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Culture, Religion and Gender in Women's Reproductive Healthcare: A Review of Evidence from Jashore District, Bangladesh

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Abstract

Women's reproductive health in Bangladesh depends on much more than hospitals and medicine. Family, religion and local customs shape how girls deal with their first period, whether pregnant women get rest and good food, and where babies are born. This article looks at how these social and cultural factors affect women's reproductive healthcare in Jashore District, in south-western Bangladesh. It is based on a review of published studies, national survey data and news reports. Very little research has been done on Jashore itself, so the article also uses evidence from Khulna Division and other parts of rural Bangladesh, including Mannan's (2013) study of a village in Tangail. The findings show a mixed situation. Compared with the national average, more women in the Khulna region give birth in health facilities with trained staff. At the same time, more teenage girls become pregnant, Caesarean births are rising quickly in private clinics, and traditional beliefs about purity, spirits, food and God's will still guide many decisions. The article argues that culture should not be seen only as a barrier. It is the way families understand health services, and health programmes in Jashore will work better if they respect and engage with local beliefs instead of ignoring them.

Keywords: Reproductive health; Culture; Religion; Gender; Jashore; Medical pluralis.

1. Introduction

Reproductive health, in the sense adopted at the 1994 Cairo conference and repeated in later United Nations documents, is about more than the absence of disease. It refers to a person's ability to have a safe and satisfying sexual life, to bear children, and to decide freely whether, when and how often to do so (UNFPA, 2008). That definition carries a quiet assumption: that the person in question is free to decide. In much of rural Bangladesh, a woman's reproductive life is decided collectively. Her mother-in-law, her husband, the village midwife, the local imam and, increasingly, the clinic agent who visits her courtyard all have a voice, and the weight of each voice depends on custom, faith and household power.

Anthropologists have long recognised this. Blanchet's (1984) classic study of birth in rural Bangladesh showed how ideas of pollution and danger organise the entire period from menarche to the end of postpartum seclusion. Rozario (2002) described the village dai as a healer pushed to the social margins precisely because she handles the polluting substances of birth. More recently, Mannan (2013) documented, in a single Tangail village, how menstrual secrecy, pregnancy rituals, home delivery, spiritual healing and patriarchal pressure around contraception together produce poor reproductive outcomes for poor women.

This review asks how far these patterns hold in Jashore District. Jashore is a useful case for three reasons. First, it belongs to Khulna Division, which national surveys consistently place among the better-performing regions for maternal care, so it allows us to ask what culture does once services are more available. Second, it has a religiously mixed population, with a large Muslim majority, a significant Hindu minority and a small Christian community, which makes the role of religion more complex than in more homogeneous districts. Third, parts of the district suffer from chronic water logging, which shows how environmental stress intersects with gender norms in ways that directly affect women's health.

2. Methodology

This is a narrative review, not an empirical field study. No primary data were collected for this article. Sources were identified through searches of PubMed Central, BanglaJOL, publisher databases and institutional repositories using combinations of the terms Jashore, Jessore, Khulna, reproductive health, maternal health, childbirth, menstruation, child marriage, traditional birth attendants and food taboos. Quantitative context comes mainly from the 2022 Bangladesh Demographic and Health Survey (NIPORT & ICF, 2023), the 2016 Bangladesh Maternal Mortality and Health Care Survey (NIPORT et al., 2019; Rahman et al., 2023) and the 2022 Population and Housing Census (BBS, 2023).

An important limitation must be stated plainly. Peer-reviewed research focused specifically on Jashore is scarce. The most substantial district-level study located is Huda et al.'s (2015) assessment of menstrual regulation and post-abortion care services across Jashore's health facilities. For many cultural practices, the review therefore relies on evidence from Khulna Division or from rural Bangladesh generally, and it says so wherever that is the case. Readers should treat claims about Jashore's cultural practices as informed expectations to be tested in the field rather than as established findings.

