

Community Characteristics, Leaders, Fertility and Contraception in Bangladesh

*Community and religious leaders should be
educated about the consequences of
rapid population growth*

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Fertility behaviour is determined mainly by the characteristics of individuals, but also by social, cultural, community and institutional factors. The primary aim of this article is to investigate the influence of social and economic institutions on fertility and contraception.

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In general, there are three cases in which individual fertility behaviour is influenced by outside factors. Firstly, individual fertility behaviour is influenced by social norms, particularly norms about desired family size. The importance of these norms with regard to decision-making cannot be underestimated, as they affect values and attitudes during childhood and remain influential during adulthood. Moreover, social and cultural norms are not static; many societies have modified their socio-cultural norms as they modernized.

Secondly, behaviour concerning intermediate fertility variables and fertility itself is influenced by the special features present in the community, which in turn may affect the costs and benefits of children. For instance, economic opportunity within a community plays an important role in fertility decisions. Perceived positive gains in the near future from having children may encourage parents to maximize their fertility. Similarly, the accessibility or the availability of clinical facilities can positively influence the community members' willingness to adopt contraception.

Thirdly, community characteristics indirectly influence fertility through households; household socio-economic characteristics have always influenced individual fertility by altering the economic value of children. The availability of certain types of facility also plays a major role in determining household socio-economic characteristics such as the years of schooling and, occupational status of both husband and wife, and household income.

In an extensive review of Bangladesh's family planning programme activities, Arthur and McNicoll (1978) concluded that the motivating factors for high fertility lie in the uncertainty and insecurity of rural life in Bangladesh. They attributed the current high fertility situation to the people's dependence on rain-fed agriculture and to the socio-cultural environment. Without a drastic change in the functioning patterns of social institutions, they suggested that a reduction in fertility in Bangladesh would be impossible.

In addition, several authors have reported that, at the community level in Bangladesh, people's daily activities are guided by various social norms (Rhaman, 1986; Maloney *et al.*, 1981). Furthermore, those social norms are maintained through the formation of both formal and informal institutions, which are an integral part of community life and have been in operation for a long period of time. The operative mechanisms of these institutions are complex and differ substantially from one community to another, but generally have considerable authority over community activities. In rural areas, these institutions are headed by village elders and supported by local political elites. Although the political institutions are primarily concerned with political and administrative tasks, in several instances political and social institutions have worked together in maintaining social norms.

To examine the influence of these social and economic institutions on community members, detailed information on several aspects of community life was collected from the guardians of these institutions, i.e., community leaders.

Data collection

The definition of a community is not unique and varies from country to country, but the basic concept is to identify a unit which is closely connected socially and economically. In Bangladesh, the smallest geographic unit is the village. The geographic area and the population size vary significantly from one village to another. In most cases, it is difficult to identify the geographic boundaries of the villages; moreover, the same village may have several names. In general, however, a collection of villages is called a *mouza*; several *mouza* form a ward. Approximately 4,000-7,000 people live in a ward. Government records are kept either on a *mouza* or ward basis. Three wards constitute a union, and several unions form an *upazila*.

For the past 30 years, the Government of Bangladesh has considered the ward to be the smallest administrative unit for all kinds of government activity. For example, development programmes are assigned on a ward basis. Since 1960, each ward has been represented by three elected representatives known as union council members in the *upazila* administration. Union council members have considerable influence over their communities and the *upazila* administration. Of the several government workers posted at the ward level, one is the family planning worker.

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) recently conducted an operations research project in four rural *upazila*, namely Sirajgonj, Gopalpur, Abhoynagar and Fultala. In a survey conducted as part of that project, wards were treated as communities and the leaders were interviewed in groups to collect information on community characteristics, and their attitudes and knowledge about several aspects of social life, particularly those concerning fertility and contraception. In total, there are 15 wards in Sirajgonj *upazila*, four wards in Gopalpur; 13 wards in Abhoynagar and four wards in Fultala. Based on geographic location and fertility level, Sirajgonj and Gopalpur were considered a single region as were Abhoynagar and Fultala.

