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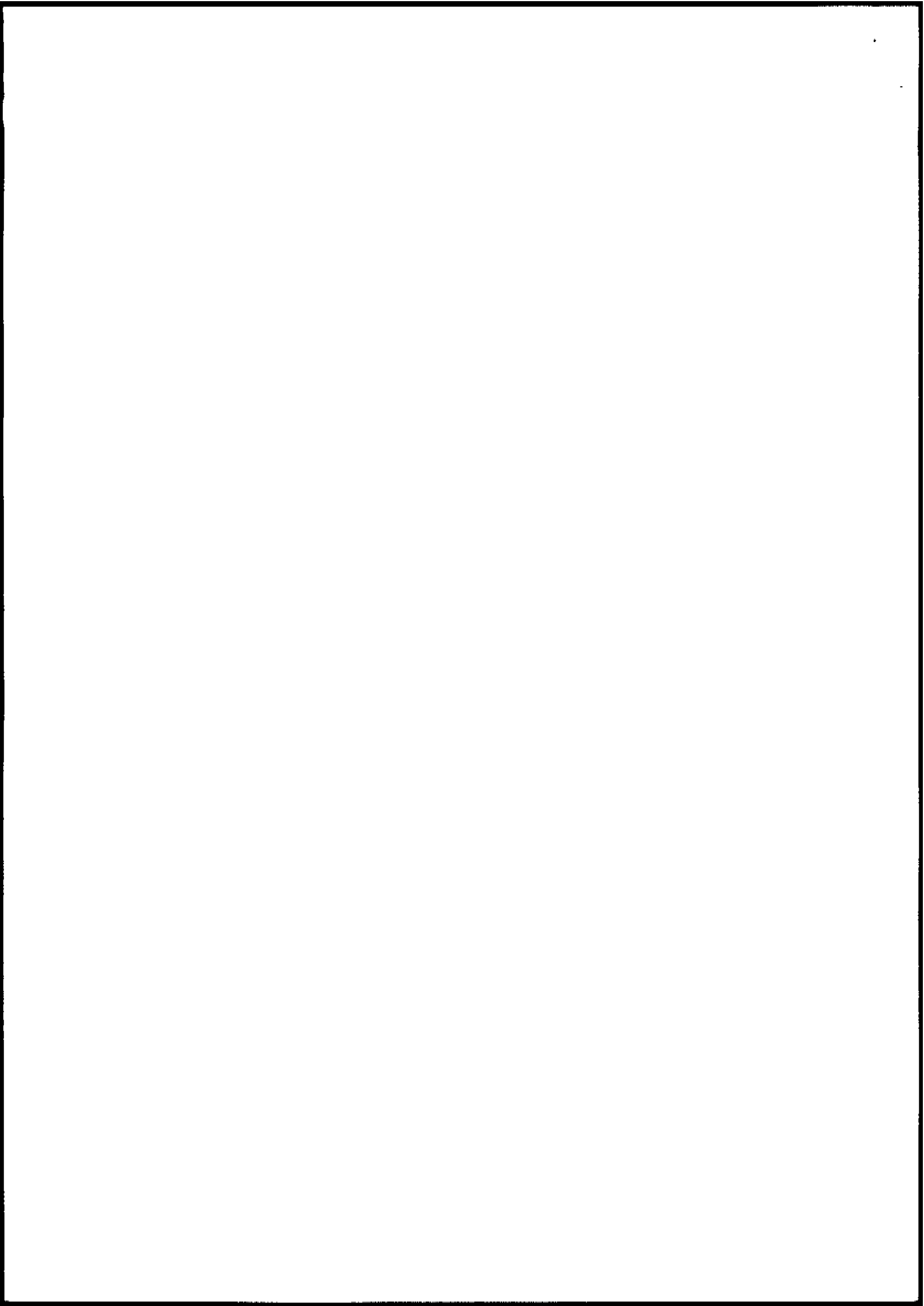
THE PREVENTIVE AND SOCIAL ASPECTS
OF PAEDIATRICS, OBSTETRICS AND GYNAECOLOGY