Jashore District: The Social Setting

Jashore lies in the south-western part of the country, close to the Indian border, and covers roughly 2,607 square kilometres. The 2022 census counted just over three million people in around 798,000 households, with an average household size of about 3.8 persons (BBS, 2023). Fewer than a quarter of residents lived in urban areas, so the district remains predominantly rural despite the commercial importance of Jashore town as a transport hub for the south-west. Muslims form the large majority, Hindus are the main minority, and a community of roughly 5,300 Christians lives mostly in Jhikargachha and Jashore Sadar upazilas (BBS, 2023).

The 2022 BDHS does not report district-level estimates, but its divisional figures provide a useful backdrop. Khulna's total fertility rate was 2.2 births per woman, slightly below the national figure of 2.3. Around four in five recent births in Khulna took place in a health facility, compared with about two-thirds nationally, and the

share of births assisted by a medically trained provider was similarly well above the national average. On these measures, women in the division are better served than women in most of the country (NIPORT & ICF, 2023).

Two other figures complicate that picture. First, about 31 percent of adolescent women aged 15 to 19 in Khulna had already begun childbearing, against 24 percent nationally. Second, caesarean section accounted for roughly two-thirds of recent births in the division, far above the national rate of about 45 percent and well beyond the level that clinical need would justify (NIPORT & ICF, 2023). Both figures point to social rather than purely medical forces: early marriage on one side, and a commercialised private health market on the other.

The physical landscape also matters. The Bhabodah area, covering parts of Abhaynagar, Manirampur and Keshabpur upazilas, has suffered prolonged waterlogging since the 1980s, when embankments and sluice gates disrupted the natural drainage of local rivers (Habib & Adhikary, 2016). Severe flooding returned in August 2026, submerging more than a hundred villages after days of heavy rain (Dhaka Tribune, 2026). As discussed below, these conditions have specific consequences for women.

3. Conceptual Framework

Two ideas guide the analysis. The first is medical pluralism. Kleinman (1980) argued that in any society health care operates through overlapping sectors: the popular sector of family and household knowledge, the folk sector of religious and traditional healers, and the professional sector of trained biomedical practitioners. People move between these sectors, often using several at once, and they make sense of illness through cultural explanations that may differ sharply from those of doctors. In rural Bangladesh, a woman with a difficult pregnancy might take iron tablets from a government health worker, drink water blessed by a pir, and avoid certain foods on her mother-in-law's advice, all in the same week. For her, these are complementary rather than contradictory efforts to secure a safe outcome.

The second idea comes from Durkheim (1912/1995), whose study of religion emphasized the division between the sacred and the profane and the role of shared ritual in sustaining a society's collective conscience. Many reproductive customs in Bangladesh can be read through this lens. Menstrual blood and the substances of birth are treated as polluting and dangerous; the woman who carries them is temporarily set apart; rituals mark her separation and her return. These practices are not merely individual beliefs. They express and reproduce the moral order of the community, including its ideas about gender, honour and the proper place of women. This helps explain why such customs persist even when individuals know that biomedicine offers a different account. To abandon them is not just to change a health behaviour but to step outside a shared moral world.

Gender runs through both ideas. Patriarchal kinship, patrilocal residence and the high value placed on sons shape who decides, who eats first, who rests and who pays for care. Cultural explanations rarely operate on their own; they work together with economic constraint and unequal household power.