In each ward, union council members were selected along with the union council chairman, if the chairman's residence was in that particular ward. The other two to three members were selected from among the local school teachers and political leaders. The selection of community leaders was done by ICDDR,B officials.

In rural Bangladesh, *imam* (leaders of daily prayers and other religious activities) are among the religious figures who have an influence on community members. They were considered religious leaders in the study. The most respected religious leader in each ward, i.e. the *imam* of the largest mosque, was interviewed to collect the required information. Nineteen religious leaders were interviewed in Sirajgonj and Gopalpur; 17 religious leaders, in Abhoynagar and Fultala. The information which they provided is presented separately from that of the community leaders.

As one of the principal purposes of the survey was to collect detailed information about the knowledge and attitudes of the community and religious leaders with respect to fertility and contraception, several questions related to attitudes were asked. The answers were recorded on a five-item scale:

- “Yes”
- “Controversial but ‘yes’ ”,
- “Controversial but no consensus”,
- “Controversial but ‘no’ ”, and
- “No”

In addition, several open-ended questions were asked and the answers recorded in detail. In each instance, the respondents were asked to give three reasons in support of their answers. Two interviewers and the principal investigator were present for each group interview and they recorded the answers independently. On average, a group interview continued for two to three hours and was conducted on location, inside each community. The religious leaders were interviewed in their homes, a typical interview lasting 20 to 30 minutes.

Variations in socio-economic infrastructure

Community leaders were asked whether certain facilities were available in their respective communities and if not, how far a typical community member had to travel to reach one, and the average travel time involved. When a facility was available, the respondents were also asked whether that facility was available; the respondents were also asked whether that facility had been there five years previously. The following are the facilities referred to in the survey:

- Educational institutions, including primary, secondary, and religious schools and colleges;
- Health facilities such as governmental and non-governmental health clinics;
- Shops and pharmacies where contraceptives are sold;

- Service facilities such as post offices, cold storage, fertilizer dealerships, marketplaces etc., and
- Transportation facilities.

Table 1 presents the percentage distribution of the communities according to the availability of education, health, transportation and public service facilities. Except for one community in Sirajgonj, each community had at least one primary school, all of which were functioning five years previously. It is worth noting that owing to the small sample size, i.e. 19 communities in the Sirajgonj region and 17 communities in the Abhoynagar region, the results presented in this article should not be generalized.

Table 1: Percentage distribution of communities according to availability of selected public facilities, by region

Facility	1986		1981	
	Sirajgonj	Abhoynagar	Sirajgonj	Abhoynagar
Primary school	94.7	100	94.7	100
Boys' high school	57.9	64.7	52.6	58.8
Girls' high school	0	17.6	0	17.6
Religious school	42.1	76.5	42.1	58.8
Govt. health centre	26.3	35.3	21.1	17.7
Private health clinic	5.3	23.5	5.2	17.7
Private pharmacy	36.8	41.2	31.6	35.3
All-weather road	68.4	94.1	a	a
Paved road to nearest town	68.4	94.1	a	a
Railway road	36.8	29.4	a	a
Motorboat service	26.3	5.9	a	a
Electricity	26.3	58.8	a	
Cinema hall	5.3	5.8	0	5.8
Post office	47.4	58.8	47.4	58.8
N	19	17	19	17

Note: a = Not asked.

In both regions, secondary schools for boys are located in more than half of the communities. However, in Sirajgonj, there is no secondary school for girls. In Abhoynagar, three communities have secondary schools for girls.

According to community leaders, in the absence of secondary schools exclusively for girls, parents send their daughters to boys' schools. However, approximately half of the community leaders in Sirajgonj are not in favour of co-education. In Abhoynagar, approximately two-thirds of the community leaders support co-education, but suggested that separate secondary schools for girls would encourage more parents to send their daughters to school. There is no college in either region. Interestingly, Abhoynagar has more religious schools than Sirajgonj, and they were there five years previously. [Table 1](#) shows that, with respect to the availability of educational facilities, Abhoynagar has an advantage over the Sirajgonj region.

