

WCH RATHER THAN MCH

SIR,—In your Round the World column (Sept 30, p 795) Dr Tahzib reports on a World Health Organisation working group's discussions on the *measurement of maternal morbidity*. One of us (R. B.) was a member of that group. Tahzib records our argument as "We should be talking of WCH rather than just MCH" but puts it wrongly.

The M in MCH (maternal and child health) used to be neglected but now it is receiving some attention.¹ WHO and the World Bank are now focusing on maternal mortality, and attempts to measure maternal morbidity have begun. However, we find that the reproductive health problems of women (the W) are related to much more than maternity. Tahzib mentions vesicovaginal fistula, obstetric palsy, sepsis, psychosis, and prolapse. Most data on women's health being hospital based, such morbidity (and cervical cancer) has been widely noticed but the prevalence of other reproductive morbidities of women have been neglected. In a community-based study on gynaecological diseases² we found that 92% of the women in villages had 1 or more gynaecological or sexual diseases, and the average was 3.6. The most common were vaginitis, cervicitis, cervical erosion, pelvic inflammatory disease, and dysmenorrhoea. There was no case of vesicovaginal fistula or cervical cancer. The prevalence of anaemia was 91% and of vitamin A deficiency 58%. 46% of unmarried girls had premarital sexual experience. Only 7.8% of women had ever received gynaecological care.

Unwanted pregnancies and the forcing of women to undergo illegal, unsafe abortions are common. One important cause of unwanted pregnancies is the failure of laparoscopic tubectomy, widely practised in India, or of vasectomy. This speaks volumes about the quality of birth control care given to the rural population. Spacing methods are practically non-existent. In our study only 7 women were using an intrauterine device (IUD) and only 5 were on oral contraceptives. The women thought that use of contraception led to health problems. That belief was not entirely misplaced for we found a significant association between tubectomy and past or present use of an IUD and of gynaecological conditions such as menstrual disorders, vaginal infections, and cervical disease. Moreover, tubectomy or introduction of an IUD often aggravated a pre-existing gynaecological disease, so such conditions must be excluded or treated before such contraception can be advised. The nurses and paramedics who form the backbone of the primary health care in rural areas cannot deal with these gynaecological conditions while the doctors in primary health centres are usually men, to whom women prefer not to reveal gynaecological or sexual problems.

Where syphilis, premarital sex, and illegitimate pregnancy are common, AIDS can not be far behind, and vaginitis, erosions, or ulcers may increase the rate of transmission of HIV infection.³

We argue⁴ that there is much more to women's reproductive health care than maternity or contraception services, which is all that policy makers and health planners seem to understand. Also needed are services for the prevention, diagnosis, and treatment of gynaecological diseases, including sexually transmitted conditions; safe abortion services; and education on reproductive health and sex. These services must be community based and participatory. This new emphasis is not to belittle the importance of maternity care or contraceptive services.

Nutritional deficiencies and occupational health problems, and discrimination against females, are all part of this wider understanding. So we should be saying WCH not just MCH.

SEARCH (Society for Education,
Action and Research in Community Health),
Gadchiroli (Maharashtra) 442 605, India

ABHAY BANG
RANI BANG

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