

Research Paper

**Indications for Gynaecological Consultation by
Women at a Rural Outreach Centre in North-
Central Nigeria**

ABSTRACT

Aims: To identify the reasons for consultations, the common clinical diagnosis and disease pattern at a rural gynaecologic outreach clinic.

Study design: Descriptive Retrospective Study.

Place and Duration of Study: NKST Hospital Mkar-Gboko, Benue state, North-central Nigeria, in seven years (1st April 2005 to 31st July 2012).

Methodology: Information from the case notes of patients who attended the outreach clinic over the study period were retrieved and analysed. Majority of the patients came by self-referral.

Results: Of the 1,733 women that attended the clinic during the study period, 1,605 (92.6%) women made the inclusion criteria and formed the study population. The age range was 15 to 78 years; mean value of 33.6 year; 78% of the women were ages 21 – 40 years. The mean parity was 2.1 and ranged between 0 to 13 children. 68% of the women were para 0 – 2 whilst 18% had parity of 5 and above. The women had 73 reasons and 2,390 presenting complaints, 49.6% of them had multiple presenting complaints (average 1.5 complaints per woman). Most common complaints were inability to conceive, lower abdominal pain and leaking of urine and /or faeces amongst 38%, 11% and 10% of the women respectively. There were 63 disease conditions with 1,793 clinical diagnoses. About 12% of the women had multiple clinical diagnoses. The three leading clinical diagnoses were infertility, genital fistulae and uterine myoma, in 46%, 12% and 10% of the women respectively; followed by sundry other gynaecological disorders (9%) and medical disease conditions (5%) in which hypertension, diabetes mellitus and retroviral diseases were more frequent in that order. Some women (n = 21; 1%) came for second opinion.

Conclusion: Gynaecological diseases are diverse and common among women in rural central Nigeria. Inability to conceive, lower abdominal pain and incontinence of urine and or faeces were the three main reasons women sought consultation with the gynaecologist at Mkar. Infertility, genital fistulae, uterine myoma, non-communicable medical disorders and retroviral diseases were leading clinical diagnoses. Extending the services of Gynaecologist to

the rural areas in the region may reduce the access gap to women's health and enhance national development.

Keywords: gynaecological consultation, women's health, Nigeria

1. INTRODUCTION

Women, men, children and the aged live different lives [1]. This poses challenge in the priority setting for planning, design and implementation of the health needs of these groups of people [2]. Being a woman has implications for one's health. The female reproductive system is vulnerable to dysfunction or disease from infancy to old age. These dysfunctions if not properly managed can give rise to increased morbidity and mortality [3, 4]. The most evident issue is of course the differences that occur because women carry a greater health burden through the health risks and hazards linked with sexual and reproduction function [5]. Issues related to childbearing (high parity and infertility) are great causes of emotional and physical morbidity among women in developing countries [5]. The quality of care the women receive also varies widely depending on where they live and who they see [1]. The existing gross inequality in the health status of the people particularly between developed and developing countries, as well as within countries is pronounced. There is no area of health in which this inequity is as striking as in women's health and yet women's health and rights are central to population and development of any nation [2]. Hitherto, both in developed and more in the developing countries, women continue to suffer needless disabilities and die prematurely of preventable causes [1]. The obstacles for optimal health remain greatest for the women living in the poverty stricken societies. They are the most likely to be deprived, abused and burdened with customs and traditions. They are the most likely to be subjected to high parity, physical labour, subjugation in decision making and impoverished. Achieving significant level of women's health requires knowledge of a true representative pattern of women morbidity. This is necessary for a country like Nigeria if cost effective measures are to be taken to improve the quality of life of the Nigeria woman and achieve millennium development goals (MDG) 3, 4 and 5. The entire operation of the health care system allocation of resources is better based on the adequate understanding of the morbidity pattern in a setting since this determines the utilization of resources by the healthcare providers and the clientele. A lot has been written about the prevalence of women's health conditions with infertility as the commonest condition in most African countries [4,6,7]. However, there is no report known to us in central Nigeria on the commonness of gynaecological diseases. It is out of this desire that the study sets to document the common presenting complaints and pattern of morbidity among women attending gynaecological clinic in a rural secondary level health facility in Benue State. It is envisaged that the data from the study will provide baseline information on women's disease pattern in the area for comparative and policy formation purposes.