Health facilities, particularly the government health centres, are available in the same proportion in both regions. Besides the existence of government health facilities, jute mills located in Abhoynagar operate health clinics for their workers. Approximately one-third of the communities in both regions are served by government health centres. Shops and pharmacies selling contraceptives are located in less than half of the communities in both regions. However, five years ago no shop in Sirajgonj and only a few shops in Abhoynagar sold contraceptives. The increase in the number of shops selling contraceptives can be attributed to the activities conducted by the Social Marketing Programme. Although family planning workers are supposed to be recruited from the same community, it was observed that 15 per cent of the communities have no family planning workers.

Approximately 68.4 per cent of the communities in Sirajgonj and 94.1 per cent of those in Abhoynagar have all-weather roads through their respective communities. Most of communities are connected with the nearest district town by roads which remain open during the rainy season. Sirajgonj has better railway and motorboat services than Abhoynagar. Community members travel on foot within the communities, but use a bus or other motor vehicle to visit the nearest district town.

In both regions, the main economic activity is agriculture, mainly the cultivation of rice, jute and pulses, although sugar-cane is grown in parts of Sirajgonj. Community leaders reported that agricultural productivity has increased, particularly in Sirajgonj where irrigation facilities are more widely available. [Table 2](#) shows that two-thirds of the communities in Sirajgonj have irrigation facilities. Although crop yields have increased during the last 10 years, none of the communities is self-sufficient in food. According to community leaders, more cash is needed now than 20 years ago, primarily for

Table 2: Percentage distribution of the communities according to agriculture-related topic, by region

Topic	Sirajgonj	Abhoynagar
Irrigation facility		
Yes	68.4	23.5
No	31.6	76.6
Crop yield increased during the last 10 years		
Yes	68.4	47.1
Remained same	5.3	17.6
No	26.3	35.3
Self-sufficient in food		
Yes	15.8	17.7
No	84.2	82.3
N	19	17

fertilizer and pesticides. The average land-holding, which is small in both areas, is cultivated by owners themselves. In both regions, approximately half of the communities have access to financial institutions. Data indicate that less than 10 per cent of the community members in both regions are engaged in non-agricultural activities.

Internal migration is common in both regions. In Sirajgonj, community leaders reported that during the major rice harvest season, a significant proportion of the male labour force migrates to nearby districts for extended periods. In Abhoynagar, very few male workers migrate for extended periods. Although industrial workers from Abhoynagar reside near their factories, they regularly visit their homes in the villages.

In both regions, approximately one-third of the communities have factories where more than 20 people are employed. In Abhoynagar, in the communities where factories are not located, there are usually factories within a three-mile radius. The average travel time to these factories is less than an hour in the rainy season.

The Government of Bangladesh gives priority to rural development programmes, primarily road construction and rural electrification. The road construction programme has helped to improve transportation facilities in rural areas, and to create jobs during the slack season for a large group of people in rural areas.

Table 3: Percentage distribution of communities according to availability of selected development programme during the previous five-year period, by region

Development programme	Sirajgonj	Abhoynagar
Road construction project	68.4	82.4
Agriculture co-operatives	31.6	35.3
Rural development societies	31.6	35.3
Women's co-operative	31.6	5.9
N	19	17

Although the Government of Bangladesh started the rural electrification programme at the beginning of 1978, only 26.3 and 58.8 per cent of the communities have access to electricity in Sirajgonj and Abhoynagar, respectively. However, less than 20 per cent of the households are electrified. According to community leaders, less than 10 per cent of the community members in Sirajgonj and 40 per cent of those in Abhoynagar have radios in their homes.

Another component of the government development programme is to encourage people to form co-operative societies, the three most active being agriculture, rural development and women's co-operatives (table 3).

Fertility, family planning and women's status

Community leaders

In every society, both formal and informal leaders are catalysts of change, and their attitudes and knowledge have a considerable influence on community and individual behaviour. Particularly in societies where the vast majority of the population is illiterate and isolated from the outside world, these leaders' understanding and perceptions can have a profound impact on individual community members. In general, community leaders are older and better educated than most of the community members, and rural people often seek their advice and help in all important aspects of social life.

