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The Quest for Reaching Replacement Level of Fertility in Bangladesh and Italy: Issues and Considerations

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Abstract

Bangladesh and Italy, while being different in terms of terms of socio-economic context, population growth, fertility rate, and religious background, among others, share a common goal of lowering fertility to reach replacement level of fertility. On this point, both countries have promoted new norms of family size, cultural values, and even curbed influences of religious institutions. This paper presents an overview of each country's efforts to reach replacement level of fertility, details problems each country has encountered in attempting to reach replacement level of fertility, and puts forth a sociological explanation that explains their attempts to reach replacement level of fertility.

Keywords

Bangladesh, Italy, replacement fertility, contraceptive use, regional differential of fertility, family planning

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1. Introduction

This paper explores the dynamics of reaching viable fertility in Bangladesh and Italy. For more than five decades, rich capitalist countries from the West, with the help of the Government of Bangladesh, have taken initiatives to promote social and economic development in Bangladesh. These initiatives have brought changes in economic growth, increased literacy, and longer life expectancy at the macro level. However, the benefits of development have not reached everyone (Chambers 1986; Korten 1990). Why have development efforts not been more successful in Bangladesh? A major reason is the high rate of population growth in the country (Huque 1999). Fertility was never as high in Italy as it was in Bangladesh. Fertility in Italy was, however, previously high among wealthy aristocrats because they married and had kids early, and experienced low infant mortality. However, they soon realized that high fertility could reduce their family wealth, and in response they started to lower their fertility. In Italy, fertility started to decline among wealthy aristocrats long before it declined throughout the country. Regionally, fertility was high in the southern regions of Italy, but since 1950 and onward, the level of fertility was not a problem.

Compared to Italy, the level of fertility changed differently in Bangladesh. With the uneven changes, initially fertility declined slowly in Bangladesh. The total fertility rate (TFR) was 7.1 in the early 1960s, but went down to at 6.3 in 1975. After 10 years, Contraceptive Prevalence Survey reported that TFR declined at 6.5. A sharp decline took place in 1989 with a TFR of 4.8. The very first Bangladesh Demographic and Health Survey (BDHS) reported a TFR of 3.3 in 1993 (Mitra et al., 1994). From 1996 to 2004, TFR stalled at three (National Institute of Population Research and Training, Mitra and Associates, and ORC Macro 2001). After 11 years, the 2007 BDHS reported that TFR went down to below three (TFR=2.7) (National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, 2009). Over the years, the contraceptive prevalence rate also went up from 8 percent to 56 percent. However, the country is still facing a high population pressure. Compared to Bangladesh, the level of fertility turned out as a cause of concern in the 1990s in Italy when the current fertility rate failed to replace the last generation even though Italians couples preferred not to use modern methods of contraception. They chose traditional methods over modern methods of contraception until the 1980s. The very trend took a different direction after the 1980s, the pills and condoms gained popularity among them but still the rate of use was low comparing the other European countries (Dalla Zuanna et al., 2005).

This paper is an exploration of fertility pattern in Italy and Bangladesh with a special emphasis to regional fertility pattern and contraceptive use to find out the possibility of ever reaching the replacement level of fertility from the two different corners: high fertility vs. low fertility.

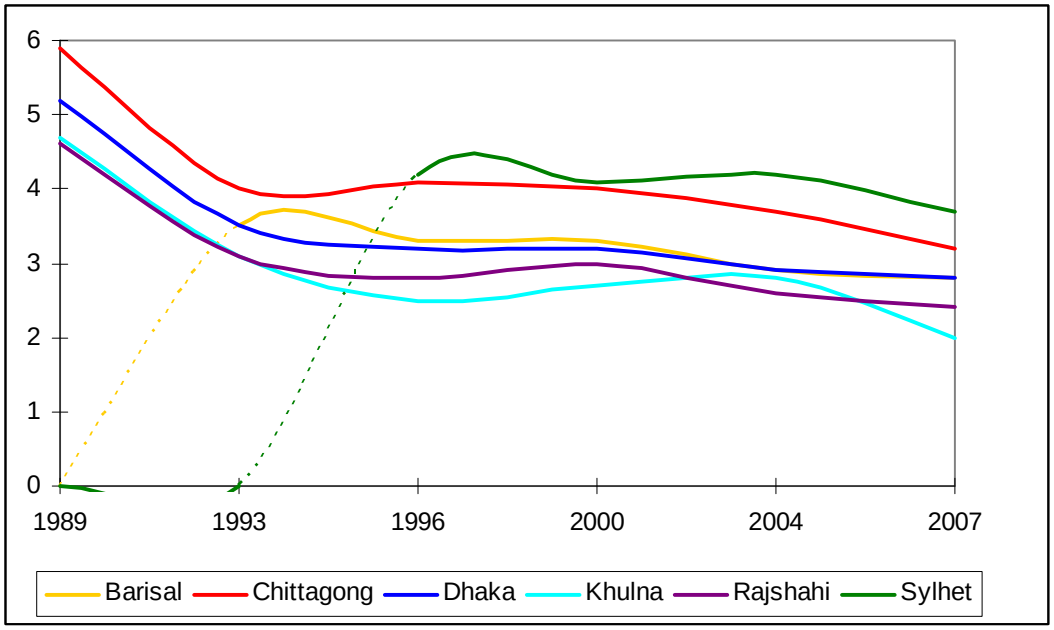
2. High or Low Fertility: South vs. North

