Population Policy 2015 - Khyber Pakhtunkhwa

20th October, 2015

Population Welfare Department

Government of Khyber Pakhtunkhwa

Peshawar

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1. Introduction

Pakistanis the 6th most populous country of the world with a Population of over 190 million. Its population is growing at an annual rate of 1.95 per cent and at the current rate of growth the population will double in the next 37 years..The country had visualized implications of rapid population in the early 1960s and adopted the philosophy of family planning through a comprehensive Family Planning Scheme launched in 1965 as an integral component of the Five-Year Plan (1965-70) to lower fertility with voluntary contraception. The programme has been sustained since then, but unable to achieve the desired objectives due to conservative environment and low level of acceptance of family planning.

Despite the constraints. Pakistan entered an era of fertility transition in the 1990's, to claim 'demographic dividend' that is demonstrated in the changing age structure (youthful population), reduced dependency ratio (with lesser dependent children and increased population joining the labor force). However, the desired outcome is not automatic, rather dependent on: effective family planning programs (to continue fertility transition process); gender sensitive accelerated policies of human development aimed at transforming the youthful population into a productive workforce; made possible by a careful and sustained investment in education, health and skill development, alongside the policies that consciously lead to the growth of productive and rewarding jobs for men and women.

High population growth rate was led by a continuously high birth rate and rapidly declining mortality rate. This situation has been confronted almost alike by all the provinces. The Province of Khyber Pakhtunkhwa with 8.5 % area of Pakistan is occupied by 12.9% country's population. The population of the province was 17.73 million in 1998,it is estimated to be 25 million in 2013 and projected to touch a 34 million mark by 2030. It is growing at 2.3% of annual growth and expected to double in 32years', with current density of 238 person per square kilometer. The population projection exercise carried-out on a longer timeframe under different scenarios further illustrates as to what difference fertility change can make on the population size, age distribution and various related outcomes, besides the effect of rapid urbanization.The details of the projection with the assumptions and effect on growth, population size, its distribution and salient related outcomes are presented in Annexure -I.

The evidence from PDHS 2012-13 and Pakistan Economic Survey 2008-09 clearly shows that Khyber Pakhtunkhwa with its fertility rate of 3.9 and low contraceptive prevalence rate of 28%lags behind in achieving various targets. The factors that contributed to slow pace of progress have been continuing low literacy, particularly among women in the province; fluctuating political support, rising poverty, limited accessibility, persistent sense of insecurity, mounting inflation and natural calamities, that has been compounded further by rural to urban migration, internally displaced persons (IDPs), prolonged conflict(militancy),and the influx of millions Afghan refugees since the 1980's. These are being considered and approached by the province as part of its Integrated Development Strategy. The province specific population policy will make the efforts further encompassing and more composite to achieve fertility levels that ensure the health and well-being of the population and facilitate the process of sustained development.

The opening up of opportunities along with growing stress related to poverty and inflation have changed parents' perceptions about the benefits of female education as reflected in increased female enrolment at 38% percent in Khyber Pakhtunkhwa during 2011-12 (i.e., for females aged 10 years and older). The modern communication technology especially spread of television channels, use of mobile phones, and social media are contributing to gradual modernization and empowering women with information to build their decision-making potential and ultimately affecting their fertility. Furthermore, women earning their own livelihood have better life chances as they get well-off and better informed to decide to advance towards their aspiration. Recent studies reveal that employment and economic autonomy at times is more important and encompassing than educational attainment for its effects on woman's autonomy. An important aspect that has steered economic affluence in families relates to greater labour mobility to Middle East and the remittances to families to acquire material gains including electronic goods. Moreover, the trends across the South Asian countries suggest that international migration brings affluence, increased mobility and decision-making power for women about their own health especially related to fertility. A similar trend is expected to continue and gain strength in the province in the years to come. In sum, the environment in the province is gradually providing alternatives for self-fulfilment to motherhood.

The cumulative effect of the social environment, however, is that Pakistani couples express very dissimilar preferences about family size until they have four children. Pilot initiatives in selected areas that encouraged husband-wife communication have revealed a breakthrough for effective family planning. Hopefully, such creative efforts if supported, expanded and sustained, will contribute to voluntary adoption of birth spacing at accelerated pace in the province.