Report on a consultation meeting

Copenhagen
20-21 December 1976



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1. Introduction

The meeting was held on two days during each of which the group addressed itself to a quite separate problem. The first day was mainly devoted to discussions concerning the Workshop organized by the WHO Regional Office for Europe, the International Children's Centre (ICC) and the Association for Paediatric Education in Europe (APEE) on the preventive and social aspects of paediatric teaching. On the second day the group considered zero-population growth, the trends, their consequences and implications. The scope and purpose document is given in Annex I, the programme in Annex II, and the list of participants in Annex III. Dr P.S. Rönisch acted as Chairman and Secretary of the meeting, and Dr C.F. Ruoss as Rapporteur.

Opening the meeting on behalf of Dr Leo A. Kaprio, Director of the WHO Regional Office for Europe, Dr S.K. Sokolov, Chief, Strengthening of Health Services of the Regional Office, said that the Office felt that it was now necessary:

- (1) to identify the special needs of mothers, children and adolescents in order to assist countries to promote effective health care policies and strengthen, within family health services, the personnel required to meet these needs;
- (2) to bring into focus the impact of rapidly changing socioeconomic conditions on the mother and the child, so as to allow for early protective measures;
- (3) to improve the information on maternal and child health required for the planning and management of these services.

There had not, however, been any WHO meeting to date which dealt specifically with the problem of population growth, especially the so-called zero-growth in many of the European countries.

He quoted from the Sixth General Programme of Work adopted by the Twenty-ninth World Health Assembly. The detailed objectives are:

"To reduce maternal, perinatal, infant and childhood mortality and morbidity, and to promote reproductive health and the physical and psychosocial development of the child and adolescent within the family context.

To collaborate with countries in the development and strengthening of the family health component of health services, including family planning and welfare."

The targets should be the reduction of maternal, perinatal, infant, childhood and adolescent mortality and morbidity by a given percentage in each country, promotion of the health of women of child-bearing age and the physical and psychosocial development of the child within the family context.

Dr Sokolov stated that the aims of the consultation meeting were:

- to formulate concrete proposals for activities to deal with the problem of "zero population growth";
- to prepare the Workshop on the Preventive and Social Aspects of Teaching Obstetrics and Gynaecology to be organized in 1977 by the ICC in collaboration with WHO and the APEE;
- to stimulate interest in social and preventive obstetrical and gynaecological teaching;
- to explore the possibilities for future, combined activities in the field of social and preventive paediatrics on the one hand, and social and preventive obstetrics and gynaecology on the other hand. This would include a second evaluation of the Workshop on the Preventive and Social Aspects of Paediatric Teaching organized in 1975.

He concluded by wishing the group every success in their deliberations.

2. Second evaluation of the Workshop on the Preventive and Social Aspects of Paediatric Teaching, September 1975, Paris (ICC/APEE/WHO)

The main difficulty found with regard to the first evaluation was to strike a balance between the content of the Workshop and its methods of work. At the closure of the meeting held in Paris in September 1975 each participant handed in a number of personal objectives that he intended to reach within the next 12 months at his local place of work. At the same time, before his departure

from Paris, each participant was informed that after 12 months he would be asked: (1) to send in a written account of the progress made towards his personal objectives, (2) to complete the questionnaire sent by APEE concerning the Workshop.

At the end of November 1976, 12 out of 22 copies of the questionnaire had been returned together with 7 accounts of the progress made. We were told that 2 of the participants were no longer in teaching positions and that their replies were therefore probably not valid. The results of the evaluation were presented by Dr A.T. Schweizer in a report; but, to summarize, he concluded that all 12 of the responding participants reached at least a few of their intended objectives in the year after the Workshop. Six had dropped, totally or partially, formal lectures, and six had started small working groups with students. These results, he felt, suggested that the Workshop had made a considerable impact.

