6)
	Posterior Compartment	11 (16.2)
	Apical Compartment	8 (11.8)
	Multicompartiment Prolapse	20 (29.4)

The sensation of a vaginal bulge was the most common complaint among women with pelvic organ prolapse, reported by 59 (86.8%), followed by pelvic heaviness in 53 (77.9%) and lower back pain in 44 (64.7%). Urinary incontinence was present in 31 (45.6%),

voiding difficulty in 27 (39.7%), and constipation in 24 (35.3%). Incomplete bowel evacuation affected 18 (26.5%) women, while dyspareunia and sexual dysfunction were reported by 16 (23.5%) and 14 (20.6%), respectively.

Table 3. Clinical Presentation among Women with Pelvic Organ Prolapse (N=68)

Clinical Presentation	N (%)
Sensation Of Vaginal Bulge	59 (86.8)
Pelvic Heaviness	53 (77.9)
Lower Back Pain	44 (64.7)
Urinary Incontinence	31 (45.6)
Voiding Difficulty	27 (39.7)
Constipation	24 (35.3)
Incomplete Bowel Evacuation	18 (26.5)
Dyspareunia	16 (23.5)
Sexual Dysfunction	14 (20.6)

Women with pelvic organ prolapse were older than those without prolapse, with mean ages of 53.2 ± 9.6 and 43.1 ± 10.8 years, respectively ($p < 0.001$). They also had a higher mean BMI (28.8 ± 4.5 vs. 26.5 ± 3.8 kg/m²; $p = 0.001$) and greater mean parity (6.7 ± 2.1 vs. 4.2 ± 1.8 ; $p < 0.001$). Postmenopausal status was more common among women with prolapse than

those without it (49 [72.1%] vs. 43 [35.2%]; $p < 0.001$). Prolonged labor (32 [47.1%] vs. 27 [22.1%]; $p = 0.001$), home vaginal delivery (41 [60.3%] vs. 44 [36.1%]; $p = 0.002$), heavy lifting (46 [67.6%] vs. 48 [39.3%]; $p < 0.001$), and chronic constipation (29 [42.6%] vs. 26 [21.3%]; $p = 0.003$) were also significantly more frequent among women with prolapse.

Table 4. Comparison of Selected Risk Factors between Women with and Without Pelvic Organ Prolapse

Variable	POP Present (N=68)	POP Absent (N=122)	P-Value
Age (Years), Mean $\pm$ SD	53.2 ± 9.6	43.1 ± 10.8	<0.001
BMI (Kg/M ²), Mean $\pm$ SD	28.8 ± 4.5	26.5 ± 3.8	0.001
Parity, Mean $\pm$ SD	6.7 ± 2.1	4.2 ± 1.8	<0.001
Postmenopausal Women	49 (72.1%)	43 (35.2%)	<0.001
History Of Prolonged Labor	32 (47.1%)	27 (22.1%)	0.001
Home Vaginal Delivery	41 (60.3%)	44 (36.1%)	0.002
Heavy Lifting	46 (67.6%)	48 (39.3%)	<0.001
Chronic Constipation	29 (42.6%)	26 (21.3%)	0.003

Multivariable analysis showed that multiparity of five or more deliveries was the strongest independent risk factor for pelvic organ prolapse, increasing the odds by 3.47 times (95% CI: 1.82–6.62; $p < 0.001$). Age 50 years or older was associated with 2.84-fold higher odds (95% CI: 1.46–5.53; $p = 0.002$), while heavy lifting increased the odds by 2.67 times

(95% CI: 1.39–5.12; $p = 0.003$). Postmenopausal status was associated with 2.31-fold higher odds (95% CI: 1.18–4.51; $p = 0.015$), home vaginal delivery with 2.12-fold higher odds (95% CI: 1.09–4.11; $p = 0.027$), and chronic constipation with 1.94-fold higher odds (95% CI: 1.01–3.75; $p = 0.046$).