As part of the Indian sub-continent, no data on the regional variation of fertility in Bangladesh were available for some periods. Only information available was the total number of person by birthplace (Census of India, 1891; Eait, 1902; O' Malley, 1913; Thompson, 1923). Overall increase of population between 1881 and 1891 was 7.5 percent in Bengal, which went up at 7.6 percent by 1901 and a 8 percent increase took place in 1911 (O'Malley, 1913). Between 1921 and 1931, an annual average birth rate was 28 per thousand (Porter, 1933). Before Bangladesh received her status as an independent state, some South Asian countries revealed a higher population growth rate than the others; Bangladesh (which was part of Pakistan back then) rather grew slowly, with a rate of above 2 percent (Veron et al., 2008). In contrast, data on the regional variation of Italian fertility pattern were available since 1801. High geographical variability exists in fertility in Italy before 1861, the period of unification. Average family

size was five or six with an average birth interval of 24 to 30 months for the first child (Livi-Bacci, 1977). However, the particular research used limited data from only five villages, namely Empoli, Fiesole, Ponte Buggiance, Valdibure, and Pitigliano. Some argued that this variability was a product of miscalculation in certain parishes. Before civil authority took charge of collecting data, the Church had had the exclusive rights to collect data on the vital events. As a result, they employed different degrees of care, reasons, and criteria to collect data for different strata. Further, while compiling and analyzing huge data simultaneously they made several mistakes. However, very few events went unnoticed and unchallenged by the Church authority.

Both Italy and Bangladesh had high fertility in some regions and low in others. Total fertility was quite high in different regions of Bangladesh until 1989 (Figure 1). The southern part of the country has always been the cause of concern. These regions persistently reported high TFR over the years, especially Chittagong and Sylhet. Total fertility rate in Chittagong was 5.9 in 1989, however, the trend started to go down in 1993. Sylhet was once part of the administrative boundary of Chittagong region until 1993 (Mitra et al., 1994). As soon as Sylhet become an independent division, total fertility rate of Chittagong went down implying that the combined effect of both Chittagong and Sylhet made high TFR in Chittagong before 1993. Compared to the other regions of the country, total fertility in Chittagong region is relatively high, except Sylhet. Total fertility of this region went down from 5.9 to 4.0 by 1993. The rate dropped in 1993, but went up again in 1996 (Mitra et al., 1997). Within 10 years, TFR went down to 3.2, which is still the second highest TFR in the country (National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, 2009). Currently a rancorous debate is going on about how to slow down fertility in Sylhet region. Fertility is still higher than the national average (national rate=2.7). After Sylhet becomes a separate division, Bangladesh Demographic Health Survey reported Sylhet's TFR is the highest in the country in 1996; the rate was 4.2. It never came down until 2007. Still the rate is 3.7 much higher than the other regions of the country.

Figure 1: Trends in Total Fertility Rate in Bangladesh by Region, 1989-2007



Data Source: CPS 1989, DHS 1993, 1996, 2000, 2004, and 2007

Compared to Bangladesh, fertility rate was all-time low in 15 regions of Italy within the French Empire. The birth rate of 24 regions was 39.2 in 1810-12. Northwestern Italy (Piemonte and Liguria) had lower births than Northeastern Italy (Lombardo-Veneto). In the South, it was higher than the North (well above 40 per thousand). However, fertility was very high in Tuscany from 1816 to 1825. It started to decline in 1846 and remained declining until 1855. During the early 19th century, fertility declined by 25 percent in Tuscany (Livi-Bacci, 1977). Between 1861 and 1971, Italian fertility pattern took a new shape. New norm of small family size established throughout the country. Unlike some other developing countries, the very transition was gradual. However, at the national level, it took 60 years to lower Italian fertility. Geo-analysis of fertility data reveals that diffusion works very well in lowering fertility in the North and the Center, which is not the case in the South (Livi-Bacci, 1977). Low socio-economic development with the linguistic border makes Southern Italy distinct from Northern and Central Italy in terms of high fertility. A class differential was also present back in 1931. Farmers had a higher fertility than clerical workers in the North and the Center did. Only professionals and artists reported to have low fertility in Southern Italy and Islands. Among white-collar workers, family size fell up to three per children. Group differential was low in the South and fertility did decline gradually. Elites of South mostly preserved traditional cultures with the help of the Church to control en masse. Middle class, professionals, and urban industrial workers could not even break the cycle of traditional cultures because they become part of the system of agrarian South (Livi-Bacci, 1977).

Livi-Bacci (1977) argues that social and educational status was responsible for fertility decline in Italy. Educated women had less than 2.5 children than uneducated women. This was not the case in the South. Traditional culture, prevalence of extended family, lack of women's freedom, and conservative teaching of the church were three major factors responsible for the late decline of fertility in the South. Moreover, school enrollment increased from 67 percent to 85 percent by 1901 in the North. South gained only a 22 percent increase in school enrollment from 1863 to 1901. Further, a less compatible system of communication forced Southern Italy to be backward, caused also a high fertility. Along with these, external migration contributed to a slow fertility decline since mass migration started from Southern Italy to Brazil, Argentina, and USA during the 1880s.