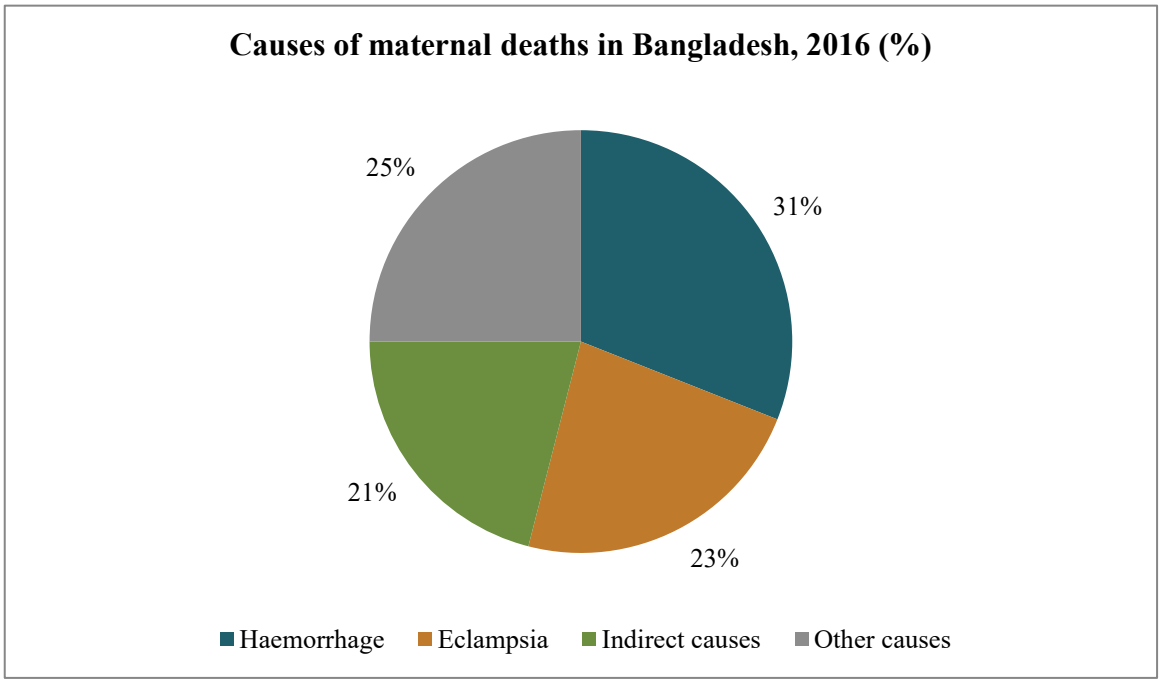
4. Menarche, Menstruation and Silence

For many rural girls in Bangladesh, the first period arrives without warning. The 2014 BDHS found that only about a third of adolescent girls aged 15 to 19 had heard of menstruation before they experienced it, and community studies repeatedly report that girls use old cloth that is washed and dried out of sight (Rabeya et al., 2023). Mannan's (2013) Tangail respondents described their first period as frightening and shameful; one woman recalled assuming she had done something wrong until an aunt explained what was happening and taught her to hide the cloths she used.

The roots of this silence lie partly in the pollution beliefs that Blanchet (1984) documented. A menstruating girl is considered impure and, in some households, vulnerable to spirits. She may be kept from cooking, from touching religious objects or from entering certain spaces. Muslim prescriptions on prayer and fasting during menstruation, and Hindu restrictions around kitchens and shrines, reinforce this sense of separation, and in a religiously mixed district such as Jashore both systems are likely to be familiar.

The consequences extend beyond embarrassment. A nationally representative survey of Bangladeshi schoolgirls found that 41 percent of those who had reached menarche reported missing school during their periods, averaging almost three days per cycle. Absence was more common among girls who were forbidden from activities during menstruation and less common in schools with a private, unlocked toilet for girls (Alam et al., 2017). Studies of rural schoolgirls show that good practice is associated with mothers' education, household income and knowledge of the risks of poor hygiene (Rabeya et al., 2023), which suggests that information passed through mothers is critical, and that silence in one generation reproduces itself in the next.

Figure 1. Causes of maternal deaths, Bangladesh Maternal Mortality and Health Care Survey 2016



Source: Rahman et al. (2023), based on BMMS 2016. 'Other causes' is the remainder (25%) after the three named categories and includes abortion-related and other direct causes.

5. Early Marriage and Adolescent Pregnancy

If any single social practice shapes women's reproductive health in Bangladesh, it is early marriage. A BRAC study published in 2023 estimated that about half of Bangladeshi women had married before the age of 18, and that more than 60 percent of surveyed households had seen a child marriage in the preceding five years (BRAC, 2023). Analysis of earlier BDHS data found that marriage before 18 significantly raised the likelihood of stillbirth or miscarriage, even after accounting for social and demographic factors.

The Khulna figures noted earlier are striking in this context. A rate of adolescent childbearing seven percentage points above the national average implies that early marriage remains deeply rooted in the division despite its better access to services. Mixed-method research has shown that families in Bangladesh generally know that child marriage is illegal; they marry daughters early anyway because of poverty, dowry pressures, fear of sexual harassment and concern for family honour (Akter et al., 2021). The practice persists not from ignorance but from a calculation in which reputation and economic security outweigh legal and health concerns.