2. MATERIAL AND METHODS

2.1 Study Background

Benue State is in north-central zone of Nigeria with an area of 34,059 km² and an estimated population of 4.22 million people, having its capital in Makurdi. Mkar, a

sub-urban community in Gboko local government area of Benue state is located at about 85 kilometres north east of Makurdi. It has a population of 35,000 (2006 est) and houses a university, a mission hospital (NKST-Nongu U Kristu U Ken Sudan hen Tiv Hospital, a 170 bed secondary level health facility, established 1925), and other higher institutions among others (Nigeria Min. of Information, 2006 National Population census). More than 90% of the inhabitants are subsistent farmers and over 98% of the populace is of Tiv ethnicity.

2.2 Study Population

All women who registered at the outreach clinic to see the gynaecological team were included in the study. Majority of the patients seen at the outreach clinics came by self-referral following announcement by way of mouth in worship places. An outpatient register is kept on all patients who came to the clinic. Clinical impression of the patient's conditions/diagnosis were arrived at after history, physical examination and minimal investigation and recorded in the case notes. , including age and parity were extracted and compiled for the period under study. This study was based on the outpatient consultations in the gynaecological clinic, therefore gynaecological emergency services of the hospital were not considered. .

2.3 Study Design

This was a 7-year descriptive retrospective study of the gynaecological illnesses seen in the gynaecological outreach clinic at NKST Hospital, Mkar between 1st April 2005 and 31st July 2012. Aall women who attended the gynaecology clinic were identified from the outpatient register. Names of the patients and their hospital numbers were obtained. With this, case notes of the patients were retrieved from the health records department and relevant data including age and parity were extracted and compiled for the period under study. The data was analysed using Microsoft Excel 2010 to obtain the mean, range and percentages and standard deviations. These were displayed on tables 1-5.

2.4 Ethical Considerations

Ethical approval for the study was obtained from the management of the Mkar Christian hospital, voluntary consent of the subjects was obtained while patients confidentiality was ensured throughout the study.

3. RESULTS

A total of 1,733 women came for consultation during the study period, 128 of them had incomplete data and some medical emergencies, hence only the records of 1,605 women were analysed. The patients were aged 15 to 78 years with a mean age of 33.6 years. Women aged 21 – 40 formed 78% of the patients. Adolescents and the elderly were 1% and 2% respectively. The parity of the women ranged from 0 to 13 with a mean of 2.1 deliveries. Most of the women (68%) were of low parity (para 0 – 2) compared to 18% with parity of 5 and above. The age and parity distribution is as shown in **Table 1**

Tables 2 show the distribution of the presenting complaints by the women who attended the clinic; and **Table 3** shows the distribution of the presenting complaints by age and by parity. The women had 73 indications that brought them to see the Gynaecologist and about half of them (49.6%) with multiple presenting complaints, giving an average of 1.5 complaints per woman. The 73 reasons were constellated into 12 categories. Most of the complaints were from women in the second and third decades of life (85%) and of low parity (68%). Most of the women (38%) complained of inability to conceive, whereas 11% and 10% of the women complained of lower abdominal pain and leaking of urine respectively. **Tables 4** show the distribution of the diagnoses among the women that presented for gynaecological consultation and **Table 5** shows the distribution of the diagnoses and

109 percentages of women by ages and by parity. There were about 63 clinical diagnoses further
 110 grouped into 14 diagnostic entities from the 73 complaints made. About 12% of the women
 111 had more than one clinical diagnosis. The three leading clinical diagnoses were infertility,
 112 genital fistulae and uterine myomas in 46%, 12% and 10% of the women respectively;
 113 followed by sundry 'other' gynaecological disorders (9%) and medical disease conditions
 114 (5%) in which hypertension, diabetes mellitus and retroviral diseases were more frequent.
 115 Genital malignancies with preponderance of cancer of the cervix were present in 1% of the
 116 women. Some of the women (n= 21, 1.0%) came to seek second opinion for intervention
 117 offered to them elsewhere.
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 119

