Internship Report:

Gender-Specific Health Benefits: Empowering Women Through Access to Health Services in the PKSF Enrich Program.

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Declaration

Student's Declaration

I certify that this report does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Student's signature

Supervisor's Declaration

This is to certify that Taiuba Akter Josna as a student of the Department of Anthropology under University of Dhaka has prepared and accomplished her internship report on "Gender-Specific Health Benefits: Empowering Women Through Access to Health Services in the PKSF Enrich Program.**"** for the fulfillment of the requirements of the degree of Bachelor of Social Sciences under my supervision. To the best of my knowledge this is an original report and she has not submitted this report elsewhere for any degree.

Internship Supervisor's signature.

Acronyms

ANC- Antenatal Care

BDHS- Bangladesh Demographic and Health Survey

BNHA- Bangladesh National Health Account

CC- Community clinic

CDIP- Centre for Development Innovation and Practices

ENRICH- Enhancing Resources and Increasing Capacities of Poor Households towards Elimination of their Poverty

FGD- Focus Group Discussion

GoB- Government of Bangladesh

HRMI- Human Richts Measurement Initiative

HSP- Health Support Program

KII- Key Informant Interview

MMR- Maternal Mortality Rate

NGO- Non-Government Organization

OOP- Out of Pocket

PKSF- Palli karma-Sahayak Foundation

PO- Partner Organization

SACMO- Sub Assistant Community Medical Officer

SDG- Sustainable Development Goal

SEARK- South East Asia Region

UHC- Upazila Health Complex

Acknowledgement

First of all, I would like to thank Almighty Allah for giving me the knowledge and power to fulfill my internship report. The journey of the internship has enabled me to explore new cultural patterns and the socioeconomic status of rural women. And how women are being empowered by accessing healthcare services from PKSF (Palli Karma-Sahayak Foundation).

My heartiest gratitude and humble thanks to honorable Additional Managing Director of PKSF Dr. Md. Jashim Uddin for allowing me in this internship. I would like to express my sincere thanks to Mr. Md. Hasan Khaled, Deputy Managing Director of PKSF, and to Mr. Md. Ziauddin Iqbal, Sr. General Manager, PKSF for their cooperations.

I would like to thanks my respective supervisor, Dr. Mohammad Ashraful Alam, Manager (Nutrition and Food) PKSF, for his guidance and constant support. His insights and instruction help me to complete my report and bring this to its current form. Without his constant support, it was impossible to complete the report.

Also, I would like to thanks Mr. Md. Abu Shaem, Deputy Manager of PKSF, Mr. Asfak Mahmud, Deputy Manager of PKSF, their support helped me to complete my internship.

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And mostly I'm grateful to the women of Kasba Upazila, mulgram unions Niamotpur and chandropur, who take part in this study. They were very helpful. In the middle of their working, they give me their valuable time. I'm very thankful to them.

Preface

This research focuses on the gender-specific health benefits and how access to health services in the PKSF (Palli Karma-Sahayak Foundation) Enrich Program empowers women This internship served as a valuable platform to apply theoretical knowledge in a practical setting, enabling me to make a substantial contribution to research. It provided an opportunity to acquire new skills, interact with experienced professionals, and establish a strong professional network. The Palli Karma-Sahayak Foundation (PKSF) granted me a privileged opportunity that profoundly influenced my career path and equipped me with essential skills for successful.

Over the course of three months, from 15 October 2024 to 15 January 2025, my internship at PKSF immersed me in a dedicated work environment. Focused on poverty alleviation through a holistic approach within the ENRICH program, I specifically worked on the "ENRICH Health" component. Title: “Gender-Specific Health Benefits: Empowering Women Through Access to Health Services in the PKSF Enrich Program." My research delved into the implementation progress of ENRICH in Mulgram, a union of Kasba Upazila.

Engaging in on-site research, I collaborated with PKSF's partner organization, CDIP (Centre for Development Innovation and Practices), and conducted interviews with beneficiaries and locals to comprehend the challenges they face and the impact of ENRICH health service on their lives; how accessing ENRICH health services they become empowered in their lives.

This research showed how accessing women in health care services makes them empowered in their social, economic lives. This comprehensive report details my internship journey, the research conducted, and the insight gained from PKSF. I express profound gratitude for this. enriching opportunity, and I am confident that the knowledge and skill acquired will significantly contribute to my future endeavors.

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Chapter 1. Introduction

1.1 Introduction:

The right to health is a fundamental human right. In the constitution of Bangladesh, article 15(a) said to ensure basic necessities of life (including medical care) to its citizens. The World Health Organization constitution defines health broadly as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Bangladesh is one of the most populous countries in the world. It is also one of the developing countries that signed onto achieving the Sustainable Development Goals (SDGs). In the new target of SDG, the issue of maternal and child health is fitting under goal number three. The estimated BNHA total health expenditure per capita increased from US$ 27 in 2012 to US$ 37 in 2015. However, Bangladesh still spends only 3.0% of its GDP on the health sector, while government health expenditure in relation to GDP is only 0.69%, placing Bangladesh among the countries that least spend on health in the South-East Asia Region (SEAR). As of 2021, out-of-pocket expenditure accounted for 73% of total health expenditures, which is highly costly for a country like Bangladesh. (world bank, 2021). Domestic general government health expenditure in 2021 is 9.78%. It is not sufficient for a healthy lifestyle for the people. 46% (almost half) of Bangladesh's overall health spending is toward purchasing medications and medical supplies, with nearly 69.4% of the country's OOP going toward this purpose. Health is a multifaceted concept encompassing not only the absence of illness or disease but also a state of complete physical, mental, and social well-being. The World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Gender: The socially constructed qualities of women, men, girls, and boys. These comprise standards, actions, and functions linked to being a woman, man, girl, or boy, as well as interactions with each other. Gender is a social division, and the norms vary from society to society; they can also change over time. Gender influences people's experience of and access to healthcare. The organization and delivery of health services can either restrict or facilitate a person's access to healthcare information, support, and services, as well as the outcomes of those interactions. The gender-based discrimination and inequality wreak havoc on their health and safety well-being. Compared to men and boys, women and girls generally face higher barriers in reaching health information and services. Gender-specific health interventions are essential for addressing the unique health challenges faced by women, especially in low-resource settings. Women's health is not only a fundamental human right but a critical factor in family and community well-being. In Bangladesh, access to healthcare remains uneven, with rural women facing substantial barriers to receiving the care they need. Women's health is directly or indirectly related to family burden, childbirth, childcare, etc. According to the Human Rights Measurement Initiative, Bangladesh falls into the "bad" category when evaluating the right to reproductive health because the nation is fulfilling only 78.8% of what the nation is expected to achieve based on the resources (income) it has available (HRMI Right Tracker, 2022). The MDG Goal five target was to reduce the maternal mortality rate (MMR) from 574 to 143 deaths per 100,000 live births by 2015 in Bangladesh. There has been a significant downfall in the MMR rates; however, the trajectory is not enough to meet the targets. This progress is linked to fertility reduction, access to qualified maternal health care,

and overall care-seeking during the antenatal period and during delivery (UNDP, 2015). This all factor are essentials for women's overall health condition. If women faced any difficulty during the pregnancy and also after the delivery, it directly affected their everyday life. They cannot do their job. On the other hand, infant mortality is one of the major reasons behind a woman's unstable condition, which makes them suffer. In Bangladesh, according to the medium fertility variant of the United Nations Revision of World Population Prospects 2024, the infant mortality rate of Bangladesh is 16.0873 infant deaths for every 1,000 live births. A -4.6% decrease from 2024, when the infant mortality rate was 16.8636 and 58,495 infants died for the year. It is a highly considerable decrease. Not only when a mother gives birth does she go through some critical stages, but also when the infant dies, she faces a long-term effect. Which damage her mental condition, also causes economic cost.

Bangladesh is one of the most densely populated countries in South Asia. In Bangladesh, health care service is a daunting challenge in Bangladesh's healthcare system. The healthcare system in Bangladesh falls under the control of the Ministry of Health and Family Planning. The government is responsible for building health facilities in urban and rural areas. The health system of Bangladesh has undergone several changes and has developed a comprehensive health infrastructure in both the public and private sectors. While globally each country has some variety in their health care systems, overall they tend to follow four main models forming the basis for most health care systems globally: they are the Beveridge model, the Bismarck model, the National Health Insurance model, and the private model. The health care system in Bangladesh is pluralistic. It has four primary players that play a crucial role in shaping its structure and operation. These actors include the government, private sector, non-governmental organizations (NGOs), and donor agencies. The constitution primarily assigns responsibilities for policy-making, regulation, and the delivery of comprehensive health services to the government, or public sector. This covers the hiring of medical staff as well as the distribution of funding. In Bangladesh, family planning and general health services are administered by the Ministry of Health and Family Welfare. Two Directorates General of Health Services (DGHS) and Family Planning (DGFP) coordinate to accomplish this. Ahmed, Syed Masud (2017). Primary, secondary, and tertiary are the three different tiers or categories of institutions that make up Bangladesh's healthcare system. Community clinics (CCs), Union Health and Family Welfare Centers (UHFWCs), Union Sub-centers, and Upazila Health Complexes (UHCs) are among the several facilities accessible at the first level of healthcare provision. A population of approximately 6,000 people is served by each community center (CC). The ward-level health facilities, which are the lowest-level static establishments in the healthcare system, are referred to as community clinics. These referral connections are made with upazila and union-level health facilities.