In the discussion which followed the presentation of this evaluation, the group commented that the reaching of objectives might be less important than the efforts made in attempting to reach them, and that great attention needed to be paid to planning the evaluation of courses before they were actually held, if such evaluation was to prove worthwhile. There was some discussion on whether further evaluation of the September 1975 Paris Workshop should continue; it was decided that a further effort should be made to contact those participants who had failed to reply, in order to provide a more complete evaluation. Thereafter the evaluation of the 1975 course should cease.

3. Preparatory discussions on the organization of the Joint ICC/WHO Workshop on the Preventive and Social Aspects of Teaching Obstetrics and Gynaecology, Paris, November 1977

It was agreed that the course will be held in French. The criteria for inviting participants were discussed at some length. It was felt that the number should not exceed 20 with 2 coming from each country, and a list of 12 or more possible countries was prepared. One participant should be a doctor, and one a midwife, both working in a teaching capacity and in a position of some authority. The suggestion was made that, if possible, two participants might come from the same institution as they would be mutually supporting when they returned home. This suggestion was considered somewhat impractical, as was the suggestion that participants might come from an institution that had already provided participants for a previous course.

It was pointed out that it is usually the policy to allow governments to nominate people to participate within rather broad guidelines, but nevertheless the group felt that the selection of suitable participants was so important for the success of the Workshop that the organizations should try to give governments clearer profiles of the sort of persons who should be nominated.

3.1 Content of course and its methods of work

Considerable discussion ensued about whether the course should concentrate on the methodology of education techniques or give priority to increasing participants' awareness of the importance of social aspects in obstetrics and gynaecology. All were agreed that both of these aims were desirable, but there was considerable disagreement about which approach would achieve the more beneficial result in the long term, and whether the course met the needs of the different areas within the European Region. As a compromise solution it was proposed that the social aspects of obstetrics and gynaecology should be presented within a framework of educational methodology.

A scheme of work for the Workshop was prepared by Dr M. Pechevis and Dr B. Pissarro with the following general objectives:

- (1) to define institutional objectives for the undergraduate period of education for doctors and midwives and to adopt them, at least for the period of the Workshop;
- (2) to define intermediate objectives for obstetrics and gynaecology, including psychosocial and preventive aspects (this implies a study of population needs and priorities in this field);
- (3) to define some specific objectives for the psychosocial and preventive aspects of obstetrics and gynaecology;
- (4) to prepare the related "Dossier Documentaire" (a "Dossier Documentaire" contains all the necessary material for the students to achieve their objectives, e.g., articles or references, directions on how and where to acquire attitudes or skills, etc.);
- (5) to construct evaluation tools for these objectives.

It was felt that there should be some modification of these objectives in order to give more weight to the content of social obstetrics and gynaecology in the methods of work.

With regard to the evaluation of the Workshop, it was agreed that the organizers should be guided by Dr J. Gallagher, Education and Training Officer of the WHO Regional Office, whom they would meet for further discussions in order to prepare a programme of evaluation by April 1977. The involvement of APEE would also be considered.

4. Zero population growth

4.1 General trends in population in the past and at present (Dr P.S. Rönisch)

By 1975 the world population had risen to four billion. This represented a 60% increase over the 1950 level and was equivalent to an average annual growth rate of nearly 2%. The two reasons for this are:

- (1) a decline in mortality and an increase in life expectancy,
- (2) an increase in birth rates.

However, population growth rates vary considerably in different parts of the world and all the countries of the European Region (except Albania) have growth rates under about 1% (1.1% for Ireland, Romania and Spain). In some countries within the Region rates of population increase have slowed to a point where births and deaths are almost equal and if these trends in diminishing fertility continue then the high income regions of the world could be facing a decline in population by the end of the century. Already this trend has been responsible for a marked reduction in the percentage of the world population in the more industrialized regions of the world.

