SUSTAINABILITY OF RURAL HEALTH SERVICES THROUGH PUBLIC-PRIVATE PARTNERSHIP

M.Phil Dissertation

By

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Declaration

I do hereby declare that this dissertation entitles "Sustainability of Rural Health Services Through Public-Private Partnership In Bangladesh: Selected Cases" submitted to the University of Dhaka, Bangladesh for the degree of Master of Philosophy (M.Phil) in Development Studies is a complete new and original work done by me.

I do also declare that this thesis or any part of it has not been submitted to any other university/institution/organization for achieving any degree.

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Certification

With reference to this thesis entitled "Sustainability of Rural Health Services Through Public-Private Partnership in Bangladesh: Selected Cases" submitted by Sharifa Haque to the University of Dhaka, Bangladesh for the degree of Master of Philosophy (M.Phil), I certify that she has carried out her research work under my direct supervision and guidance. The thesis reflects the candidate's own work and personal achievement. This thesis does not contain any conjoined research work either by me or with anyone else.

The final copy of this thesis which is being submitted to the university of Dhaka, Bangladesh, has been read and verified by me for its material and language; and it is hence a piece of work to my satisfaction.

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Abstract

Achieving universal health coverage is one of the key preferences of Bangladesh where people can receive health care without financial hardship. However, resource allocation is insufficient in health sector to ensure health service for all socio-economic groups. The disadvantaged and poor people still have notably less access to health care facility than the privileged and rich in Bangladesh. Globally growing resources limitations have increased the demand for and willingness of organizations to work together as partnership program. Thus, Public-private partnerships have become a familiar method to address health care issues in many countries. As a means of coping with these challenges, Bangladesh is also trying to ensure health service to all through organizational reform. As a result, community clinics have taken place as one of the crucial reforms in Bangladesh aiming cost-effective, responsive and sustainable initiative to ensure primary health service to all. In this context, this research seeks to find out the nature of this PPP, the extent of community participation, strengths and challenges of this program. In order to achieve the inquiry, purposive selection sampling was dealt at three unions in two districts. A qualitative research approach was used for the purpose of exploring into the research objective. Interview, case study, focus group discussion, review of secondary literature, key personnel interview and a personal observation were used as the research tools. From the empirical investigation, the research found that this PPP is a distinctive example of partnership between government and community people. This PPP is followed by contemporary public governance model where goal is not only cost reducing good designed contract mechanism but also a standard of mutual trust and collaboration between parties. There is a well-built structure of community involvement in this program by empowering community people through decentralization of power. This involvement is a sustainable attempt by the government as this partnership enhances greater capability of administration to focus on function that is not generally performed well by central government. However, though this service is satisfactory to most of the respondents, there is a gap between structure and practice in execution. The study has shown that some amount of caution is essential to mitigate the coordination gap between central government and community groups. The research provides some policy recommendations that will facilitate further useful attempt

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to ensure the goal of this PPP and concludes with a persuasion for further research on this study area.

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ABBREVIATIONS

ADB	Asian Development Bank
ADBI	Asian Development Bank Institute
AIDS	Acquired Immune Deficiency Syndrome
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BOO	Build, Own, Operate
BOOT	Build, Own, Operate, Transfer
CBHC	Community Based Health Care
CC	Community Clinic
CCN	Community Care Network
CG	Community Group
CHCP	Community Health Care Provider
CHW	Community Health Worker
CMSD	Central Medical Stores Depot
CSBA	Community Skilled Birth Attendants
CSC	Community Score Card
CSG	Community Support Group
DBFMO	Design Build Finance-Maintain Operate
DCM	Design, Construction, Maintenance
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DMCH	Dhaka Medical College Hospital
EDCL	Essential Drug Company Limited
EPI	Expanded Program on Immunization
ESP	Essential Service Package
EU	European Union
FBO	Faith-Based Organizations
FM	Facilities Management
FWA	Family Welfare Assistant

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GDP	Gross Domestic Product
HA	Health Assistant (Health assistant provides domiciliary services at village or ward level under supervision by assistant health inspector from union level)
HED	Human Engineering Department
HIV	Human Immunodeficiency Virus
HRM	Human Resource Management
HUD	Housing and Urban Development
IMCI	Integrated Management of Childhood Illness
IMED	Implementation Monitoring and Evaluation Division
JICA	Japan International Cooperation Agency
MCH	Maternal Child Health
MDG	Millennium Development Goals
MIS	Management Information System
MOH	Medical officer of Health
MoHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
NGO	Non-government organization
NHP	National Health Policy
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NNS	Neonatal Screen
OECD	Organization for Economic Cooperation and Development
PFI	Private Finance Initiative
PHC	Primary Health Care
PPD	Partners in Population and Development
PPP	Public- Private partnership
RCHCIB	Revitalization of Community Health Care Initiatives in Bangladesh
SACMO	Sub-Assistant Community Medical Officer
SDG	Sustainable Development Goal
THFPO	Thana Health and Family Planning Officer
TICA	Thailand Incentive and Convention Association

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UHC	Universal Health Coverage
UHC	Upazila Health Complex
UHS	Upazila Health system
UH&FPO	Upazila and Family Planning Officer
UN	United Nation
UNICEF	United Nations International Children's Emergency Fund
UNO	Upazila Nirbahi Officer (UNO is the chief executive officer of Upazila Parishad for executing all decisions taken by upazila parishad. Upazila is an administrative region called sub-district in Bangladesh)
UP	Union Parishad (Union parishads are the smallest local government and rural administrative units in Bangladesh)
USAID	United States Agency for International Development
VHA	Veterans Health Administration
WB	World Bank
WHO	World Health Organization

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Chapter One

Setting the Scene

1.Setting the Scene

Introduction

This chapter reviews background information and greater concern of this study that reveals a general understanding about the current scenario of health sector in Bangladesh. First section reviews increasingly concerned issues of health sector. Second section reviews the research problems and significance of the study. Third section presents research objectives and fourth section shows organization of this thesis paper.