Northern regions of both countries show sign of hopes in reaching the replacement level of fertility. One part of the northern region Khulna observes the lowest TFR. This region apparently has the lowest age at marriage, 15.7 years. Some scholars have suggested that a one-year increase in age at marriage has subsequent effect on the number of children a couple has (Henry, 1976; Inaba 1996; Billari et al., 2000), but this assertion does not work for Khulna. This reflects a widespread use of contraceptive in Khulna that curbed the fertility rate even with a low age at marriage. Except in 2004, Khulna's TFR consistently dropped down. Khulna now acts as a role model for the rest of the country. Its TFR is right now below replacement level (TFR=2). Rajshahi, adjacent to Khulna region, also shows a very impressive statistics of fertility decline. In 1989, TFR of Rajshahi was 4.6. Within 4 years, it went down to 3.1. Like Khulna, with minor variation, TFR consistently dropped from 4.6 to 2.4. Rajshahi is trying to catch up with the trend of Khulna. No data was available on Barisal until 1993 as it was a part of Khulna (Mitra et al., 1994). Compared to the other regions, total fertility was not high when first report on Barisal came out. In less than 15 years, this region gained a tremendous success in declining fertility, the current rate is 2.8. Being mostly rural, this region is competing with other urban regions like Dhaka and Rajshahi (National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, 2009).

The Dhaka region started with a very high fertility when the 1989 report came out. A sudden decrease in fertility was observed between 1989 and 1993 (Mitra et al., 1990; Mitra et al., 1994). Within 4 years, total fertility rate went down to 3.5 from 5.2. However, total fertility rate in Dhaka has been stalled from 1996 to 2000 (Mitra et al., 1997; National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, 2001). The fertility rate remained stable for a while. The very first change came in 2004, the rate become 2.9. By 2007, TFR of the Dhaka region fell down to 2.7. However, since the Dhaka

region is mostly urban, a rapid decline in fertility is expected, but the trajectory is not encouraging compared to other regions. TFR went down in different regions in Bangladesh because of an increasing number of couples have started to use contraception.

The path of reaching low fertility was quite different in Italy. A moderate level of legitimate fertility was common among Italian population during 1806-1971 (Livi-Bacci, 1977). However, before fertility started to decline, wide variations have been observed on the levels of fertility compared to Bangladesh. Interestingly, among Jewish and Aristocrats fertility tend to decline way before a widespread fertility decline has begun in Italy. Prolonged birth intervals and widespread habit of breastfeeding mostly controlled natural fertility, which, implies that the groups controlling fertility had both knowledge and necessary will to reduce their marital fertility. This allowed concluding that changes in behavior of some parts often started before actual pattern originated. Historical data show that in the beginning, rich families carried on the burden of large families because of early marriage, high fertility, and low infant mortality. The trend became quite opposite during the first half of the 20th century. The rich started to have a small family and, as a group, the poor carried on the burden of having large families. Mostly innovation and diffusion caused this pattern of fertility decline. However, the decline was relatively rapid, accomplished between 1911 and 1931.

Since 1940, compared to Bangladesh, the fertility rate went down to all parts of Italy. Its low fertility reached to the lowest low fertility in 1992 (Caltabiano, 2008; Caltabiano et al., 2007; Billari and Kohler, 2004). Most scholars claimed that Italy experienced lowest low fertility in 1992 (Caltabiano, 2008; Caltabiano et al., 2007; Billari and Kohler, 2004). If a country's fertility rate falls below 1.3, that particular country becomes an example of lowest low fertility (Kohler et al., 2002). Mean number of children went down from 2.43 in 1970 to 1.64 in 1980. The rate became 1.33 in 1990 and 1.24 in 2000 (Dalla Zuanna et al., 2005).

For 10 years, 1993-2003, Italy went through a critical stage of continuous fertility decline. The rate went below 1.3 (Caltabiano et al., 2007). Billari and Kohler (2004) argued that Italian adults leave their parental home very late compared to other European countries, meaning that they marry late causing low fertility in the country. Moreover, a low proportion of out of wedlock birth and low divorce rate influenced the lowest-low fertility in Italy (Billari and Kohler, 2004). However, this assertion is no longer valid for Italy as some scholars found that at least 30 percent births occurred out of marriage, which boosted fertility up marginally (Caltabiano et al., 2007).

Currently fertility rate is going up in Italy. However, the real contribution of high fertility comes from immigrants; among the native Italians, the fertility rate is still low. In 2004, TFR was 1.26 among Italians, but the rate among immigrants was 2.61 (Societa Italiana di Stattistica, 2007). This is a flick of hope for the region because with an increasing TFR and a large flow of migration results in a more youthful population, thereby help increasing the labor force. In Southern Italy, 1970 cohort still follows the trajectory of low fertility, but 1980 cohort shows no clear pattern (Caltabiano, 2008). Consequently, fertility in the Northern regions went up compared to the Southern regions. Interestingly, this is the historical event for Italy because the level of fertility has always been higher in Southern Italy than in Northern Italy. Current TFR is 1.45 in Northern Italy and 1.35 in Southern Italy (ISTAT, 2009). Caltabiano and others (2007) suggested that one way to recover Italy's fertility is if mothers have their first child early, which will give them enough time to have a second child without curtailing their careers.
The very indication of lowering fertility started way before 1990s (Table 1). After Second World War, Piedmont, Lombardy, Liguria, Emilia-Romagna, Tuscany, Umbria, and Marche had already experienced a low fertility. Since then, Liguria, Emilia-Romagna, Tuscany, and Umbria had had not reached the replacement level. Apart from Abruzzi-Molise and Sardinia, none of the Southern regions followed the path of below replacement level of fertility before 1984. Data on Abruzzi-Molise and Sardinia reveal that both of these Southern regions revealed signs of low fertility in 1979.