120 **Table 1** **Age and parity distribution of the women that attended outreach clinic**
 121 **to see the gynaecologist (no = 1605)**

	Variable	Number (%)
122	AGE (YRS)	N=1, 605
123	<16	11 (1)
124	16 -20	51 (3)
125	21 - 25	203 (13)
126	26 - 30	422 (26)
127	31 - 35	341 (21)
128	36 - 40	280 (18)
129	41 - 45	116 (7)
130	46 - 50	70 (4)
131	51 - 55	31 (2)
132	56 - 60	23 (1)
133	>=61	26 (2)
134	No Age	31 (2)
135	Range 15 to 78 years	Average 33.6 years

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137 **Parity Distribution of the Women**
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	Variable	Number (%)
140	PARITY	N = 1605
141	0	598 (37)
142	1	339 (21)
143	2	156 (10)
144	3	101 (6)

145	4	92 (6)
146	>=5	287 (18)
147	not stated	32 (2)
148	Range 0 - 13 Average 2.1	Total deliveries 3294

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150 **Table 2 Distribution of presenting complaint(s) among women at gynaecology clinic at**
151 **NKST hospital Mkar (n=2390)**

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153	<u>S/No</u>	<u>Reason(s)</u>	<u>Primary</u>	<u>Secondary</u>	<u>Tertiary</u>	<u>Quaternary</u>	<u>Total (%)</u>
154	1	Abdominal pain	5	2	1	0	8 (0)
155	2	Abdominal swelling	1	1	0	0	2 (0)
156	3	Abnormal genitalia	2	0	0	0	2 (0)
157	4	Abnormal genitals colour	1	0	0	0	1 (0)
158	5	Abnormal vaginal bleeding	8	0	1	1	10 (0)
159	6	Acne	0	1	0	1	2 (0)
160	7	Bad breath	1	0	0	0	1 (0)
161	8	Bleeding at intercourse	2	6	4	0	12 (1)
162	9	Blood in stool and urine	0	1	0	0	1 (0)
163	10	Blood in urine during menses	0	1	0	0	1 (0)
164	11	Itching of the Body	1	1	0	1	3 (0)
165	12	Cervical lesion	1	4	0	0	5 (0)
166	13	Cervical tear	0	2	0	0	2 (0)
167	14	Chest pain	2	1	0	0	3 (0)
168	15	Complete family size	2	2	0	0	4 (0)
169	16	Constipation	0	1	0	1	2 (0)
170	17	Cough	0	1	0	0	1 (0)
171	18	Diabetes mellitus	0	8	1	1	10 (0)

172	19	Discharging nipples	0	12	6	5	23 (1)
173	20	Dizziness	1	1	1	0	3 (0)
174	21	Husband with weak erection	0	1	0	0	1 (0)
175	22	Excessive hair growth	0	5	6	3	14 (1)
176	23	Fear of Fibroid	0	2	0	0	2 (0)
177	24	Fear of HIV	0	1	0	0	1 (0)
178	25	Fever	0	2	3	0	5 (0)
179	26	Frequent urination	0	1	3	1	5 (0)
180	27	Headache	2	3	2	1	8 (0)
181	28	Heavy menstruation	40	39	7	0	86 (4)
182	29	Feeling heat over the body	7	8	5	1	21 (1)
183	30	Hypertension	0	12	7	13	32 (1)
184	31	Irregular menstruation	18	36	4	0	58 (2)
185	32	Joints pain	1	1	0	0	2 (0)
186	33	Leaking stool	0	6	0	0	16 (1)
187	34	Leaking urine	220	11	6	4	241 (10)
188	35	Leaking urine and stool	5	0	0	0	5 (0)
189	36	Low sexual feeling	0	1	1	0	2 (0)
190	37	Lower abdominal pain	214	53	5	0	272 (11)
191	38	Lower abdominal swelling	21	45	4	1	71 (3)
192	39	Lower back pain	5	19	9	0	33 (1)
193	40	Lump in the breast	3	3	0	0	6 (0)
194	41	Multiple body complaint	1	0	0	0	1 (0)
195	42	Narrow vagina	2	6	1	0	9 (0)
196	43	Neck swelling	2	0	0	0	2 (0)
197	44	No menstruation	51	81	6	3	141 (6)