1.1 Health Sector in Bangladesh: Growing Concerns

Health care is essential for achieving a good standard of life. Healthy people tend to be economically more productive and to earn higher incomes. They are probably to have healthy children. As a result, their families will be stronger, which in turn, promotes the strength of their societies. A healthier society, on a national level, will lead to productive economic growth and contribute an economy better able to participate in international markets. For the changing world economy, we must have a quality and healthy workforce who can obtain new skills as well as lead productive lives consistently. For Bangladesh, though resource allocation is insufficient in health care compared to other sectors, health care service is a policy priority (Rahman, 2019).

In Bangladesh, health system relies deliberately on the public sector or government for setting policies and financing and service providing mechanisms. Although this sector is facing huge challenges, health sector receives minimal priority regarding national capital allocation. World Health Organization states that only 3.4% GDP or Gross Domestic Product is spent on Bangladesh health services (Islam & Biswas, 2014). On the other hand, there is only 34% total government expenditure on health whereas the 66% is out of pocket expenses. That means- there is only 3.4% GDP is spent on health sector in Bangladesh out of 1.1% contribution of government (Islam & Biswas, 2014). In terms of dollar, the overall health expenditure is about US$ 12 per capital per annum in Bangladesh, of which the public health expenditure is only around US$ 4 only. More than

two-third of the total expenditure is privately financed on health, through out-of-pocket payments. Of the remaining one-third public financing, about 60% is financed by public sector out of development outlays, tax revenue and the remaining 40% through international development assistance. The Ministry of Health and Family Welfare's expenditure on health care shows that 27% of the primary level health care allotment is going to wealthy people and 21% to the poorest portion. Health financing is basically tax-based, along with the development partner's financing. But poorest people often face impoverishment due to spending more money on health care through out of pocket amount. In Bangladesh, health insurance is nearly non-existent. In recent years, some NGOs though have piloted health insurance schemes, it will take a prolonged period of time to obtain wider public acceptance (Islam & Biswas, 2014).

Government budget mostly goes for doctors, nurses, equipment and infrastructure development. But the inability of patients is often neglected. 67% cost for medical care patients spend from their pocket. 64% goes for medicine. It is notable that where health care services should be free in the government hospitals, it is often seen that there is huge unseen cost involved with the total process. This cost involvement in public hospitals is a great obstacle to the disadvantaged and poor people. Furthermore, in many public hospitals, ambulances are used by physicians and other medical staffs. It deprives common people in case of emergency. Briefly, there is a big gap between practice and principle in public health care facilities where poor are often deprived from proper health care. Around 66% of health care expense are out of pocket cost borne by families and individuals serious restricts the entry of the poor to the health care system undermining the concept of equity so incorporated in the country's constitution (Islam & Biswas, 2014).

In Bangladesh, per capital health expenditure stands at USD 32 while it is USD 111 in Vietnam, USD 76 in Cambodia, USD 61 in India, USD 720 in the Maldives and USD 39 in Nepal (Rahman, 2019). According to the report of National Health Account, every year the out-of-pocket expenditure about health forces 4 to 5 million people into poverty in Bangladesh. In this context, poor people are suffering the most. Therefore, to achieve

the target universal health coverage will be extremely hard unless this trend is reversed. Besides this low budgetary allocation problem, Bangladesh is paving other obstacles including lack of fiscal accountability, reduced foreign aid flow, poor development planning, manpower shortage, absorptive capacity, widespread corruption, etc. The health sector's failure to ensure proper allocation of resources at the local and national levels is another crucial barrier to establish health care for all in Bangladesh.

Financing in health is a consequence of dissatisfaction among people in both low-income and developed countries (Fahim et al., 2018). In Bangladesh, health cost is substantial because of both unofficial and official fees such as availability of hospital seats, cash payment for access to health service and medicine in health care provisions. In addition, corruption, mismanagement, long distance to health care setting, absence of adequate amenities amplifies the disappointment and expenses among people. Yet, the right to receive treatment is shelter in the constitution of Bangladesh. Government is firstly responsible for providing primary medical care to its citizen. Furthermore, state is necessarily liable for upgrading the nutritional status and amelioration of public health provisions throughout the country. In order to consider the ideals of constitution, a national health care policy was adopted in 2000. After 11 years, the National Health Policy was updated to direct contemporary issues and integrate it with global goals like Universal Health Coverage (UHC) and Sustainable Development Goal (SDGs) (Fahim et al., 2018).

The disadvantaged and poor people still have notably less access to health care facility than the privileged and the rich. Only 8% of pregnant women from poor income quintile take the advantage of their baby delivery at any clinic or health care center compared to 53% pregnant woman from the wealthiest income quintile (Islam & Biswas, 2014). There is serious inequality in terms of post-natal and antenatal care too. While 31% pregnant women from low-income quintile seek antenatal care, the percentage from richest income quintile is about 82%. The corresponding figures for post-natal care are 7% and 51% for the poorest and richest income quintile mothers respectively. The death rate is also high among poor than their rich compatriots. The new born mortality rate varies from a low of

43 per 1,000 live births among the richest income quintile to over 85 per 1,000 live births among the poorest income quintile (Islam & Biswas, 2014). The Ministry of Health and Family Welfare did not take any effective measure in this regard to take necessary action. Though this health system problem is well known, proper initiative from top level hardly gave concentration on it.

Such inequality is a vital problem that affecting the health sector. There are total 536 public hospitals with 37, 387 beds for 160 million people in Bangladesh (Islam & Biswas, 2014). There are 413 Upazila Health Complexes with limited care services. There is only 20 beds in those Upazila Health Complex to emergency pregnancy care. It is hugely observed that in the many Upazila Health Complex with 50 bed for patients, there is only 5 to7 doctors are available for the huge number of population ("Khurie Cholche Chikitsha", 2019). Although in pen and paper there are ten but actually not. Even in some Upazila complex there is no ward for children. There is also lack of different health testing provision ("Khurie Cholche Chikitsha", 2019). It is also very common complaint by patients that drugs or medicine that are supposed to be accessible with minimal fee or free charge often vanish from the Upazila Health Complex. It is also reported that due to inappropriate use or misuse, almost 65% ambulances in Upazila Health Complex are unusable or inoperable. As a result, patients from rural areas suffer for the mismanagement and inefficiency of health care system (Islam & Biswas, 2014).

