The population policy pendulum

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Family planning can reduce maternal and infant mortality by as much as 25% by enabling women to space and avoid unwanted and high risk births.[9] It saves lives and is therefore an important public health measure. But is it a medical problem? Women using contraceptives are symptom free. Why not view them as customers wishing to control their fertility to plan their families and enjoy afertile sex? We should look at this as a marketing challenge. Shelton et al identified several medical barriers to the provision of low cost, high quality contraceptive products, including inappropriate or anachronistic contraindications, tortuous "rights of passage," eligibility hurdles, and restrictive practices over who provides contraception.[10]

Another barrier is an undue emphasis on the absolute risks of contraceptives, rather than the relative risks. The mortality of an unplanned pregnancy is at least 20 times that of any modern contraceptive and 10 times that of a properly performed abortion.[11] But many programme managers believe the most serious obstacle to improved family planning access is the use of doctors. They are expensive, overworked, based in cities, overqualified, and scarce.

Condoms, oral contraceptives, intrauterine devices, and male and female sterilisation account for 98% of all modern methods used in developing countries.[12] Competent, appropriately trained paramedics or specialist auxiliaries can provide these methods as safely as medical practitioners.[13] Moving reproductive health provision down the medical skills' pyramid is critical if, in a world of six billion people, we are serious about reaching the millions of couples who want children by choice, not chance.

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The population policy pendulum

Needs to settle near the middle—and acknowledge the importance of numbers

Whether loved or unwanted, the birth of the six billionth child will be of great importance to his or her family. In a world that adds one million more births than deaths every 110 hours, however, the aggregate of human numbers is also important. Unfortunately, in such an emotional area, interest groups have often promoted their own priorities at the expense of the bigger picture.[1]

Over the past 25 years population policies have swung back and forth like a pendulum. At the United Nations conference in Bucharest in 1974 India and China proclaimed "development is the best contraceptive," yet shortly afterwards China introduced the one child per family policy and India flirted with coercive sterilisation. In 1984 in Mexico City the United States asserted that every demographic problem could be solved by a free market economy, while developing countries supported mainstream family planning. At the 1994 conference in Cairo a new generation of advocates shifted the emphasis from "population control" to a holistic, reproductive health approach.[2]

At one level the Cairo conference was a superb achievement, but no single message emerged to rouse the western public or focus aid agencies' budgets. Indeed, some of the loudest voices created a false and damaging dichotomy, portraying any quantitative concern for population as intrinsically coercive. This was particularly misleading as the world is not keeping up with the unmet need for family planning.

Cairo estimated that donor governments needed to contribute $5.5bn ($6.4bn in inflation adjusted dollars) annually to help provide basic family planning and reproductive health services by the year 2000. They have given less than half this amount.[3] Yet decision makers must also make the best use of the money they have. If it is well managed they should be able to provide basic family planning services and begin to control sexually transmitted diseases—an essential step in slowing the devastating spread of HIV.[4]

But after Cairo many non-governmental organisations and governments have gone down a different road, producing numerous demonstration projects on topics ranging from literacy to domestic violence. Even if these projects succeed there is no money to expand most of them. Loss of a sense of scale is undermining what might be achieved, and millions of women are worse off than they were before Cairo.[5] The yearly toll of maternal deaths has reached almost 600 000, most of them in the world's poorer nations.[5] In some parts of Africa a quarter or more of pregnant women are HIV positive, and the unmet need for family planning is growing.

Emphasis was diverted from family planning services just as evidence showed that birth rates always fall when individuals are provided with a variety of family planning methods, backed up by safe abortion.[6 7] For example, in Bangladesh logistic problems were addressed, the social marketing of pills and condoms developed 100 000 outlets, and safe early abortion became increasingly available. The country has

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remained desperately poor but the total fertility rate has fallen from 6.3 in 1975 to 3.3 today.[8]

Even in countries that have not done so well total fertility is declining. The absolute increase in numbers, however, remains high. India alone grows by one million more births than deaths every 23 days.[9] The largest cohort of young people in history is just entering the fertile years, and the momentum built into population growth means that delays in meeting the need for family planning will have a huge effect on the final population of many countries.

Lack of attention to numbers makes it likely that the world of the 21st century will divide along a new geopolitical fault line. Today only 5% of the population of developing countries outside China live in countries where fertility is below replacement level. Those countries likely to reach replacement level fertility by 2010 or 2020 can move forward economically and socially, whereas those that are not, such as Nigeria and Pakistan, will slip backwards under the weight of human numbers. In Nigeria a dramatic decline in fertility from today's six children on average to 1.6 (comparable to Europe) would still result in population doubling by 2050 to 200 million.[9] But even a decline to 2.6 children—unlikely on present showing—will triple that country's population to 300 million in just 50 years. The rich countries will damage the biosphere through global warming and other changes. The poor countries may grow short of food and water. Millions of feral young males with no hope of employment will be fodder for political or religious extremism.[10]

It is time for the population pendulum to settle nearer the mid-point, the reasonable ground. People in rich and poor countries, and the planet as a whole, will benefit if priority is given to large scale, cost effective family planning programmes that respect individual choice without losing sight of quantitative measures of success. Policymakers must look beyond the clamor of confusing voices. Anti-abortion, anti-family planning groups are not a majority. Free marketeers who insist that, because Europe's and Japan's populations have begun to decline, the world no longer has a population problem need to check their figures. Women's groups that consider attention to numbers coercive on need to find consensus with those who emphasise the opportunity to accelerate fertility decline by meeting the unmet need for family planning. The joy of family planning has always been its commitment to helping individuals as well as being concerned about numbers.

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Failure of an intervention to stop teenagers smoking

Not such a disappointment as it appears

Given the recent upturn in teenage smoking,[1] would the innovative West Midlands prevention programme, described in this week's issue (p 948)[2] be the magic bullet so many have been waiting for? Alas, as the authors have convincingly shown, it turned out to be a blank. This is not surprising, since the methods used did not appear to correspond with the findings from decades of research into "effective" antismoking programmes for schools.

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Successful programmes have usually been based on the social influences theory, which involves persuading teenagers to develop the skills and commitment to resist cigarettes.[3] Since success depends on working with socially interactive groups, the individualised computer component of the West Midlands programme would have had little to contribute.

The programme's class lessons component focused on the "stages of change" model of behaviour change, which was developed from studies of adults who stopped smoking. It is difficult to understand the application of this to the different process of preventing teenagers from starting to smoke. It is even more difficult to believe that it would be preferable to tried and tested approaches based on the social influences theory.

Nevertheless, the programme might have been expected to have had an effect on existing teenage smokers. Its failure even in this group reinforces evidence that the acquisition and shedding of a smoking habit in the teenage years is essentially chaotic. Unlike adult quitting, it does not follow any readily definable stages.[4] The stages of change model is therefore unlikely to be relevant.

But, paradoxically, a positive result from either part of the trial might have led to a greater disaster. It has proved relatively easy to obtain favourable results from school antismoking interventions under research conditions—with their budgets for training and the prestige conferred on schools by participating.[5] But, as follow up studies in Minnesota and Britain have shown,[6 7] the favourable effects from the original trials disappear in later years. Teachers soon start to take short cuts with the protocols, while the pressure for examination success causes schools to reduce the time available for the programmes.[5]

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