Mannan's (2013) ethnography contains a revealing case: a family planning worker, well versed in the risks of adolescent pregnancy, who nevertheless married her own son to a 13-year-old girl. Individual knowledge, in short, does not easily overcome collective norms tied to status and honour. For Jashore, the high adolescent pregnancy rate in Khulna Division suggests that programmes focused only on awareness are unlikely to be

sufficient. Keeping girls in school, providing economic alternatives and engaging religious and community leaders are more likely to shift the underlying calculation.

6. Pregnancy: Work, Food and Ritual

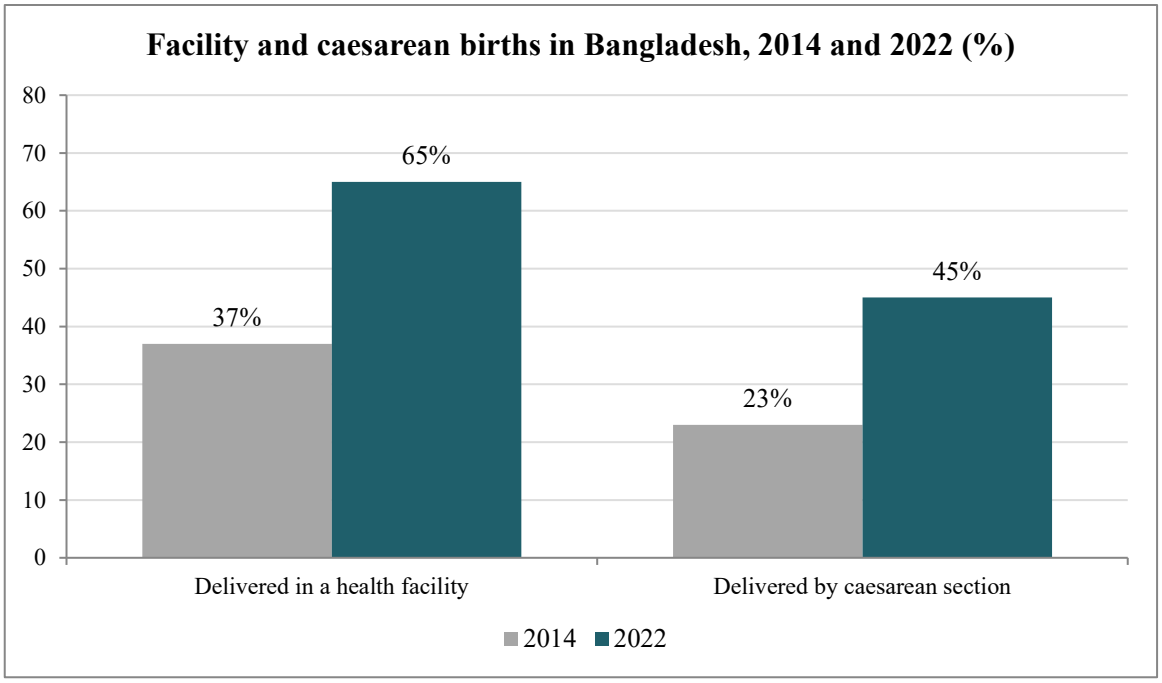
Pregnancy in rural Bangladesh is often treated as a natural condition rather than a medical one. Women commonly continue cooking, carrying water, tending livestock and, in agricultural seasons, working in post-harvest processing until close to delivery. Mannan's (2013) respondents reported that pregnancy brought no special rest or diet; they ate what the household ate. This reflects economic necessity and an older generation's view, often voiced by mothers-in-law, that special care in pregnancy is unnecessary.

Food beliefs add a further layer. A qualitative study across four rural districts found that taboos during pregnancy cover animal foods, certain fruits and vegetables, and other items, and that women observe them mainly out of concern for the baby and deference to elders (Food Taboos Study Group, 2024). One widespread belief, reported in Mannan's (2013) work and elsewhere, is that eating less during pregnancy keeps the baby small and makes delivery easier. In a context where many women already enter pregnancy undernourished, deliberate restriction can contribute to anaemia and low birth weight. The same study found that taboos weakened when community health workers provided nutritional counselling, when families understood maternal nutrition better, and when women saw that breaking a taboo had no harmful effect. Change is possible, but it travels through relationships rather than leaflets.