District medical college hospitals also have limitations. Besides these, there are other special health care centers like tuberculosis hospitals, infection diseases hospitals, leprosy hospitals etc. under secondary health care facilities. The regional urban hubs based medical college hospitals are considered as tertiary hospitals that provides high end medical services. Last few decades, this country has experienced a fast expansion of tertiary and secondary health care networks. However, considering huge population in Bangladesh, there is a huge limitation about specialists, laboratory services and diagnostics in these hospitals. Compared with many other developing countries, Bangladesh has not adequate health facilities considering its huge population. For example, while Ghana has 0.9 beds for per 1000 population, Bangladesh has only 0.4

beds for per 1000 population. With similar economic development, Kenya has 35% higher number of hospital beds comparing with Bangladesh.

Table 1.1 Health scenario of Bangladesh at a glance

Population	16,46,00000
Population Density per square kilo	1,116
Population growth rate	1.37%
Fertility rate	2.2
Ratio of Men and Women	100.20 : 100.00
Average life expectancy	72.3 years
Population over 60 years	7.9%
0-4 age child	8.4%
Young people (age 18-28)	22%
Infant mortality rate	16 per 1000
Child mortality rate (below 5)	30 per 1000
Government hospital bed	49, 414
Private hospital bed	87, 610
Registered Doctor	1,02, 927
Government Doctor	20, 914
Nurse and other health service provider	55,733
Medical college	111
Lack of nutrition	2, 42, 00000 people
Nutrition sufferer	1 out of 6
Bangladesh's position in Global health Index	88 out of 117 countries
Helath expenditure is done from patient's own pocket	67%

Source: Institute of health matrix and evaluation and Bangladesh National Health Accounts, 2019, p.6

Developing countries normally follow mixed health system (Joarder, 2019). That means both government and private sector work for health service. Private sector can be divided as profit oriented like private medical or private doctor and non-profit organization like NGOs. In 2007, a study conducted by Prof. Kokfrot, Macgil University shows that in Bangladesh, 87% medical care is given by private sector (Joarder, 2019). Health Bulletin (2018) by health department shows that 63% medical bed out of 1,90,587 goes to private sector (Joarder, 2019). On the other hand, from domestic source for medical expenditure of government has reduced from 29% to 18%. Bangladesh Health Account shows that in 1997 GDP for health sector from government was 0.83% which is 0.68% in 2015. Whereas in private sector it is increasing from 1.44% to 2.31%. Therefore, it is very much visible that private sector for health in Bangladesh is becoming stronger day by day (Joarder, 2019).

Primary medical care still provided by mostly government and some NGOs. However private medical hospital basically focus on high treatment not primary that indicates profit (Joarder, 2019). A study shows that 80% doctor work in both government and private sector which undermine their integrity (Joarder,2019). Civil surgeons are accountable to supervise the district health system and UH&FPOs or Upazila Health and Family Planning Officers are the responsible personnel of the Upazila Health Complexes. Usually physicians or civil surgeons are most of the UH&FPOs (Islam & Biswas, 2014). It is very common picture of absenteeism practice of doctors and other health professionals. Although there is a government declared office hours, many doctors maintain their own office hours for the sake of their private practice. As a result, patients are frequently neglected even sometimes abused by the caregiver or health professionals. Morality and ethics have disappeared frequently that clients are often enticed or diverted to private physicians. Even due to doctor’s absenteeism, pregnant women often go at life risk or expensive surgery in private clinic that is beyond their ability. Ethics and morality that used to direct health professional or physicians seem to have vanished in Bangladesh. Hippocratic Oath that leaded physician-patient relationships- no longer gets sheltered to the medical education in Bangladesh (Islam & Biswas, 2014).

One study shows that health facility in Bangladesh suffered from lack of readiness in diagnostic capacity (Shawon et al., 2018). Though Bangladesh has achieved significant gains to reduce child mortality, globally around 5.9 million children under the age five died in 2015 (Khan et al., 2018). In addition, 36% of children aged under 5 are stunted in Bangladesh (Hossain et al., 2019). Women face severe maternal complications at their adolescent age in Bangladesh (Sarker et al., 2018). Letest Niport report also shows that health institutions are not ready to provide sufficient health service that might be a challenge to achieve SDG goal (Morol, 2019). Information around 1,524 institutions were taken for this survey in 2017 from community clinics, union health center, union health and family planning center, mother and child welfare center, District hospital and medical college hospital. This report shows that the overall scenario about medicine supply and delivery related facilities have decreased compared to 2014.

A survey of BBS shows that half of the population in Bangladesh can't get proper medical care whenever they sick (Morol, 2019). Because after getting sick most of the people don't go to certified MBBS doctor. This BBS survey was conducted in 2016. It shows that around 16% patients take health care service from community clinics, 26% from private hospitals and some goes abroad for medical care. This survey shows that there are some reasons for why patients are not taking medical care here. Furthermore, the survey shows- 57.77% people think that the problem is not major issue to go for doctor and 16.73% people think that treatment is an expensive process. Around 5.14% people don't get anyone to go to doctor and 5.05% can't go for medical care due to ignorance of decision makers in family. 1.84% people can't go for health service due to distance, 1.45% people never go for health care outside due to fear of major diseases and unfortunately O.94% people doesn't know where to go for treatment. This survey also shows that among 1000 people 170 are sick somehow. This scenario said that a large portion of people are not getting proper health care (Morol, 2019). BDHS survey of 2017-18 shows that child mortality rate is not decreasing in Bangladesh (Morol, 2019). Child mortality is an indicator to measure socio-economic condition and life standard of a country. This survey shows- though at past it decreased but last five year it is stagnant. 30 infants out of 1000 died before age 28 days (Morol, 2019).

