

Chapter II

Overview of population issues in Bhutan

Introduction

Bhutan can be considered to have entered a new phase of demographic transition. This transition has been brought about by the drop in mortality since fertility has remained almost unchanged (National Health Survey, 1984 & 1994). The drop in mortality has given rise to a higher population growth rate of 3.1% in 1994 as compared to 2.6% in 1984. This growth is expected to increase due to a momentum effect if not for any other reason. Moreover, considering the continuing advances in health technology, there is every reason to believe that the population will continue to grow because of further decreases in mortality.

This leads to examination of some possible responses to population growth in terms of services and facilities, and how these responses could translate themselves into public health concerns. The whole line of argument is based on the interacting relationship of health and social problems, i.e., social problems are either a cause or consequence of health problems, and vice-versa. Quality of life is a concept used to define the status of social condition but has been under a lot of debate and as such has

more than one interpretation. Quality of life here means the overall social condition of the population.

Potential Problem of Population Growth

The concern for rapid population growth existed as far back as the eighteenth century although the concern in Bhutan has started of late. The consequence of rapid population growth as put forward by Malthus was poverty (Weeks, 1996). The Population Council states that, the consequences of rapid population growth can be viewed in light of the carrying capacity of the earth but also, and more importantly, in relation to human capacities to improve welfare and reduce poverty, that is, “the caring capacity of human beings for each other” (The Population Council, 1994). The concept of carrying capacity refers to questions of population pressures on an environment (Mazur, 1994). However, the relationship is not straight forward and as such the discussion that follows emphasizes on the achievement of the Royal Governments aims and objectives, and how the quality of life of the people could be affected.

Land Area

Bhutan is not only limited by the small size of the country (with an area of 46,500 sq. Km) but more so by the nature of the terrain which is rugged and mountainous. These

characteristics afford a very small area for habitation, estimated to be only around 4000 sq. Km. Area according to land-use and vegetation is presented in Table 2.1.

The figures in Table 2.1 were based on the land use survey carried out in 1983 and, as such changes in some of these figures is expected. Non-agricultural land seems to be almost non-habitable except for the 0.7% of land which is below 3500 meters of sea level. Thus, the increase in population has to be accommodated either by increasing the density of population on the existing inhabited land, or by expanding the size of the habitable land by cutting down the forested area. The choice of alternatives in either way could have detrimental effects on the quality of life without other parallel developments (economic) taking place to balance out the effect of population growth. The density of population is increasing noticeably in urban areas and so are the problems associated with it, for example, juvenile crime, housing, sanitation, water supply, etc.

Table 2.1 Area according to land use and vegetation types.

Land-use and vegetation types	Area ('000 hectares)	Percent
Non-forested	1,185.1	29.4
Non-agricultural	829.2	20.6
Perpetual snow/ glaciers	400.6	10.0
Barren exposed and rocky areas (above 3500 meters)	345.6	8.6
Barren land, grassland and scrubs (below 3500 meters)	30.7	0.7
Water spreads	52.3	1.3
Agricultural	355.9	8.8
Valley cultivation (slope <30%)	64.9	1.6
Terraced cultivation (slope>30%)	175.9	4.4
Old shifting cultivation	115.0	2.8
Forested	2,840.0	70.6
Tree cover	2,573.4	64.0
other	266.6	6.6
Total surveyed area	4,025.0	100
Area not yet surveyed	625.0	
Total area	4,650.0	-

Source: Adapted from Statistical Year Book, 1993.

Food Security

Bhutan has promoted a policy of self-sufficiency in trying to meet the food demands of the country or at least in the area of staple food grain, by providing incentives and enacting legislation. One case of such is the incentive provided for converting dry land into wetland [where paddy can be grown] and imposing restrictions on the use of wetlands for other purposes like building infra-structure. Agriculture has been accorded high priority since about 95% of the population is involved in that sector. High yielding varieties and double cropping have long been introduced. However, statistics reveal evidence to the contrary. The importation of food grains like rice and wheat are still continuing. Considering the fact that no export of food grain is made, it can be surmised that the local production is not enough to feed its population with the present consumption pattern. The agricultural growth is estimated to be around 2.9 percent only (Ministry of Planning, Bhutan, 1996) which is less than the present estimated population growth rate. The local production of some major crops and the importation of food grain for 1993 are shown in Table 2.2 and Table 2.3 respectively for comparative purposes.

