Readers’ Forum

Consequently, it should not be difficult to get the support of management for health promotion programmes. Trade unions are likely to be cooperative, and can help to negotiate with management on the implementation of programmes that workers believe are needed.

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Schoolchildren as conveyors of health information for family members

SIR—In India the conventional methods of health education have not produced the desired results, probably because of widespread illiteracy among adults. We have investigated the extent to which health information is passed by schoolchildren to adult members of their families. Our study was conducted in the Solapur district of Maharashtra over a two-month period. Initially, baseline sociodemographic data were collected, including material on the knowledge of schoolchildren and their family members about health. Adults were also asked to indicate their single major source of health information; 48% of them were illiterate, 37% had farming as their major occupation, and 15% were manual labourers. The average monthly per capita income was approximately US$ 10.

Students of the sixth to tenth standards, aged 11-15 years, were taught hygiene, sanitation and immunization by a trained health educator who used audiovisual aids. They were encouraged to discuss the topics with their families at home. After ten sessions the knowledge of students and their family members was retested. We found a statistically significant increase in knowledge about health among both the students and their families after the teaching sessions. Moreover, 23% of family members who were questioned at this stage mentioned that their children were a source of health information, whereas only 2% had done so previously. Other major sources of health information for adult family members both before and after their children had attended the teaching sessions were posters and hoardings (about 28%) and health personnel (about 34%). It would be difficult to say whether the health information acquired by family members would be used in daily life, for old habits die hard. Perhaps, with additional training, schoolchildren could influence the decisions of adults on health matters. In India it is not uncommon for schoolchildren in early puberty to influence domestic decision-making, especially if the adult members of the family are of low educational level.

School students aged 11-14 number about 29 million in India. In the long run they could play a significant role in imparting health information to adults.

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Education: the key to preventing vesicovaginal fistula in Nigeria

SIR—Vesicovaginal fistula, a tear from the bladder to the vagina, is one of the most serious gynaecological problems found in Hausa and Fulani women in northern Nigeria. Its prevalence is associated with a high frequency of cephalopelvic disproportion resulting in difficult deliveries and birth injuries. It is most commonly caused by obstructed labour. Delivery often takes place unassisted at home because many villages are long distances from hospitals. Women who
sustain vesicovaginal fistula during delivery become incontinent and continuously leak urine. As a consequence they are socially stigmatized and often live on the fringes of society. They are at risk of being divorced by their husbands and rejected by their families.

Certain birth practices also cause the condition. Traditional midwives, when treating prolonged obstructed labour and numerous other problems of women, may cut into the vagina (the gishiri cut) and in some cases create a tear between the vagina and bladder.

Sociocultural factors play an important role in placing women at risk of the condition, in particular the early marriage of girls, a custom defended on the ground that it prevents premarital sex and unwanted pregnancies. Unfortunately, girls are predisposed to vesicovaginal fistula if they marry at extremely young ages, perhaps only 10–12 years; they are likely to become pregnant long before their bodies have reached a stage of maturity consistent with safe delivery.

Another risk factor is the low status of women. Married women are allowed out of the household only in exceptional circumstances, such as a death in the family or severe illness. Education for girls is given low priority. Wives are excluded from important decision-making, and their husbands often choose not to send them for medical care at government hospitals because most of the doctors are men.

Economic factors also serve as a disincentive to the use of modern health facilities for prenatal, delivery, and postnatal care. Hospitals are often located in urban areas and for people with extremely limited resources it is expensive to travel to them from remote villages. Furthermore, the hospitals do not have sufficient capacity to admit all pregnant women and they are poorly equipped and staffed.

Perhaps the greatest barrier to preventing vesicovaginal fistula is the ignorance among villagers of the danger of unsupervised delivery in women at risk. In rural communities, people know little about health.

In Mujedawa, a village in Kaduna State, 304 heads of household and their senior wives were personally interviewed between June and August 1989 in a study funded by the University of Maine-Orono. The mean ages of the two categories were 41 and 29 years respectively. The heads of household were slightly better educated than their senior wives, 20% and 13% respectively having attended primary school, and 3% and 0% having benefited from secondary education; 0.3% of the husbands reported having reached the level of postsecondary education. None of the villagers interviewed had attended university. Koranic education had been imparted to 86% of the wives and 76% of the husbands.

The majority of the men (65%) knew what vesicovaginal fistula was and were able to describe it accurately. Only 24% of senior wives knew what the condition was; all but one of this minority could describe it accurately. Only 15% and 13% of the heads of household and senior wives had known anyone with vesicovaginal fistula personally.

Respondents who answered negatively were given a description of the condition and were then asked if they knew what caused it. The greatest number of both heads of household and senior wives could not answer this question correctly. Of the correct answers, childbirth was the reason most frequently given by senior wives, and the gishiri cut was indicated by 16% of heads of household. Early marriage was mentioned as a risk factor by 13% of the husbands and 5% of the wives.

Some of the incorrect answers referred to immoral behaviour, too much sex, working too hard, eating unpalatable foods, miscarriage, and early circumcision. Clearly, only a small number of respondents knew of vesicovaginal fistula and its causes. A significant finding was that heads of household were more aware of and knowledgeable about the condition than their senior wives, although the level of knowledge in both groups was low.

In northern Nigeria, women are at risk of vesicovaginal fistula because of early marriage, home delivery, inadequate prenatal care, and low
social status. Increased awareness that the condition can result from birth injury is obviously desirable, particularly among women, whose health is directly affected by it. However, since men are the major decision-makers it is also important that they receive information on the subject.

Women who suffer vesicovaginal fistula as a result of childbirth or cuts made by midwives have to face a life of emotional and physical incapacity. It is essential to prevent the condition in a society where health services are scarce. The first step should be to make communities aware of how this can be achieved through health education programmes for both men and women.

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