The community leaders in Sirajgonj and Abhoynagar were asked several questions regarding fertility, contraception and women's status; their responses are presented in table 4. To test their knowledge of the fertility situation they

Table 4: Percentage distribution of the community leaders on selected topics, by region

Topic	Sirajgonj	Abhoynagar
Typical family size		
Three	0	5.9
Four	21.1	64.7
Five	52.6	23.5
Six	26.3	5.9
Average number of children during the last 10 years		
Decreased	79.0	94.1
Remain same	10.5	5.9
Increased	10.5	0
Should adopt family planning after having three children (2 sons and 1 daughter)		
Yes	100	100
Male children are considered as old-age security		
Yes	100	100
Children are less dependable compared with 20 years ago		
Yes	94.7	100
No	5.3	0
Religious leaders speaking against family planning		
Yes	26.3	47.0
No	73.7	53.0
Most popular contraceptive method		
Oral pill	63.2	58.8
Condom	26.3	0
IUD	0	23.5
Sterilization	0	17.8
Acceptable for married women from good social background to work outside the home		
Yes	68.4	58.8
No	31.6	41.2
N	92	79

were asked to estimate the number of children in a typical family in their respective communities. Approximately 65 per cent of the community leaders in Abhoynagar reported that a typical family there has four children. In contrast, approximately 53 per cent of the community leaders in Sirajgonj reported that a typical family there has five children. In a few instances, the community leaders mentioned that there are some families who have more than seven children. Answers given by the community leaders closely coincided with the actual fertility situation observed in the respective localities.

The respondents were also asked whether they thought that fertility had increased or decreased during the previous 10 years. The vast majority of community leaders reported that fertility had fallen during that period; however, approximately 11 per cent of the respondents in Sirajgonj suggested that fertility had increased.

When asked whether a person would be considered strange or different if he or she practised contraception, over 80 per cent of the community leaders from both regions gave a negative reply. According to them, the practice of contraception is currently accepted behaviour, but they mentioned that some couples find it difficult to express their desire to practise contraception owing to perceived objections from religious and social groups. The respondents stated that many women were not reporting their use of contraceptives out of shame, or fear related to religious objections.

The community leaders were uniformly in favour of contraception for women who already have three children. They suggested that both permanent and temporary methods should be used to regulate fertility. In general, they tended to favour temporary over permanent methods. Mainly economic reasons were cited by the respondents as justification for limiting the size of one's family; in a few cases, health reasons were also mentioned. The community leaders stated that the contraceptive use rate has increased during the last five years.

According to these leaders, the most popular method of contraception in both regions is the oral pill. In Sirajgonj, approximately 63 per cent of the respondents reported oral pills as the most widely used method, and the condom as the second most popular method. In Abhoynagar, approximately 59 per cent of the respondents reported oral pills as the most popular method, followed by IUDs and condoms.

Security, particularly old-age security, has been cited as the most important factor leading to high fertility in countries where social security programmes are either non-existent or unreliable. Several authors have suggested that in Bangladesh, where there is no old-age security programme, children are viewed as an important source of support for their parents when they

become old (Cain, 1982). The risk of unemployment, natural disasters, the dependent position of women, and high morbidity and mortality are incentives for high fertility in Bangladesh (Cain, 1982). The author also stated that children, especially boys, are an important source of income and a form of security against the death or illness of the head of household or other family members with important economic responsibilities; this view was borne out in the survey of community leaders. In addition to economic reasons, the respondents stated that male children are necessary for arranging funerals and for maintaining the family lineage.

In a follow-up question, the respondents were asked whether they think that children are less dependable today compared with 20 years ago; the answers were always positive.