Table 2.2 Local production of some major crops.

Crop	Quantity (tons)
Paddy	38,890
Wheat	3,480
Maize	29,830
Total	72,200

Source: Adapted from Statistical Year Book of Bhutan, 1993.

Table 2.3 Import of food grain

Commodity	Quantity (tons)	Quantity (tons)	Quantity (tons) 1992-3
	1990-91	1991-2	
Rice	8,776.0	10,301.3	10,087.5
Wheat	1,450.0	1,469.9	1,912.0
Total	10,226.0	11,771.2	11,999.5

Source: Adapted from Statistical Year Book of Bhutan, 1993.

It is seen from the above tables that the importation of rice and wheat was about 50% of the local production (data for other year not available to show trends). The production figures are based on agronomic surveys (1988,1989) and may not tally with the recent figures. The livestock production figure has not been available except in a report that aggregate output of livestock products in 1990 was below the level of demand Kachoncham. Thus, with limited scope of expansion in arable land and rising population growth, the country might not only never achieve self-sufficiency in food (unless consumption patterns changes and major technological advancements occur to increase the productivity of the land) but could lead to other serious problems of poverty. However, food security is not considered from the point of self-sufficiency alone. The type and the amount of other resources that a country possesses are also equally important to determine the purchasing power of that country since production in itself does not solve the problem of hunger or productivity. It is more important to work on a system of fairer (more equitable) distribution so that food is made available to the poor and the needy.

Social Welfare Services

Bhutan is a welfare state with the Royal Government's strong commitment to improve the quality of life of the whole population. His Majesty the King's keen concern for the welfare of the people has succeeded in providing education and health services along with other services like safe drinking water, irrigation canals, agricultural assistance, etc. to the people virtually free of cost. However, with rising population, it will become harder for the government to pursue this policy. This in turn would lead to deprivation of availing basic facilities like health care and education for some of the disadvantaged groups. Thus, some of the national goals like universal health coverage, universal primary school enrollment to name a few could become difficult to achieve without some compromises. The compromises could be in the quality of service or higher percentage of expenditure on this sector that could affect the policy of balanced development. The present quality of life status as indicated by some of the common and available indicators, shown in Table 2.4, reveal that much more effort is needed to enhance the quality of life and to achieve the national goals.

Table 2.4 Indicators of present status.

Population access to health care	90
Population access to safe water	54
Population access to sanitation	60
Life expectancy at birth	66
Population per doctor	6681
Maternal mortality rate/1000	3.8
Infant mortality rate/1000	70.7
Dependency ratio	91.7
Primary School enrollment (%)	72
pupil-teacher ratio (primary)	41
Literacy rate (%)	54

Source: Information, Education, and Communication for Health Bureau,

Environmental degradation

The Royal Government's policy is to maintain 60 percent of the land area under forest cover. Bhutan has presently been able to maintain about 70% of the country under forest cover as a result of the Royal Government's strong commitment and sound policies towards conservation. However, though an important factor, this is not the only concern in environmental degradation. Dumping of hazardous wastes and other forms of pollution like air and water pollution are equally important as they as have an impact on the health of people. One of the major causes of environmental degradation according to Ehrlich and Ehrlich (1990) is rapid population growth, and (Weeks,1996) mentions that,

Arresting population growth should be second in importance only to avoiding nuclear war on humanity's agenda. Overpopulation and rapid population growth are intimately connected with most aspects of the current human predicament, including rapid depletion of nonrenewable resources, deterioration of the environment (including rapid climate change), and increasing international tensions. But there are some who argue that the connection between population growth and environmental deterioration is difficult if not impossible to quantify, and is probably understated. They further argue that the environmental impact depends upon the consumption pattern and not plainly on population growth. Lester Thurow, for example writes that,

“ if the world's population had the productivity of the Swiss, the consumption habits of the Chinese, the egalitarian instincts of the Swedes, and the social discipline of the Japanese, then the planet could support many times its current population without privation for anyone. On the other hand, if the world's population had the productivity of the Chad, the consumption habits of the United states, the inegalitarian instincts of India, and the social discipline of Argentina, then the planet could not support anywhere near its current numbers (quoted in Mazur's, 1994).”