From 1850 to 1900 the increased population growth rate of the more developed regions was due to declining death rates. Since 1900, however, changing birth rates have become the dominating determinants of population growth rates in these areas and that dominance has been steadily increasing.

4.1.1 Fertility

Once again there is great variability between different countries and regions of the world. Several general features are apparent, however. The difference in fertility between the more and the less developed regions is increasing and is probably the highest ever at the present time. The past 25 years has witnessed the only appreciable period of years on record to demonstrate a major reversal of population trends and, during the last 10 years particularly, there has been an acceleration in the decline in fertility in the more developed regions of the world, so that many of them are close to, or below, replacement at the present time.

4.1.2 Social factors

Too little is known about the effects of a decline in the population on social structure and social needs, because so much attention has been devoted in the past to population growth. This new situation needs to be investigated urgently, with analysis and policy-orientated monitoring of the changes in the composition of demand for services and their supply.

Numerous social changes are influencing current population trends. For example rates of dissolution of marriage for non-mortality reasons have risen almost everywhere, and it seems that one of the reasons for this increasing number of divorces may be that longer life expectancy and lower birth rates extend the period of married life after child-bearing.

The family unit may also become less cohesive because, with fewer siblings, the children may rely more on social contacts outside the family. In addition, one result of the changing role of women is the increasing economic dependence their families may have upon their wage earnings, and this in turn may result in a desire for fewer children.

5. Zero population growth - trends and socioeconomic health consequences (Dr A.P. Beck)

The World Population Plan of Action has put forward the proposal that developed countries should aim at zero population growth. This results in a constant population where the number of deaths balance the number of births. At present several European countries have already reached zero population growth. In 1975 four countries, the German Democratic Republic, the Federal Republic of Germany, Luxembourg and Austria, had stable or declining populations. If recent trends

continue, the United Kingdom and Belgium will achieve population equilibrium in 1976. These cases demonstrate that population growth can come to a halt even without an explicit population policy. This situation has been brought about by a historical transition from a stabilized population prior to 1750, maintained by high birth rates, high and erratic death rates and short life times, towards the stabilized population of the present time which is characterized by low birth rates, low death rates and long life times. The transition has passed through two other phases: one of increasing population at first with lower death rates and increasing birth rates, followed by a subsequent phase with a decline in birth rates to the present time. When birth rates again equal death rates the demographic transition will have been completed.

It is interesting that, as implied in the previous paragraph, none of the four countries which have now achieved zero population growth was among the lengthening list of those with an explicit policy of stabilizing the population. The cessation of population growth came about as a result of a combination of economic, social, and demographic factors. The German Democratic Republic was the first country to bring its births and deaths into equilibrium in 1969 in a situation where there existed both high levels of education and employment for women and relatively low numbers of young people in their reproductive years. In the Federal Republic of Germany, the second country to bring its population growth to a standstill, the number of births fell below deaths in 1972. There the birth rate of 18 in 1969 fell steadily before levelling off at just under 10 in 1975. Austria achieved zero population growth in 1975 and since that time the German-speaking population of Europe has been declining slightly. These countries all have: (1) high levels of income; (2) high levels of education and employment for women and (3) easy access to contraceptives. As stated above, if recent trends continue the United Kingdom and Belgium will achieve population equilibrium sometime in 1976, bringing the total of countries to six. Together in these six countries live 152 million people, or nearly 4% of the world population. Although this percentage may seem small it is none the less a short step towards the eventual stabilization of world population. Several other countries have birth rates that are now nearly below 15, falling steadily, and approaching a balance with death rates. France and Italy, as well as several smaller European countries such as Sweden, Norway, Denmark, the Netherlands and Switzerland, comprise this group.