Table 1.2 Child mortality per thousand (before age 28 days)

2007	2011	2014	2017
37	32	28	30

Source: BDHS 2017-18. Adapted from Morol, 2019, p.1

Table 1.3 Basic medical equipment

2014	42%
2017	38%

Source: NIPORT Report, 2017. Adapted from Morol, 2019, p.1

Table 1.4 Basic medicine

2014	42%
2017	33%

Source: NIPORT Report, 2017. Adapted from Morol, 2019, p.1

Despite all these drawbacks, Bangladesh has attained notable growth in most of the health indicators at the fifth decade of its establishment (Fahim et al., 2018). This country has put an example in achieving Millennium Development Goal (MDGs) in health-related issues, especially in child mortality and maternal health. According to recent report, the health care access standard index of Bangladesh has upraised from below 42.9 to 52 in a period increases from 1990 to 2015. Such achievement is better compared with adjacent neighboring countries. However, the health system of Bangladesh is suffering poorly from inadequacy of man power, poor funding and inadequacy of logistics and infrastructure.

Growing resources limitations have increased the demand for and willingness of organizations to work together (Alter & Hage, 1993). As a result, public-private partnerships have become a familiar method to health care problems globally and recently there has been zest for using this approach to improve health care services for a wider range of health complication (Barr, 2007). Various reforms initiative in the late 90s were taken to solve health issues. A gradual shift was found that emphasized on the value of social bond (Newman, 2004) through holistic governance, network building and partnerships (Torchia et al., 2013). By the 1980s, major reforms were taken place in the public sector due to growing financial pressure on general accounts (Torchia et al., 2013). These reforms incorporated of an advanced disengagement of the state from different parts of activity. Therefore, governments that produced and also provide services previously now tend to continuously more depend on the market either for direct service and provision or for inputs to government provision and production (OECD, 2008). Public-private partnership is part of this movement (Torchia et al., 2013).

There were impacts at different level from international to local about partnership. For example- World Health Organization (WHO) encouraged and welcomed partnerships between the market and state in provisioning, researching and financing health care (Baru & Nundy, 2008). Moreover, due to growing financial pressure on health service providers from both public and private community was searching this types of partnership as a means of tackling a wide area of community health demands and rationalizing the distribution of local health care (Bazzoli et al., 1997). In addition, due to rapid change in health care provision like medical-technological developments, ageing population and policy changes, there was a huge health care costs as well as decreasing governmental budget that had to face by governments all over the world (Torchia et al., 2013). Thus, for many government, public-private partnerships between the private parties and health care givers represented a means of coping with such challenges. In this dynamic scenery, a report of Center for Studying Health System Change (1996) shows that the role of the governments evolved and moving away from the straight provision of service delivery towards the arrangement of partnerships in community health arrangement at enhancing community health.

After 29 years of its independence, Bangladesh adopted its first National Health Policy (NHP) that was revised again in 2011. National health policy marked most of the things pertaining to country's health care service system including health care expenditure and health care financing. Freshly adjusted National Health Policy suggested a considerable increase in budgetary allotment for health care delivery and services system. As a result, to National Health Policy, government assumed health care financing scheme 2012 to 2032 with the aim of grating more funds in reducing out-of-pocket payments and health to 32% by 2032. Sadly, the existing context depicts the opposite. Budgetary allocation for health is being expended in a scary manner for the past several years alarming the forward development towards achieving universal health coverage (Fahim et al., 2018).

In recent years, donor agencies are recommending for partnership initiative to the developing countries to shelter that limited resources where people can get health service at affordable price and health care service is client-oriented (Client satisfaction, 2010). Though there are some useful evidences in achieving Millennium Development Goals in health, still there are some challenges, like- inadequate resource allocation, old regulatory framework in some cases, scarcity of expert workforce, lack of readiness, lack of public health provision etc. Significantly, the vital challenge is the absence of proactive and dynamic stewardship that is able to plan and enforce government policies to further enhance and strengthen the total health system. A strong framework is needed to bring effective and meaningful health service reform that will ensure the values of accountability and equity in health system (Islam & Biswas, 2014).

In this regard, Bangladesh is also trying to improve its health service system that emphasizes on quality health care through organizational restructure and reform. As a result, community clinic take place as a reform aiming cost-effective, responsive and sustainable to client needs (Client satisfaction, 2010). Community Clinic is a flagship program of government. Presently there are around 14,000 community clinics are on board and the number is gradually expanding (Morol, 2019). In case of complicated cases medical officers and SACMOs visit clinics periodically and give services. Internet connection and laptop is given to all the community clinics. E-health activities from

community clinics (CC) to Upazila Health Complex (UHC) has been introduced in some locations. It is hoping that community clinics will be able to contribute effectively in achieving Sustainable Development Goals (SDG) and health for everyone will be ensured (CBHC, 2018).

With an aim to protect Primary Health Care for its citizens, the Government of Bangladesh has undertaken a set of initiatives where community clinics plays a vital role (Billah et al., 2018). It was identified that lack of community people's participation is one of the main reasons of inaccessibility and unavailability of primary health care. As a result, community clinics, a one-stop service on health, family planning and nutrition were preferred into light by Honorable Prime Minister Sheikh Hasina in 1996. At that time the government designed to establish one community clinic for 6000-8000 rural population aiming at expanding primary health care at the door step of the rural people all over the country (Billah et al., 2018).