Thus, the means of production, pattern of consumption, equity of distribution system, and conservation ethics of the population dictate the relationship of population growth and environmental degradation. However, more population means more consumption in general and therefore more enviromental degradation.

Employment

In a growing population the number of prospective entrants into the labor force increases every year as each group of young people matures to an economically active age. It means that more jobs have to be created to avoid unemployment. The Royal Civil Service Commission (RCSC) responsible for employment in the civil service of the country, is under pressure to absorb the graduates from various institutions. The Royal Government's policy of maintaining a small, compact, and efficient civil service, with very little scope of increased job opportunities in other sectors, does little to alleviate the situation. Moreover, Bhutan being predominantly agricultural with about 85% of the population working on their farms could be a cause of serious problem as the per-capita land holding gets smaller after every successive generation because of the population growth, if other sources (non-farm) of income generation are not made available. According to Weeks (1995), economists have estimated that countries experiencing a 3% population growth rate require a 9% economic growth rate just to maintain employment at the current level. It means that in our situation, the economic growth has to be around 9.3% but statistical reports show a growth rate of not more than 5-8%. Thus, growing unemployment is likely to occur if proper measures are not taken in the immediate future.

Housing

The increase in the population increases the demand for housing and so the cost of houses or construction of houses rise up leading to an increase in the number of houseless people. It is believed that the number of houseless people in Bhutan is increasing and will continue to grow because of the population growth. Moreover, the number of people living in each house is increasing in most houses, at least in the urban areas, because of higher demand for houses which leads to huge increases in rent.

Income

In general, high rates of population growth mean more consumption, less investment, and ultimately a lower level of per capita income. This is because more money has to be used for the maintenance of the population rather than for the development of the economy (Weeks, 1994). This means that purchasing power is reduced leading to a poorer quality of life.

Summary

In summary, the major determinants of health, like that of population density, food availability, education, employment, housing, etc., have been discussed to show how population growth could affect those determinants. These determinants affect the quality of life either directly or indirectly. The examination of the potential sources of

problems indicates that Bhutan could face some problems if the population growth continues unchecked. The impact of population growth is not straight forward as pointed out by Timothy E. Wirth (1994). Its effect can be magnified or mitigated by a host of social, economic, and environmental factors. But we do know this: in many parts of the world, slowing rapid population growth could help spur economic development, ameliorate poverty, achieve a livable environment, and foster greater opportunity for women (Mazur, 1994).” Assuming that what wirth says is true, I will next explore the possible ways by which fertility can be regulated.

Fertility Regulation

The cause of high population growth is a complex one, often involving elements of economic, social and political issues. Whatever the cause, there is wide agreement in the international arena on its consequences that high population growth affects adversely the quality of life in general. There has been a lot of debate on the means of fertility regulation, that is, development versus contraceptive. However, of late, both development and contraceptive has been recognized as an important element in fertility regulation as pointed out by John Boongaarts, W. Parker Mauldin and James Phillips: “Investments in socioeconomic development and family planning programs have much more than additive effects on fertility. Instead, they operate synergistically, with one reinforcing the other”(Quoted in Mazur’s 1994, 14).

The family planning programs are now measured by a concept known as “unmet needs” which has picked up lot of significance after the Cairo Conference. However, family planning was not without criticism. It was criticized for being coercive and abusing human rights. Thus, one of the achievements of the Cairo conference was to establish family planning in the wider context of reproductive health (Pachauri).

“The World Health Organization defines reproductive health as, a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. Reproductive health addresses the reproductive process, functions and systems at all stages of life. Therefore, it implies that people able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice and the right of access to appropriate health care services” (Sanjeev Kumar in Reproductive health, PP).

This means that the population policy has to broaden its vision beyond family planning. In this regard, Anrudh Jain and Judith Bruce proposes an approach that they call the “1994 strategy” which include the following:

- Promote policies and legal frameworks to create conditions conducive to voluntary fertility decline, that is, give priority attention to girl’ education, lincrease

women's access to and control of valued resources, reduce infant and child mortality, and distribute domestic costs more equitably, especially that of raising children, between men and women;

- redefine the family planning program to emphasize helping individuals to achieve their reproductive intentions in a healthful manner; and

- Increase attention to those aspects of reproductive health that interact directly with avoidance of unwanted and unplanned child bearing (pp 9).