2.4 Improving System Barriers of the Programme

The commitment of financial resources being the main driver for attention and action relating to population issue and a manifestation of seriousness of the Government is a vital determinant. The Government's budget has been progressively increasing over the last decade, but not enough to meet growing needs. . The Programme received substantial funding from the Federal Government under 10th Five Year Plan (2003-08), but available funds remained unutilized and returned in the presence of low utilization capacity and poor planning process. The devolution process undertaken with an unprecedented speed in 2010-11, landed the Department into serious difficulties especially in taking-over and managing several new functions. At the same time the provinces were given an opportunity to manage and execute the population welfare programme as they would visualize and prioritize in the context of their development endeavour.

This will take in to consideration the outstripping feature of rapid population growth against socio-economic statewhich converges on a single important area for intervention. It is the pursuit of voluntary fertility moderation to facilitate and contribute to equitable and sustainable development. This in turn brings into focus the need for specific population policy.

OBJECTIVES

Medium Term

- Achieve universal access to safe and quality reproductive health/family planning services by 2020.
- Increase Contraceptive Prevalence Rate (CPR) from the existing level of 28% to 42% by 2020.
- Raise modern CPR from existing level of 20% (PDHS 2012-13) to 28% by 2020.
- Reduce unmet need for family planning from existing level of 26% (PDHS 2012-13) to 15 % by 2020.

Long Term:

- Raise contraceptive prevalence rate from 28% in 2012-13 to 55 % by 2032.
- Decrease total fertility rate from 3.9 in 2012-13 to 3.3 births per woman by 2020 and attain replacement level fertility (2.1 births per woman) by 2032.
- Reduce Annual Population Growth Rate from 2.2 % in 2013 to 1.3 % by 2032.
- Encourage increased investment for acceleration of female education and empowerment to facilitate attainment of population sector related objectives.

Assumptions:

The population policy is based on the following assumptions:

- Firm and sustained political commitment and administrative support at all levels.
- Full ownership of family planning programme by provincial land district governments.
- Staff Security addressed to enable them to carry out their responsibilities undeterred.
- Mandatory provision for and delivery of family planning services by Health Department.
- Commitment for resource availability by the provincial Government as per Integrated Development Strategy to meet programme requirement.
- Broad based support to family planning by all public and private entities.

3.1 Framework for Implementation of Policy

The Policy provides a framework for advancing the goals and prioritizing strategies to meet the reproductive and child health needs of the people as part of the overall wellbeing. This framework is based upon the need to simultaneously address issues of contraception, child survival, and maternal health, while increasing outreach and coverage of a package of reproductive healthcare services by all stakeholders. The Policy promotes family planning as a state of art service on the basis of informed and voluntary choice through all channels and service delivery outlets of the public and private sectors. Preventing early age and unwanted pregnancies - - that leads to unsafe abortions and maternal deaths- - necessitates focusing efforts on unmet need as the principal area for intervention and action for maximum return.

The primary requirement for the implementation set-up is of a strong leadership support and open commitment at the highest level for continued and enhanced social acceptability of birth spacing, with a mechanism to foster inter-sectoral linkages and support to turn the population programme into a collective cause for social progress of the society as a whole. This is to be supported with adequate resource envelope and an institutional set-up managed by a competent head, appointed for 3-5 years tenure and assisted by professional staff of high calibre. The core activity to be managed is service provision and service delivery, with all time availability of contraceptives, and demand generation through advocacy, motivation and counseling, with dedication to service delivery and follow-up care. The support

stakeholders. Lack of adequate and sustained investment for improved access to family planning will neutralize the important gains made in economic progress, and will reduce the returns on improvements made in education and women empowerment. Investment in family planning is, therefore, a major step towards this direction, which will lead the way to better health and improved human capital. The investment directed towards building and revamping the systems will benefit the province and its people, especially the young first time mothers who are entering the reproductive cycle of life, in millions every year. The large cohort of women wanting to regulate their fertility and use family planning and contraception, have difficulty to access and avail the services due to inadequate supplies, fewer facilities and limited services. All these highlight the constrained environment that contributes to high risk pregnancies and warrants persuasive efforts to encourage voluntary birth spacing practices.

