demographic entrapment and of our exceeding of the biosphere's carrying capacity. To duck the issue, through apathy, ignorance, or uncritical optimism, is to opt for the default position—the first wisdom.

So what next? Should demographers broaden their discipline and include research into entrapment? Learned societies and research funding agencies are reminded that taboos are detrimental to learning. We hope that the *BMJ* will receive many communications on such issues as: the tensions between sustainable development, economic growth, and employment; human rights in the face of demographic pressures; humankind's reasonable share of the world's natural resources and habitats; more user-friendly, safe, long term, and "forgettable" contraceptive technologies, freely or cheaply available and uninhibitedly advertised[6]; and state of the art (often peer provided) age specific sexual health education for the young. We need vigorous initiatives in both North and South, with vastly increased funding to ensure that everybody in the world who wants contraception can actually get it.

Politics, it has been said, is health, and health is politics. Here, in the politics of population, as we charge past the 6 billion mark, we have both on the largest possible scale.

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Impediments to effective fertility reduction

Contraception should be moved out of the hands of doctors

On 12 October world population will reach 6 billion. It is just 12 years since the five billion mark was passed. In another 12 years we will approach seven billion. On the front line of reproductive health provision there is optimism, tempered with frustration. The good news is that a revolution in reproductive behaviour is sweeping the developing world; the bad, that we are failing to meet the needs of millions of couples who want to plan their families but cannot access contraceptive services.

In the 1960s 10% of couples in developing countries used contraception. Today 50% do. Total fertility has fallen from six children per couple to just over three. The principal cause of this decline has been the rapid and widespread adoption of contraception.[1] The number of couples practising contraception is approaching western levels of use (75%). In Latin America it has reached 68%, in Asia 60%, and in the Middle East almost 50%. In Africa, contraceptive use, at 18%, is only just beginning to rise, primarily because of weak programmes rather than lack of demand. Strong evidence exists that couples everywhere, under virtually all circumstances, will use contraception if armed with the knowledge and means.[2]

But we are also witnessing unprecedented numbers of unwanted conceptions. Over 35 million abortions are performed annually in developing countries and one in four births is unwanted.[3 4] More than 150 million women have an unmet need for contraception, which, if satisfied, would reduce fertility in developing countries by an average of 18%.[5] The figures represent the failure of family planners to meet the needs of the fertile. Improved access to services is essential.

In many Latin American and African countries over half of all contraceptive users rely on private outlets for their family planning requirements.[6] Contraceptive programmes that mass market condoms and oral contraceptives as branded consumer goods, sold through ordinary outlets at subsidised prices, are proving extremely efficient and cost effective world wide. These enterprising programmes have highlighted the weaknesses, inefficiencies, and rigidities of the traditional provider determined, free (often freely non-available) medical service models that have dominated family planning for the past 30 years. The real impediments to satisfying the unmet need for contraception are money, bureaucracy, and doctors.

The annual global spend on family planning is about £3.75bn—the amount Britons spend on confectionery every year.[7] Nearly 70% is domestic expenditure, the balance being international population assistance and development bank loans. In 1996 rich nations gave £875m (2.46% of all foreign aid) and development banks £312m. Just 37% of these funds were actually spent on family planning services.[8] In real terms population assistance has not increased for the past 20 years. Developing countries can increase their resources only by cost sharing through user charges, productivity gains, and more efficient programmes.

Bureaucracy is a global problem. State family planning programmes are hampered by ideology and slow decision making. Import duties on contraceptives, corruption, archaic prescription and advertising regulations, and dumping of free products are also detrimental to family planning provision by non-governmental or private sector agencies.

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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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