The data from the 1994 Health Survey reveals that the high population growth in Bhutan is almost entirely due to the natural increase (difference of births and deaths) of population and is quite high (3.09%). Comparison of these figures with 1984 Health Survey shows that the high rate of natural increase has been mainly due to the decline in death rates (13.4/1000 in 1984 to 9.0/1000 in 1994) since birth rates have remained fairly constant (39.1/1000 in 1984 and 39.9/1000 in 1994) although a slight increase. The improvement in the expectation of life at birth from about 48 in 1984 to 66 in 1994 can also be attributed to the decrease in death rates besides reduction in infant and maternal mortality rates. However, the decrease in mortality has to be negated by decreases in birth rate if population growth needs to be controlled. The present birth rate of 3.99% is very high compared to most of the countries in the Asia region (fourth highest after Afghanistan, Laos, and Pakistan- The population council, 1993). Since fertility is very high and mortality continues to decline, it is quite likely that population growth will

increase further unless concerted efforts are made to lower the level of fertility (birth rates).

Level of Fertility

Level of fertility can be expressed in so many ways of which total fertility rate (TFR) is one and is generally used. It is defined as the total number of live births which a woman will experience in her reproductive years under current age specific rate. The TFR of Bhutan is 5.5 as estimated from the results of national health survey, 1994. The rate is almost triple the rate required to maintain the population at the replacement level and one of the highest in Asia, next to Afghanistan, Pakistan and Laos (The Population Council, 1993). Weeks has summarized the means of regulating fertility.

“The means for regulating fertility have been popularly labeled the Intermediate variables (Davis and Blake, 1956). These are the variables through which any social factors influencing the level of fertility must operate. Davis and Blake point out that there are three phases to fertility: intercourse, conception, and gestation (see Table 2.5). Intercourse is required if conception is to occur; if conception occurs, successful gestation is required if a baby is to be born alive. Although all the intermediate variables play a part in the fertility transition, the key variables according to Boongaarts has been found to essentially four. These are: “(i) the age at marriage, (ii) contraceptive use rates, (iii) the number of postpartum sterility, (iv) the rate of induced abortion. Of the four,

contraception has the strongest effect, with age at marriage second, in most developing countries.”(Mazur “Ed”, PP-98116).

Thailand has achieved low level fertility primarily by means of increased contraception (Dennis P. Hogan, Aphichat Chamratrithirong, and Peter Xenos, 1987). However, there are differing views and explanations for the fertility transition. The other view holds that social and economic developments are necessary prerequisite for fertility decline and have come up with slogans such as ‘development is the best contraceptive’ and ‘take care of the people and population will take care of itself.’ The debate according to Anrudh Jain has been put to rest, at least in the international arena, during the 1994 International Conference on Population Development(ICPD). “Both the need for providing the means to reduce unwanted fertility and the importance of creating conditions favorable to promoting the desire for smaller families have been recognized.” (1995, PP-296). In the context of these arguments, the situation of key variables in Bhutan is examined with the help data that has been available.

Table 2.5: Intermediate Variables through which Social factors influence fertility.

- I. Factors affecting exposure to intercourse (“intercourse variables”).
 - A. Those governing the formation and dissolution of unions in the reproductive period.
 - 1. Age of entry into sexual unions (legitimate and illegitimate).
 - 2. Permanent celibacy: proportion of women never entering sexual unions.
 - 3. Amount of reproductive period spent after or between unions.
 - a. When unions are broken by divorce, separation, or desertion.
 - b. When unions are broken by death of husband.
 - B. Those governing the exposure to intercourse within unions.
 - 4. Voluntary abstinence.
 - 5. Involuntary abstinence (from impotence, illness, unavoidable but temporary separation).
 - 6. Coital frequency (excluding periods of abstinence).
 - II. Factors affecting exposure to conception (“conception variables”).
 - 7. Fecundity or Infecundity, as affected by involuntary causes.
 - 8. Use or nonuse of contraception.
 - a. By mechanical and chemical means.
 - b. By other means.
 - 9. Fecundity or Infecundity as affected by voluntary causes (sterilization, medical treatment, and so on).
 - III. Factors affecting gestation and successful parturition (“gestation variables”).
 - 10. Fetal mortality from involuntary causes.
 - 11. Fetal mortality from voluntary causes.
-

Source: Weeks, 1996.

