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Family planning: a missing priority in Pakistan's health sector?

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According to Alex Ezeh and colleagues, "Pakistan's failure to promote family planning in the 1970s and 1980s" has already had, and will lead to, great repercussions: a population that is anticipated to be "41% larger than Bangladesh's" by 2050.[1] Currently, Pakistan's population is estimated to be more than 180 million, increasing at a rate of 1·9% per year. It is projected to be between 266 million and 342 million by 2050 (figure), largely to be determined by the uptake of family planning and consequent fertility decline.[2]

Pakistan has a poor record of reducing fertility: although the fertility rate has fallen from about six births per woman in 1990 to 3·6 in 2012, it is higher than that in the rest of south Asia.[3] Family planning is perhaps the most overlooked and neglected component of women's health in Pakistan. Contraceptive use rose sharply, from 12% to 28%, during 1991–98 (corresponding to a 2% increase per year), but the rate of increase has slowed and reached a plateau at about 30% since then. There is, however, a renewed possibility after the 18th Constitutional Amendment[4] to focus on family planning as a means to improve maternal and child health with each newly evolving provincial health strategy.

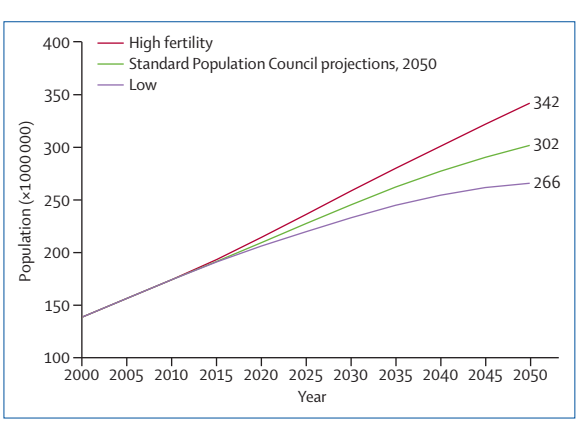

Figure: **Pakistan's population projections for high, standard, and low fertility**
Data from Bongaarts and colleagues.[2]

More recently, in research leading up to the London Summit on Family Planning in July, 2012, the association between the fall in fertility and a period of favourable age structures resulting from falling dependency ratios has been linked strongly to the economic wellbeing of families and macroeconomic growth.[5–7] The opportunity to capture the demographic dividend in the next few decades has led to a growing realisation in Pakistan that investments in a strong family planning programme and in human development are imperative.[2] It is now a question of matching the realisation with a strong policy and programmatic response, especially in Pakistan's provinces.

Many economists and academics still doubt that Pakistan will achieve a substantial increase in the use of family planning because of religion, social conservatism, or preferences for larger families. Yet these apprehensions are not borne out by the evidence—there are at least three strong arguments that go against this premise.

First, a quarter of women in the reproductive age group (15–49 years) in Pakistan have an unmet need for family planning.[8] In Khyber Pakhtunkhwa and Baluchistan, the unmet need for family planning is greater than 30%. Nearly 1 million women in Pakistan seek unsafe abortions every year, a decision determined by the high level of unwanted pregnancies. Improved access to quality services will reduce the number of abortions and maternal and child deaths.

Second, it is clear from inequities in unmet need for family planning and contraceptive use by income levels, and across urban and rural populations, why women who are poor have as many as two unwanted pregnancies compared with a quarter of this number for women who are not poor. The health system, unable to

cater for the unmet need in family planning, is at fault here and not the determination of women to reduce the number of unwanted pregnancies.[9] With the exception of the Lady Health Worker Programme, the delivery of family planning services is not a priority for the public health system. The private sector is active mostly in urban areas but the costs are unaffordable for women who are poor. Services need to be prioritised for women who are poor and those living in rural areas.

Last, there is evidence that an increase of 2·5% per year in contraceptive use is achievable even in mainly rural districts of Pakistan.[10] The Family Advancement for Life and Health project, designed to revitalise family planning, used the evidence available in Pakistan about factors that prevent the adoption of family planning to improve communications and strengthen existing service delivery structure by making it functional and effective. The project, implemented in several districts in all four provinces of the country, was designed to test different approaches to community mobilisation, communication, training, and district strengthening efforts. The final assessment has shown that unmet need is real and can be reduced and that contraceptive use can be increased for rural, poor, and younger women. Religious and social resistance has been disproved as a result of an impressive uptake of contraception of more than 10% in 4 years in Khyber Pakhtunkhwa. The results of tested approaches show that change is possible and that programmes can be scaled up.

Renewed and focused efforts for a strong family planning programme can change the future trajectory of population growth in Pakistan. What is clearly required is strong new investment in family planning that would not just ensure better health and a lower mortality rate, but would strike a better balance between resources and population size. If Pakistan is to increase the prevalence of contraception, huge effort and commitment are required both programmatically and financially at the provincial level. The effort to prioritise family planning as a public health and development priority will have to be supported by donors, and coordinated and monitored by the federal government. Although the financial requirement will be about US$150–200 million per year,[11] it is the clarity of priority and the capacity to reach this goal that will determine the turnaround in outcomes.

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I declare that I have no conflicts of interest.

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Anti-interleukin-2 receptor alpha for multiple sclerosis?

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In *The Lancet*, Ralf Gold and colleagues[1] report the results of their 52-week, randomised, placebo-controlled, dose-ranging, phase 2 study of daclizumab high-yield process (HYP)—a humanised monoclonal antibody against CD25—in patients with relapsing-remitting multiple sclerosis. CD25, the α subunit of the interleukin-2 receptor, is expressed mainly on the surface of activated and regulatory T cells, activated B cells, myeloid precursor cells, and thymocytes,[2] and is of particular importance because nucleotide polymorphisms in the CD25 gene confer increased risk of multiple sclerosis.[3,4] Because CNS tissues are infiltrated by activated T cells in patients