3.4 Broad Based Support

To continually elicit broad based support and synergy in operations, it is reiterated that inter-sectoral linkages is significant to actively engage and secure assistance from different sectors including education, health, nutrition, agriculture, technical training, and water and sanitation to provide inroads to family planning. Equally important is to transform the image of limiting births that, over the years had antagonized conservative and religious segments of population and presented a face of the programme that was not readily internalized by local populace for attitudinal and behavioural change. Working closely with Provincial Assembly members, local champions, and civil society activists will enable building of environment to support the cause. This is crucial and essential ingredient to support family planning with understanding. All segments of the society will have to shoulder responsibility and contribute toward sustainable development for the progress and welfare of the society as a whole, as simply ensuing family planning will only achieve partial results and not full success.

3.5 Mobilizing Men for Support and Care of Elderly Population

Men remain the key decision maker and actively involved in the family setting and decisions. Population programmes in the past have partially attended to engage men folk for their family planning needs. Active cooperation and participation of men is vital for ensuring acceptance of family planning in supporting contraceptive use, birth spacing and family size, arranging skilled care during delivery and avoiding delay in seeking emergency obstetric care. Sensitizing men to their role as responsible parent and in recognizing the critical role of women in the health of the family is necessary and highly relevant.KP is taking a lead role to mobilize male in planning families by including Ulema in holding regular dialogue with the male community and sensitize the elders and parents. Provision for male contraceptive surgical procedures will be strengthened, and the method promoted through Men Advisory Centres with focus efforts by male workforce.

Elder population in Khyber Pakhtunkhwa (age 65 and above) is expected to increase rapidly in the coming years. The proportion of elderly population (65 years and above) is 3.7% of total population (an estimated one million) of the province and expected to increase to 4.9 percent by 2030, 2.6 million (6.7 percent) by 2040 and touch 4 million size (10 percent) by 2050. It is reality approaching in the future time and need support in the advance ages of life cycle. They will be given due attention for their care as living asset possessing of wisdom of experience which serves a useful purpose for guidance of the youth. The family support system will be highlighted and encouraged for their care and treat them with respect and grace as emphasized in the code of Islamic living. Special measures will be pursued for their health, economic security and facilitation accessing to public service facilities and for their mobility.

ensured at the facilities to promote birth spacing. Furthermore, small family norm can only be successful if efforts are focused on low-parity and first-time mothers. The workers will identify and target this group to motivate and educate them regarding healthy timing and spacing of pregnancies and benefits of spacing by using innovative job-aids and counseling skills. Follow-up visits will be specially undertaken to ensure method continuity and for responding to client's queries. Community based workers will participate in promotional activities related to safe delivery and infant health. The Lady Health Workers and the Community Midwives of Department of Health will be encouraged for linkage with FWCs for mutual support and referral of clients for long acting methods.

3.10 Supportive Role of Partners

The policy encourages all partners to enhance access to family planning services through consolidation, up-gradation and placement of service outlets closer to the target population. The Health Department in particular (with vast infrastructure of hospitals at district and tehsil levels, RHCs, 1,489 BHUs and community based workers consisting of 12,729 lady health workers, 530 LHS and1,800 Community Midwives) will be persuaded to include family planning as an essential part of service package of primary health care and declare family planning services mandatory through all its outlets, with contraceptives provisioned in the essential drug list. This is important in its own right due to commonality in objective for advancing the health of women and their offspring, besides contribution to fertility decline. The Department of Health to support the health outlets managed by Rural Support Programme and PPHI in training, supplies and to make birth spacing/family planning services available where antenatal, natal and postnatal care and routine child immunization are administered ; ensure that family planning services fully adhere to essential requirements and adopt quality service protocols; and share their performance reports for inclusion in the consolidated regular reports for reflection of holistic picture of progress about family planning. Nonetheless, the limitations of Health Department will be appreciated, as they have multiple roles and wide range of health services to be covered while facing understaffing situation and overburdened with patients requiring curative treatments. This leaves little or no time for attention and concentration on family planning clients. Family planning efforts require devotion of time for counseling and motivation through initial and repeated interactions with potential clients/acceptors for motivation, deeper understanding of their concern, need, choice and specific support for acceptance, with assured follow-up care for continuation rate-on which rests the effect to achieve fertility decline. Therefore, besides training of health service providers about family planning, consideration will also be given to deploy a trained family welfare worker at the outlet for family planning specific work to attend to the vast group of potential clients visiting the health outlets for curative care. The health staff would refer all family planning cases to this worker for counseling, motivation and services, particularly those visiting the health outlets for post-abortion care to counsel them for birth spacing in the future. This worker would also be entrusted to work on post-partum family planning initiative under the guidance and support of Gyneacologist to visit Gynae ward for interaction with patients for counseling, motivation and services. The leadership of Health and Population Welfare Departments to work closely with understanding of the mutual benefit of family planning and for mutual support to maximize coverage and minimize duplication of services and work-out crash arrangements for training of all enlisted health outlets in the public and private sectors. Similar spirit is to be demonstrated by working together for acquisition of contraceptives, its uninterrupted availability at all outlets and sharing of performance reports to enable present holistic picture of contraceptive performance in the periodic provincial and district returns.