Examination of key variables in Bhutan

The intermediate variables that are of importance in affecting fertility as pointed out by various studies are discussed here to shed light on the current situation.

Entry Age into marriage

The reported age at first marriage has shown that 55.4% of the women were married before their 20th birthday. This has a significant impact on the fertility level as shown by Table 2.6.

Table 2.6 Average parity by age at first marriage.

Age at first marriage	< 15	15-19	20-24	25-29	30-34	35-39	40-45	Total
Average parity	4.5	3.8	3.9	3.1	2.1	1.1	0.7	3.9

Source: Health Division, Bhutan, National Health Survey(June 1994),January 1996.

The findings from the above survey are consistent with the general findings from other countries that the lower the age at marriage, the higher the number of children born. This is largely attributed to the longer duration of being at risk of child bearing. Also, the same holds true in terms of entry into sexual union. However, unmarital fertility does also contribute to the overall birth rate and since there is no data available, the effect of

unmarital fertility on population growth cannot be determined. There is also a need to understand the broader issues of why the women marry at an early age since more than 50 percent of the ever-married had married before the age of 20. This has so many other implications for instance like continuing education, and also places increased dependence on children, which is a motivating factor to have more children. Delayed age at marriage has been found to be positively associated with educational attainment, female labor force participation, and occupational status by most studies. Therefore, consideration may be given to raising the age of marriage through both direct and indirect interventions. Direct intervention could be like raising the legal age of marriage to at least 18 years of age. This will have impact not only on population growth but will have other positive health benefits in terms of child rearing and motherhood. Indirect interventions could be raising the educational level and labor force participation of women that has proven outcome of delayed marriages.

Contraception

The finding from two sources, the Annual Health Bulletins and the National Health Survey report the contraceptive prevalence rate to be around 20% (the rate is for modern methods only as data on natural or traditional methods are not readily available). It is interesting to note that the proportion of users for Individual methods differ quite significantly when comparing the results of the Survey and Bulletins. It is found that the percentage of users for Pills, DMPA, and condoms are much higher in the Health

Bulletins whereas IUD, vasectomy, and tubectomy are much higher in the health survey. The Health Bulletin has not taken into account the cumulative aspect of the permanent methods. The contraceptive prevalence rate after taking into account the cumulative figures of the permanent methods is around 33 percent (details discussed in chapter 4)

Abortion

No official figures exist for induced abortion. The cases of abortion reported in 1994 Annual Health Bulletin was 216 which are either cases of spontaneous abortion or Medical Termination of Pregnancy. The absence of induced abortion cases is due to the fact that abortion services are not provided by the health facilities except Medical Termination of Pregnancy (MTP) i.e. when the life of the mother is in danger due to the pregnancy. Abortion in Bhutan, is a moral issue shaped by the 'Buddhist' belief that taking away any form of life is a sin and as such is illegal in the country. Buddhism considers taking life as the highest form of sin and that there is no difference in the magnitude of sin between killing another life and abortion. Nevertheless, there were incidences of young pregnant women who has made use of the services provided in the outside border towns of Bhutan, where operating conditions are far from safe. There was one incidence of maternal mortality reported in the national newspaper but I suspect that lot more of mortality and morbidity due to unsafe abortion do exist which are not reported based on hearsay evidence. Thus, consideration may be given to look into the possibility of providing safe abortion services as part of the comprehensive reproductive

health program. The data on post-partum sterility is not readily available and as such no discussion has been provided.

Recommendations

Although fertility is affected by the intermediate variables as discussed, the outcome of these intermediate variables is determined by social, cultural and economic factors to a large extent. Therefore, these factors has to be affected to bring about change in fertility. Some of the interventions that are widely accepted among the different groups is presented. I have deliberately left out the interventions that are controversial on the issues of individual freedom and human rights, like for instance, providing incentives and disincentives.

Satisfy unmet need for contraception

It is apparent that unmet need and unmet demand for family planning exists in almost all countries of the developing world. It has been shown from analysis of the survey results of seventeen countries of the developing world which had demographic targets that meeting the unmet need results in higher contraceptive prevalence rate than would have been achieved by meeting the demographic target (Mazur). This approach has a lot of advantages and satisfies all the groups concerned. The concept is client-centered and thus the concern of women activists about family planning being coercive is

resolved, while at the same time achieving the demographic goals of the individual country.