Table 1: Fertility Pattern in Italy by Region, 1952-2008

Year Region	1952	1954	1959	1964	1969	1974	1979	1984	1988	1998	2005	2007	2008
NORTHERN ITALY													
Piedmont Aosta Valley	1.49	1.51	1.63	2.22	2.14	2.03	1.41	1.16	1.11	1.11	1.26	1.35	1.39
Aosta Valley	-	-	-	-	-	-	-	-	-	1.17	1.34	1.48	1.56
Lombardy	1.89	1.85	1.95	2.42	2.22	2.09	1.47	1.23	1.16	1.14	1.35	1.45	1.48
Trentino-Alto Adige	2.52	2.43	2.63	3.01	2.71	2.25	1.65	1.45	1.38	1.41	1.53	1.56	1.60
Veneto	2.36	2.32	2.44	2.71	2.50	2.24	1.53	1.23	1.15	1.15	1.35	1.43	1.46
Friuli-Venezia Giulia	1.75	1.73	1.88	2.25	2.04	1.97	1.32	1.10	1.02	1.03	1.24	1.35	1.36
Liguria	1.38	1.37	1.53	2.07	1.93	1.79	1.17	1.01	0.99	0.99	1.18	1.25	1.30
Emilia-Romagna	1.68	1.66	1.76	2.12	1.98	1.90	1.27	1.02	0.95	1.05	1.33	1.43	1.46
Tuscany	1.64	1.67	1.77	2.12	1.98	1.94	1.40	1.12	1.07	1.05	1.26	1.33	1.38
Umbria	1.85	1.89	1.88	2.09	2.00	1.96	1.54	1.27	1.17	1.11	1.32	1.37	1.40
Marche	2.01	1.97	2.00	2.23	2.13	2.02	1.61	1.27	1.17	1.15	1.27	1.35	1.41
Lazio	2.20	2.23	2.23	2.66	2.40	2.27	1.67	1.38	1.26	1.12	1.27	1.31	1.42
SOUTHERN ITALY													
Abruzzi Molise	2.46	2.38	2.28	2.55	2.42	2.29	1.88	1.54	1.34	1.17	1.20	1.25	1.29
Molise	-	-	-	-	-	-	-	-	-	1.20	1.14	1.16	1.17
Campania	3.17	3.29	3.23	3.57	3.33	2.99	2.41	2.03	1.82	1.50	1.43	1.45	1.44
Apulia	3.38	3.36	3.26	3.48	3.15	2.94	2.35	1.84	1.63	1.34	1.28	1.30	1.32
Basilicata	3.49	3.37	3.15	3.21	3.11	2.72	2.13	1.83	1.61	1.23	1.15	1.18	1.21
Calabria	3.38	3.47	3.41	3.40	3.15	2.75	2.33	1.94	1.73	1.32	1.24	1.27	1.27
Sicilia	2.96	3.07	3.04	3.10	3.00	2.75	2.25	1.88	1.68	1.44	1.41	1.40	1.43
Sardinia	3.80	3.78	3.46	3.41	3.07	2.81	2.07	1.56	1.26	0.99	1.05	1.09	1.10

Data Source: 1952-1988 Abrami, V. T. and Sorvillo, M. P. 1993 ; 1998-2008 ISTAT

Overall, TFR was below 2.1 in northern regions from 1952-1959. The period between 1964 and 1969 has marked with an increase in fertility (Table 2). After 1969, another decrease has been observed from 1974 and onward. The total fertility rate never reached the replacement level since in Northern Italy. The same pattern has been observed for the Central region as well. Fertility started to fall below replacement in the southern region in 1984. Though many scholars argued that lowest- low fertility started during the 1990s, but it started even before the 1990s. As a nation, Italy experienced below replacement level fertility in 1979 and the lowest-low fertility in 1988.

Table 2: Regional Fertility Pattern in Italy, 1952-2008

REGION	1952	1954	1959	1964	1969	1974	1979	1984	1988	1998	2005	2007	2008
North	1.84	1.82	1.93	2.37	2.20	2.05	1.42	1.17	1.11	-----	1.32	1.41	1.45
Center	1.94	1.96	2.01	2.38	2.20	2.11	1.57	1.28	1.18	-----	1.27	1.32	1.41
South-Island	3.16	3.21	3.13	3.30	3.09	2.82	2.28	1.87	1.65	-----	1.32	1.35	1.36
Italy	2.33	2.35	2.38	2.70	2.50	2.32	1.76	1.45	1.33	1.20	1.32	1.37	1.41

Data Source: 1952-1988: Abrami, V. T. and Sorvillo, M. P. 1993 ; 1998-2008: ISTAT