1.2 The Research Problem and its Significance

The above-mentioned background sets the platform for my study. Resource allocation is insufficient in health sector to ensure health service for all socio-economic groups. The disadvantaged and poor people still have notably less access to health care facility than the privileged and rich in Bangladesh. Globally growing resources limitations have increased the demand for and willingness of organizations to work together as partnership program. However, achieving universal health coverage (UHC) is one of the key preferences of Bangladesh where people and communities can receive necessary health care without suffering financial hardship. As a means of coping with these challenges, public-private partnerships have become a familiar method to address health care issues in developing countries. Bangladesh is also trying to ensure health service to all through organizational reform. As a result, community clinics have taken place as one of the crucial reforms in Bangladesh aiming cost-effective, responsive and sustainable initiative to ensure primary health service to all. In this context, this study will offer insights into the operational reforms needed to enhance the quality of health service delivery in the rural areas of Bangladesh. Moreover, not many researches have been conducted in this

field yet. Though some researches have been conducted on quality assessment of CCs, very few has conducted to examine the reform side of this program. In this regard, this research will contribute to minimize the gap in academic research about this issue. Upon completion, this study will also come up with specific strategies and policy recommendations to achieve this operational reform. In this regard, this research explores the nature of community based PPP, the extent of community participation is this program and the strengths and challenges of this program.

This research is not meant to be a comprehensive analysis of health sector of Bangladesh. It is not either an extensive review of activities and programs of the well-known private sectors or NGOs or other private and public sectors. Information about rural health service delivery through community clinic programs which is considered as public-private partnership has been considered to throw light about sustainable health service delivery involving community member for pro-people.

1.3 Research Objectives

The aim of the study is to investigate the sustainability of public-private partnership through community participation to deliver primary health care service in the rural areas Bangladesh.

The objectives of the study are:

1.To examine the nature and characteristics of community clinics based PPP to the rural health service delivery in the study area.
2. To explore and review the nature of community participation in this partnership along with sustainability.
3. To identify the strength and challenges of this PPP to the primary health care service in the study areas.

1.4 Organization of the Research

This introductory chapter-1 has discussed about background information of this study about research problem and research objectives. Chapter 2 reviews the literature of different types of PPP, conceptual framework of citizen participation and some global practices of PPP. Chapter 3 sets out the research plan for the study and the logics for choosing the specific sites in Bangladesh. The research methodology of the field study is also narrated with their context. Chapter 4 presents the empirical findings of the research. This chapter is divided with three sections to find out the query of three research objectives. Chapter 5 summarizes the main findings of the research along with some useful recommendations.

Table 1. 5 Articulation of the thesis

Broad Thematic Focus	Investigating Points	Research Objectives	Research Questions	Corresponding Chapters
1. Nature and Characteristics of PPP for primary health care delivery in Bangladesh.	# Current status of PPP from secondary sources of data # Exploration the extent of collaboration in existing PPP from selected sites.	1.To examine the nature and characteristics of PPP to the rural health service delivery in the study area.	1. What is the nature and characteristic feature of collaboration-based PPP in the delivery of rural health services in the study area?	Chapter-2 Chapter-4.1
2. Nature of community participation in this PPP.	#Explore extent of decentralization of power, functional link	2. To explore and review the nature of community participation in	2. What is the extent of community participation in this PPP?	Chapter- 2 Chapter- 4.2

	between parties and flexibility	the study area and the sustainability of PPP through community participation.		
3.Strengths and challenges of this PPP.	# Strengths of this program # Challenges of this program	3. To identify the strength and shortcoming of PPP in the primary health care service to the rural areas.	3. What are the strengths and challenges of this PPP in the health care delivery sector in the study area?	Chapter- 4.3

Chapter Two

Literature Review

2. A Review of Concepts and Global Practices

Introduction

This chapter reviews the characteristics of different PPP and nature of community participation from different models and evidence from frequent literature reviews concerning the objectives of this study. The account provides a background for understanding the nature of existing community based PPP and the extent of community participation in this PPP for the Bangladesh cases. First section reviews about nature of PPP, second section reviews on community participation, third section reviews some global cases and last section defines the conceptual framework of the study.

2.1 Concept about Nature and Characteristics of PPP

Public-Private Partnership has come to the consideration of scholars in a diversity of research domain as potential tools for channelling collaboration in long-established public sectors. Many scholars in the public management sphere have emphasized the theoretical foundation of Public-private partnership. The first stream research has originated PPP as an instrument for promoting the privatization of the functions of government through infrastructure based public service provisions. On the other hand, sociological methods to partnership have marked the significance of PPPs as a contemporary public governance model to boost the effectiveness and efficiency of public service delivery. That means, their functioning demands not only a cost reducing good designed contract mechanism but also a standard of mutual trust and collaboration between parties (Cappellaro & Longo, 2011). The spread of the use of Public-Private Partnership in health care service around the world has resulted in the recognition of an increasing number of complications related to the execution of PPPs projects (Torchia et al., 2013). Therefore, it is important to examine PPPs characteristics and execution issues in the health service sector through the light of academic articles.

There are various forms of Public-Private Partnerships in the health sector on the basis of public and private party's risk and responsibility. They are characterized by the risks,

sharing common objectives and reward in a form of partnership or contract or through a divergent arrangement (Nikolic & Maikisch, 2006). Therefore, public-private partnerships are not a new notion though there is no single agreed-upon definition of Public-private partnership (Hodge and Greve et al., 2007). Synthesizing many rich approaches, Alter and Hage (1993) provide an approach where they mentioned that collaboration effort depends on the perceived need for alliance and willingness of the organizations to collaborate. Perceived need and willingness- these two concepts are central themes in inter-organizational relation and resource dependence theories to achieve common organizational goal. These theories concentrate on dependencies among concern organizations (Sofaer & Myrtle, 1996). Alter and Hage (1993) identify variety of potential dependencies: the need to manage risk, the need for capital, the need for maintaining flexibility for adaptation etc. All these relate to perceived need and willingness to collaborate of the organization.

The term PPP is used as an umbrella word describing collaboration relations between private and public actors for the attainment of common goals (Singh and Prakash et al., 2010). Koppenjan (2005) defines Public-private partnership as a form of structured partnership between private and public actors in the planning exploitation of infrastructural facilities and construction in which they share costs, risks, resources, benefits and responsibilities. On the other hand, Grimsey and Lewis (2007) asserts “PPPs can be defined as arrangements whereby private parties participate in, or provide support for, the provision of infrastructure, and a PPP project results in a contract for a private entity to deliver public infrastructure-based services.” It seems that the significant characteristics of Public-private partnerships are sharing of risks, development of mutual services/products, costs, mutual value addition and benefits (Klijn & Teisman, 2003). In addition, Zhang and colleagues (2009) suggest three distinct features of Public-Private Partnership compared to more traditional forms of co-operation (Osborne et al., 2000) mentioned these features like this:

First, there is no common ownership structure in PPP: one side is public and another side can be private or business enterprise. Therefore, they can pursue different strategic goals.