5.1 Causes for the decrease of the birth rate

Causes for the decrease of the birth rate were outlined in Dr A.P. Beck's presentation and included:

- (1) demographic factors,
- (2) altered reproductive behaviour,
- (3) the employment of women and their new role,
- (4) the availability of housing, jobs and career possibilities,
- (5) the attitudes of young married couples, which are dominated by economic and social considerations.

Reproduction is postponed and children today are no longer considered a security factor for old age.

5.2 Effects on the population structure

Immediate zero population growths would not be possible in most countries without considerable disruption to society. Many countries had a post-war baby boom in the early 1950's and this population is at present in the reproductive age. Even if they merely replaced themselves the number of births would still rise for several years before levelling off. To produce the number of births consistent with immediate zero growth, they would have to limit their child-bearing to an average of only about one child. This would have effects on the school system and subsequently on the number of persons entering the labour force. Thereafter a constant population could be maintained only if this small generation in turn had two children and their grandchildren nearly three children on an average. Then the process would again have to reverse, so that the overall effect for many years would be that of continuous expansion and contraction. This state of affairs would obviously be undesirable because of the social and economic fluctuations that would result. It is preferable that the path to stabilization involves a minimum of fluctuation from period to period in the number of births.

5.3 Changes in the age structure

In those countries where the population growth is at or below replacement level, should the trend of low birth rates continue for the next decades, the age scale will become constricted from the bottom, with fewer infants and more people in the older age-groups. In later decades the constriction will include first the teenagers, then persons in their twenties and thirties and so on, until the middle of the next century, when all age-groups of high fertility level will have died and the population will stabilize. The age scale will then have the shape of a slender bell, indicating a drop in the total population and a slow further decrease of the population. This decline in birth rate will give rise to an older population and this trend will require many adjustments.

5.4 Effect on rural and urban regions

Zero growth for a nation will mean an average of zero growth over all local areas. Stabilization will be likely to slow the growth more rapidly in the largest metropolitan centres and somewhat less rapidly in the small and intermediate sized centres.

5.5 Effects on social institutions

In areas with a deficit of social institutions the drop in birth rate will improve the amenities available if these are not subsequently restricted. In rural areas, however, it will be more difficult to justify the establishment or continuation of so many social institutions for a declining population. Such institutions would become farther apart and travel requirements would, therefore, increase. Such considerations are equally valid for all institutions frequented mainly by young people. Such an effect might result in an increase in urbanization for, in making the decision where to settle possibly for the rest of their lives, young couples consider the availability of social institutions to be an important factor. Such young people in the fertile age-group are particularly mobile and any migration will accentuate the decline in the rural population.

5.6 The effect on family life

As the birth rate declines women spend less of their lives in maternal functions. By the time they reach 50 it is highly likely that all children have left the family home. On the other hand, children will have an opportunity to grow up in big families because grandparents and even great-grandparents will still be alive.

It can be seen, therefore, that the desirable aim is toward population stabilization. This aim should be achieved, if possible, with minimum fluctuations in the number of births, while at the same time allowing individuals freedom of choice in their family planning. Most of the problems should be predicted in advance and preparations to overcome them should be made.

6. Zero population growth and family planning - the present situation and medical training (Professor K.H. Mehlan)

Professor Mehlan endorsed the recent changes in reproductive behaviour in Europe where many countries are showing a clear trend towards a preference for smaller families. The reasons for this are:

- (1) the changing status of women,
- (2) the changes in the number and duration of existing marriages,
- (3) the timing of births.

It was stressed that zero growth means a long-term stationary balance with equal death and birth rates and an equal age structure. Professor Mehlan felt that in the developing countries this should be achieved by decreasing mortality and abolishing poverty in order to encourage a decrease in births associated with steady socioeconomic development. He stated that population and economic policy in the socialist countries aims at a balanced reproduction of the population accompanied by a higher quality of life. He felt that decreasing reproduction causes a further aging of the population and he did not agree that progress in industrialization could be possible with a decreasing population. He therefore felt that a somewhat limited population growth was a desirable objective.