Pregnancy is also marked by ritual. The seventh-month ceremony, known in many areas as sadh or sath, is widespread across Bengal among both Muslims and Hindus. Female relatives gather, the expectant mother is bathed, dressed in a new sari and blessed, and special sweet dishes are shared. Mannan (2013) recorded a version in Tangail that included a playful test to predict the baby's sex. Such rituals bring kin together and offer emotional support, though the preoccupation with the baby's sex also reflects and reinforces son preference.

Antenatal care is one area where Khulna performs close to the national average. In 2022, a little over four in ten recent mothers in the division had made the recommended four or more antenatal visits, a figure almost identical to the national level (NIPORT & ICF, 2023). That relatively low share is notable because Khulna's facilities are, on average, better prepared to provide antenatal services than those in Dhaka Division (Hakim et al., 2022). The cultural view of pregnancy as a normal state that does not require repeated medical visits, combined with costs, travel and the need for a family member to accompany the woman, keeps many women from completing the recommended schedule.

Figure 2. Rise in facility births and caesarean sections, Bangladesh, 2014–2022



Source: BDHS 2014 (as reported in Begum et al., 2018) and NIPORT & ICF (2023), BDHS 2022.

7. Childbirth: From the Dai to the Clinic

For generations, rural Bangladeshi women gave birth at home with the help of a dai, a traditional birth attendant who usually learned her craft by apprenticeship to an older female relative. The birth room, often a dark corner or a temporary hut, was treated as polluted, and the mother and baby were secluded there for days or weeks. Rozario (2002) argued that the dai's low status derived from her close contact with birth pollution, and that this marginality limited both her authority and her willingness to adopt new practices.

Qualitative research has documented why families continued to prefer home births even as facilities spread. Poverty is the most frequently cited reason, followed by traditional views, religious beliefs, poor roads, women's limited voice in family decisions, lack of transport, fear of caesarean section and the scarcity of female doctors (Sarker et al., 2016). Concern about male providers reflects purdah norms of modesty.

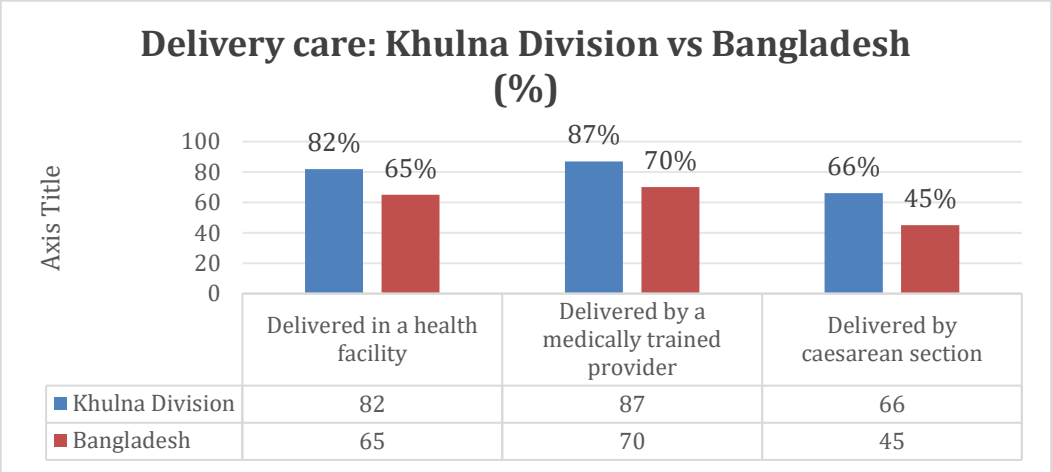
Jashore and the wider Khulna Division have moved further from this pattern than most of the country. Even a decade ago, deliveries attended by skilled providers in Khulna were around twice as common as in Sylhet, and analysis of BDHS data has shown that Khulna stood apart from other divisions in the factors associated with skilled attendance (Kibria et al., 2017). By 2022, around four in five births in the division took place in a facility (NIPORT & ICF, 2023).