PKSF is working to achieve Bangladesh's desire. Palli Karma-Sahayak Foundation (PKSF) is Established in 1990, a non-profit organization in Bangladesh that finances and supports rural development. Its main objective is to help those who are economically disadvantaged find work and reduce poverty. In order to carry out projects like credit extension, consulting services, and capacity building programs, the foundation works with NGOs and community-based groups. In order to guarantee that every citizen can live a life of dignity, the PKSF seeks to eradicate poverty in Bangladesh. To assist people in escaping poverty and moving toward a sustainable future, it provides financial, non-financial, and natural catastrophe management services. "ENRICH," one of

the six core programs offered by the Palli Karma-Sahayak Foundation (PKSF), aims to increase the resources and capabilities of low-income households in order to eradicate poverty. ENRICH (Enhancing Resources and Increasing Capacities of Poor Households towards Elimination of their Poverty) is a flagship program of PKSF. Education, training, food security, nutrition, health, cooking stoves, solar energy, special savings plans, and youth development are some of these programs. Providing inclusive primary healthcare services to households within specific unions is the goal of the ENRICH health component. Monthly visits from health visitors collect health-related information from families, which is then recorded in a health card and input into a computer database. Health assistants manage fieldwork, set up clinics, and administer specialized medical care. Access to hospitals and clinics, both public and private, is made easier via a referral system. In order to refer patients with serious illnesses to low-cost public and private clinics, ENRICH regularly hosts health camps. During a treating initiative, in which enrolled homes receive free drugs.

Empowerment in women's lives is so important. Because for a long time, women have been the victims of social inequality, gender discrimination, cultural taboo, etc., and so many. Almost everywhere in rural areas in Bangladesh women face cultural taboos, economic inequalities, and social barriers. According to Worldometer, the current population of Bangladesh is 174,626,878, where 42.6% of the population live in urban areas and the rest of them live in rural areas. A great number of the rural women have a lack of awareness, less education, unhealthy lifestyles, a lack of access to health care services, etc. Because of all of those factors, women's lives are more vulnerable. Any country needs a strong, skilled, and aware human resource for its best economic structure. If we can make our women more empowered, we can make our nation proud. PKSF's Enrich program is directly helping women to be empowered by accessing them in health care services. lack of access to primary healthcare, lack of awareness, financial crisis, etc., and many more causes are responsible for poor health and various non-communicable diseases. These have an impact on a person's whole life, from early childhood to their working years to old age. When combined, they cause low productivity, early mortality, and higher health care costs, which put extremely poor households in a permanent financial bind. PKSF targeted this sector and made a remarkable change in the lifecycle of women. By the help of Enrich project women become more empowered in their everyday life.

1.2 PKSF:

The Government of Bangladesh established the PKSF in 1990 with the intention of actively contributing to the reduction, elimination, and general development of the country. Headquarter is located at PKSF Bhaban, plot E-4/B, Agargoan Administrative area, Sher-e-Bangla Nagar, Dhaka-1207. The organization in question is a microfinance development firm that mostly works with non-governmental organizations (NGOs) to support the expansion and development of microfinance institutions in Bangladesh. To improve the functioning of its partner organizations, the organization provides financial services, capacity building support, technical assistance, and other pertinent services. PKSF provides loanable funds to its Partner Organizations (POs). Currently funds are being provided under its four mainstream credit programs those are Buniad, Jagoron, Agrosor and Sufolon. Besides the mainstream programs, PKSF has been implementing different projects in order to address the diversified needs of the people of the community. According to the annual report of PKSF 2024, The organized members at the grassroots are the life force of PKSF's operations. As of June 2024, the aggregated number of members organized through all the Partner Organizations of PKSF stands at 20.0 million, 92.0% of whom are women. At the same time, the number of borrowers is 15.20 million. Of them, 14.10 million are women (92.76%) and it has more than two hundred Pos. Over time, scholars have critically examined the impact of micro-credit on poverty alleviation. Various research like Lamia Karim, have indicated that only providing access to micro-credit is insufficient in establishing a sustainable means of escaping poverty. In her "Microfinance and Its Discontents: Women in Debt in Bangladesh," published in 2011, offers a detailed critique of microfinance operations in Bangladesh.

Figure 1: The Headquarter of PKSF

In the year 2010, the Palli Karma-Sahayak Foundation (PKSF) underwent a significant transformation in its organizational objective, shifting from a focus solely on economic independence to a broader goal of promoting human dignity. As a result of this, the organization was motivated to launch several programs aimed at accomplishing this objective, thereby establishing itself as a pioneer in comprehensive development endeavors in Bangladesh.

1.3 Vision and Mission of PKSF:

All the important ancillary processes involved are essential for sustainable poverty alleviation and subsequent socio-economic progress because Human life is multidimensional; so is poverty. The motto of PKSF is sustainable poverty reduction through employment generation. It also works towards improving the livelihoods of the deprived people by providing them access to microcredit, capacity building, and other interventions at the grassroots level. The vision of PKSF is "A Bangladesh where poverty has been eradicated; the ruling development and governance paradigm is inclusive, people-centered, equitable and sustainable; and all citizens live healthy, appropriately educated and empowered and humanly dignified life."

The major objectives of PKSF are:

1. The PKSF is committed to providing a variety of financial means and aid to various non-government, semi-government, government organizations, voluntary agencies and groups, societies, and local government bodies. To generate income opportunities for economically disadvantaged individuals in our society.

2.To boost the institutional capacity of POs so they can effectively manage their program for sustainable paper.

3.Devoted to establishing, encouraging, and identifying secure employment opportunities for the extremely poor, small farmers, and micro-entrepreneurs. Moreover, PKSF provides them with assistance such as education services that will help enhance their capacity while also offering health support and risk reduction training.

1.4 Funding of PKSF:

According to the PKSF goal, PKSF management is authorized to receive funding from a variety of sources, including the capital markets, foreign governments, private individuals and organizations, the Government of Bangladesh (GOB), and international donors and lending agencies. So far, PKSF has received funding from the Asian Development Bank (ADB), USAID, DA/World Bank, and International Fund for Agricultural Development (IFAD).

1.5 Programs and Projects of PKSF:

There are some current programs:

1.Jagoron

2.Sufolon

3.Agrosor

4.Buniad

5.ENRICH

6.ABHASON

7.Cultural and Sports Program

8.Integrated Agriculture Unit

9.Kuwait Goodwill Fund (KGF) Program

10.Uplifting the Quality of the Lives of the Elderly People

11.Program for Adolescents

12.Livelihood Restoration Loan (LRL)

The current Project:

1.Sustainable Enterprise Project (SEP)

2.Bangladesh Rural Water, Sanitation and Hygiene for Human Capital Development Project

3.Extended Community Climate Change Project-Flood (ECCCP-Flood)

4.Low Income Community Housing Support Project (LICHSP)

5.Promoting Agricultural Commercialization and Enterprises (PACE)

6.Pathways to Prosperity for Extremely Poor People (PPEPP) Project

7.Skills for Employment Investment Program (SEIP)

1.6 ENRICH Program:

As a “Not for profit” organization, Palli Karma-Sahayak Foundation (PKSF) started its journey in 1990 with the mission of poverty alleviation and sustainable development through employment. There was popular prevailing thought in the country that poverty alleviation was possible only through microcredit. In that context, PKSF through its affiliates (mainly NGOs) continued to function as a financing institution providing only micro-credit to the poor population and conducting some technical-assistance and training programs in the field, i.e. basically an ancillary fund for providing micro-credit. But only providing micro credit is not enough for the poor, along with they need nutrition, awareness, skill development training, structure education, etc. Also need-based financing is an important component of this integrated program.

Figure 2: The Components of ENRICH Program

ENRICH was initiated by the former Chairman of PKSF Dr. Qazi Kholiquzzaman Ahmad in 2010, targeting the poor families at the grass roots level, overall poverty alleviation is aimed at "Enhancing Resources and Increasing Capacities of Poor Households”. Adopts an integrated program titled Towards Elimination of their Poverty (ENRICH). The main objective of this program is to empower the participating families with necessary advice and assistance, taking into account their current resources and capabilities, so that they can first ensure maximum utilization of their resources and capabilities and gradually increase their resources and capabilities to break out of poverty on a sustainable basis. Socio-economically, everyone can be established in human dignity. The main concept of human-centered development as laid down in the current government's Vision-2021 is reflected in this program.

From the initial days to date, the core objective of ENRICH is a multidimensional approach to poverty reduction. Since then, ENRICH has provided access to education, health, and nutrition,

social security, housing, and other basic amenities. ENRICH aims to facilitate the best utilization of the existing capabilities and resources of poor households and to help enhance both their capabilities and resources to enable them to come out of poverty and move ahead towards a life of human dignity. Health is one of the 29components of ENRICH. It aims to enhance the health of underprivileged households and communities, with a focus on women, men, children, and the elderly. Family planning and reproductive health, maternal care services, child health care services, noncommunicable disease (NCD) preventive programs, and so forth are the main pillars of ENRICH health and nutrition.

Health and Nutrition Programs various steps of PKSF:

Figure 3: health and Nutrition programs various steps.

The ENRICH health component has been designed to offer comprehensive primary healthcare services to all households within the specified union. Each month, a health visitor calls on each household to obtain related health information about its members. And assigned health officer supervises what is collected and recorded on the family's Health Card and computer database for accuracy and precision. Every day, the health officer in a comfortable place hosts static clinics to look after patients referred by their health visitors.

For those requiring further treatment, they are encouraged to attend one of the satellite clinics located across each ward on a weekly basis where MBBS doctors will be available for consultation. ENRICH also collaborate with numerous public and private hospitals and clinics should any patient require specialized medical services at discounted rates-or even free of charge if they have limited financial means. Currently,375 health officers and 2,650health visitors are providing healthcare services to around 60.30 lakh people of 13.36 lakh households in all 198 ENRICH Unions under the 'Healthcare and Nutrition' component of ENRICH.

1.7 Internship Description:

As a holistic study, Anthropology helps us explore and appreciate the vast diversity of human cultures, traditions, and beliefs. Now-a-days, everywhere anthropological knowledge are needed.

Primary aim the internship was to offer practical experience in the realm of anthropology, cultivating a deeper grasp of research concepts and their real-world applications. The focus was on applying theoretical knowledge into practical skills and refining analytical capabilities. Over the course of the 12-week internship at PKSF, interns underwent training for field visits and actively participated in the activities of PKSF's ENRICH Health program. Through collaboration with project staff, researchers, healthcare professionals, and partner organizations, I gained valuable insights. This report outlines the objectives, activities, and findings of the study conducted during the internship, providing an analytical overview of my learning experiences.The core of my work centered around "Gender-Specific Health Benefits: Empowering Women Through Access to Health Services in the PKSF Enrich Program". Specifically, it explores how maternal health care and the services empower women within the ENRICH union of Mulgram, Kasba Upazila.