198	45	Increasing weight gain	0	10	5	1	16 (1)
199	46	Pain at intercourse	6	6	3	0	15 (1)
200	47	Pain in the breast	1	0	0	0	1 (0)
201	48	Pain with menstruation	7	3	2	0	12 (1)
202	49	Pain with urination	3	5	1	1	10 (0)
203	50	Palpitation	0	1	2	0	3 (0)
204	51	Perineal pain	2	3	1	0	6 (0)
205	52	Perineal tear	0	1	1	1	3 (0)
206	53	Poor sleep	0	1	1	0	2 (0)
207	54	Positive Pap smear	1	0	0	0	1 (0)
208	55	Pregnancy check	0	5	2	0	7 (0)
209	56	Recurrent child losses	8	0	0	0	8 (0)
210	57	Recurrent miscarriages	25	5	2	0	32 (1)
211	58	Living with HIV	0	24	9	1	34 (1)
212	59	Scanty menstruation	4	9	5	0	18 (1)
213	60	Wants another opinion	17	4	0	0	21 (1)
214	61	Swelling in vagina	45	22	5	2	74 (3)
215	62	Swelling of the body	1	0	0	0	1 (0)
216	63	Swelling of the legs	1	0	0	0	1 (0)
217	64	Vaginal discharge	11	20	11	6	48 (2)
218	65	Vomiting	1	0	0	0	1 (0)
219	66	Vulval itching	5	10	7	0	22 (1)
220	67	Vulval swelling	1	1	0	0	2 (0)
221	68	Vulval warts	0	0	1	0	1(0)
222	69	Want contraception	1	1	0	0	2 (0)
223	70	Wants IUD removed	1	0	0	0	1 (0)

224	71	Unable to conceive	822	67	24	3	916 (38)
225	72	Wets bed at night	1	0	0	0	1 (0)
226	73	Feels vagina too wide	1	0	0	0	1 (0)
227	Total		1,594	579	165	52	2,390

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230 **Distribution of the constellation of presenting complaint(s) at gynaecology clinic at**
 231 **NKST Hospital Mkar (n=2390)**

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233		Variable	Primary	Secondary	Tertiary	Quaternary	Total (%)
234	1	Abnormal vaginal bleeding	68	83	16	1	168 (7)
235	2	Lower abdominal pain	235	69	12	1	317 (13)
236	3	Lower abdominal swelling	22	46	4	2	74 (3)
237	4	Leaking urine & or Stool	235	17	6	4	262 (11)
238	5	Medical disorder	0	44	17	15	76 (3)
239	6	No menstruation	55	95	13	3	166 (7)
240	7	Others	53	96	47	15	211 (9)
241	8	Recurrent miscarriages	25	5	3	0	33 (1)
242	9	Swelling in vagina	46	23	5	2	76 (3)
243	10	Second opinion	17	4	0	0	21 (1)
244	11	Vaginal discharges	16	30	18	6	70 (3)
245	12	Unable to conceive	822	67	24	3	916 (38)
246		Total	1,594	579	165	52	2,390 (100)

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248 **Table 3 Distribution of the clinical diagnosis among the women at gynaecology**
 249 **clinic at NKST Hospital Mkar (n=1795)**