The health care needs were as follows:

- (1) further progress in reducing mortality and morbidity,

- (2) the improvement of geriatric care,
- (3) further development of the protection of maternal and child health.

He outlined some of the services which needed to be developed in the current situation in order to achieve these aims, including marriage advisory centres, improved child and adolescent health care and promotion of the desire to have children by improving medical care.

6.1 Training of the medical team in human reproduction and family health

The training objectives and curricula should take account of the changing responsibilities of the professions in the present demographic and medical situation. A well-designed programme for teaching family planning and population dynamics required proper emphasis on the social, biological and medical aspects of the problem.

7. Plenary discussion

Two major implications for health due to declining population growth rates were emerging for consideration.

(1) Because fewer children are being born in Europe, where the infant mortality is already very low, additional care should be paid to the quality of children born. Perinatal morbidity needs greater attention, with the further development of those techniques that aid the diagnosis and prevention of potential handicaps in the future child. The same can be said of education, because if there is going to be a diminishing work force having to support a proportionately aging population, the work force is going to need to be better trained.

(2) Birth control methods should aim to allow families flexibility of choice, if possible without prejudice to their future fertility. Some methods of birth control are obviously less flexible than others. For example sterilization should always be considered permanent and irreversible at the present time. Other methods may have complications or undesirable sequelae which lead to either subfertility or, on occasions, sterility.

Abortion is one example where such harmful side effects are being increasingly recognized. However, even such methods as the intra-uterine device or the oral contraceptive pill can occasionally result in infertility. Genital tract infections occur, not uncommonly, in association with intra-uterine devices and thereby cause some degree of infertility. A recent survey in Sweden suggested that over 20% of nulliparous patients using this method for contraception developed signs of infection within three years of the insertion of a device. If these figures are confirmed it may be that this form of birth control will be found undesirable for nulliparous women in particular who still have their child-bearing days ahead. As stated above, even oral contraceptives have been shown to give rise to a minor degree of infertility, mainly because of the delay in the onset of ovulation which occurs after the cessation of treatment. Although this delay in the resumption of normal fertility is usually only of short duration, a small proportion of women do suffer prolonged amenorrhoea and failure to ovulate after oral contraception, which can constitute a serious individual problem. It can be seen, therefore, that the choice of a method of birth control requires considerable attention if potential fertility is going to be preserved.

The group realized that WHO cannot influence, and does not try to influence, the demographic policies of individual countries. At the present time within the world there are two broad areas with different needs. Although it is obvious that family planning is necessary for the health of the developing nations, it is less obvious that even in those areas where the population growth is becoming stable, family planning is needed to promote and improve health. The aim should be to try and help individuals and nations to achieve their targets, and family planning is still necessary to improve the quality of life among wanted children.

8. Group discussions

The members of the consultation meeting divided into two smaller groups to consider the health problems of a society with a diminishing population growth, and how to improve the quality of life of families in such circumstances. Each group drew up a list of problems and possible ways of resolving them. The two subgroups subsequently came together again to present and discuss each other's proposals. Many similar conclusions had been reached and what follows is a composition of the presentations of the two groups and their subsequent discussions.

The problems arising were considered throughout the reproductive life of an individual from conception, through intra-uterine development to birth and subsequently through infancy, childhood,

adolescence and adult life, until embarking upon a pregnancy. Obviously there are different problems at different times in the life cycle. Such health problems can be considered in accordance with the WHO definition of health as somatic, psychological or social.

8.1 Infertility

There are two reasons why people do not have children: because they cannot, and because they do not want to, and sometimes not wanting to leads to not being able to. Into this latter group fall those individuals referred to earlier in whom a method of birth control leads to a greater or lesser degree of infertility. There are no accurate statistics for infertility, but in the earlier part of this century, 10% of all couples were thought to be medically infertile. Mr P. Steptoe, Chairman of the British Fertility Society, is certain that the figure has now risen to 15%.