1.8 CDIP – Partner Organization:

Centre for Development Innovation and Practices (CDIP), establish in 1995 inaugurated its development and innovative initiatives from Kuti, a remote village under Brahmanbaria district., is a Non-Governmental Organization. CDIP is one of partnership organization of PKSF among 114 organizations. According to CDIP, Its vision was to be a trend setter for innovation and change for sustainable human development by economically empowering women. Starting with the provision of credit facilities, CDIP has expanded its primary program to include other social services, including health and education assistance programs for rural children, as well as social commodities to raise the standard of living for the impoverished masses.

CDIP Health Support Program (HSP) started its journey in 2013 with two branches to the members of the society at village level. The Health Support Program provides:

- Outpatient care
- Primary healthcare
- Faily planning service
- Other preventive healthcare services to the mess people at rural level.

The object of the program is to improve maternal, neonatal and child health as well as reduce vulnerability to non- communicable disease and common ailments.

CDIP health program coverage:

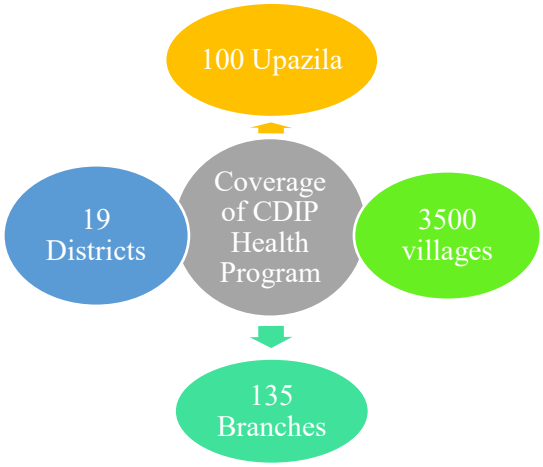


Figure 4: Coverage of CDIP Health Program.

In 2023- 24 they serve total 2,79,160 families, 2,93,607 patients which is a huge amount. In their health services they provide 3 registered doctors. According to BNHA- 2020, 60% people take informal services; 16% do not go to hospital or doctor Even when needed.

CDIP Doctor service:

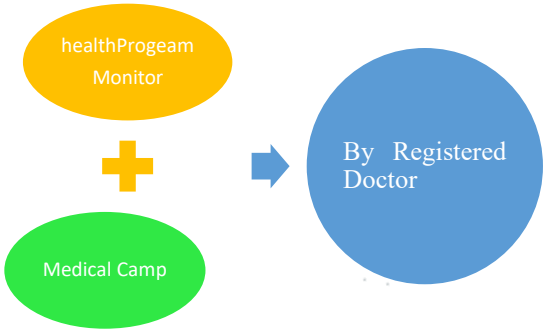


Figure 5: Doctor services.

They also provide 138 registered SACMOs (Sub Assistant Community Medical Officer) and 215 health volunteers. Also 2 skilled Optometrists.

Health services of CDIP:

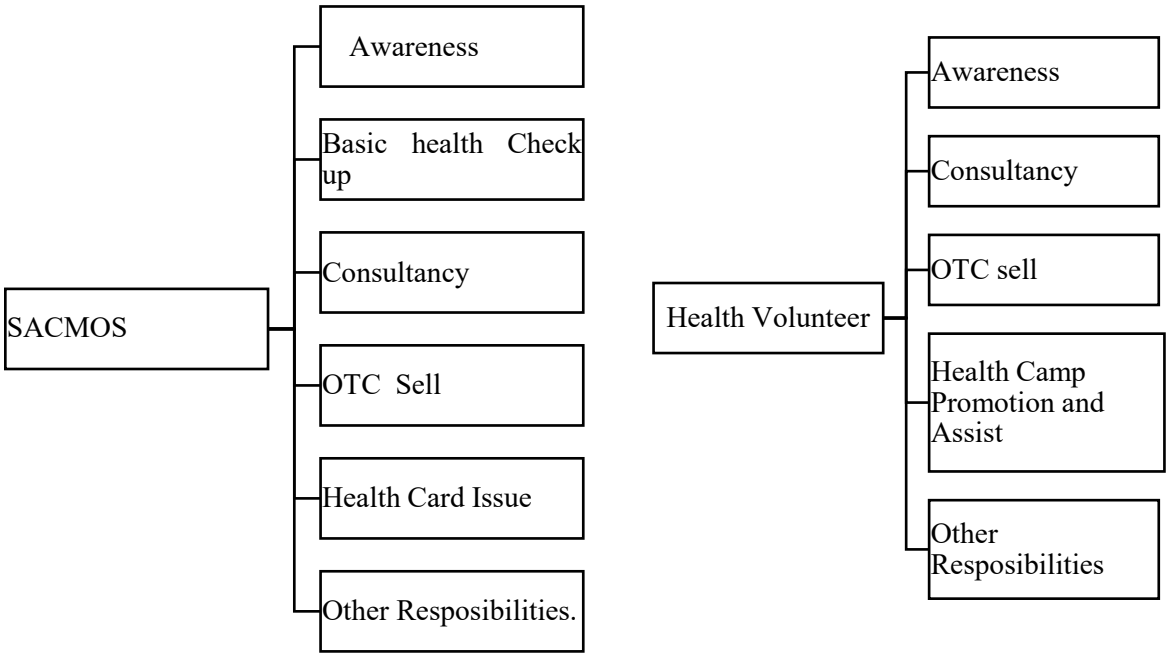


Figure 6: Health services of CDIP.

According to CDIP, “Since July 2019, CDIP has been working with international eye health organization (Orbis International) to integrate primary eye care into the HSP to increase access and ensure universal eye health coverage including vision center operation in Bangladesh by paying special attention to remote communities.”

Chapter 2: Literature Rivew

2.1 Literature Review

2.2 Study Area

2.3 Significance of The Study

Chapter 2

This chapter will discuss about the literature reviews, study area and the significance of the study. Literature review is a core part of any study. It reviles new ideas and knowledge for the study. And choosing study site is a major part of any research, there is no site is statics and bounded anymore. And finally, this chapter will discuss about the significance of the study.

2.1 Literature Review:

Gender and Health in Bangladesh:

Globally, women face unique health challenges influenced by gendered social norms, economic inequalities, and structural barriers. In Bangladesh, these issues are compounded by a patriarchal society where women's health needs are often deprioritized due to financial dependency, restricted mobility, and limited access to information (Ahmed et al., 2021). Anthropological studies reveal that health-seeking behaviors are deeply embedded in cultural practices, with many women relying on informal networks, traditional healers, or delaying care until health issues become critical (Rashid et al., 2011). Additionally, maternal health remains a critical concern, with high rates of maternal mortality and limited access to reproductive healthcare. Bangladesh has made strides in addressing these issues through community-based health interventions, yet gender disparities persist in areas such as nutrition, mental health, and non-communicable diseases. Cultural norms often perpetuate health inequities by prioritizing male health over female health, especially in resource-constrained settings. Anthropologists have examined how traditional gender roles limit women's access to health services.

In Bangladesh, most of the rural women practice traditional gender roles. Women are considered less important than men. As men can contribute to fulfilling economic demand, they have a privilege position over women in society. In feminist anthropological tradition, most of the feminist anthropologists argue that gender is socially constructed, which provides a social lens of man and woman differences. While sex means the biological difference. In Michelle Rosaldo's Women, Culture, and Society (Rosaldo and Lamphere 1974), she proposed that "an opposition between 'domestic' and 'public' provides the basis of a structural framework necessary to identify and explore the place of male and female in psychological, cultural, social, and economic aspects of human life" (1974:23). This tried to find how a universal framework for conceptualizing the activities of the sexes creates gender-specific barriers in their lives.

The PKSF (Palli Karma-Sahayak Foundation) Enrich Program aims to improve livelihoods by providing integrated services, including healthcare, education, and skill development. A

cornerstone of the program is its focus on preventive and curative health services, emphasizing maternal and child health, nutrition, and disease prevention (PKSF, 2020). The program explicitly seeks to empower women by enhancing their access to health services and information.

Cultural Barriers and Gender Norms in Health Access:

Anthropological research emphasizes the importance of cultural context in shaping health interventions. In rural Bangladesh, where traditional gender roles are entrenched, women's health often depends on male gatekeepers such as husbands or fathers-in-law, who control household finances and decisions (Hossen & Westhues, 2011). This dynamic restricts women's ability to seek timely care, particularly for reproductive health or non-urgent issues.

Cultural norms around modesty and stigma further limit women's access to healthcare. For example, many women avoid male healthcare providers due to societal expectations of seclusion (purdah). Addressing these barriers requires community-sensitive strategies, including female healthcare workers, community outreach, and education campaigns that challenge harmful norms. Researchers, policymakers, and practitioners acknowledge that women's health and experiences are influenced not only by sex and gender but also by various factors including race, class, culture, income, education, age, ability, sexual orientation, immigration status, ethnicity, indigeneity, and geography. The intersection of gender, ethnicity, and class often exacerbates health inequities. Marginalized women face compounded barriers, including discrimination in healthcare settings. Many rural Bangladeshi women are marginalized not only for their low education, poor income, and class difference but also for their disability, cultural differences, indigeneity, etc.

Farmer (2003) describes how "structural violence," embedded social inequalities, limits marginalized populations' access to healthcare, especially women. That "different dimensions of social life cannot be separated into discrete or pure strands" is one of the fundamental tenets of intersectionality (Brah & Phoenix, 2004, p. 76). People's subjective, cultural, political, economic, and experience lives all come together to form a whole that is more than the sum of its parts.

Anthropology offers valuable insights for designing and evaluating health programs. By understanding local belief systems, power dynamics, and cultural practices, anthropologists can help tailor interventions that are both effective and culturally sensitive. For example, Rashid et al. (2011) argue for engaging traditional healers and local leaders as allies in promoting biomedical health practices. Participatory research methods, such as focus groups and ethnographic studies, can also inform program designs that resonate with community needs and values. Additionally, intersectional approaches are critical, recognizing how gender intersects with class, ethnicity, and geography to shape health outcomes.