250	S/No	Diagnosis	Primary	Secodary	Tertiary	Total (%)
251	1	Adenomyosis	4	1	0	5 (0)
252	2	Carcinoma of the cervix	14	1	1	16 (1)
253	3	Angiomyxoma	2	0	0	2 (0)
254	4	Anovulation	112	9	5	126 (7)
255	5	Asherman's disease	26	1	0	27 (2)
256	6	Bladder neck incompetence	7	0	0	7 (0)
257	7	Cervical incompetence	13	2	1	16 (1)
258	8	Cervical lesion	8	0	0	8 (0)
259	9	Cervical polyps	5	1	0	6 (0)
260	10	Pelvic inflammatory disease	4	0	0	4 (0)
261	11	Chronic pelvic pain	59	1	1	61 (3)
262	12	Climentaric	11	2	3	16 (1)
263	13	Complete family size	3	1	0	4 (0)
264	14	Delayed menarche	1	0	0	1 (0)
265	15	Depression	1	0	0	1 (0)
266	16	Dysfunctional uterine bleeding	23	0	0	23(1)
267	17	Fear of cancer of the breast	1	0	0	1 (0)
268	18	Fear of cancer of the cervix	3	1	0	4 (0)
269	19	Fear of fertility failure	2	0	0	2 (0)
270	20	Fear of IUCD complication	1	0	0	1 (0)
271	21	Fear of pregnancy	3	1	1	5 (0)
272	22	Fear of STI	1	0	0	1 (0)
273	23	Fear of uterine fibroid	1	0	0	1 (0)
274	24	Genital prolapse	47	7	2	56 (3)

275	25	Genital tract infection	28	5	6	39 (2)
276	26	Gynaetresia	2	2	0	4 (0)
277	27	Inadequate coital frequency	9	3	0	12 (1)
278	28	Male factor	101	18	9	128 (7)
279	29	Menopause	12	0	1	13 (1)
280	30	Nothing abnormal detected	37	0	0	37 (2)
281	31	Ovarian tumours	20	3	0	23 (1)
282	32	Pelvic adhesion disease	15	3	0	18 (1)
283	33	Perineal tear	6	1	2	9 (1)
284	34	Polycystic ovary syndrome	24	1	0	25 (1)
285	35	Pregnancy	19	4	4	27 (2)
286	36	Pregnancy induced hypertension	1	0	0	1 (0)
287	37	Premature ovarian failure	10	0	0	10 (1)
288	38	Premenstrual syndrome	4	0	0	4 (0)
289	39	Previous urinary diversion	1	0	0	1 (0)
290	40	Rectovaginal fistula	6	0	1	7 (0)
291	41	Second opinion	3	0	0	3 (0)
292	42	Stress incontinence	3	6	2	11 (1)
293	43	Transverse vaginal septum	3	0	0	3 (0)
294	44	Tuboovarian mass	6	0	0	6 (0)
295	45	Tuboperitoneal factor	484	10	3	497 (28)
296	46	Ureteric fistula	17	0	0	17 (1)
297	47	Urethral leak	2	0	0	2 (0)
298	48	Urge incontinence	5	3	4	12 (1)
299	49	Uterine displacement	1	3	0	4 (0)
300	50	Uterine myoma	160	11	3	174 (10)

301	51	Vesicouterine fistula	8	0	0	8 (0)
302	52	Vesicovaginal fistula	164	0	0	164 (9)
303	53	VVF/RVF	5	0	0	5 (0)
304	54	Congenital uterine anomaly	0	1	1	2 (0)
305	55	Femoral hernia	0	1	0	1 (0)
306	56	Pulmonary oedema	0	1	0	1 (0)
307	57	Guilt	0	0	1	1 (0)
308	58	Helminthiasis	0	0	1	1 (0)
309	59	Residual ovary syndrome	0	0	1	1 (0)
310	60	Urinary retention	0	0	1	1 (0)
311	61	Medical disorders	40	33	19	92 (5)
312	62	Surgical conditions	10	2	0	12 (1)
313	63	Others	23	0	2	25 (1)
314	Total		1,581	39	75	1,795 (100)
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316 **Distribution of constellation of the diagnosis among the women (n = 1795)**
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319	S/no	Variable	Primary	Secondary	Tertiary	Total (%)
320	1	Uterine myomas	160	11	3	174 (10)
321	2	Chronic pelvic pain	59	1	1	61 (3)
322	3	Dysfunctional uterine bleeding	23	0	0	23 (1)
323	4	Urinary & or Faecal fistula	210	0	1	211 (12)
324	5	Genital prolapse	47	7	2	56 (3)
325	6	Genital tract infection	38	5	6	49 (3)
326	7	Infertility	771	45	17	833 (46)
327	8	Medical disorders	40	33	19	92 (5)
328	9	Malignant genital tumours	14	1	1	16 (1)
329	10	Menopausal symptoms	33	2	3	38 (2)
330	11	Nothing abnormal detected	37	0	0	37 (2)
331	12	Others	119	28	16	163 (9)
332	13	Pregnancy	20	4	4	28 (2)
333	14	Surgical disorders	10	2	0	12 (1)
334		Total	1,581	139	75	1,795 (100)