Second, it is not output oriented rather than outcome oriented for big society or public. Third, such PPP usually remains in effect for long periods of time between specific partners. Because they are regarded as cost efficient and effective, PPPs have become a key mechanism for implementing social and public policy. The benefits are for large society aiming a cost-efficient service.

The Ministry of Municipal Affairs (1999), British Columbia presents the definition as "Public Private Partnerships arrangement between government and private sector entities for the purpose of providing public infrastructure, community facilities and related service. Such partnerships are characterized by the sharing of investment, risk, responsibility and reward between the partners." A report by the Asian Development Bank Institute (2000) identified a range of interactions and relationships between the private and public actors is exist and possible in reality. This can be situated in a spectrum from no interaction or relationship between the private and public actors to a multi-faceted and close relationship as shown below:

Parallel activities: Private and public activities are accomplished without any contact or acknowledgement with each other.

Competitive activities: The activities in the private and public sector are carried out with similar or same objectives and competing with each other, targeting common clients which may represent either enlargement of option for the beneficiaries or wasteful duplication of activities.

Complimentary activities: Services or activities from the private or public sector compliments each other regarding content or nature of population coverage, geographical or content of services either by incidentally or by design.

Contractual Services: The government or public sector contracts private sector for providing designated services for agreed payment where contractor are accountable to the public sector.

Cooperation and collaboration: Private and public actors work jointly on the basis of common objectives, agreed criteria and strategies assessing outcome and process.

The above-mentioned criteria are not certainly mutually exclusive. A collaborative relation many include elements of complementary, parallel or contractual arrangements when such a union is mutually undertaken for advancing the common shared objectives.
As policy makers articulate their tasks with economic development aspects, it is important to categorize number of Public Private Partnership and how it function and form. Therefore, there are different types of PPP. What suitable depends on the scope, risk and nature of the project. According to Peter and Scott (2002) there are four types of Public-private cooperation. These are: 1) Leader-Follower Relationship 2) Seller-Buyer Relationship or Exchange Relationship 3) Joint Ventures 4) Partnerships

Leader-Follower Relationship: Leader-Follower Relationship is mainly a contract that develops over time through experience not through negotiation (Peter & Scott, 2002). It happens usually when the power position of parties is not equal or too imbalance. It is widely used method where government's initial investment reduces the risk of private parties. For example, there was a project named HOPE VI taking place at Guinette Manor in Kansas City by Department of Housing and Urban Development's (HUD's) where the tenant association combined with a private organization to compete for agreement from the housing Authority. Here private company acknowledged their follower role gradually as HUD holds resources and experiences (Peter & Scott, 2002).

Seller-Buyer Relationship or Exchange Relationship: In seller-buyer relationship, the public and private party concert their decisions. Here decision-making is competitive and negotiated. Formal agreement and duration of such relationship depends on complexity of such transaction. For example: In Monongalia and West Virginia, public transport is supplied by private subcontractor. Though government takes citizens complaint about the service (Peter & Scott, 2002).

Joint Ventures: Joint venture is one kind of partnership where two or more participants work jointly on a common purpose. Such type of partnership not open ended and partners usually wish to remain their independence from others. Decisions-making isn't easy here but strong coordination can be achieved from this partnership. According to Peter and Scott (2002), "Public-private joint ventures are particularly appropriate when a project requires the complementary powers and capabilities of the public sector and the private sector."

Partnerships: According to Kleinberger (1995) and Steffen (1977) "we define an ideal-typical partnership as an open-ended agreement to work together." In such partnership, purpose is defined by the partners though always open to new opportunities and development. Peters (1998, p.13) asserts that "Rather, in a partnership there is a continuing relationship, the parameters of which are negotiated among the members from the outset".

There are several 'families' of Public-Private Partnership categorizations can be perceived rounding from long period infrastructure projects of development projects with civil society institution (Alford & O'Flynn, 2012, p.88). Infrastructure Partnership is one of them. Infrastructure Partnership is known as private finance initiatives (PFIs) in the UK and further afield (Alford & O'Flynn, 2012). This type of partnership usually take place under a long-term contract. According to Alford & O'Flynn (2012, p.88), "what makes these arrangements ambiguous is that they usually do not involve partnerships in the sense that we use the term here, in that typically the producing of the service is not shared by the government and external provider, but rather all performed by the provider, usually under a long term contract." According to Gerrard (2001), the role of public sector organization here- "Define the scope of business; specify priorities, targets and outputs; and set the performance regime by which management of the PPP is given incentives to deliver. The essential role and responsibility of the private sector in all PPPs is to deliver the business objectives of the PPP on terms offering value for money to the public sector." There were huge numbers of PFI initiatives were in UK. In Japan, there were more than 90 private finance initiatives were taken place from 2001 to 2007.

Certainly, the existing community based PPP in Bangladesh is not a PFI project. In PFI, the motive is mainly business oriented. However, like other PPP, it also gives emphasis on value for money.

Contracts governed public-private partnership: Public-private partnership comprise diverse package of design, maintenance and construction tasks. These arrangements comprise with various combinations (Alford & O'Flynn, 2012). Such as-

DCM (Design, Construction, Maintain): Public-private partnership may take the shape of a DCM where the private parties design, construct and maintains the property.

BOO (Build, Own, Operate): Public-private partnership may take the shape of a BOO where a private consortium or firm builds infrastructure and subsequently owns and operates this for a payment (either paid by users or government)

BOOT (Build, Own, Operate, Transfer): Public-private partnership may take the shape of a BOOT where the property is transferred to public organization after finishing the contract.