All Public Sector Corporations and entities operating in the province will be advised and pursued forin corporation and dispensation of family planning services through their health set-up. Their service providers will be imparted training about management and motivation for family planning with essential supplies made available to provide services to the specific target population. Review sessions will be held at periodic interval for experience sharing, reflection on their contribution and mechanism for reporting

consideration the WHO Medical Eligibility Criteria and strict compliance ensured. Creating conditions and provision for widest possible choice of contraceptives will be pursued by diversifying the method mix availability, alongside specific promotion of clinic based long acting methods.
The primary requirement for improving quality of services is to keep the clients and their need in the forefront. Counseling and support will be extended through regular and repeated contact with due care and respect to build confidence so that the clients share their concern and express their requirement in an

atmosphere of trust. The services to be provided by providers who are familiar with the local conditions and living pattern of the clients. Supervision of service delivery is essential to observe that the prescribed standards and protocols are followed and applied; this will be of supportive nature, intensive and frequent to aid the providers in real work condition. It will be sporadically followed-up through client flow studies and other related instruments to assess quality and satisfaction with the given services. All these requirements will be backed-up with trainings and regular refreshers, alongside sustained availability of all essential inputs.

3.12 Contraceptive Commodity Security

Commodity Security remains a high priority area for all family planning stakeholders. Continuous and regular availability of complete range of contraceptives at affordable prices at all facilities is the lifeline of family planning and reproductive health services. In view of the significant improvement in service packages and choices to be promoted, changes in method mix are anticipated. Furthermore, increase in the use of contraception is also foreseeable in the coming years in view of the increase in the target population. The contraceptives requirements will, therefore, increase substantially. The supply chain management system faced several challenges in the past, has been reviewed, improved and revitalized. It will be enforced and followed in letter and spirit. Qualified professional staff will manage the technical aspects of commodity acquisition and distribution system to public, private and NGOs sector. Assured budgetary provision already earmarked in the Integrated Development Strategy will meet contraceptive commodity security requirement. With focus on long acting contraception, method mix will shift towards IUCD and implants and add injectables to it.

Reproductive health and family planning contraceptive services (birth spacing methods) are offered on charge basis since early 1990s by both the public and private sectors in Pakistan. Public sector charges are nominal and have already established an environment of payment for services. Different demographic and health surveys over the years have brought out the acceptability of such charges. The users' desire for quality product has long been identified as an important step towards branding and raising the price tag. Experiences from other countries do support the idea to pricing a package of contraceptive services, but this policy would make available highly subsidized contraceptives at a nominal price/ free for the next 5 years and until the time the prevalence rate touches a range of 40-45 %.Till that time a standard price package for services/ contraceptive methods will be charged for branded products. The service package will be well advertised and displayed for transparency and accountability. The district authorities will oversee its full implementation across all public sector facilities. The right for access to quality contraceptive services by the poorest segment of population will be protected by adopting socio-economic status scale measurement to identify such households/clients.

appropriate method, care in extending services, with post acceptance assurance and support to enhance retention rate and reduce drop-outs.

- The RTIs and RHSC training centres will prepare special training packages for the health training institutions and train the faculty as master trainers to undertake and continue with the training of the health service providers in dispensing and managing the services through the health facilities. Use of technological innovations for quality supervision will be specially undertaken. Similar focused packages (including e-Learning modules) will be supported and prepared.
- Training of community based workers will be given due attention to establish quality work force closely engaged with communities and for interpersonal sessions on norms and practices with care and in an environment of trust and confidence.
- Contraceptive choice will be broadened and service providers imparted with competency training in latest technologies to deliver services with commitment.
- Administrative and supervisory skills will be strengthen through trainings, with focus on building rapport and relationship with specialized training institutions. Programme's own institutional set-up will be reinforced with appropriate faculty and improved curricula that best meet programme needs. Periodic reviews and evaluation of training activities and application in the real job situation will be undertaken to improve this input.