Table 4 Distribution of women for gynaecological consultation according to their chief complaint by age and parity (n=1605)

Age (yrs)	Abnormal Vaginal Bleeding	Lower Abd Pain	Lower Abd swelling	Leaking urine & or Stool	No Menses	Others	Recurr Abortions	Swelling in Vagina	Second Opinion	Vaginal Discharge	Unable to Conceive	Total (%)
<16	1	3	0	4	0	3	0	0	0	0	0	11 (1)
16 -20	3	9	0	24	2	3	2	0	0	0	8	51 (3)
21 - 25	2	23	3	42	3	3	3	2	3	2	117	203 (13)
26 - 30	10	42	3	36	10	9	7	7	3	4	291	422 (26)
31 - 35	11	37	7	30	8	7	8	3	3	3	224	341 (21)
36 - 40	12	50	5	33	13	11	6	4	6	4	136	280 (17)
41 - 45	16	26	3	14	11	7	0	5	2	1	31	116 (7)
46 - 50	7	22	0	14	4	7	0	8	0	1	7	70 (4)
51 - 55	2	11	0	8	0	2	0	5	0	0	3	31 (2)
56 - 60	0	4	2	11	0	1	0	2	2	1	0	23 (2)
>=61	4	0	1	17	0	2	0	2	0	0	0	26 (2)
Not stated	3	8	6	4	0	1	0	1	2	1	5	31(2)
Total	71	235	30	237	51	56	26	39	21	17	822	1,605 (100)

Distribution of women for gynaecological consultation according to their chief complaint by parity (n = 1605)

Parity	Abnormal Vaginal Bleeding	Lower Abdom Pain	Lower Abdoml swelling	Leaking urine/stool	No Menses	Others	Recurrent Abortons	Swelling in Vagina	Second Opinion	Vaginal Discharge	Unable to conceive	Total (%)
0	12	66	14	7	13	13	7	0	3	3	460	598 (38)
1	3	28	1	82	10	1	5	3	3	1	202	339 (22)
2	5	14	2	21	5	5	6	3	2	2	91	156 (10)
3	4	14	0	14	4	12	4	5	3	0	41	101 (6)
4	13	18	2	22	8	4	3	4	3	1	14	92 (6)
>=5	31	86	7	87	10	19	1	22	7	8	9	287(18)
Not stated	4	9	4	4	1	2	0	2	0	1	5	32 (2)
Total	72	235	30	237	51	56	26	39	21	16	822	1,605 (100)

Table 5: Distribution of women for gynaecological consultation according to their primary diagnosis by age and parity (n=1605)

389	Distribution of women for gynaecological consultation according to their primary diagnosis by parity (n=1605)															
390																
391	Parity (yrs)	Uterine	Chronic	Dysfunc	Genital	Genital	Genital	Infertility	Medical	Malig	Meno-	Nothing	Other	Pregnancy	Surgical	Total (%)
392		Myomas	Pelvic	Uterine	Fistula	Prolapse	Tract		Disorder	Genital	pausal	Abnormal			Disorders	
393			Pain	Bleeding			Infection			Tumour	Syndro	Detected				
394	0	67	15	1	5	3	11	413	8	2	6	14	38	8	1	592 (37)
395	1	23	7	0	79	3	5	187	8	1	3	1	13	5	0	335 (21)
396	2	13	2	1	18	3	6	82	9	0	2	3	15	1	1	156 (10)
397	3	7	5	2	11	6	3	38	4	0	5	5	14	1	0	101 (6)
398	4	19	7	8	18	4	1	16	1	1	0	2	12	13	0	102 (6)
399	>=5	28	39	11	77	27	5	10	6	16	8	12	43	1	4	287 (18)
400	Not stated	3	0	0	6	0	1	13	1	0	0	0	7	1	0	32 (2)
401	Total	160	75	23	214	46	32	759	37	20	24	37	142	30	6	1,605(100)