Many men are demonstrated to have fertility problems, but it may be that the men's diffidence about fertility is diminishing rather than the incidence of infertility increasing. However, it seems likely that many more women are infertile than in the past. Women are postponing child-bearing and are attempting to conceive at an age when they are naturally less fertile; for women who have fertility problems, the pill has exacerbated their condition; the diminishing use of condoms has led to an increase in venereal disease, which can physically cause damage to the reproductive system. Multiple abortions can endanger reproduction, and it is no longer unusual for women to have had two or three abortions; more women are having themselves sterilized. There are also psychological and social problems of infertility.

The effects on fertility of various methods of birth control are already under urgent review in many centres and the results of such studies will indicate the best course of action. The establishment of fertility clinics, comparable to family planning clinics, might be encouraged to deal with infertility. Very little money is at present spent on the management of infertility, compared with that spent on family planning and there are wide differences in the quality of service from one area to another, between what can be done in those centres of the highest excellence and what is actually done, if anything, in those areas where health care services are poor. The problems associated with providing services for artificial insemination and adoption were also mentioned.

9. Major problem areas

The group then tried to identify major problem areas relevant to the situation outlined above and, in the short time available, possible ways of resolving these problems were suggested.

PROBLEMS	TOOLS TO COMBAT THEM
<u>Pre-conception</u>	
Infertility	Infertility clinics - artificial insemination - adoption
Anti-natalistic attitudes	Research on causes - public education
<u>During pregnancy</u>	
Genetic disorders	Counselling centres
Spontaneous abortion	Early antenatal care - legislation on the employment of women with regard to pregnancy
Malformations during pregnancy	Detection and facilities to terminate such pregnancies
Infections	Improvement of health education and housing conditions
<u>Perinatal period</u>	
Hypoxaemic morbidity	Optimum conditions for antenatal care and delivery
Low birth weight (including prematurity)	Legislation including socioeconomic measures - special care baby units

Infancy

Infections	Immunization - education and hygiene
Nutrition	Breastfeeding - education and hygiene
Handicaps	Early detection and comprehensive management services (the psychological and social effects on the parents and the child should be considered)
The family and children at risk (including institutionalized children)	Socioeconomic measures and legislation

Childhood

Accidents	WHO programme
Developmental and educational problems	Education in family life, including sex education for prospective parents and parents

Adulthood

Birth spacing	New research into the effects of age at first pregnancy
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The group realized that in a society where fewer births are taking place, increased attention must be paid to the psychological and social aspects of family health. Doctors are becoming increasingly aware of these aspects and tools to combat these particular problems are slowly being developed. Many such tools involve better education and understanding of the problems by both patients and their medical attendants, improving socioeconomic conditions generally and adapting legislation.

The health consequences of zero population growth need careful study. For example it may be necessary for people to retire from employment at a later age than at present for economic reasons and this will have effects which might be either beneficial or harmful to the physical, psychological or social health of the individual. What is best for the individual may not be best for society at large. It was stressed that there is a need to think in terms of decades or generations, rather than in years. It was suggested that a study of the problems of zero population growth might help those developing countries with increasing population growth rates, both for the future and perhaps by exposure to different attitudes concerning optimal population conditions for health.

10. Conclusions and recommendations

There is a need:

to study the effects of declining population growth rates and the consequences for health and social institutions;

to study anew the relevance of previously accepted health statistics in the light of modern trends in maternal and child health;

to improve tools for collecting data concerning needs, including psychosocial needs, to establish priorities and to evaluate the consequences of action;

to investigate the social needs of countries and how far the health care services meet those needs;

to continue endeavours to prevent the birth of handicapped children by research into the physical and social etiological factors involved;

to correct the incongruence between the needs and the learning of health personnel in matters of social obstetrics and gynaecology at all levels of medical education;

to convene a meeting to study the consequences of declining population growth rates, including contributions from experts of several related disciplines.