Yet the shift to facilities has created a new problem. The rise in caesarean deliveries, especially in private clinics, is perhaps the most important recent change in childbirth in south-western Bangladesh. A qualitative study in Matlab found that clinic agents, often called brokers, and local health workers strongly influenced women's choice of facility, and that obstetricians who preferred caesarean section received more referrals from these agents (Begum et al., 2018). Mannan (2013) described the same practice in Tangail, where clinic representatives visited pregnant women's homes, urged families to deliver in private clinics and earned commissions on operations. Investigative reporting in Manikganj in 2024 found similar networks of doctors, clinic owners, health workers and brokers steering women towards surgical births (Daily Star, 2024).

The stakes are high. The 2016 maternal mortality survey estimated a maternal mortality ratio of 196 per 100,000 live births, essentially unchanged since 2010. Haemorrhage and eclampsia caused more than half of

maternal deaths, and a third of women who died had sought care from three or more places before their death, a pattern of being shuttled between facilities that reflects weak referral systems (Rahman et al., 2023). For women in Jashore, better access to facilities matters only if those facilities provide timely, appropriate and affordable emergency care.

Figure 3. Delivery care among live births in the two years before the survey, Khulna Division and Bangladesh, 2022



Source: NIPORT & ICF (2023), Bangladesh Demographic and Health Survey 2022, Key Findings: Khulna.

8. The Postpartum Period and the Newborn

After birth, many rural households observe a period of seclusion for mother and baby, typically lasting several days and sometimes longer. During this time, the mother may be restricted to a narrow diet; Mannan (2013) recorded a practice of eating little more than rice with black cumin for the first week, avoiding fish, meat and green vegetables. Such restrictions deny a recovering woman the protein and micronutrients she most needs.

Beliefs about spirits are especially prominent at this stage. The new mother and infant are seen as vulnerable to evil spirits and the evil eye, and protective measures range from keeping iron objects nearby to tying amulets on the baby. When a newborn falls ill, families may first consult a religious healer rather than a doctor. In Mannan's (2013) account, a baby's illness that the villagers attributed to a ghost was likely neonatal jaundice or infection, conditions that require prompt medical attention.

Newborn feeding illustrates the persistence of custom with particular clarity. Medical guidance calls for breastfeeding within the first hour, including colostrum, with no other food or liquid. In practice, many rural families give honey, sugar water or mustard oil before the first breastfeed, often explaining it as tradition or as a way to clean the baby's mouth. An early study in Matlab found that more than nine in ten infants received such pre-lacteal feeds, with honey the most common (Tarannum et al., 1997). More recent community studies report lower but still substantial rates, with roughly a third to a half of mothers giving pre-lacteal feeds and honey still among the most common items (Das Gupta et al., 2016; Karim et al., 2023). Some families now give infant formula instead, encouraged by advertising that presents processed milk as modern; formula has become a new custom adopted as much for status as for nutrition.

9. Religion, Spiritual Healing and Infertility

Religion pervades reproductive life in rural Bangladesh, both as formal practice and as everyday belief. Many families consider children a gift from God and see fertility, the sex of the child and the outcome of a pregnancy as ultimately in divine hands. This belief can be a source of comfort and resilience. It can also discourage active help-seeking, if a complication is understood as fate.

Shrines, pirs, fakirs and kabirajs occupy an important place in this landscape. Mannan (2013) described women visiting a saint's shrine to make vows and collect blessed water and amulets in the hope of conceiving, and a female healer who treated childlessness, threatened miscarriage and childhood illnesses with herbal mixtures, recitations and charms. Such healers listen, share the patient's frame of reference and are available when formal services are distant or costly.

Nowhere is the role of spiritual healing more visible than in infertility. In a pronatalist society where a woman's status depends heavily on motherhood, childlessness carries severe social consequences. Nahar's research found that rural Bangladeshis view infertility more as a social problem than a medical one, that childless women face stigma, blame and the threat of their husbands remarrying, and that public infertility services for the rural poor were essentially absent (Nahar, 2010; Nahar & Richters, 2011). Rural women therefore moved from healer to healer, sometimes suffering harm and exploitation. Yet Nahar and van der Geest (2014) also showed that childless women were not merely passive victims; they found ways to resist stigma and rebuild a sense of worth.