More than 90 per cent of the respondents in Abhoynagar and Sirajgonj reported that economic hardship, the lack of religious teaching, and the negative impact of modernization have contributed significantly to a situation in which children are less willing and able to support their parents than 20 years ago. Nevertheless, children continue to be considered old-age security. Community leaders reported that owing to the increased cost of living, child-rearing has become more costly today compared with 10 years ago.

At what age do children start to work? The answer to this question has several interpretations. In a society where child labour is considered a responsibility of children to their parents, children start working at the age of seven or eight years, by participating in routine household activities such as cleaning the house and courtyard, washing utensils and collecting fuelwood. The community leaders were asked how old most children are when they begin working, either at home or in the paddy fields. They said that, depending on the types of activity, boys begin productive jobs (work related to crop production) starting from age 11. In contrast, girls generally participate in household activities as soon as they are physically able, i.e. from six or seven years of age. Similar results were also reported by Cain (1977) in a study conducted in rural Bangladesh. According to Cain, the median age at which male children started working with their parents varied between 8.3 and 14.1 years. In both Sirajgonj and Abhoynagar, no significant difference was found in the perceived role of children either as old-age security or as a source of labour for the family.

Despite the influence of religious leaders on other aspects of life, the community leaders reported that religious leaders had little influence on an individual's fertility decisions. The respondents stated that because several religious leaders had spoken publicly against family planning, this might have discouraged some people from adopting contraception. At the same time,

community leaders mentioned that a few religious leaders have supported family planning activities by speaking in favour of birth control.

In Bangladesh, the status of women is lower than men in all aspects of life. Social and religious sanctions discourage women's participation in the labour force. Moreover, the occupational structure and the paucity of jobs for women make it difficult for women who want to break with tradition to enter the labour force. Community leaders in both regions expressed strong opposition to women working outside the home. Particularly in Sirajgonj, respondents stated that it is against social norms for an unmarried woman to work outside the home.

When asked whether it is acceptable for married women from "good" social backgrounds to work outside the home, more than half of the respondents in both regions replied positively. But the jobs they suggested as acceptable are primarily "white collar". Interestingly, the leaders are in support of poorer women working outside the home. In Abhoynagar, the community leaders reported that women from the poorer socio-economic groups worked outside the home in recent years, particularly in the "Food for Work" Programme.

These findings suggest that the leaders' perceptions and attitudes with respect to fertility, contraception and women's status do not vary widely. In both regions, they support family planning. The leaders in Sirajgonj tend to be more conservative in allowing women to work outside the home. Nonetheless, the same respondents expressed their support in favour of poorer women working outside the home. In general, community leaders are less supportive of unmarried women working outside the home. However, it should be kept in mind that the sample size does not permit generalization about the findings; further research is needed in order to draw conclusions.

Religious leaders

It is widely held that Islam is opposed to birth control, and that Muslim religious leaders are against family planning. Although there are no direct injunctions against contraception in the Quran, evidence from the *hadith*, the explanatory tradition, would seem to favour contraception.

The Government of Bangladesh and non-governmental organizations working in the family planning field have reported that religious restrictions are an important barrier to family planning activities in rural areas.

In rural Bangladesh, individuals get their religious teachings and interpretation of the Quran from *imam*. Thus, an attempt was made to interview one *imam* from each community to learn of their attitudes towards family

planning and contraception. A total of 36 religious leaders from Sirajgonj and Abhoynagar were interviewed, using the same questionnaire but with necessary modifications.

At the early stages of the survey, several researchers from the ICDDR,B and other research organizations suggested that religious leaders would not express their opinions on such controversial subjects as fertility and contraception. Except in a few instances, the opposite was found to be true. In general, these leaders were co-operative and expressed their opinions freely. A large majority of the religious leaders said that they would participate in family planning activities if asked to do, so by the Government.

In general, the religious leaders are aware of the high fertility and low contraceptive use rates in their respective communities. [Table 5](#) presents the percentage distribution of religious leaders' opinions on selected topics. According to these leaders, a typical family in Sirajgonj has five children; in Abhoynagar, four children.