The Palli Karma-Sahayak Foundation (PKSF) Enrich Program offers an integrated model that combines health services with education, nutrition, and economic development. By targeting rural and marginalized communities, the program seeks to address both immediate and structural determinants of health disparities. Key components of the program include mobile clinics,

maternal health support, health education sessions, and nutritional supplements for women and children (PKSF, 2020). Anthropologically, the program's approach aligns with participatory development principles, fostering community ownership and engagement. By embedding health services within broader livelihood initiatives, the program enhances women's agency, enabling them to access resources without fear of social reprisal or economic burden.

The Role of Reproductive Health Services in Gender Empowerment

Bangladesh is among the most densely populated countries in the world. Its population is the world's eighth largest and among the poorest in South Asia. 42.0% of the population is urban, while the rest of the population is rural. The foundation of gender-specific health empowerment is reproductive health services. Anthropologists have examined how family planning programs have changed the lives of women in nations like Bangladesh. According to Schultz and Schultz (2001), there is a direct correlation between lower fertility rates and better socioeconomic outcomes for women. With an average of six children per woman, Bangladesh had one of the highest fertility rates in the world in the 1970s. Social conventions prioritized early marriage and high childbearing as cultural aspirations, and women's health services were scarce. Nonetheless, a national drive for family planning and reproductive health services was spurred by demographic pressures, economic difficulties, and international health initiatives (Kabeer, 1994).

From an anthropological standpoint, these initiatives represented societal changes rather than only health treatments. Women were the main change agents in early family planning initiatives, including the door-to-door distribution of contraception. By enabling women to make choices regarding their reproductive life, especially in homes where men predominate, this focus questioned established gender roles. Access to contraceptives and reproductive health education has enabled women to control their fertility, reducing the burden of frequent and early pregnancies. Studies have shown that women who have access to these services are more likely to participate in decision-making within their families. This autonomy extends beyond reproductive choices to areas such as education and employment (Schuler et al., 1997). Also, Bangladesh has achieved significant reductions in maternal mortality, decreasing from 574 per 100,000 live births in 1990 to 173 in 2020 (World Bank, 2020), which shows a great t difference. This progress is attributed to investments in different sectors such as antenatal care, skilled birth attendance, and emergency obstetric services. Anthropologists note that these services empower women by reducing health risks, enabling them to contribute more effectively to their families and communities.

Empowerment Through Health Access:

Health access is increasingly recognized as a critical pathway to empowerment, particularly for marginalized populations. The relationship between health and empowerment is multidimensional, spanning physical, social, economic, and psychological domains. The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, and achieving this requires addressing structural inequities such as poverty, gender discrimination, and systemic exclusion (WHO, 2022).

Community-based health programs often succeed where top-down interventions fail because they integrate local knowledge and practices. One widely cited example is the *Barefoot Doctors* program in China during the 1960s and 1970s, where female practitioners were trained to provide basic healthcare in rural areas. Anthropologists studying this model highlight how empowering local women as healthcare providers creates a ripple effect, improving health literacy and access in their communities. Similarly, this study will focus on some conditional incentives, like maternal health checkups through "Uthan Boithok," which is provided by PKSF's Enrich program. How does this community-centered approach create access to health empowerment for women?

Access to quality health services can be transformative, improving women's autonomy and decision-making capacity within households and communities. Empowerment is not just about health outcomes but also about the process of enabling women to make informed choices about their well-being. Studies have shown that when women gain control over their health decisions, they experience greater social respect, economic participation, and political involvement (Schuler et al., 2015). Programs integrating health services with financial literacy, education, and skill building—such as the PKSF Enrich Program—show promise in advancing these goals. Such initiatives go beyond addressing immediate health needs, offering platforms for long-term social change by fostering confidence and independence among women.

2.2 Study Area:

Kasba is located in Brahmanbaria District. It has a total area of 209.77 km² (80.99 sq mi). It is bounded by Brahmanbaria Sador upazilas on the north, Brahmanpara upazila on the south, Akhaura and Tripura state of India on the east, and Nabinagar and Muradnagar upazilas on the west. Kasba upazila is divided into Kosba municipality and ten union parishads. Kasba upazila has 5532 households.

The geographical location of Kasba Upazila is below there:

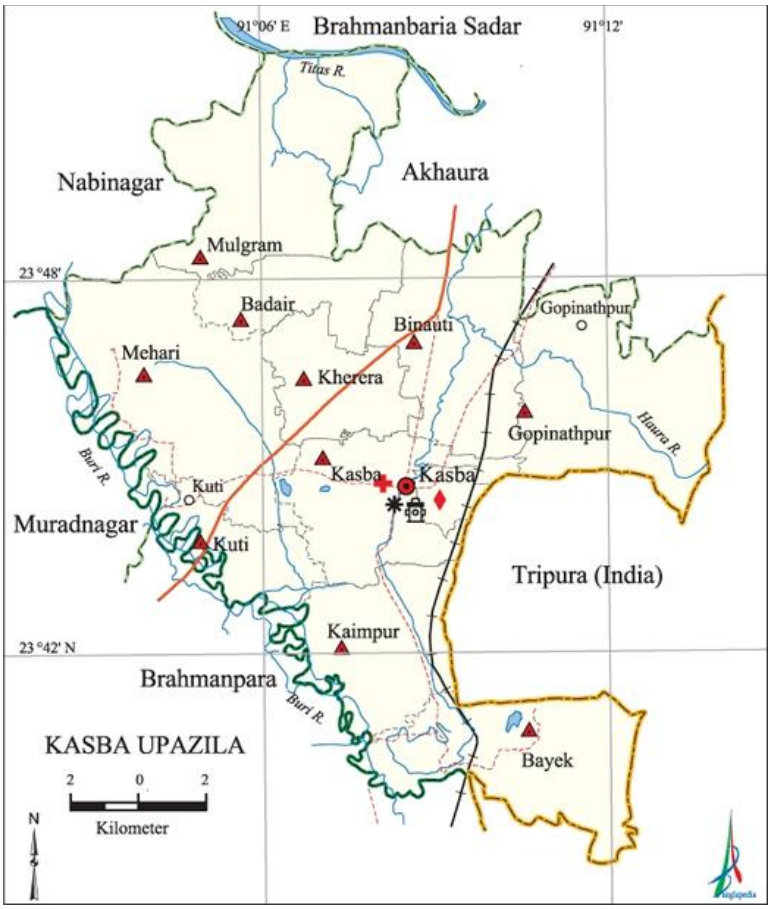


Figure 7: Geographical location of kasba upazila

Among the ten union parishads, this study focuses on Mulgram union, where the PKSF Enrich program is conducted. The No. 01 Mulgram Union is located in the southern West region of Kasba Upzela in the Brahmanbaria district. This union has 17 villages. To the west of this union is Kaitala South Union and Newer Subzela. The union is in the southwest of the Mehari Union, and in the south is the Badair Union. This study was conducted in two villages named Niamotpur and Chandrapur.

And a close location of Mulgram Union is there:

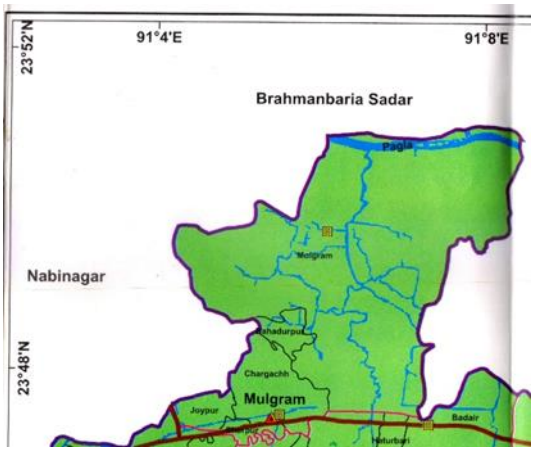


Figure 8: Mulgram union.

2.3 Significance of The Study:

Women in rural and low-resource settings often face unique barriers to accessing healthcare, including cultural norms, financial dependence, and lack of decision-making power. By exploring gender-specific health interventions within the PKSF Enrich Program, this research will highlight ways to reduce these inequalities, ensuring that healthcare services are equitable and inclusive. Health is central to women's ability to lead fulfilling lives, participate in the workforce, and care for their families. This research will provide evidence on how access to healthcare through PKSF Enrich improves physical and mental health outcomes for women, enabling them to break cycles of poverty and dependence. Improved health not only enhances a woman's quality of life but also strengthens her capacity to engage in education, work, and community activities. By examining the link between health services and empowerment, this research will contribute to understanding how health programs can foster self-reliance, confidence, and leadership among women. Also, the research aligns with key Sustainable Development Goals, particularly: SDG 3 (Good Health and Wellbeing): By improving health outcomes for women, SDG 5 (Gender Equality): By empowering women through equitable access to healthcare, SDG 10 (Reduced Inequalities) By addressing gender-based disparities in health services.

Chapter 3. Methodological Consideration

3.1 Choosing the Study Site

3.2 Research Question

3.3 Research Objective

3.4 Sampling

3.5 Sources of Data

3.6 Technique of Data Collection

3.7 Techniques of Data Analysis

3.8 Research Ethics

Chapter 3. Methodological Consideration

Any research demands a careful and nuanced approach to methodology, given the multifaceted and interdisciplinary nature of the subject. This chapter discuss the methodological considerations addressing choosing the study site, research question, research objective, sampling, sources of data, technique of data collection, techniques of data analysis, research ethics, etc. To conduct valid research, methodological consideration is very important.

3.1 Choosing the Study Site:

The first thing to deal with in this study methodology is to define the study site. Anthropologists don't see anthropological sites as bounded and static places anymore. The dynamism of any place and its temporality are considered to define an anthropological site. This study tried to understand the cultural process that has been in action in the society that creates value for certain behaviors and practices. Gender-specific health benefits are very important subjects for this modern world. Significantly, a lot of women face a great number of diseases, immature death, inequality in health care, difficulties in pregnancy, malnutrition, difficulties after pregnancy, etc., and many more. All the factors cause women to have a great number of absences at work. According to the World Bank (2019), malnutrition leads to more than a 10% potential reduction in lifetime earnings for each malnourished individual. PKSF has played an important role in achieving various SDG indicators, including reducing maternal and child mortality. At the national level, the neonatal mortality rate is 17 per thousand, which is highly responsible for women's vulnerable situation. And the maternal mortality ratio in childbirth is 156; the death rate in rich areas is 101 (SDG target-70). This study tried to find the narratives of how women in rural areas are empowered by the help of the ENRICH program of PKSF.