In Jashore, the presence of both Muslim and Hindu traditions probably widens the range of spiritual options rather than narrowing it. How women in Jashore navigate these options, and how their choices differ by religion and class, deserves fieldwork.

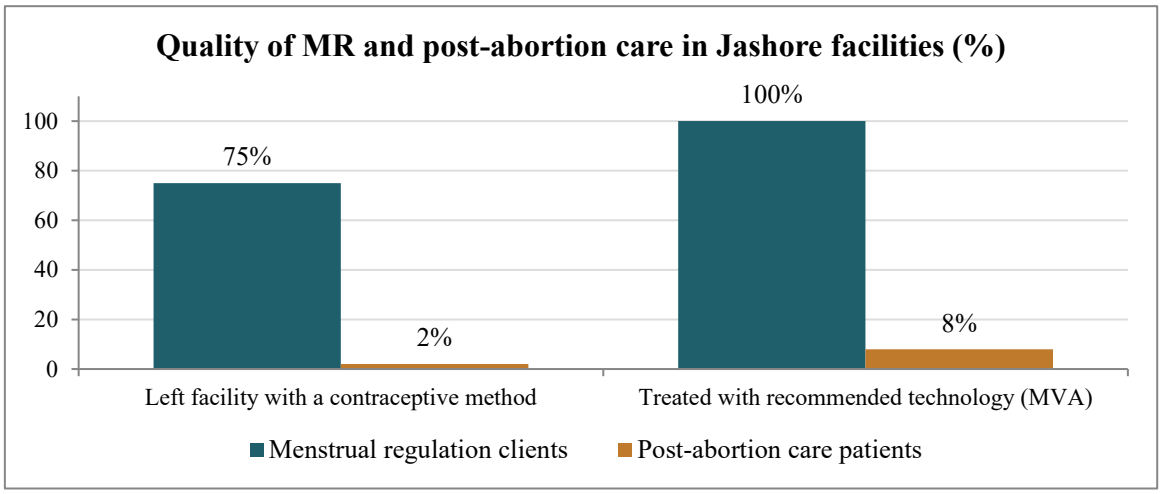
10. Contraception, Menstrual Regulation and Gender

Bangladesh's family planning programme is one of the most celebrated in the developing world, and contraceptive use in Khulna Division is relatively high, with unmet need for family planning slightly lower than the national level (NIPORT & ICF, 2023). The 2022 BDHS also found that most married women in Khulna reported making family planning decisions alone or jointly with their husbands, although this share was slightly lower than nationally.

Behind these figures lies a marked gender imbalance in who bears the responsibility for contraception. The great majority of modern method use in Bangladesh consists of methods used by women, such as pills and injectables, while male methods remain marginal. Mannan (2013) reported that men in her study village regarded contraception as women's business and pressured their wives to use it, and that female clients far outnumbered male clients at the local health complex. The cultural association of fertility with women, together with male reluctance to use condoms or undergo vasectomy, places both the burden and the side effects of contraception largely on women.

Menstrual regulation offers another window into the interplay of law, culture and service quality. Abortion in Bangladesh is legal only to save a woman's life, but menstrual regulation, an early procedure to establish non-pregnancy, has been permitted since the 1970s. Huda et al.'s (2015) study of 69 public, private and NGO facilities in Jashore found that no facility met the criteria for comprehensive care, and only one met basic criteria at the end of the project. Menstrual regulation clients received recommended technology and usually left with a contraceptive method, but women treated for abortion complications were rarely given modern evacuation methods and almost never left with contraception. In plain terms, women arriving after an unsafe abortion, who are likely to be the most vulnerable, received the poorest care. The study also noted that the administrative division between the health and family planning wings of the public system made it harder to provide integrated care.