A large majority of the religious leaders in Abhoynagar stated that fertility had decreased during the previous 10 years, whereas less than half expressed this opinion in Sirajgonj. A large percentage of the religious leaders strongly favoured family planning for those couples who already have more than three children. However, 32 per cent of the respondents in Sirajgonj and 29 per cent of those in Abhoynagar said that they were against family planning. Those who favoured family planning also approved of permanent methods of contraception. Approximately 25 per cent of the respondents in Sirajgonj and 6 per cent of those in Abhoynagar reported that contraception violated the tenets of Islam.

The oral pill was reported to be the most popular method in both regions; it was followed in popularity by the condom. According to these leaders, a significant number of couples do not report their use of contraceptives out of shame.

In general, religious leaders recognized that they had little influence on the daily lives of people, particularly with regard to the number of children a couple should have.

Approximately one-third of the religious leaders admitted that they have spoken against family planning in public. Another third have supported family planning, while the remainder were neutral. The religious leaders who opposed family planning did so mainly because of their belief that contraception is contrary to the tenets of Islam. Economic reasons were cited as important by the group favouring family planning.

When asked whether they consider male children as old-age security,

Table 5: Percentage distribution of religious leaders' views on selected topics, by region

Topic	Sirajgonj	Abhoynagar
Typical family size		
Three	5.3	11.8
Four	10.5	52.9
Five	57.9	35.3
Six	26.3	0
Average number of children during the last 10 years		
Decreased	47.4	82.4
Remained same	10.5	17.6
Increased	42.1	0
People should adopt family planning after having three children (2 sons and 1 daughter)		
Yes	63.2	76.5
No	36.8	23.5
Male children are considered as old-age security		
Yes	100	100
Children are less dependable compared with 20 years ago		
Yes	94.7	100
No	5.3	0
Have spoken about family planning		
In favour of	42.1	23.5
Neutral	26.3	35.3
Against	31.6	29.4
No information	0	11.8
Most popular contraceptive method		
Oral pill	63.2	64.8
Condom	5.2	0
IUD	5.2	17.7
Sterilization	5.3	5.8
No information	21.1	11.8
N	19	17

they were unanimously positive. However, according to these leaders, children are less dependable today than they were 20 years ago. The lack of religious schooling was cited as the main reason for this perceived phenomenon.

It is clear that the religious leaders from both regions have nearly the same perceptions and understanding of social life. Although a higher proportion of the religious leaders in Abhoynagar expressed opinions in favour of family planning, not as many of them did so in public. The higher concentration of religious schools in Abhoynagar could be an important reason for the lower level of public support of family planning. In Sirajgonj, religious leaders are more supportive of family planning activities. However, as the results are derived from a very small sample, they should not be generalized.

Community characteristics and contraception

Nevertheless, development programmes with non-demographic objectives have had important demographic consequences. In general, development programmes which have generated changes in communication, education and transportation at the community level have in turn stimulated changes at the household and individual levels. It has been argued that improved communication and transportation facilities provide individuals with exposure to western values, and it is assumed that eventually, some individuals adopt "modern" ideas. Moreover, it has been suggested that access to modern facilities such as electricity, higher education and modern consumable items encourages people to modify their behaviour, fertility regulation being one such modification.

The distribution of communities by contraceptive prevalence rate (CPR) is presented in [table 6](#). In Sirajgonj, only six communities have rates in the range of 20 to 29 per cent; in contrast, all communities in Abhoynagar have rates higher than 20 per cent. The CPR in more than half of the communities

Table 6: Distribution of the communities according to contraceptive prevalence rate (CPR) in 1985, by region

CPR	Sirajgonj	Abhoynagar
0-9	1	0
10-19	12	0
20-29	6	7
30-39	0	7
40-49	0	2
50-60	0	1
Total	19	17

in Abhoynagar is above 30 per cent, and one community has a prevalence rate as high as 51 per cent. In general, it was observed that the contraceptive prevalence rate is higher in geographically smaller communities. Presumably, the family planning workers in smaller communities may have a smaller work load and would therefore be able to visit households more frequently.