3.2 Research Question

How the whole process of gender-specific health care concern takes place in Bangladeshi rural women's lives?

- How does gender-specific health in a rural area constructed and influenced by social and cultural patterns?
- How does socioeconomic structure create barriers specifically for women in accessing healthcare services?
- How are women empowered through access to health services by the PKSF Enrich Program?

3.3 Research Objective:

The primary objective of the "Gender-Specific Health Benefits: Empowering Women Through Access to Health Services" initiative within the PKSF Enrich Program is to enhance the health and well-being of women in Bangladesh by ensuring equitable access to comprehensive, gender-sensitive health services. This objective will be achieved through the following specific aims:

- To examine the impact of the Enrich Program on women's maternal and reproductive health outcomes.
- To explore the relationship between improved health outcomes and women's economic empowerment.
- To assess the role of gender-sensitive healthcare services in reducing health disparities and increasing women's participation in decision-making processes within their households and communities.

3.4 Sampling:

Sampling is an important initial step for fieldwork. As the study was qualitative and more importance was given to the subjective opinion of women about health care, development, and empowerment, this study used a non-probability technique named purposive sampling in the fieldwork. The sole purpose of the study was to investigate the women's empowerment through the accessing of the health care services by the Enrich program of PKSF. A total of 29 informants have been interviewed; of them, everyone was married women. The informant was taken from two areas name Niamotpur and Chandropur.

3.5 Sources of Data:

To conduct this research, two types of data sources have been used, secondary and primary data. Secondary data are extracted from relevant journal articles, books, the health status of the Bangladesh government, and various official documents. This study has used that secondary source to plan for the pre-fieldwork stage of this research. This study also has used data from secondary sources to analyze the data extracted from the fieldwork.

Primary data was taken from fieldwork in the two villages of Mulgram Union in Kasba Upazilla, Brahmanbaria District. This study has used convenient techniques to gather the necessary data for this research.

3.6 Technique of Data Collection:

The techniques that used in the research are being discussed here. Giving a brief description of these techniques and further elaboration of the functionality of these techniques in the research process.

Observation Technique

To conduct the fieldwork for this study, the opportunity to conduct a full-fledged ethnography was limited. Rather, this study used the observation method to fill this gap. Observation techniques are a key to qualitative research, as they create a general understanding of the researchers in their field.

Due to CDIP's program having ended five months ago in the study area, this study did not have the opportunity to participate in any enriched health service program. But those who take services from the ENRICH Program, this study observed their lifestyle activities, socio-economic status, and cultural beliefs. It was harvesting time, so the fieldwork was conducted in the field for a certain time. This study was also done during their work. This study tried to understand the symbolic process that has been in action in the village. This study has used observation techniques in the village to study the concept of health care and to realize the cultural patterns and social influences on them. This study also observed the ways women were empowered by the help of the Enrich program.

Interview

This study used the semi-structured interview to collect data from the participant. Through the interview, this study tried to unveil the socio-economic status, health concept of the participant, how Enrich health service makes them empowered, etc. Enrich health care service field volunteer was my key informant. They make the interview easier.

A total of 29 informants have been interviewed during fieldwork; they all are married women, and all of them have children. 12 hours of interviews were tape-recorded in the fieldwork and were transcribed later after the fieldwork. All of the interviews were approximately 24-30 minutes long.

Focus Group Discussion

Focus group discussion (FGD) is an important element for conducting cross-check data. This study conducted an FGD where almost all the participants were married women in the 18-50 age group. And there were 3 participants who were more than 50 years old. During the FGD, this study also observes their opinion.

Case Study

This study has used the case study method during the time of taking interviews. This method helps to get the subjective and real-life experiences of the informants about the issues intended to be encountered in this research. Case study methods help me to deepen the understanding of data that

this study has gathered during the interviews and observations. Through it, this study has come to know how women in their life become empowered through accessing health care services.

Reflexive Method

During fieldwork, this study positioned itself as a researcher in the field**.** I tried to avoid my direct interaction in the field; rather, I observed their dynamics. Doing fieldwork with rural working women was challenging. First of all, I had to conduct my fieldwork in a culture where I am indirectly a native (Grandfather's House). I completed my primary level education in Kasba.

Anthropologists use reflexive approaches to understand how the researcher's self, background, and social position are latent in the research and writing process (Emerson et al., 2011). I used a reflexive approach in this research to position myself in the research context and analyze how my experience is influencing my research. To do this, I have managed field notes and reflexive notes during my fieldwork.

3.7 Techniques of Data Analysis:

While analyzing data, this study coded different perspectives on "health care" and tried to portray the consensus and the contrasting views of different persons. Then it tried to understand whether any cultural or social belief or economic status is responsible for those consensus or contrasting views. To study relevant phenomena with the study, it has compared the secondary data and primary data for synthesizing existing literature with the data collected from the fieldwork. After the fieldwork, it has transcribed all of the interviews. Then it coded data from interviews and field notes by using a thematic approach. This technique helps to answer different questions that it has posed in the pre-research plan.

3.8 Research Ethics:

Ethics is an important step in conducting research. In this research, the study has used standard anthropological ethical guidelines. It has informed every informant of the research about the research topic and intentions. Consent has been taken during recording interviews. It has delivered a consent form to every one of my informants and asked them to fill it out. To maintain privacy, it has used pseudonyms for my informants to ensure that their identity and personal information won't be published anywhere. It has used pseudonyms of the informants to make sure that the anonymity and confidentiality of the informants are maintained throughout the research**.**

Chapter 4: Findings And Discussion

4.1 Assessing the Impact of the Enrich Program on Maternal and Reproductive Health

4.2 Exploring the Nexus Between Health Outcomes and Women's Empowerment

Chapter 4: Findings And Discussion

This chapter presents the findings of the research and provides a comprehensive discussion to interpret and contextualize the results. The findings are organized based on the themes that emerged from the data analysis, addressing the key research questions and objectives outlined earlier in this study.

4.1 Demographic Data analysis:

1. Age:

In the study, the age of women has been taken are:

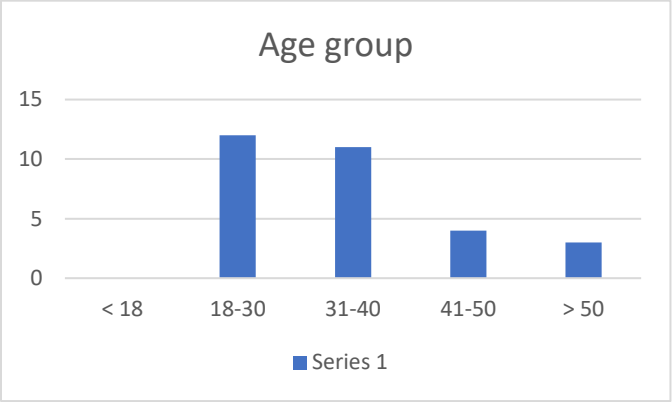


Figure 9: Age of the participants

There were no mothers less than 18 in the participants. 12 mothers are 18-30 years old, and 11 were 31-40 years old. and there were 3 informants more than 50 years old.

2. Education:

Napoleon Bonaparte's popular quote is, "Give me an educated mother, and I shall promise you the birth of a civilized, educated nation." Basic education is important for everyone. An educated mother can maintain a proper lifestyle during and after pregnancy.

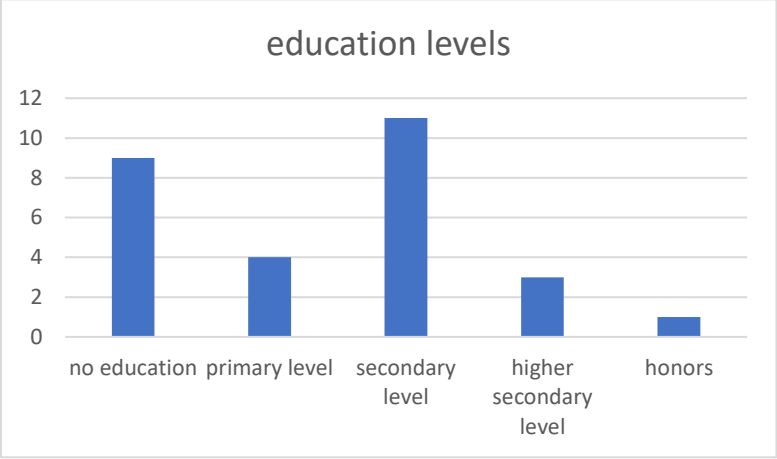


Figure 10: Education levels of participants

In the study, the education levels scenario is not satisfactory; there was only one participant who completed her honors and MA. Most of them just reach the secondary level.

3 Husband occupation:

In rural areas, most of the women are dependent on their husbands. So, a husband's occupation is important to measuring their accessing health care service.

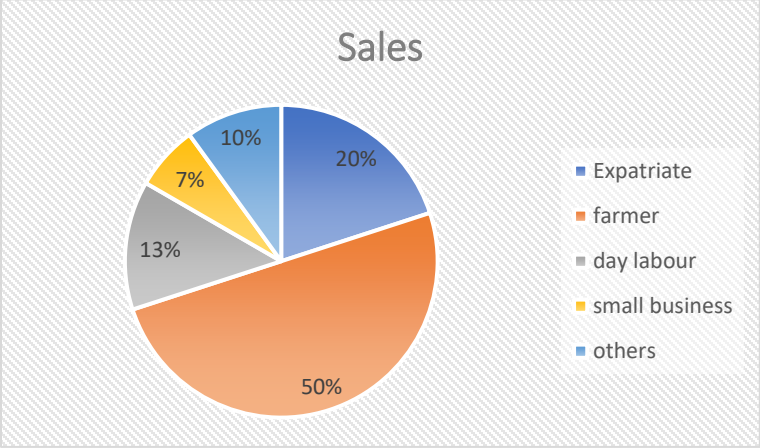


Figure 11: Husband occupation

This pie chart shows that 50% of the participant's husbands are farmers. Some of them work; others land as an employee too. Of them, 20% of husbands are expatriates, and they are more likely to access health services. Only 7% of participants husbands run small businesses.