3.1 DISCUSSION

The burden of gynaecological illnesses is diverse and much among women in central Nigeria with unpretentious need and increasing awareness to seek gynaecological consultation. Inability to conceive, lower abdominal pain and incontinence of urine and or faeces were the three main indications women sought consultation with the gynaecologist at NKST hospital Mkar. Interestingly, some women came to seek second opinion over treatment offered to them elsewhere for their gynaecological illness.

The age range of 15 to 78 years and the distribution among the study population represented the full spectrum of gynaecological patients, from paediatric to senescent age group. This agrees with the earlier statement that female reproductive system is vulnerable to dysfunction or disease from infancy to old age [4]. The average age of 33.6 years, with preponderance of women aged 21 – 40 (78%) is similar to findings in studies from other centres [8, 9, 10,] and shows that gynaecological illnesses affect the most productive segment of the population with obvious socio economic and developmental consequences.

The wide range of parity (0 – 13 deliveries) among the women studied notwithstanding, the average fertility (2.1 deliveries) of the women was low compared to the north central zone total fertility rate of 5.4 [11]. Disaggregating indications for consultation among the women by parity showed that majority of the women were of low parity (para 0 – 2) giving the reason for the low fertility rate.

Inability to conceive/infertility was the commonest reason (38%/46%) women came to consult with the gynaecologist during the study period. This is similar to the findings in Nnewi and Osogbo where they found infertility as reasons for gynaecological consultation in 41.9% and 48.1% respectively. Like in most centres in Africa, infertility remained the leading indication for gynaecological consultation. The desire for pregnancy was expressed across all the ages and parity group. This is similar with the findings in other studies [9, 10] and reflects the high premium placed on fertility in the region.

Lower abdominal pain was the second common reason (13%) the women sought to see the gynaecologist. Lower abdominal pain in women can be of physiological, psychological or pathological cause. Table 4 shows several conditions that are capable of causing pain. Dysmenorrhoea, genital tract infection and its sequelae, chronic pelvic pain, lower abdominal tumours (benign and malignant) and 'presentation' of infertility among others are known to manifest as lower abdominal pain in women [12]. In this study, the prevalence of genital tract infection particularly pelvic inflammatory disease (PID) was lower than the findings from other centres [4, 7, 10,12], however, we may be dealing with the sequelae of the PID and presenting as infertility and chronic pelvic pain. Hence lower abdominal pain presenting as the second commonest reason the women sought to see the gynaecologist.

Leaking urine and or faeces was the third common reason (11%) the women came to see the gynaecologist. This is much higher than the findings from other centres [4, 7], including some community based studies in low resourced parts of the world where incontinence of urine or faeces were not reported among their findings [13, 14 ,15,]. Table 3 shows that, the women with the problem of incontinence cut across all the age groups. In Nigeria, the central zone is reported to have high prevalence of incontinence of urine among the women. Though most of the reports are from dedicated fistula centres in the zone [16, 17, 18], National Demographic and Health Survey (NDHS) 2008 corroborated their findings in the zone. The finding from this study further confirms the high burden of female genital fistula in central Nigeria [11]. If obstetrics fistula is considered a proximate to maternal mortality, it becomes obvious the high maternal mortality ratio reported from the region [19]. Fistula patients are mostly found in rural areas, dedicated fistula centres or in programs that are responsive to them [20, 21]. The outreach centre was a rural community, the gynaecologists had fistula surgical expertise and the fistula surgeries

were offered free or at very minimal cost. This might explain for the high number of women with incontinence of urine that came for consultation. But it also shows that the problem is there and developing programs that are accessible and responsive to the fistula women will attract them from their seclusion and alleviate this human suffering.