3.15 Monitoring and Evaluation

Effective monitoring and evaluation mechanism is critical to ensure achievement of desired objectives. The framework for monitoring and evaluation of the programme will take these elements into consideration and adopt result based management (RBM) framework. Population Welfare Dept. will work to develop this approach to shift the focus of monitoring from outputs (number of contraceptives distributed, number of clients contacted and recruited), to outcomes (proportion of clients contacted, served, counseled, and contraceptive prevalence rate, etc.). It will focus on the processes and outcomes to observe contribution towards the achievement of clearly stated programmatic objectives and that lessons learned fed into the decision-making. Population Welfare activities are built on two basic pillars, one aimed at change in outlook and behaviour through advocacy, motivation and counseling and the other is adoption of the means, which embraces a wide range of activities, including coverage, easy access to services, all time availability of contraceptives as per need and choice, care in extending the services and post-acceptance assurance to encourage continuation. This will be emphasized on continued basis.

The important outcome indicators to be regularly followed up include: proportion of women falling in the category of 'Unmet Need for Contraception'; Contraceptive Prevalence Rate; Contraceptive Method Mix; Source of Accessing to Services; Quality of Service and Satisfaction with Services; Fertility related indicators includeknowledge and proper understanding of HTSP Messages; Proportion of Women intended to adopt birth spacing in the future; interval between last two births; infant and neonatal health; and place of delivery for care and quality services.

The process indicators include: facilities with necessary stocks of contraceptives; number of FP clients served – old and new clients; facilities fully adhering to quality standards; service provider's competencies analyzed especially in long acting methods; service providers frequency in refresher trainings; service provider's counseling skills analyzed; community sessions organized in the catchment area; Number of visits conducted by Technical Supervisor to each service outlet; number of new clients verified, facilities with stock outs, etc. Necessary mechanism will be evolved to track and record data on these critical indicators, and presented to forums reviewing performance and progress at provincial and district levels.

4. Resource Commitment for Population Welfare Programme

The province has already demonstrated its ownership of the population welfare programme by earmarking PKR4,032 million for the period 2014-15 to 2017-18 in the Integrated Development Strategy. The programmes, projects and schemes premised on the goals and objectives of the Policy 2015, covering all out efforts at reaching population replacement level by 2032 and advancing towards stabilization by 2045, will be adequately resourced and sustained in view of their critical importance and linkage with provincial development endeavour. Priority in commitment of funds will be given to improving coverage through infrastructure and out-reach services at the community and various health centres in rural areas. Critical gaps in manpower will be remedied by acquiring the services of competent professionals and redeployment, particularly for service delivery to extend services to under-covered and inaccessible areas, and improve referral linkages to implement immediately the action plan. The year to year allocation will be increased as per need to overcome shortfalls in infrastructure, services and supplies. Nevertheless, major emphasis for resource adequacy will be stressed for contraceptive availability and promotional campaign for behaviour change.

5. Governance and Accountability

The Population Welfare Department will be the focal and frontal organization advancing family planning efforts in Khyber Pakhtunkhwa, impressing upon the need for multi-sectoral support to effectively implement the population welfare programme and highlight the well-considered investment in youth to enable the province toreap the benefit of demographic dividend. The Department will specifically promote voluntary acceptance of family planning by persuasion and by providing the means for contraception through its own service delivery network of family welfare centers, reproductive health service centres and mobile service units, with the district set-up as the core operating tier managing the work in the field. Co-ordination and collaboration with all stakeholders will be enhanced and pursued effectively to harness their potential through mutually supportive space and operational framework. The efforts will be backed-up by an effective and sustained promotional campaign through all media channels and followed-up with intensive inter-personal communication for social mobilization and behavior change.

Strategic direction and functional enhancement will be ensured by turning the implementation setup into a vibrant and purpose-oriented professional organization. A review and re-organization exercise will be commissioned to make adjustment for acquiring and positioning professionally competent hands. This will specially meet the requirement for specialized roles such as behavior change communication, monitoring and evaluation, managing research with understanding, management of commodity security process including forecast and establishment of a special unit of appropriate level to guide, manage and liaison with non-programme service infrastructure. This will also look into the need for professionals who have background of demography, development economics and understanding of population dynamics with ability to undertake population projections. All positions for management and service delivery will be filled-up on the basis of merit and placement made as per need to improve execution, coverage and easy access to services by adhering to the laid down standard operating procedures, with all inputs made available. The staff will be provided regular training and refreshers in key areas to improve output, with ultimate focus on the clients, service providers and their immediate supervisors.