Table 5. Multivariable Logistic Regression Analysis of Independent Risk Factors for Pelvic Organ Prolapse

Variable	Adjusted Odds Ratio (95% CI)	P-Value
Age ≥ 50 Years	2.84 (1.46–5.53)	0.002
Multiparity (≥ 5 Deliveries)	3.47 (1.82–6.62)	<0.001
Postmenopausal Status	2.31 (1.18–4.51)	0.015
Heavy Lifting	2.67 (1.39–5.12)	0.003
Home Vaginal Delivery	2.12 (1.09–4.11)	0.027
Chronic Constipation	1.94 (1.01–3.75)	0.046

DISCUSSION

This study attempted to determine prevalence and associated risk factors of pelvic organ prolapse in 190 rural women attending department of gynaecology and obstetrics,

Saidu group of teaching hospital, Swat. The mean age of the participants was 46.7 ± 11.3 years, and the mean BMI was 27.3 ± 4.2 kg/m². Over one-third of the women were 50 years old or older, 61.6% were not educated

and the average number of deliveries was 5.1 ± 2.3 . The findings are consistent with the demographic characteristics associated with pregnancy, physically strenuous labor, poor health education, and delayed health care seeking for women residing in rural areas. Another study found that pelvic organ prolapse was more prevalent among older women with multiple pregnancies, and in socioeconomically disadvantaged women who resided in rural areas [16]. The overall prevalence of pelvic organ prolapse in this study was 35.8%. Of the affected women, stage II prolapse was most common (41.2%), followed by stage III (27.9%), stage I (22.1%) and stage IV (8.8%). Most commonly (42.6%), the prolapse was in the anterior compartment, and 29.4% had multicompartiment prolapse. Other studies have reported a significant prevalence of prolapse in rural women, and a variant of prolapse usually consists of Stage II and anterior compartment prolapse. It may be due to atrophy of the anterior vaginal wall and supporting structures from multiple vaginal births and obstetric strain [17]. The most common presenting clinical symptoms (reported by more than 80% of women with prolapse) were a sense of a vaginal bulge, pelvic heaviness and lower back pain. 45.6% experienced urinary incontinence, 39.7% had difficulty urinating, 35.3% constipation and 26.5% incomplete bowel emptying. 23.5% of affected women reported dyspareunia and 20.6% reported sexual dysfunction. Other studies have also found that the symptoms of pelvic organ prolapse include vaginal bulging, pelvic pressure, urinary symptoms, bowel dysfunction and sexual complaints. These symptoms may also have a considerable impact on women's functional and quality of life, but some women may postpone seeking health care due to embarrassment and cultural barriers [18].

The mean ages of women with prolapse and without prolapse were 53.2 ± 9.6 and 43.1 ± 10.8 years, respectively, with the prolapse group being significantly older than the non-prolapse group. They also had a higher mean BMI of 28.8 ± 4.5 kg/m² compared with 26.5 ± 3.8 kg/m² and greater mean parity of 6.7 ± 2.1 versus 4.2 ± 1.8 . Other factors, such as postmenopause, prolonged labour, home vaginal delivery, heavy lifting and chronic constipation were also statistically more prevalent among women with prolapse. The previous studies have always demonstrated a strong association between advancing age, obesity, high parity, menopause, obstetric trauma and the

development of prolapse, which is related to pelvic floor weakness [19]. Multiparity (5 or more deliveries) had the highest independent risk with a 3.47-fold increase in the likelihood of prolapse in multivariable analysis. Heavy lifting, postmenopause, home vaginal delivery, and chronic constipation increased the risk by 2.84, 2.31, 2.12, and 1.94 times, respectively, at age 50 years or older. Similar correlations have been reported in the past especially for advanced age, high parity, menopause and physically labour intensive occupations [20]. Multiple births can lead to an accumulation of injuries to the nerves, fascia and pelvic muscle, and estrogen loss during menopause decreases the elasticity/support of tissues. Further aggravation of prolapse can be caused by heavy lifting, or chronic constipation, which puts on the abdominal pressure when repeated. The study was conducted at a single centre and was hospital-based, which might restrict the applicability of the results to the general population of rural areas. Obstetric, and lifestyle data were collected, in part, self-reported and may suffer from recall bias. Furthermore, the study failed to assess the treatment response and long-term results in women with pelvic organ prolapse (POP).

CONCLUSION

It is concluded that pelvic organ prolapse is a common condition among rural women attending the Department of Gynaecology and Obstetrics, Saidu Group of Teaching Hospital, Swat, with more than one-third of the study population affected. Multiparity, advancing age, postmenopausal status, heavy lifting, home vaginal delivery, and chronic constipation were identified as significant independent risk factors. Early identification of high-risk women, promotion of institutional obstetric care, pelvic floor muscle strengthening, and community-based awareness programs may help reduce the burden of pelvic organ prolapse and improve women's quality of life.

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