Table 7 presents community-level contraceptive prevalence rates by availability of selected public institutions and development programmes. The availability of secondary schools shows an inconsistent relationship with the CPR in Abhoynagar. However, in both regions, the presence of religious schools is negatively related to contraceptive use rates. In contrast, the availability of government health centres shows a clear positive association with the CPR in each region. Results suggest that the contraceptive use rate is significantly higher in those communities where government health centres are located. However, it should be remembered that the information was collected from fewer than 20 communities in each region; therefore, the findings are subject to the sampling errors.

The availability of community development programmes showed an unexpected variation in relation to contraceptive prevalence rates. In Abhoynagar, the CPR was consistently higher in those wards where development programmes had been in progress during the previous five years. The opposite pattern was observed in Sirajgonj. One explanation of this unexpected finding in Sirajgonj may be that institutions dealing with rural development aim primarily at increasing agricultural production, basically through the introduction of high-yielding-variety seeds, fertilizers and irrigation. In general, family plan-

Table 7: Contraceptive prevalence rates in 1985 by the availability of selected public institutions and development programmes in the communities, by region

Facility	Sirajgonj		Abhoynagar	
	Present	Absent	Present	Absent
Secondary school	17.1	14.5	31.4	35.3
Religious school	14.8	18.7	31.8	35.8
Govt. health clinic	19.9	15.3	39.0	29.8
Co-operative societies	16.2	17.7	33.3	28.0
Electricity	15.4	17.2	34.9	28.6
Road construction project	16.0	17.8	33.5	23.1
N	19		17	

ning activities are not included as a component in such development programmes.

Another possible explanation of the inconsistent relationship between the development programmes and contraceptive use derives from the operative mechanism of those programmes. In rural areas, development programmes are implemented through the formation of co-operative societies. Given the rural power structure, rich farmers dominate these co-operatives and benefit from government-sponsored development projects. In Sirajgonj, less than 10 per cent of the total households belong to co-operatives. Rahman (1986) also found inconsistent patterns of association between the development programmes and the contraceptive prevalence rate in another part of the country.

Summary and conclusions

Results presented in this article suggest that there are no major infrastructural differences between the communities in the Sirajgonj and Abhoynagar regions.

In both regions, a large majority of the community leaders support the use of modern contraceptives. However, they expressed strong opposition to women's participation in jobs outside the home. Male children are considered as old-age security in both regions. However, community leaders also recognize that owing to worsening economic conditions, children are less dependable for this purpose than they were in previous times. Beyond old-age security, children, particularly male children, are valued for fulfilling funeral duties and performing other religious activities following the death of parents.

Approximately a third of the religious leaders in both regions are against family planning. The religious leaders in Sirajgonj are more supportive of family planning than those in Abhoynagar. However, in both regions, a large proportion of the religious leaders report that they have little or no influence on the individual's fertility decision. At the same time, they recognized that, owing to perceived religious objections, people are not practising contraception. As with the community leaders the religious leaders in the two regions are also against women's participation in any job outside the home. Some religious leaders expressed a willingness to participate in family planning activities.

No consistent relationship was observed between the availability of educational facilities and contraceptive use. However, the presence of a religious school has a depressing impact on the contraceptive use rate. In both regions, the presence of government health clinics has a strong positive association with the contraceptive use rate. Community development programmes, such as road construction and the operation of co-operatives, showed an inconsistent relationship with the contraceptive use rate.

However, owing to the small sample size, the findings presented in this article cannot be generalized, particularly with regard to the relationships between the availability of educational facilities and contraception, and community development programmes and contraception. But several suggestions can be put forward for consideration. It is evident that a large percentage of the religious leaders have not directly supported family planning, but expressed their desire to participate in such activities. Therefore, the Government should take the necessary steps to encourage religious leaders to participate in family planning activities. Similarly, community and religious leaders should be educated about the consequences of the rapid population growth. In addition, appropriate policy measures should be undertaken to improve women's status in the rural areas. Also, clinical facilities should be made more widely available in the communities in order to provide health care and family planning services.

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