3. A Discord between Modernity and Traditionalism

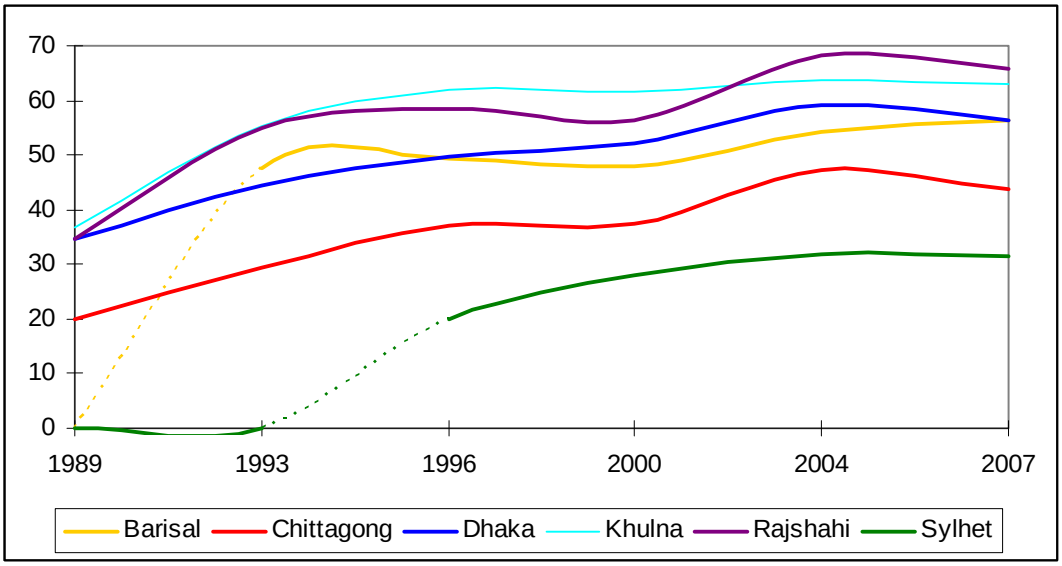
A location explains the existing cultural traits (Bhabha, 2007). However, cultural expression did not prove its efficiency in predicting contraceptive use pattern. As part of the modern world with rich historical background, expectation was that Italian couples would be using modern methods and will not rely on the traditional methods, but the trend was opposite as they used more traditional methods in Italy. Contrary to popular expectation, Bangladeshi couples took a new form of limiting their family size by using modern methods rather than traditional methods. From the very beginning, the pill was by far the method of choice in Bangladesh. However, Italian couples made different choices. Withdrawal was and still is a preferred method of contraception, which has a deep-rooted social and religious connection. In case of failure of this traditional method, the second choice has always been induced abortion. As a result, Southern Italian women went through more abortions than their Northern counterparts did (Dalla Zuanna et al., 2005).

Regional data on contraceptive use is not rich in Bangladesh and Italy. No data on the regional variation of contraceptive use were available in Bangladesh before 1983. Scattered data show that the introduction of sterilization as a contraceptive method made clients suspicious about using any method at all (Hartmann, 1987). In 2007, on an average 30 percent couples use the pill in the northern regions of Bangladesh (National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, 2009). A rapid gain in IUD has been observed in the central region (Dhaka), but the same pattern was missing in the rural areas of central region. Even though, total fertility rate is low in the northern regions (Rajshahi and Khulna), but still a slow rise in injectable contraceptives has been observed. However, use of condom in all regions of Bangladesh is quite low. From 1983, only one urban area of Rajshai reported an increase in condom use. In contrast, the capital of Bangladesh Dhaka reports the lowest prevalence of using condoms. Less than 5 percent use condoms (National Institute of Population Research and Training, Mitra and Associates, and ORC Macro, 2009). Overall, the whole country has not observed any gains in sterilization, except some parts of the South and North, Chittagong, and Rajshahi. Until 2007, no men had performed sterilization in Sylhet compared to 3 percent women in Sylhet. In Chittagong, only 4 percent women performed sterilization compared to 0.2 percent men. However, use of traditional methods is on the rise in Khulna. Currently, 10 percent of couples use traditional methods. Another 9 percent of couples of Dhaka, Rajshahi, and Sylhet use traditional methods. Change in use of modern methods and traditional methods was not significant in other regions from 1983 to 1996 (Sabir et al., 1996).

When comes to using contraceptives, Sylhet never reached the desired goal. Within 10 years of period, use of any modern method has been increased only 8 percent, which is high, but the rate is still low in comparing other divisions. Contraceptive prevalence rate once went up to 25 percent in 2000. This has been the threshold point for Sylhet since then. Considering the relative difference, a huge gap in contraceptive use is always there between Sylhet and other high performing areas (Figure 2). With its

economy and low rate of the hardcore poverty might logically make Sylhet one of the high performing areas but the region still is a cause of concern among the policy makers (Khan et al., 2008).