SCOPE AND PURPOSE

The Regional Office for Europe has long been involved in the promotion of family health. There can be no doubt that the health of mother and child, and all the preventive and curative health and welfare measures designed to safeguard maternal and child health, bear a direct relation to family planning, as pointed out during the Conference on New Trends in Maternal and Child Care in Moscow, 1974, organized by this Office. A new stage has, however, been reached with the implementation of family planning programmes, particularly where these are intended to protect the health of the mother and children by judicious spacing of births. There is an increasing acceptance within the European Region of the concept of planned families in relation not only to birth control but also to the improvement of the psychological, physical and material quality of life. Projecting this concept into the future, more and more European countries are facing zero population growth, and the accompanying changes resulting from a stable population. In anticipation of this transition, the time has come to begin considering possible directions for action in this field.

The very strong links between this question and questions of social gynaecology and obstetrics, as well as social paediatrics, are quite obvious. The present situation calls not only for direct action in this field but also for teaching. For this reason, the meeting will also evaluate the joint International Children's Centre/Association for Pediatric Education in Europe/WHO Regional Office for Europe Workshop on the Preventive and Social Aspects of Paediatric Teaching organized in 1975 and will prepare the Workshop on the Preventive and Social Aspects of Teaching Obstetrics and Gynaecology to be held in 1977 by ICC/WHO.

To review the above issues and to suggest appropriate action, the Regional Office for Europe is convening a meeting in Copenhagen on 20 and 21 December 1976, with participants experienced in the fields of social medicine, teaching and clinical work.

PROGRAMME

Monday 20 December

- 9.00 - 9.15 Registration and opening. Adoption of agenda
Introduction of participants
- 9.15 - 10.30 1. Second evaluation of the ICC/APEE/WHO Workshop on the Preventive and Social Aspects of Paediatric Teaching (September 1975) (Dr A.T. Schweizer/ Dr B. Pissarro)
- 11.00 - 12.15 2. Principles of social paediatrics and relationship to social obstetrics and gynaecology
- 13.15 - 14.45 3. ICC/WHO Workshop on the Preventive and Social Aspects of Teaching Obstetrics and Gynaecology to be held in Paris, November 1977 (Dr M. Pechevis)
- 15.15 - 17.00 Discussions on the organization, participants and contents of the 1977 Workshop

Tuesday 21 December

- 9.00 - 10.30 (a) Zero-population growth: general trends in population in the past and at present (Dr P.S. Rönisch)
- (b) Zero-population growth: trends and socio-economic and health consequences (Dr A.P. Beck)
- (c) Zero population growth and family planning: the present situation and medical training (Professor K.H. Mehian)
- 11.00 - 12.30 Group discussions on zero-population growth
- 13.30 - 15.00 General discussions
- 15.30 - 16.30 Conclusions and recommendations
- 16.30 - 17.00 Closing session and report

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LIST OF PARTICIPANTS

TEMPORARY ADVISERS

- Dr A.P. Beck
2nd Gynaecological Clinic, Vienna, Austria
- Professor M. Manciaux¹
Director General of the International Children's Centre, Château de Longchamp, Paris, France
- Professor K.H. Mehlan
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- Dr M. Pechevis
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- Dr B. Fissarro
St. Antoine Faculty of Medicine, Paris VI University, France
- Dr C.F. Ruoss (Rapporteur)
Worthing and Southlands Hospitals, Shoreham-by-Sea, Sussex, United Kingdom
- Dr A.T. Schweizer
Secretary of the Association for Pediatric Education in Europe, University Hospital, Leiden, Netherlands

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Officer for Public Health Nursing/Midwifery
- Dr P.S. Rönisch (Chairman and Secretary)
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- Dr D.K. Sokolov
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- Dr S. Alexaniants
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¹ Participation expenses not paid for by WHO.