Menstrual disorders represented by abnormal vaginal bleeding and no menstruation for longer than three to six months were the fourth reasons the women sought gynaecological consultation and formed 7% of the reasons each. Menstrual disorders are frequent complaints in gynaecological clinics [4]. However, the finding from the study of 7% each of women with amenorrhoea and dysfunctional uterine bleeding (DUB) respectively is higher than the 5.51% for amenorrhoea and 4.09% for DUB reported from south east (SE) Nigeria [4]. Causes of the menstrual disorders among the study group included anovulatory infertility, dysfunctional uterine bleeding, uterine myomas, delayed menarche, Asherman's disease and menopause.

Medical disease conditions (mainly hypertension, diabetes mellitus and retroviral diseases) and genital malignancies were observed in 6% of the women. All the medical disease conditions were secondary or incidental findings during the evaluation of the patients and not primary presentation. Except for the retroviral diseases, the presence in about 6% of the women of non-communicable diseases in the rural setting affirms the opinion of Non-Communicable Diseases (NCD) Alliance [2] on the threat to life of these conditions among girls and women even in Africa.

Swelling in the vagina suggestive of genital prolapse was a complaint in 3% of the women. This is lower than the finding of 7.41% from Eastern Nigeria/other studies [4, 7]. This difference notwithstanding the high fertility rate among families in north central zone as compared to families in SE Nigeria [11] will require further study.

Some women (1.0%) came because of abnormal vaginal bleeding that was discovered to be as result of advanced cancer of the cervix. This is lower than the finding of 2.38% among the gynaecological patients in Southern part of the country [4, 7]. Carcinoma of the cervix was still the commonest malignancy of the female genital tract seen.

Twenty one women (1%) came seeking second opinion over treatment offered to them by other physicians. To the best of our knowledge, this is the first reported record of such reasons for gynaecological consultation in this part of the country. Small as this number is, it is significant as representing growing consciousness among women for good quality care and recognition of their right for what is done on their bodies. It is beginning of a paradigm women assuming more control over their own lives and wellbeing, and challenging the medical professionals in their treatments. This should be a wakeup call for the medical professionals to reappraise themselves in the management of illnesses in women and offer interventions that can stand contention within the resources offered.

4. CONCLUSION

In conclusion, the reasons women in north central Nigeria seek to see the gynaecologist are genuine and similar, like inability to achieve conception when desired, but diverse with significant regional variation like problems of incontinence of urine. The burden of gynaecological diseases in the study area is equally much with growing desire for quality care and consciousness of interventional outcome as shown by search for second opinion. There is an urgent need for reorganization of the human resource distribution towards improving health care delivery to the rural communities with increasing access to specialist like gynaecologist. Programs like opening satellite specialist centres in the district hospital and scheduling regular visits from the regional tertiary hospital from the state capital will increase

the rural women access to the specialized and quality care needed. These visiting specialists will undertake complex surgical procedures that are beyond the competence of the resident medical personnel and yet alleviate the economic and psychological hardship of referral to the specialist centres. The common gynaecological problems identified among the study group like infertility, genital fistulae, and cervical cancers among others are preventable. Extending programs that will address control of genital tract infection in women, improving obstetrics care and cervical cancer screening even in the simplest ways like visual inspection will significantly alleviate the suffering of these women. There is need to bring in human right and security approach to women's health not only for the urban population but for the rural women too. Neglecting the rural women is risking failure of attainment of all the MDG but particularly the 3, 4, 5 goals by the year 2015.

ACKNOWLEDGEMENTS

The authors acknowledge with gratitude the cooperation and support of the leadership and staff of the NKST Hospital Mkar-Gboko for the permission to use their facility for the medical outreach. We also appreciate the staff of the Safe motherhood partners for the record retrievals and our colleagues from various institutions who covered our duties while in the field for the outreach work. We thank you all.

COMPETING INTERESTS

No conflicting interest exists in undertaking this study and writing of the manuscript.

ETHICAL APPROVAL

Ethical approval for the study was obtained from the management of the NKST Hospital Mkar, voluntary consent of the subjects was obtained while patients confidentiality was ensured throughout the study.

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