4 Number of children:

In this study all of the participants have children. Most of them have more than one baby.

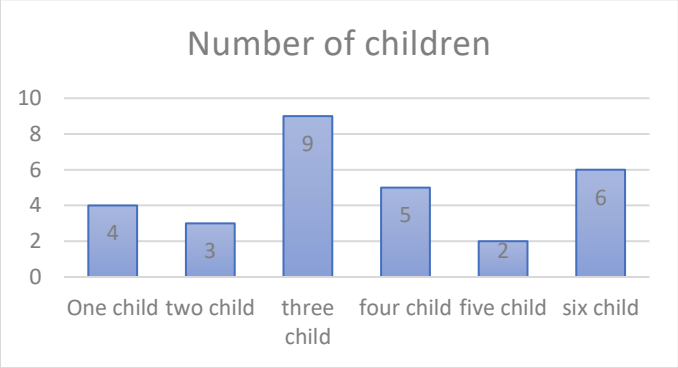


Figure 12: Number of children.

The figure shows that there is no participant without any child. 10% of participants have 2 children. Out of 29 participants, 31% have 3 children.

5. Antenatal care place:

In Enrich area, ANC is given by health visitor, static clinic and satellite clinic.

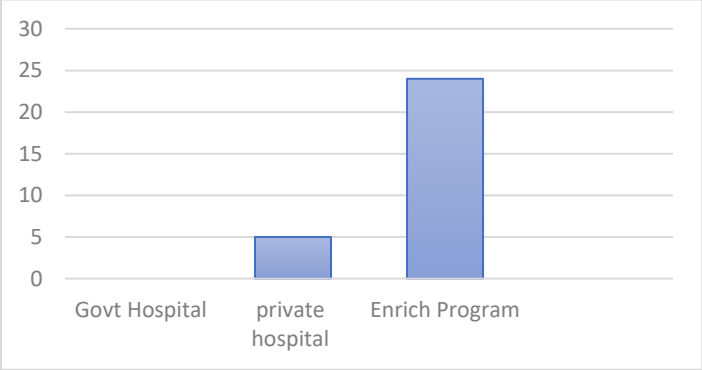
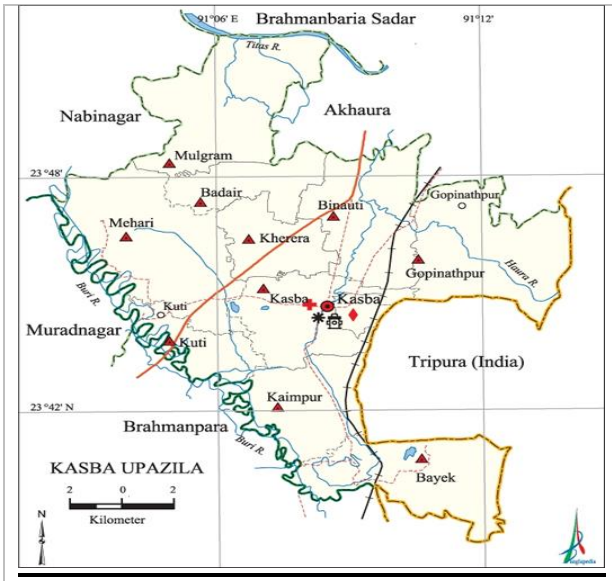


Figure 13: Antenatal taken place

This figure shows that out of 29 participants, 24 of them take antenatal from the Enrich Program. The rest of them were taken from a private hospital in their 1st pregnancy. But in their 2nd or 3rd pregnancy, they were taken from the Enrich program.

At a glance, Kasba Upazila and the public healthcare services at the local level in Kasba Upazila, Bangladesh.

Kasba upazila:



Kasba Upazil at a Glance

Population: 3,19,221

Sex ratio: 91

Density per sq.km: 1521

No. of. Household: 60,919

no. of city corporation: 01

No. of. Union: 10

No. of. Word: 90

No. of. Villages: 237

Mauza: 152

Figure 14: map of Kasba upazila, Brahmanbaria. Source: Bangladesh national portal.

The public healthcare services at the local level of Kasba Upazila:

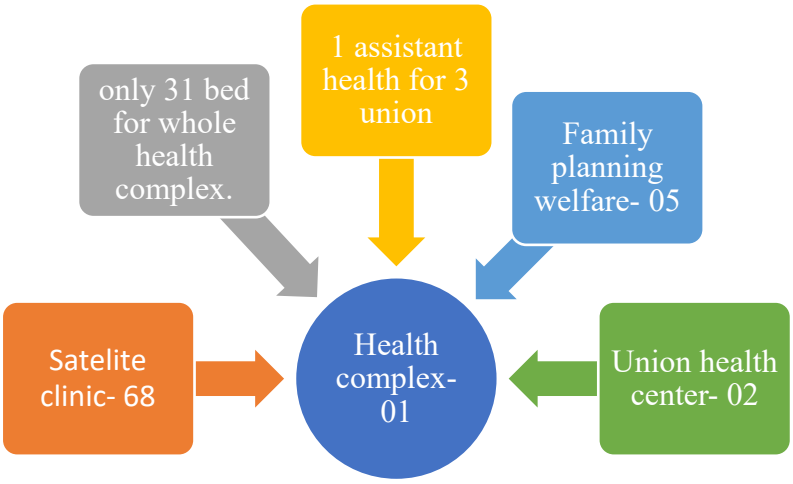


Figure 15: Public Healthcare services at the local level in Kasba upazila.

In comparison to the population, the governmental healthcare services are very limited. And the most important thing in this upazila is that it only has 105 km of paved road where 225 are dirt roads. Firstly, the participants do not go to the government hospital because of a lack of sufficiency in the services. And secondly, for the condition of the road and distance. PKSF's (Palli Karma-

Sahayak Foundation) partner organization CDIP (Centre for Development Innovation and Practices) provide a great support at the local health care services.

By the help of PKSF ENRICH Program, CDIP in their health service provide:

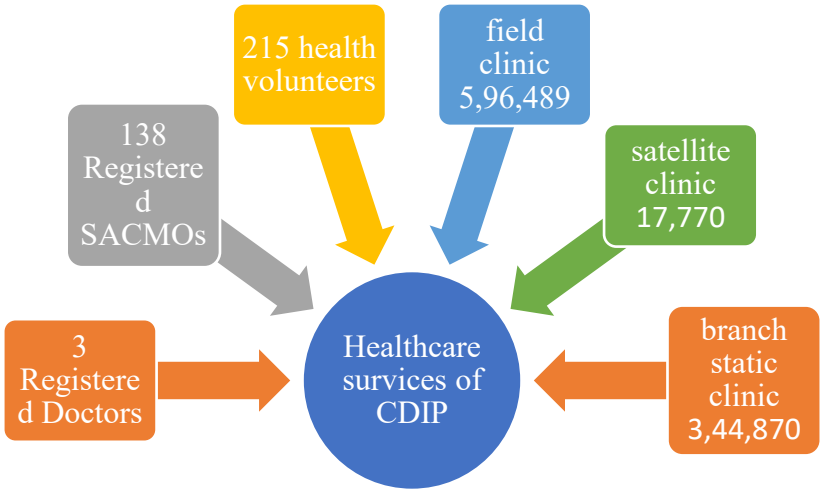


Figure 16: health program of CDIP. Source: CDIP web side.

CDIP in their MIS (Management Information System) system, they launched a mobile app in their health camp program. In the current technological era, it is crucial to manage patient information effectively.

MIS System of CDIP:

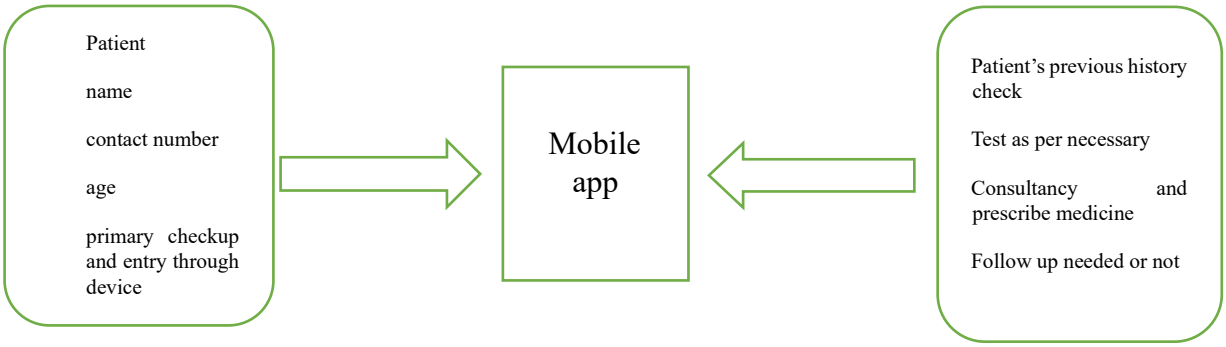


Figure 17: MIS system of CDIP.

4.2 Assessing the Impact of the Enrich Program on Maternal and Reproductive Health:

Maternal health refers to the health of women throughout pregnancy, childbirth, and the postpartum phase. It includes a variety of medical services meant to protect mothers' and their infants' health. These services include access to family planning and reproductive health services. Reproductive health maintenance for women typically focuses on the age range of 15 to 44 years. In addition to reducing maternal fatalities, maternal health also focuses on addressing potential pregnancy and delivery difficulties. Additionally, it seeks to advance favorable health outcomes, including safe deliveries, healthy pregnancies, and the long-term welfare of both mothers and children.