Figure 2: Trends in any modern method use, 1989-2007

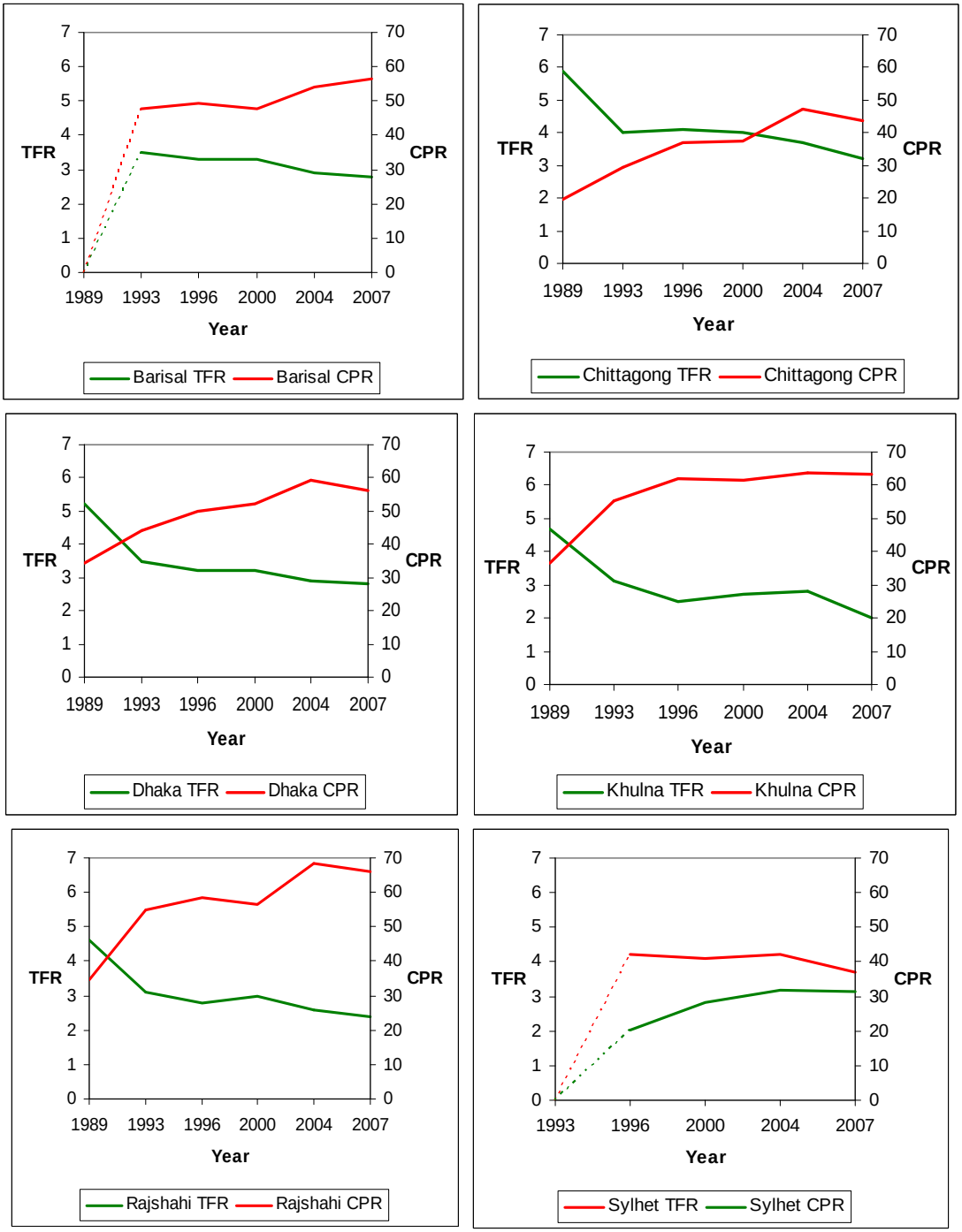


Data Source: CPS 1989, DHS 1993, 1996, 2000, 2004 and 2007

With no exception, long-lasting methods to limit family size are also not popular in Sylhet region. Compared to other divisions, Sylhet falls back in using modern methods, which reflects in the use of long-lasting contraceptive methods. Up until 2007, less than 5 percent of clients used long-lasting methods. Moreover, no upward trend has been observed in this case either. However, it is worth noting that long-lasting methods have always been concern of policy makers. In fact, use of long-lasting permanent method (LAPM) has taken downward trend, which has severe implication for achieving the replacement level of fertility by the year 2015.

In Bangladesh, use of contraception played a critical role in reducing fertility. Apart from Chittagong and Sylhet region, all other regions indicate a relationship between contraceptive use and total fertility rate. In general, TFR decreases as contraceptive prevalence rate increases. Initially, this relationship was slow, but within 4 to 5 years, a sudden jump in using contraceptives has been observed with a rapid low rate of fertility. However, this process of decline is relatively slow in Chittagong and Sylhet (Figure 3). In terms of both fertility and contraception, the very success of lowering TFR in Bangladesh depends on many factors. Many believe that family-planning program in Bangladesh is mostly responsible for lowering fertility (Carty et al., 1993; Cleland et al., 1994; Simmons 1996). Like many other countries, contraceptive use is no longer considered as risky behavior or dangerous to the health and well-being of couples in Bangladesh. In contrast, some scholars suggested family planning programs have no effect on fertility; this is merely a coincidence between onset of fertility decline or the result (Bongaarts and Watkins, 1996). Some even suggested that overall socio-economic-cultural changes, from a subsistence economy to a mixed economy, penetration of monetized economy, employment outside of agriculture, growing urban population and infrastructural development along with family planning program, played a critical role in changing route from high fertility to low fertility(Caldwell et al., 1999).

Figure 3: Trends in Total Fertility Rate and Contraceptive Prevalence Rate, 1989-2007



Data Source: CPS 1989, DHS 1993, 1996, 2000, 2004 and 2007

Like Bangladesh, southern Italy cherishes traditional cultural norms and values. Since withdrawal is mostly a male dominated method, it provides only limited protection against births unwanted by women. Consequently, women performed more abortions even before legalization of abortion in 1978. Attitude towards using contraception started to change in the 1960s. Availability of cheap condoms encourages couples to use this method as a mode of protection against unwanted births. Fear of gaining weight, side effects, and doctors' attitudes make the pill unpopular among Italian couples. Intra-uterine Devices (IUD) became the preferred method, followed by condoms. Even Gynecologists prefer prescribing IUD and diaphragm instead of the pill. In contrast, unmarried single women use either condom or pill as a safety net, which is similar to their Central and Northern European cohorts. Unlike married women, single women infrequently use withdrawal (Dalla Zuanna et al., 2005).

Even though other European countries successfully motivated couples and sexually active adults, even adolescents to use contraceptives, but the same pace was absent in Italy. Transforming women's image from mothers to professionals has an important bearing on the late use of contraceptive in Italy. It was hard for women to change their identity from being mothers to being professionals. In Northern Italy, secular culture prompted women to accept new ideas of practicing contraception. Women with modern attitudes toward their jobs and relationship with their parents wanted to accept IUD and the pill. Moreover, women who emphasized sexual pleasure decided to use pill or IUD. Competing demand between motherhood and job responsibilities forced some women not to have children, resulting in lowest low fertility, which was prevalent from 1980 onward (Dalla Zuanna et al., 2005).