Figure 4. Contraceptive provision and use of recommended technology for menstrual regulation (MR) and post-abortion care (PAC) clients, 69 health facilities in Jashore District, 2008–2009



Source: Huda et al. (2015). MVA = manual vacuum aspiration. The PAC figure for MVA is the baseline value (8%); it fell below 1% at endline.

11. Environment and Vulnerability: The Case of Bhabodah

The waterlogged Bhabodah region offers a clear example of how environmental stress amplifies gender-based health risks. Reporting from the area has described women eating and drinking less during the day to avoid using inaccessible or exposed toilets, waiting until night for privacy, and suffering from skin diseases from prolonged contact with stagnant water (Daily Star, 2016; Habib & Adhikary, 2016). A multi-agency assessment of flooding in Jashore, Khulna and Satkhira in 2011 identified worsening sanitation for women and girls and reduced access to health services as major concerns (Coordinated Assessment, 2011).

For pregnant and menstruating women, these conditions are especially hazardous: restricting food and water raises the risk of dehydration and urinary infection, menstrual hygiene becomes far harder, and flooded roads delay travel during labour. Modesty norms here interact with a physical crisis to produce direct health harm. A culturally informed response would include women-friendly sanitation, mobile antenatal and delivery services, and boat ambulances during the monsoon, designed with local women's participation.

12. Discussion

Several themes emerge from this review. The first is that improved access to services does not erase the influence of culture. Despite better facility coverage, Khulna Division shows higher adolescent pregnancy, no better antenatal care completion and caesarean rates far beyond clinical need. Norms around early marriage, household authority and the meaning of modern care continue to shape outcomes even where clinics are close at hand.

The second theme is that culture and biomedicine are not two separate worlds. Women move between them constantly, in line with Kleinman's (1980) description of medical pluralism. Programmes that treat traditional practices simply as obstacles risk alienating the people they aim to help. More effective approaches distinguish between practices that are harmful, such as postpartum food restriction or pre-lacteal feeding, those that are neutral, and those that are protective, such as the social support offered by pregnancy rituals and female kin networks.

The third theme concerns gender and power. Across almost every stage of the reproductive life course, the decisive constraint is not belief alone but who holds authority. Mothers-in-law influence diet and rest; husbands influence contraception and spending on care; families decide on early marriage. Durkheim's insight that ritual sustains a collective moral order helps explain why these patterns are so durable: they express shared ideas

about honour, purity and proper female conduct. Changing them requires engaging the community, including religious leaders, older women and men, rather than addressing women as isolated individuals.

The fourth theme is the commercialisation of care. The private clinic and its brokers represent a new kind of authority in the reproductive lives of rural women. Decisions about caesarean section may now be made under pressure from agents and providers with a financial stake in the outcome (Begum et al., 2018). Regulation of private facilities and transparent information for women about the indications for surgery are urgent needs.

13. Conclusion and Recommendations

Women's reproductive healthcare in Jashore is shaped by an interplay of culture, religion, gender and economic constraint, alongside a health system that is better resourced than in many districts but has problems of its own. Neither tradition nor modern care is in itself the solution or the problem. What matters is whether women have accurate information, a real voice in decisions, and access to care that is safe, affordable and respectful.

Several recommendations follow. Menstrual education should begin before menarche, in schools and through mothers, and should be paired with private, clean school toilets. Efforts to reduce child marriage should combine school retention, economic support for families and engagement with religious and community leaders. Community health workers should be supported to provide nutritional counselling that directly addresses local food taboos during pregnancy and after birth. Breastfeeding promotion should explicitly address pre-lacteal feeding and formula marketing. Private clinics should be regulated, caesarean indications should be audited, and broker commissions should be prohibited and enforced. The health and family planning wings should integrate post-abortion and contraceptive services, as Huda et al. (2015) recommended. Programmes in waterlogged areas should prioritise sanitation, mobility and emergency transport for women. Male involvement in contraception and reproductive decision-making deserves sustained attention.

Above all, researchers and policymakers need better evidence from Jashore itself. Ethnographic and mixed-method studies in villages across the district, comparing Muslim, Hindu and Christian households and attending to class and location, would allow the expectations set out in this review to be tested, refined or overturned. Only then will programmes be able to work with the cultural frame through which Jashore's women and families understand their reproductive lives.

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