The causes of maternal mortality can't be measured by a single indicator. It is related to so many other social and economic factors. According to intersectionality theory by Kimberlé Crenshaw, intersectionality examines how overlapping systems of oppression (e.g., gender, race, class) create unique experiences of disadvantage. Women's health access is shaped by their intersecting identities. For example, rural women from low-income backgrounds face compounded barriers compared to urban, wealthier women.

As a developing country, in Bangladesh women face many health problems during their journey of maternal era. Severe bleeding, hypertension, infections contracted during pregnancy, complications from unsafe abortions, and underlying diseases (including HIV/AIDS and malaria) that pregnancy can aggravate are the main causes of maternal death. All of these can be significantly avoided and treated with access to considerate, first-rate medical care. In the 21st century, a considerable reduction has been seen in the rate of maternal mortality. Although there has been a significant decrease in recent decades, maternal mortality rates in Bangladesh continue to be elevated. In Bangladesh, Maternal death for every million live births rate are 136 people (2023) at the national level where it is 109 people at the Enrich area.

In this study, 29 married women were interviewed in multigram union. Almost 85% of them face different kinds of barriers. Because of a large number of family members, a shortage of income, social barriers like women having to sacrifice for the other person of the family, etc., and cultural norms like one's mother did not visit any medical facilities during her pregnancy, so she does not need to visit any medical, etc., they do not take any health care services. A large portion of members face one of the most common barriers, which is economic barriers. Even some of the village women in the study believe that during the process of ultrasonography, doctors use something, and that's why women need to do C-sections. Which is a socially created idea for illiteracy? According to Jorina (45), who works in agricultural cultivation on her own land, she gives birth to 5 children. She normally delivers all of them. She does not need to face a C-section because she did not do ultrasonography for a single time. But she takes ENRICH health services. During her last child, she was sick. Then she took service from a satellite clinic, and taking iron tablets, she felt well.

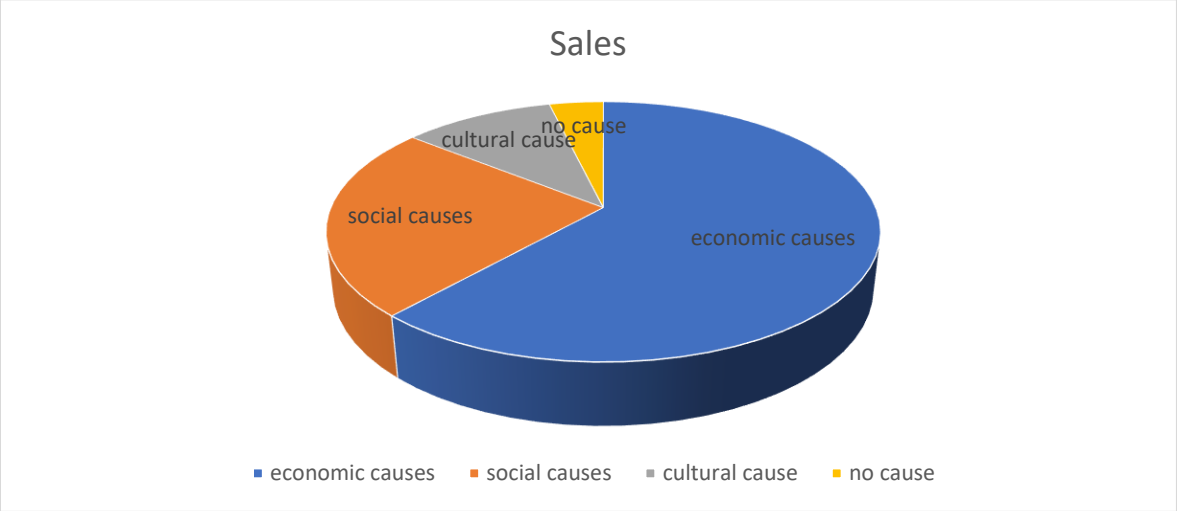


Figure 18: causes women suffer most

In those areas, the ENRICH health service program does a great operation. The local volunteer of the ENRICH health program, with the help of CDIP, visits every single pregnant woman whenever they need. Aklima (25), who is a housewife and also a farmer on her husband's land, has 4 children. Among them, her last son is 3 years old. In those areas, the ENRICH health service program does a great service. The local volunteer of the ENRICH health program visits every single pregnant woman whenever they need.

Case Study 1:

"I have 3 daughters and 1 son. My husband is a farmer. When I got pregnant for the 2nd time, I was suffering from a uterine infection in the early days. I was hesitant to visit a male doctor. Also, the distance of the hospital is too high, and roads are not suitable to travel. As my husband is a farmer, we do not have that money to go to a private hospital. Then I was suffering a lot. Sometimes I was supposed to work with my husband in the land. But the situation was too critical to work. Then Chachi (a volunteer of the health service program) came and told me to take the service. After that, without any cost, I was checked up by Boro Dacter (health specialist). Though I do not have any lobing, they recommended me to a nearby renowned hospital. We are poor people; it is very helpful for us. Since then, I have taken service during all children's births."

Like Aklima, other women of Niamotpur and Chandonpre, Mulgram union, most of them have some stories. This health care service helped them to overcome social and cultural barriers and also financial costs. The achievements of the Health and Nutrition Program of PKSF are providing health care at people's doorsteps at low cost. Which is Tk 32/- per person per annum.

4.3 Exploring the Nexus Between Health Outcomes and Women's Empowerment:

The term "health" refers to both physical and mental well-being, particularly that which is connected to the body's normal functioning and the absence of illness, pain (including mental pain), or injury. Wellness is very much important for human beings. To lead a healthy life, one must ensure his/her good health. Although in Bangladesh public health conditions have been developed, a large number of diseases are still noticeable. In the study area, most of the women face some common disease or sufferings. During their pregnancy, according to the interviewer, there are some common diseases.

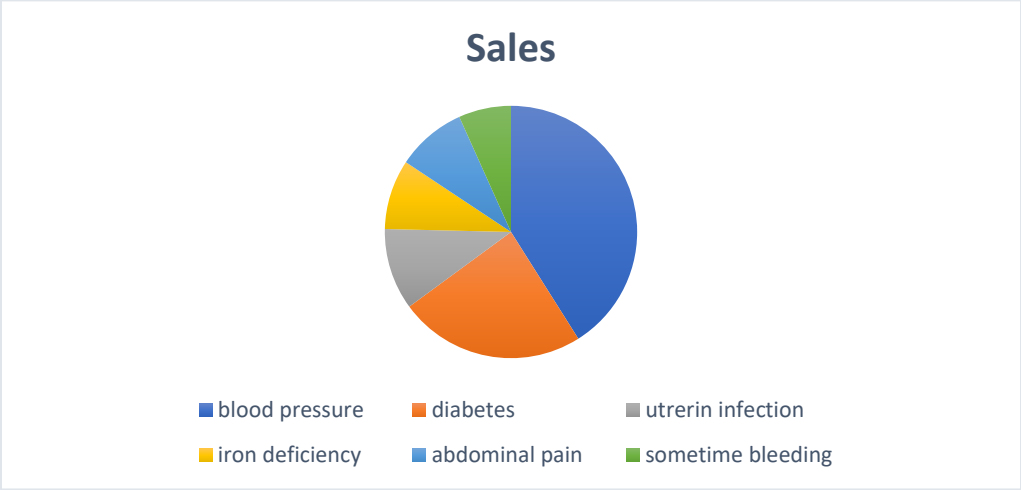


Figure 19: most common disease during pregnancy

Due to those critical causes, most of the women said they were not able to do their work properly. After they had taken the service, they felt better. Tahmina (35), one of the interviewers, has her own animal husbandry. She has 6 children. She a large portion of her family cost cover by herself.

Case Study 2:

"I have 4 daughters and 2 sons. My first 3 children were normally delivered. But I face difficulty during my 4th pregnancy. I was suffering from iron deficiency, high blood pressure, chest pain, early edema, etc. I have my own animal husbandry. Because of my suffering, I did not pay attention to my business. It cost me a lot in the early days of my pregnancy. Before taking services from here (the ENRICH Program), I was so weak. Then I come to know about this health service. After joining the service, they regularly check my blood pressure, give me iron tablets, and teach me what to eat at this time. Apa (a volunteer of the ENRICH Program) was very friendly with everyone. After taking the services, I feel more strength. A great portion of my family costs comes from my animal husbandry. My husband runs a small bakery. Their services help

me a lot. Whenever I felt any problem, I shared it with them. I was taken to their health services for my last two children from the beginning. By the mercy of Allah, yearly I earn more than 1 lakh taka."

Economically developed women are one of the indicators of women's empowerment. Vulnerable health condition is the biggest barrier to making women economically developed.

Economically making women strong is a great thing that the ENRICH Program is doing. 90% of the interviewers said that most of them do not visit medical facilities because of the financial cost. But the ENRICH Programs employee visits "Uthan" (the Yard), providing health care at people's doorsteps at Tk 32/- per person per annum, which is a very low cost. By the home yard they know what to do. In the study, 2 families are found, where there are seven couples living. All of them take the services.

Figure 20: during FGD with the informant.

Also, the distance of the government hospital is disappointing for them. They have to travel a long distance to take a primary checkup. Also, the condition of the road is not suitable for pregnant women. Some of them said that sometimes well people get sick by the journey of the road.

Not only economically, but there are also some other factors that can measure women's empowerment. In rural areas, even in the modern world, women are treated negatively. According to early feminist anthropologist Michelle Rosaldo's Women, Culture, and Society (Rosaldo and Lamphere 1974), it shows how "an opposition between 'domestic' and 'public' provides the basis of a structural framework necessary to identify and explore the place of male and female in psychological, cultural, social, and economic aspects of human life" (1974:23). Women can feel empowered when they can make a decision for their families, whenever they can make a positive self-image, and by making a supportive relationship.

Case Study 3:

“This is my father’s place. Now I’m here to visit my parents. My in-law's house is in the next village. During my 1st pregnancy I faced so many difficulties. When I was 3 months pregnant, the doctor advised me to take bed rest. I could not do anything. In my in-law's house, they admonish me so many times. My husband costs a lot for my regular checkups. In my in-law area there are no health services like the Enrich Program.