The organization will maintain an effective management information system (MIS) for evidence -based decision making and for vigorous oversight functions, with quick feedback mechanism to the field formation. Real time assessment of performance will be reinforced by applying latest information technology such as mobile applications. Accountability checks will be built into the programme matrix through independent assessment and social accountability system with feedback from the beneficiaries.

and support to continually raise/improve awareness and appreciation of the benefit of birth spacing for voluntary adoption on continued basis as per need."

The Population Welfare Department will support strengthening of District Set-up proactively and commits through sustained action to undertake review of district government instruments what it contains, what is missing for district-up of family planning (in comparison with health and education in particular) and what needs to be done to equate and equip them, in order to draw on the support of district government. The Department will revisit the working of the district set-up and seek suggestions to improve purposeful local linkage and working; and designate a group to work on this with full concentration.

several years, including: proportion of school age children, youth, labour force, married women of reproductive age, and elder population. School age children (aged 5-14) represent less than fourth (23.0 per cent) of KPK's population (Table A1). The current number of these children (5.7 million) will rise to 6.3 million (by 2020) and continue to increase the size by 2032 before leveling off and gradually falling in the subsequent years. These children need to be educated and properly nourished to become good productive citizens. Youth population (age 15-29) currently at 7.9 million (27.0 percent of total population) will rise to 8.5 million in 2020 and 9 million by 2030 (26.5 percent of total population). The youth population will continue to increase to 10.1 million (by 2040) before leveling off and gradually falling in the subsequent years. The proportion and number of population in labour force (ages 18-60 years) will continue to grow over the years from current 13.3 million (52.5 percent of total population) to 15.9 million (in 2020) and onwards to 19.8 million in 2030 (58 percent of total population). Youth of today and tomorrow is better educated than yesteryears, more conscious about political and personal matters, and have greater expectations from the state and society. KPK needs to recognize these potential trends and take necessary measures (invest in education and skill training) to produce skilled manpower for enhanced productivity. In order to reap the *'demographic dividend'* during the period of transition to a low population growth regime of 2030, educated and skilled labour force is essential, otherwise the population in productive age groups may not fully meet growing demands.

Elder population in Khyber Pakhtunkhwa (age 65 and above) is expected to increase rapidly in the coming years. By turn of the current decade, KPK should prepare itself for chronic diseases and epidemiological changes starting with care for the elder population. The demographic change (small family units) along-with emerging disease pattern is expected to place enormous burden of care of this segment. These changes need to be acknowledged and foreseen to evolve policy with necessary social support, and health set-up required to address emerging issues of this segment of population.

Assumptions for Population Projections, Khyber Pakhtunkhwa

	2011	2020	2025	2030	2035	2050
High Variant (Low Effort and Progress)						
Total Fertility Rate	3.8	3.4	3.1	2.9	2.6	2.0
Population Growth Rate	2.3	2.2	2.0	1.7	1.4	.98
Life Expectation (M)	66.5	68.4	69.5	70.6	71.7	75.0
Life Expectation (F)	64.4	67.8	69.9	71.4	72.8	76.9
Sex Ratio	104.0	104.8	104.9	105.0	105.0	104.7
Medium Variant (Moderate Effort and Progress)						
Total Fertility Rate	3.8	3.1	2.6	2.3	2.06	1.9
Population Growth Rate	2.3	2.0	1.7	1.3	1.1	0.81
Life Expectation (M)	66.5	68.4	69.5	70.6	71.0	75.0
Life Expectation (F)	64.4	67.8	70.0	71.4	72.0	76.9
Sex Ratio	104.0	104.7	104.9	104.9	104.9	104.5
Low Variant (Very Strong Effort and Fast Progress)						
Total Fertility Rate	3.8	2.7	2.1	2.06	2.02	1.9
Population Growth Rate	2.3	1.8	1.3	1.2	1.1	0.67
Life Expectation (M)	66.5	68.4	69.5	70.6	71.6	75.0
Life Expectation (F)	64.4	67.8	69.9	71.4	72.8	76.9
Sex Ratio	104.0	104.7	104.8	104.8	104.8	104.5