In addition, the very restriction on advertisement of contraceptives ended in 1971, but this had only limited effect on the use of contraceptive methods. With widespread fear against AIDS, use of contraceptives was encouraged. Interestingly, Italian couples hesitate to visit centers where contraceptive information and assistance were made available for them, let alone single unmarried. Divorce law, law permitting contraceptive advertisements, and legalization of abortion make Italian society more secular than ever because the Catholic Church was never enthusiastic about any forms of contraception, divorce, and abortion. This has far-reaching implications for Italian couples, as 97 percent of them are Catholics. It was hard for them to overcome orders prescribed by the Church (Dalla Zuanna et al., 2005).

Beginning of the 20th century marks the upward trend of using condoms as couples found a nice balance between keeping fecundity at a desired level, avoiding unwanted births, and keeping healthy sexual relationships. However, the whole socio-cultural set up went through a major change as contraception become more of women's responsibility as it used to be either couples or males (Dalla Zuanna et al., 2005). A recent study found that compared to 1979, Italians used more pills in 2006. Withdrawal lost its popularity as a method. This result suggests that a new wave of contraception came into being in Italy with new hope for reaching replacement level of fertility.

4. Reality and Realization: Launching Need based State Programs

Reaching clients to provide contraceptive information and make contraceptive available to all is quite different in Italy and Bangladesh. With the growing burden of population in Bangladesh, both couples and policy makers made critical choices to reduce the fertility rate. In contrast, Italy had never experienced a high growth of population. Fear of losing population due to below replacement-level fertility makes it hard to come up with the concrete plans for boosting up population growth. However, the opposite steps were taken to reduce population growth in Bangladesh. In 1953, a female doctor in Bangladesh launched an organization called the "Bangladesh Family Planning Association" whose main target was to provide family planning services to urban populations (Zaman et al. 1996). Persuaded by the success of this organization, government decided to start a clinic-based approach (1960-1965). Condoms, diaphragms, and jelly were made available to all clinics and hospitals. More and more family planning workers had been recruited at the regional level. The next course action of reducing fertility was a field-

based family planning program (1965-71). The family planning program promoted intra-uterine devices and vasectomies as an effort to reduce fertility rate (Zaman et al. 1996). The government announced monetary incentives for male field workers who brought an additional client and for people willing to go through the process. The government stopped all sorts of monetary benefits under integrated health and family planning program (1972-74), and oral pill became an alternative to sterilization.

In 1976, the government program withdrew part time male workers and recruited more female field workers to make house-to-house visits (Zaman et al. 1996). Their job was to inform couples about contraceptive choice and distribute contraceptives. Functionally integrated programs came into action in 1980 and lasted until 1985. Mostly, development of infrastructure was the key agenda during this period. Later, couples' registration was initiated after introducing intensive family planning program (1985-90). More fieldworkers were appointed to intensify the family planning program. The record keeping system was made simple to reduce workload and get better work. In the 1990s, the government took an integrated approach to include reproductive health in the existing family planning program; however, family planning remained the priority. The goal was set to reduce fertility to the replacement level by the year 2005 (Ministry of Planning 2000). Because of the funding crisis, the government shifted the program from a community-based distribution to a static-site or clinic-based approach (Routh et al. 2001).

Since the beginning of the family planning, more and more females have received jobs as field workers. Female workers mostly discuss methods with female clients, they let go off male clients. As a result, vasectomy has become a missed method, and as a method, no one realizes the full potential of this method. Examples from Ghana and Tanzania show that men feel uncomfortable in family planning clinics. They ask for separate service hours (Bertrand et al., 2008). Moreover, medical officers have complained that female workers refuse to stay with clients while they perform vasectomy, as it is a male method. The most important factor influencing LAPM use is non-availability of skilled personnel who would perform the actual jobs. Tanzanian clients expressed the same opinion about the shortage of providers and postponed doing vasectomy (Bunce et al., 2007). Shortage of Medical Officers (MO) at the field level came out as a strong determinant of low performance of LAPM. One missed time opportunity is to talk to clients when they come with their newborn to get shots. Only a MO has the opportunity to convince the clients to go for a LAPM.

Family planning programs in Bangladesh frequently offer different methods, opportunities, and services needed to encourage couples. In sharp contrast, Italian couples never traversed the same path. The family planning services had never been institutionalized in Italy before 1975 (De Rose et al., 2008). Couples and sexually active singles started to receive information about different contraceptive methods through recently established information centers in the different parts of the country. However, no public policy to raise fertility was available until 1996. From 1996, the government introduced a pro-population family policy. Families with children receive both indirect and direct financial supports. Employed persons get fiscal deduction for both children and for other dependent relatives. They receive allowances for three or more children, if their income is close to the poverty line. Poor pregnant mothers also receive maternity allowance up to 5 months. This facility is also available for non-Italian women (De Rose et al., 2008).

Apart from financial support, couples also receive support from their work place to have children. All women get 5 months maternity leave. Women can keep their jobs while taking maternity leave from the job with 80 percent of their salary. This rule is initially applicable for only employed women. In 1987, this system also includes self-employed women. Since 1991, the government ensured that skilled professional and even women with temporary jobs could take time off when they give birth to a child. Moreover, fathers can take paternity leave from jobs with 30 percent of salary; can even receive 80 to 100 percent salary if they are public sector employees. Moreover, in congruence with the lowest-low fertility, the labor market in Italy has changed too. Now part time jobs, flexible work hours, shift work, shared jobs, and remote work make it possible for more couples to have flexible work hours to balance both

family life and working life. Administrative support also helps childcare services. The government partially finances kindergarten in private workplaces for the children aged 0-2 years in 2002. Without financial assistance from government, only 7 percent of children aged 0-2 used to go to kindergarten. In big cities, public and private schools allow parents to choose different time schedule to send their children to schools (De Rose et al., 2008).