Collaboration based Partnership: There is also variation in the level of collaboration as a fashion of coordination (Alford & O'Flynn, 2012). In collaboration based partnership, decision-making and communication mechanism of parties to manage each other's requirement is significant than contribution to production by the concern parties (Alford & O'Flynn, 2012). A greater degree of collaboration can be measured by the level of empowerment among parties that they provide to each other. There are three indicative points in this regards (Alford & O'Flynn, 2012). First, mutual access to knowledge or information where all parties get accessibility from each other about relevant information (Alford & O'Flynn, 2012). The second important thing is consultation on the basis of all parties combined feedback and opinions about latter's actions and plan. The third element is combined decision-making where all parties enjoy the right to determine and deliberate issues in the relationship (Alford & O'Flynn, 2012). The greater range of

connectedness in deliberation indicates that each party has influence and knowledge over decisions and they enjoy greater mutual empowerment. Without this collaboration, parties will not enjoy equal power. Generally, the non-government parties have less money, information, legislative authority than government organization. It is also true for voluntary agencies/non-profit organizations than private firms. Here the most crucial point Alford and O'Flynn (2012) asserts "The point is that collaboration between governmental and non-governmental organizations will usually require the public sector agency to cede some power to external providers. They need to do this not because collaboration is a nice idea, replete with friendly, harmonious overtones, but because in some circumstances it may be the only way to secure the benefits of externalization. Especially relevant here is the role of inter-organizational trust" (Alford & O'Flynn 2012, p.116).

There is also variation in the level of collaboration as a fashion of coordination (Alford & O'Flynn, 2012). In collaboration based partnership, decision-making and communication mechanism of parties to manage each other's requirement is significant than contribution to production by the concern parties (Alford & O'Flynn, 2012). A greater degree of collaboration can be measured by the level of empowerment among parties that they provide to each other. There are three indicative points in this regards (Alford & O'Flynn, 2012). First, mutual access to knowledge or information where all parties get accessibility from each other about relevant information (Alford & O'Flynn, 2012). The second important thing is consultation on the basis of all parties combined feedback and opinions about latter's actions and plan. The third element is combined decision-making where all parties enjoy the right to determine and deliberate issues in the relationship (Alford & O'Flynn, 2012).

2.2 The Concept and Connotation regarding Community Participation

All over the world, many social scientists are searching means and ways around obstacles that hamper successful program and project in developing countries (Gonzalez, 1998). In this regard, community participation has been advising since mid-1970 as a miracle remedy. With the help of nongovernmental organizations and academics, community

involvement became the virtual cure of the 1980s. Accordingly, the 1990s witnessed multilateral and bilateral development organizations like the World Bank, The Asian Development Bank, The United States Agency for International Development which emphasized the financial, technical and economic aspects of different development projects and slowly began to put more serious affair for a programs civic and social dimensions initially to grow the likelihood of development sustainability. At the local public sector level in developing countries, growth stakeholder participation was strengthen, empowering the community people to take responsibility for preserving a project's output with smaller amount or no support from central government. Some particular examples of such socioeconomic development achievement are: preventive health care, quality education, environmental awareness and preservation consciousness. For this reason, concern of community involvement intensified in both research and practice to the development fields in Asia and the many developing countries in the world.

However, there are some negative arguments also against involvement of local people in health care accountability mechanism. George (2003) argues that in a poor legal system, local people feel vulnerable to raise their voice about doctors or any person who hold a superior position. Mosquera et al. (2001) added that doctors might feel uncomfortable about interference of local unqualified people in their service which might influence the relationship of local community people and government.

Though there are some limitations, empirical evidence shows that community participation can be an effective tool to foster health service activities. Mulgan (2003) asserts that public accountability is an alliance of exchange and social correspondence. Benington and Moore (2011) give significance on building a coalition of stakeholders to create an authorizing environment. Many health policies admit the World Health Organization's vision that to shape primary health services community should be involved (McEvoy et al., 2019). However, regarding models, operational challenges, definition to community participation, there is always debate among researchers. Using

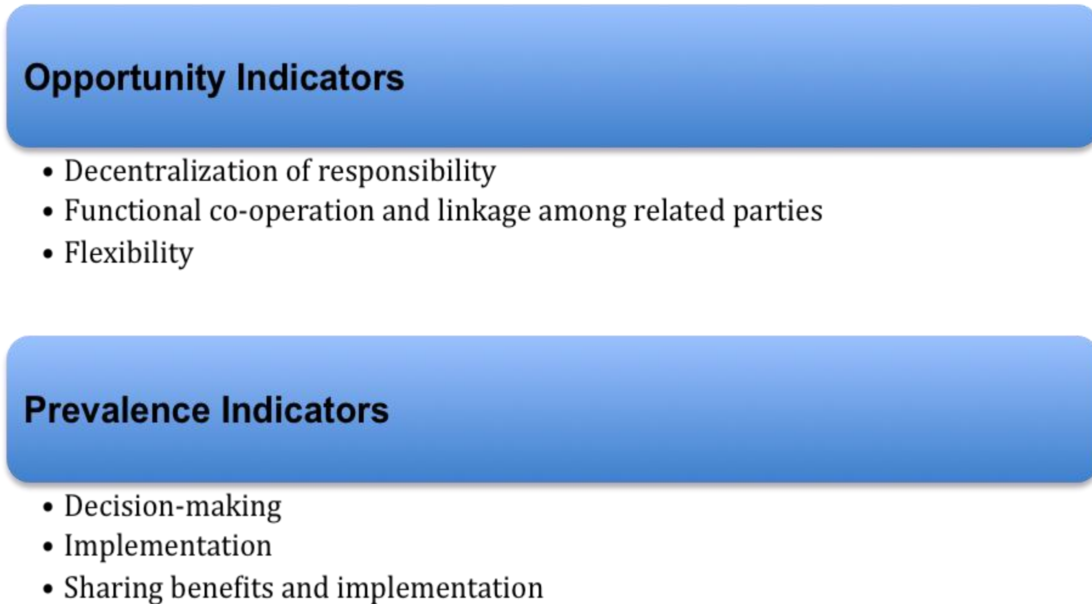
Zaman's citizen participation concept is a conceptual-framework, this qualitative study is designed to explore the extent of community participation of this community based PPP.