Table A-1: **Population Projection Summary for KPK's: 2010-50**

Based on Medium Variant (TFR 2.1 by 2032)

Year	Total Population	School Going Children (age 5-14 years)	Youth Population (age 15-29 years)	Number of WRA (age 15-49 years)	No in Labor Force (age 18-60 years)
2010	23,272,578	5,677,833	7,226,911	5,920,689	11,605,968
2011	23,815,312	5,694,321	7,435,602	6,112,258	12,053,445
2012	24,368,388	5,713,599	7,626,188	6,300,043	12,502,774
2013	24,931,266	5,737,495	7,797,406	6,483,034	12,947,176
2014	25,502,738	5,767,663	7,948,698	6,660,365	13,384,948
2015	26,081,272	5,806,339	8,080,035	6,831,621	13,816,697
2016	26,665,118	5,881,781	8,193,160	6,996,917	14,240,851
2017	27,252,499	5,972,994	8,289,171	7,156,802	14,656,089
2018	27,841,433	6,077,179	8,367,399	7,312,078	15,061,899
2019	28,429,619	6,190,561	8,426,765	7,463,834	15,458,855
2020	29,014,488	6,308,429	8,468,438	7,613,407	15,848,418
2021	29,593,531	6,397,930	8,522,736	7,775,117	16,232,668
2022	30,164,414	6,492,837	8,557,078	7,932,179	16,614,175
2023	30,724,428	6,590,984	8,578,150	8,084,586	16,995,745
2024	31,271,165	6,689,614	8,595,151	8,232,433	17,407,846
2025	31,802,623	6,784,352	8,616,569	8,376,004	17,814,234
2026	32,317,889	6,844,038	8,672,615	8,530,783	18,214,391
2027	32,816,294	6,885,761	8,743,285	8,686,234	18,608,391
2028	33,295,696	6,907,424	8,829,431	8,841,603	18,997,575
2029	33,755,172	6,907,594	8,931,168	8,996,025	19,410,087
2030	34,194,199	6,885,631	9,047,386	9,148,478	19,826,121
2031	34,613,603	6,842,466	9,175,866	9,297,909	20,244,629
→ **2032**	**35,014,418**	**6,779,146**	**9,313,489**	**9,443,395**	**20,664,136**
2033	35,415,645	6,696,210	9,456,221	9,584,057	21,082,772
2034	35,817,522	6,595,043	9,599,097	9,718,944	21,498,587
2035	36,220,370	6,477,711	9,736,395	9,846,886	21,909,623
2036	36,624,192	6,347,622	9,834,683	9,967,179	22,313,679
2037	37,029,023	6,208,216	9,926,854	10,078,577	22,708,278
2038	37,435,137	6,080,896	10,009,961	10,178,484	23,090,421
2039	37,842,617	5,968,682	10,081,048	10,263,964	23,456,772
2040	38,251,311	5,874,190	10,136,167	10,333,022	23,804,042
2041	38,659,902	5,798,346	10,146,163	10,384,883	24,128,792
2042	39,066,651	5,742,029	10,129,622	10,420,558	24,428,034
2043	39,470,558	5,707,016	10,085,802	10,442,323	24,699,527
2044	39,870,344	5,694,367	10,014,830	10,453,767	24,942,688
2045	40,264,742	5,704,507	9,917,710	10,457,778	25,157,353
2046	40,651,821	5,735,387	9,796,989	10,455,552	25,342,442
2047	41,029,545	5,784,280	9,655,505	10,447,332	25,498,181
2048	41,396,385	5,831,710	9,513,800	10,442,827	25,623,856
2049	41,750,875	5,876,124	9,374,687	10,442,760	25,717,822
2050	42,091,606	5,915,905	9,241,190	10,447,481	25,777,757