Some argued that political and cultural forces prohibited introducing family policy or support for women with children (Saraceno, 2000). Political and cultural conflicts on family issues, the role of Catholic Church, and the conflict between Democrazia Cristiana and the leftist party make it virtually impossible to reach couples or to motivate couples not to postpone childbearing. The government introduced state nursery and municipal kindergarten schools in 1969. The divorce law (1970), optional maternal leave for employed women (1971), the new family legislation, the institution of family planning services (1975), and equal opportunities for both male and female in the work place (1977) implemented to encourage couples to have children. For the first time in 1978, the government legalized abortions and created a national health system to make life easy for couples.

5. Conclusion: A Sociological Explanation of Fertility and Contraceptive Behavior

While contrasting two countries with an uneven level of development, new observations came out. Bangladesh is still struggling with high population, trying to reach the replacement level of fertility. TFR went down to 2.7 from 7.1 in 2007. For a country like Bangladesh, this is a huge success. Contraceptive use went up from 8 percent to 56 percent. Cleland and Streatfield (1992) argued that total success in fertility decline falls on to mortality decline, which comes with the help of Western technology. Scholars raised rancorous debates on what causes this success (Carty et al., 1993; Cleland et al., 1994; Simmons 1996; Caldwell et al., 1999). All of their argument always revolved around the role of family planning programs, mortality decline, infrastructural development, the diffusion process, and so on. With such a good trend in TFR, Bangladesh too is experiencing little difficulty in its progress towards the replacement level of fertility. The total fertility rate stalled for last three BDHS Surveys (1996, 2000, and 2004); now the target is to reach replacement level of fertility by 2015. Moreover, regional fertility level in Bangladesh is not at all encouraging, especially in the Southern region.

In contrast, Italy's situation is still worrisome for not to reach the replacement rate since the 1980s. Italian couples show no motivation to have children due to a rigid labor market, influence of the Catholic Church against practicing contraception, prevalent images of women as mothers, conflict between the Catholic-spirited political party vs. leftist parties, and few services available for childcare. As a result, lowest-low fertility took place in Italy. Northern and Central Italy experienced the lowest-low fertility earlier than their Southern part. By late 1980s, all regions of Italy experienced the lowest-low fertility. Before and after unification, Southern regions always reported a high fertility compared to North and Central Italy. Likewise, Southern regions of both Bangladesh and Italy experienced high fertility compared to the Northern and Central regions. However, several programs took place to reduce fertility in southern regions of Bangladesh, which is not the case in Italy. In the late 1980s, when both Southern and Northern Italy experienced lowest low fertility, not much concern was expressed at the national level until country got hard hit by the lowest-low fertility. For Bangladesh, reaching the replacement level from high fertility to a viable fertility is the main concern among the policy makers, whereas Italy is struggling to reach the replacement level of fertility from very low fertility.

Sociological perspective can provide an explanation for using certain methods to lower down fertility. For many, reasons become instrumental because capitalism changes people's perception about knowledge. Instead of improving human life, people learn to value economic and political efficiency (Habermas, 1987). Lyotard argues that capitalism is solely responsible for producing knowledge, conducting research,

and developing the contemporary society (cited in Malpas, 2003). A mediated person is born rather than a modern person because of the increasing role of mass media and advertisement. Consequently, identity becomes weaker, so does one's sense of self. Baudrillard argues that de-centered selves and identities reject individualism, thereby promote broader social goals (cited in Allan, 2006). A much-commodified culture established in due course because of capitalism and mass media, which encourages people to act economically. Human beings transform themselves to consumers. If his assertions were correct while explaining fertility behavior, it is likely that couples think it is economical to use certain contraceptive methods and thereby reach a desired state of fertility. For years, clients have received free services in Bangladesh through the public programs, which encourage them to use modern methods rather than traditional methods. They endorsed public programs, as it is economical for them.

In a modern world, culture becomes fragmented. Baudrillard argues that the very interrelationship between culture and identity makes identity fragmented too. Both become multidimensional. Consequently, people develop endless choices (cited in Allan, 2006). However, these choices can be constrained if religious institutions controlled people's behavior. This is what happened in Italy. For a long time, the Catholic Church mostly defined people's fertility behavior as the Church always took position against contraception. As a result, couples maintain their traditional family size. Since contraception was not encouraged, their limited choices allow them to use traditional methods in which traditional authority has less control over people's behavior; however, these methods are less effective in controlling fertility.

Economic liberalism brought freedom among women with increasing education and employment. This has nothing to do with women's relationship with men or services provided by the state rather a conflict between economic liberalism and social conservatism proved as major causes of having fewer children in European countries, let alone Italy (McDonald, 2000). Chesnais (1996) argued that since Italian men take fewer burdens on rearing children, women's share of work in rearing children climbs up to an unbearable stage, prompting women to have fewer children and keeping family size low by most any methods. Thus, whatever option is available to them becomes the social norm. Further, he concluded that the current population growth in Italy comes to a halt, and will be 8 million by 2100, which is an alarming issue (Chesnais, 1996). If men fail to provide desired help women needed, with social conservatism, reaching replacement level of fertility in Italy will be a far-reaching goal. Without men taking new responsibilities, reaching replacement level of fertility will be difficult.

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