Reproductive health

Family planning programs which offer a wide range of reproductive health services have been shown to attract and sustain clients more effectively than programs that focus only on contraception delivery (Mazur, PP 16). Moreover, family planning program should:

a. Promote advantages of small family norm and awareness of family planning methods. Ansley Coale(1973) states that there are three preconditions for a substantial fertility decline:

- The acceptance of calculated choice as a valid element in marital fertility
- The perception of advantages from reduced fertility, and
- Knowledge and mastery of effective techniques of control (Weeks, 131)

Fertility behavior, like any other behavior, is in large part determined by the information we receive, process, and then act on (Weeks, 1996). Thus, information is vital to make any rational decision and doing that fulfills the second and the third preconditions of Coale.

b. Make contraceptives easily accessible and available to all by increasing the number of service delivery points: Accessibility and prevalence of contraceptives has

been found to be closely related - easier accessibility leads to higher prevalence (Population Council, 1989). Accessibility has to be considered in terms of the choice of methods, amount of time it takes to get to a supply outlet, travel cost, waiting time at the clinic, etc.

c. Improve the quality care by providing proper counseling and follow up services: Quality of care is increasingly recognized as an important determinant of contraceptive acceptance and continuation. Providing proper counseling (giving detailed and needed information) helps to prepare the client for any possible problems that may be encountered and knows what, where, or how to take care of it. Follow-up services helps to maintain continuity of clients and to take corrective measures if clients are dissatisfied.

d. Provide safe abortion services to those who demand it: Lapham and Mauldin has found out that more available abortion is in a country, the lower the fertility rate (Population Council, 1989). Abortion can also help to prevent unwanted births especially out of the wedlock which is considered a disgraceful act in almost all societies. So much of shame and disrespect for both the mother and the child can be spared by providing safe abortion services.

Child survival

Child mortality encourages high fertility in several ways: “It encourages excess births to insure that some children will survive; it instills a sense of fatalism and inability to plan for the future; it discourages parents’ investment in children’s health- which perpetuates high mortality rates (Mazur, PP 16-17).” Although, this theory is generally accepted, it is based on logical deduction and lacks hard evidence. No direct connection between child mortality in a family and the fertility level of that couple has been observed (Weeks).

Increase access to education

The level of education has been found to be the most consistent among all of the socio-economic factors that affect fertility behavior (Boongaarts, 1994, PP 16). Worldwide, in average it has been observed that women who have completed seven years of school have three children less than their unschooled counterparts. The observed reduction in fertility among these women is linked to delayed marriage, effective fertility regulation, and more modern forms of investment in children (Mazur, 154-55). A difference of approximately five years has been observed among Asian women with no schooling and those who attained a high level of education (Chamrathirong, 1980).

Increase labor force participation

Research has shown that women who earn can not only negotiate more effectively with partners over sexuality and fertility matters but also rely on themselves and less on

their children for security now and in old age. As a result, women with steady livelihoods are likely to desire fewer children, as well as invest more effectively in those they do have (Mazur, 1952). It has also been found that increased female labor force participation leads to delay in marriage, however, causality may run in opposite direction, and women who do not marry early may enter or remain in the labor force (Chamratrithirong, 1980).

Provide adequate old age security

This is particularly important in a society whereby children are looked upon as a source of labor and security against old age. Many contend that birth rates remain high where children are needed for social and economic security; where parents rely on children for support in old age, for example. In an agrarian society, human beings are the principal economic resource. Even as youngsters they can help in many tasks, and as they mature they provide the bulk of the labor force in the family and support those who cannot work. Also, the notion that some of the children, at least one, would be able and would look after them in their old age makes them have a somewhat large family despite the problem in bringing up the children. Therefore, it is logical to assume that provision of old-age security by the government will reduce the dependence on children and hence limit fertility.

Conclusion

Considering the limitations that Bhutan has in terms of sustaining high population growth, which will in turn affect the quality of life of the people, fertility needs to be regulated. However, the efforts should not be driven by the demographic goal but instead by creating environment for people that will motivate them to have fewer children and fulfilling the unmet need for contraception.