But after two years, when I got pregnant for the 2nd time, I was at this place (Mulgrm union). Farjana Apa (one of the volunteers of Enrich) told me to take the services. From very early days of my 2nd pregnancy, I took ENRICH health care services. I take 5 ANC from them. They (volunteers) regularly visited me. By the mercy of Allah, I do not cost a single taka. During the whole journey of my pregnancy, my husband has to pay a little for the medicine or medical test they cannot provide. But at a free cost, I took their services. You see, they were visiting my house. It was the most useful service, I think, for my condition.”

By accessing health care services of ENRICH, like Rima, many women have the stories. Those are the stories of women's empowerment.

Social awareness is another important element for a healthy life. Among 29 informants, all of them told that they came to know what to eat during pregnancy, when to take ANC, where to take the other medical test that the program cannot provide, the primary necessary things for a normal delivery, etc. Among them, 28 participants told that by knowing from a health specialist, they feel empowered. The other one told her she knew the thing because she is educated. She completed her honors. She also highly appreciates ENRICH Health service positively. When they know the right things, they can talk confidently in their family and in their community.

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Chapter 5. Learning and Conclusion

5.1 Challenges and Limitations of The Study

5.2 Recommendation

5.3 Learning Experience from Internship

5.4 Influence on My Future Goal

5.5 Conclusion

Chapter 5. Learning and Conclusion

This chapter summarizes the key insights and learning derived from the research while concluding the study by reflecting on its overarching objectives. The chapter discusses the broader learning gained throughout the research process, including practical, theoretical, and methodological insights. These reflections provide a holistic understanding of the topic and highlight the significance of the study in addressing the identified gaps.

5.1 Challenges and Limitations of The Study:

The limitations of the study have been the following:

Sample size: A sample size of 29 has limited the generalizability of our findings. It may not be large enough to capture the full diversity and complexity of the population we're studying.

Geographical Limitation: Our research is limited to only 2 villages of one union. This has limited the applicability of your findings to other areas or regions.

Time Constraint: The three-month time frame for the research was not sufficient to capture all the nuances of the phenomena of the study. As some effects or trends only become apparent over a longer period.

Financial Constraints: Lack of funding has limited the scope of the research. It has restricted the resources we can access, the number of participants we can recruit, the type and amount of data we can collect, and the methods we can use for the data analysis.

Potential bias: There has always been a risk of bias in social research. This could come from the way questions are phrased in the questionnaires, the way participants have interpreted these questions, or even the way the researcher, I, have interpreted and analyzed the data.

Recognizing the research's shortcomings is not a sign of weakness. Indeed, it has demonstrated a thorough comprehension of the research issue and methods.

5.2 Recommendation:

From the work on the ENRICH health program, here are some recommendation:

> To expand outreach, there is a need to enhance both the size and qualifications of the workforce, facilitating the establishment of more satellite clinics across various wards within the union, thereby increasing their frequency.

To alleviate the burden of diagnostic tests, PKSF may explore collaborations with existing facilities in unions where it lacks a hospital or medical center.

ENRICH Health Card holders would be entitled to additional discounts on essential diagnostic tests.

Health visitors should undergo more frequent and comprehensive training sessions to enhance their communication skills, cognitive abilities, and technical knowledge, thereby fortifying their effectiveness in the field.

The ENRICH Program can be taken to other zilas of our country to enhance the health care facilities in the whole country.

To reduce the burden of C-section delivery and health care costs, PKSF and NGOs can collaborate on some special loans and facilities for the families.

Given the community's profound trust in ENRICH Health and the expressed demand for delivery services, judiciously providing such services whenever feasible would represent a strategic initiative to enhance community welfare.

5.3 Learning Experience from Internship:

From becoming fully immersed in the professional office setting to actively participating in a particular program union, my time at PKSF has been a journey full of profound insights. This has been a rewarding experience, and I am grateful for the opportunity to help ENRICH Health succeed.

Acquiring Research Experience: My only experience with research during my undergraduate degree was participating in a study as a field enumerator. However, by coming up with my own research question at PKSF, I made a big advancement. This experience has been outstanding, from developing a study proposal to finishing my report, which included designing questionnaires, conducting literature reviews, going on field trips, and analyzing data. It marks a significant turning point in my academic career and gives me access to knowledge and perspectives that I had not previously had. I have no doubt that this new experience will be the basis for my upcoming research-based endeavors.

Project Management: This internship provided insights into the indispensable role that non-governmental organizations play in society by delivering essential services that might otherwise be unavailable or inaccessible to people. Through this experience, I gained valuable lessons in project management and people management skills. It offered a firsthand understanding of the challenges PKSF faces in implementing ENRICH Health in Mulgram Union.

Enhanced Innovation: I had the opportunity to apply my knowledge and creativity to find solutions to challenges encountered during fieldwork. This internship not only allowed me to navigate the intricacies of problem-solving but also offered valuable insight into the transformative potential of innovative ideas in addressing pressing issues. Working with PKSF-ENRICH highlighted how even the smallest innovations can have a profound impact on improving the lives of individuals.

Teamwork & Collaboration: The internship also served as a platform for enhancing my teamwork and collaboration skills. Collaborating with colleagues at PKSF provided valuable insights into effective teamwork and the intricacies of working with diverse stakeholders during program implementation. This experience proved instrumental in refining my interpersonal skills, which are indispensable in any professional setting.

Leadership Abilities: I took on a leadership role. Organizing the tour, managing the budget, and coordinating other necessities in Kasba were part of my responsibilities, requiring collaboration with individuals from CDIP. This experience significantly strengthened my leadership skills. Additionally, collaborating with PKSF's staff and observing their work methods provided invaluable insights into efficient leadership practices.

Data Analysis: Analyzing the data collected during field visits and composing a comprehensive report was a pivotal task. This experience played a crucial role in honing my problem-solving skills, demanding creative solutions for the challenges encountered. Additionally, it provided me with valuable expertise in data analysis and report writing, skills that will undoubtedly be advantageous in my future endeavors.

5.4 Influence on My Future Goal:

This internship has been contributory in shaping my future aspirations. It has heightened my understanding of the practical challenges faced by individuals in rural areas and shed light on the impactful role that non-governmental organizations can play in their improvement. Motivated by my experiences at PKSF, I am now inspired to direct my efforts towards similar causes and apply my knowledge for the greater good. Acknowledging areas for improvement in my role as a student and researcher, I am dedicated to evolving into a professional capable of making substantial contributions to the development sector. Looking forward, my goals for higher education revolve around achieving academic excellence and personal growth, fostering strong ethical values, professionalism, and organizational skills that will be highly valued by prospective employers.

5.5 Conclusion:

Access to healthcare is a fundamental human right, and addressing gender-specific health needs is critical for achieving equitable and sustainable development. This research on Gender-Specific Health Benefits: Empowering Women Through Access to Health Services in the PKSF Enrich Program underscores the transformative potential of targeted health interventions in improving women's health outcomes and fostering their empowerment.

As articulated by Dr. Qazi Kholiquzzaman Ahmad, the visionary behind ENRICH, the United Nations Development Program (UNDP) prioritizes human-centered development, a mission initially outlined in 1990 through the Human Development Report. This approach, instrumental in promoting global well-being and progress, underscores the significance of enhancing all aspects of human life for the betterment of the world. According to Dr. Ahmad, human dignity is ensured through lifelong learning and the right to work, emphasizing the imperative to provide opportunities for those with limited financial means, a core objective of ENRICH.

The Palli Karma Sahyayak Foundation serves as an exemplar of how the government, in collaboration with civil society, can advance the mission of human-centered development. Through the introduction of programs aimed at enhancing the livelihoods of the poor and vulnerable, PKSF not only endeavors to alleviate poverty but also strives to ensure equal opportunities for all. This internship has provided a profound understanding of the practical challenges faced by individuals in rural areas, often overlooked by the government. The success of the ENRICH program, focusing on infrastructure development, provision of essential services, and equitable resource access, signifies progress in developing rural communities. While acknowledging the strides made by programs like ENRICH, it is evident that there remains a substantial journey ahead until marginalized populations can fully enjoy their rights and privileges. Nonetheless, optimism prevails, with the belief that initiatives like ENRICH will continue guiding the nation in the right direction.

This internship has been beneficial to me for the engagement in endeavor of human development and giving me the knowledge and experiences. I extend my gratitude to the department of Anthropology, University of Dhaka, for providing me with the opportunity to intern at PKSF. My aspirations involve contributing further to the development sector, and I am confident that this internship will serve as a robust foundation for my future endeavors.

The eradication of poverty and inequality is feasible through universal access to resources and opportunities, facilitating a dignified life for all. The commendable efforts of PKSF and ENRICH in this regard inspire confidence that Bangladesh can make strides towards achieving sustainable development goals. My gratitude for the enriching experience as an intern at PKSF extends to the organization's impactful contributions to societal betterment.

Research questionnaires:

1. What is your age?
2. What is your level of education?
3. What is your primary occupation?
4. What is your monthly income?
5. How long have you been married?
6. What is your husband's occupation?
7. Do you have children? If yes, how many children do you have?
8. what is your last child's age?
9. Have you faced any difficulties during your pregnancy or in delivery before taking services from Enrich Health Services? If yes, can you explain it?
10. How did the enrichment health care program help you to reduce difficulties during your delivery after getting service through the program?
11. Have you taken antenatal care under the ENRICH program?
12. Have you incurred any costs to get antenatal health care before getting enriched health care services? If yes, how much was it?
13. What are some cultural, social, or economic barriers women face in accessing healthcare in your area?
14. In your opinion, what are the most critical health challenges faced by women in your community?
15. Have you attended any health awareness sessions organized by the PKSF Enrich Program? If yes, what did you learn?
16. How do you perceive the role of the PKSF Enrich Program in addressing gender-specific health needs?
17. Can you share a specific story or example of how the program has positively impacted you or someone you know?
18. How do you think the availability of health services through the PKSF Enrich Program has influenced women in your community?
19. Could you describe how your family or social life has changed as a result of easier access to health services?
20. Can you describe any situation where you felt empowered because of the knowledge or support you received through the program?
21. Do you think women who take Enrich health services are more beneficial than those who do not? If yes, how does it?

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