ADP 2016-17 POPULATION WELFARE DEPARTMENT, KP

Expenditure July 2016 to April, 2017

S#	ADP Sr.No.	Code, Name of the scheme, (Status) with forum and date of last approval	Cost	Exp. July 14 to June 2016	Allocation for 2016-17			Release	Expenditure upto April, 2017	Already Surrender	Re-appro-priation	Further Surrender	Revised allocation	Throw Forward beyond 2016-17	%age on releases	%age on revised allocation	
					Local												
					Cap	Rev	Total										
		ONGOING SCHEMES															
1	849	140075 Establishment of Regional Training Institute, Malakand PC-1 approved by PDWP on 28.10.2014.	87.367	27.509	0.000	55.468	55.468	18.000	4.990	27.398	0.000	18.054	10.006	4.390	28	50	
2	852	140073 Establishment of 100 Family Welfare Centres in Khyber Pakhtunkhwa. PC-1 approved by PDWP on 28.10.2014.	300.000	52.058	0.000	100.000	100.000	71.384	26.730	14.004	-14.612	0.000	71.384	147.942	37	37	
3	853	140083 Establishment of Mobile Service Units in Districts, Battagram, Dir Upper, Malakand and Torghar PC-1 approved by DDWP on 26.09.2014.	31.242	9.151	0.000	8.000	8.000	6.632	2.665	1.368	0.000	0.000	6.632	14.091	40	40	
4	855	150003 - Construction of Reproductive Health Services Centres A-type, Tank & Dir Lower	29.990	3.500	11.887	0.000	11.887	26.499	5.302	0.000	14.612	0.000	26.499	14.603	20	20	Physical Progress of RHSC-A Tank & Dir (L) 50% & 85% respectively.
5	856	150004 - Construction of Building for Regional Training Institute, Abbottabad and Batkhela.	120.000	0.000	29.000	0.000	29.000		0.000	14.000	0.000	15.000	0.000	91.000	0	0	
6	857	150006 - Establishment of Population Research & Training Institute and Social Mobilization.	15.000	0.526	0.000	8.000	8.000	6.000	2.871	2.648	0.000	0.000	5.452	6.474	48	53	
		Total Ongoing Schemes	**583.599**	**92.744**	**40.887**	**171.468**	**212.355**	**128.515**	**42.558**	**59.318**	**0.000**		**119.973**	**276.500**	33	35	
		NEW SCHEMES															
1		Involvement of Imam/ Khateeb/Religious Scholars for promotion/ Advocacy of Population Welfare Program	100.000	0.000	0.000	17.645	17.645			17.645	0.000		0.000	82.355		0	The scheme has been deleted from ADP 2016-17, however Chief Minister has asked ACS to "**please discuss**" vide CM Secretariat letter No.SO-III/ CMS/4-1/2013/ P&D Department dated 07.12.2016.
		Total New Schemes	**100.000**	**0.000**	**0.000**	**17.645**	**17.645**	**0.000**	**0.000**	**17.645**	**0.000**		**0.000**	**82.355**		0	
		Total Population Welfare	**683.599**	**92.744**	**40.887**	**189.113**	**230.000**	**128.515**	**42.558**	**76.963**	**0.000**		**119.973**	**360.855**	33	35	

D:\ADP\ADP 2016-17\ADP 2016-17 Final 7 ongoing and new schemes

Deputy Director (PC&T)

upon file
index may be
after sections

7/6/17

Government of Khyber Pakhtunkhwa
Directorate General Population Welfare
Plot No 18, Sector [illegible] Phase-I, Hayatabad, Peshawar.

No. [illegible]/2017/Admn/3879-81
Dated Peshawar the 31/7/2017.

To: Deputy Director (IT)
PHQ, Peshawar.

Subject: PROACTIVE DISCLOSURE OF INFORMATION UNDER RTI ACT, 2013

I am directed to refer to your letter No. 4 (26)/2016-17/M&E/PIO dated 20-7-2017 on the subject noted above and to enclose herewith the requisite information for further necessary action.

1. Seniority list of [illegible] Accontant (BPS-16), Assistant District Population Welfare Officer (BPS-16), Statistical Investigator/Mobile [illegible] (BPS-16), Senior Scale Stenographer (BPS-16), Accounts [illegible] (BPS-12), Theatre Nurse (BPS-12), Statistical Assistant (BPS-[illegible]), Senior Clerk (BPS-14), Projectionist (BPS-[illegible]), Stenotypist (BPS-8), Field Technical officer (BPS-[illegible]), Chowkidar (BPS-03).
2. Approved Service Rules of [illegible] Class-IV to J/Clerk (BPS-11) and Jr Scale [illegible] to Sr.Scale Stenographer (BPS-16).

(Hidayat Khan)
Dy Director (Admn)

Endst No. [illegible]

Copy to:
PS to Director General Population Welfare, Peshawar.
PA to Advisor to CM for PWD, Population Welfare, Peshawar.

DS (Copy E) may kindly put up on file immediately please 1/8/17

Director (Admn)