Zaman's citizen participation concept is a conceptual framework designed to explain how to measure the extent of community involvement in a program using some indicators. Zaman (1984) has developed a framework that provides a general understanding about the character of citizen participation. Other studies have used similar framework to assess participation very successfully in many rural development projects (Khan & Begum, 1997).

Zaman (1984) has evolved two sets of measure of participation. First – the opportunity indicators that refer to the feature of a particular plan or program structure that decide the degree of access or opportunity available to the people in local area. Decentralization of responsibility is one of the key measure here. Then functional co-operation and linkages among the related parties is another important measure. Flexibility is another measure of participation developed by Zaman. He also added incentive as measure to motivate the local people to participate.

Secondly, Zaman developed another set of indicators which is termed as prevalence indicators. Through these indicators a researcher can measure the nature of participation in the concern project. These indicators include decision-making, implementation, sharing benefits and implementation (Zaman 1984). These indicators help to understand the effectiveness of citizen participation to function the concern project.

Figure 2.1: Zaman's Citizen Participation Framework



Source: Developed by author based on Zaman's (1984) framework

In the concern section about community participation, this research will use this framework to assess the nature of community participation.

Over the last few decades, community participation and public accountability is widely used in the public administration literature to health service delivery. According to Mulgan (2003, p.12) 'by making government answer to their ultimate owners, the people, accountability encourages public deliberation and participation, key aspects of democratic citizenship.' From the current scenario of Bangladesh health sector, it is proved that accountability is one of the crucial factors to ensure effective health service delivery. It enables clients, beneficiaries and citizen participation directly in the service delivery procedure. Therefore, they get the scope to deliver their ideas and views for better service delivery to the government (Mulgan, 2000). Public accountability is important due to three reasons: 'One: the 'job' of public accountability is important to provide a democratic means to monitor and control government conduct. Two: accountability should help prevent executive abuses. Three: it should enhance the

learning capacity and effectiveness of the executive branch and its partners in governance' (Bovens et al., 2008, p.230). Citizen or client participation is widely popular in health sector to control and monitor the activities of health workers through various public accountability mechanism like report card, health committee, patient's right charter etc. This public accountability mechanism empowers democratically legitimate persons like community leaders and local politicians to monitor and assess executive performance in in accordance to their preference (Bovens et al., 2008).

Development experts believed that decentralized the role of bureaucracy is the solution in a highly centralized bureaucratic system towards development. It is opined "Health decentralization is specially meant for peoples' participation, increased transparency and a higher degree of accountability to provide comprehensive and quality health services at the grassroots level" (Nanjunda, 2020). The problem of executing plans through a centralized administrative approach guide to a call for a more decentralized bureaucratic approach. In a major study Cheema & Rondinelli (2008) found a plethora of logics for a more decentralized development point of view to planning and implementation:

1) It can be a method of overcoming the limitations of centralized administrative system by delegating substantial authority for development management and planning to the field official who are closer to the problem.

2) Decentralization can reduce the negative impact of red tape in bureaucracy and it minimizes the concentration of authority, power and resources from the center of government in the state capital.

3) By decentralization, central government officials get chance to involve with local level. It enhances their sensitivity and knowledge to local problems to be solved.

4) Decentralization could permit better administrative and political penetration of central government plans into places remote from national capital.

5) Decentralization allows greater representation for religious, political, tribal and ethnic community in the decision-making process of development that lead to substantial equity in the allotment of investments and government resources.

6) Decentralization enhances greater capability of administration to focus on function that is not generally performed well by central government.

7) Decentralization increases the efficiency and effectiveness of central government.

8) Decentralization can plan a structure through which tasks of several central government agencies and ministries involved in development could be harmonize more efficiently with each other. It also provides structure of activities to local leaders and nongovernment organizations.

9) To institutionalize the participation of community people, a decentralize government form in essential in development management and planning.

10) Decentralization creates opportunity of alternative ways of decision making by involving influential elites as they are often insensitive and unsympathetic to national development plan and policies. Their involvement enhances the scope of policy implementation.

11) Decentralization leads to more innovative, creative and flexible administration.

12) Decentralization of development management and planning allows local leaders to take active role in planning and implementation development plan through strong involvement and participation.

13) Decentralization enhances national unity and political stability by allowing opportunity to direct decision-making and participation to community people and others.

14) Decentralization can enhance the number of public services and good as well as efficiency at lower cost by minimizing diseconomies of scale (Cheema & Rondinelli 2008).

Development practitioners and governance embrace community empowerment and community participation as a basic means of building capacity to local people towards improving health service delivery at local level. However, there is on-going debate about measurement of sustainability in community participation regarding models or frameworks of sustainability. Dora et al. (2015) assert that the UN-led dialogue about the post-2015 SDG or sustainable development goal provides an opportunity to thrive targets and indicators that show the significance of health as an outcome and precondition of policies to stimulate sustainable development. As a precondition for development, health has received considerable recognition in terms of achievement of Milllennium Development Goals related with health. Using this ‘plethora of logics’ conceptualized by Cheema & Rondinelli (2008), this qualitative study will examine the sustainability

measure of decentralization of power in this program. Using this concept, this research will also measure the effect of community empowerment on the sustainability of community people driven PPP under decentralization initiatives through this community based program.

2.3 Views from Selected Global Cases

This section examines the global practice of PPP in the health care in different areas of the world. The objective was to find out the practice of PPP for health service in global aspects. It is observed that there is no liner conclusion, rather than there are different dimensions of Public-Private practice is existing in different zones in the world to face the health challenges.

The European Union has developed an integrated and consistent policy framework to respond to common challenges in the area of health that combines cooperation, legislation and financing: "Together for Health" is the EU Health Strategy (Seychell & Hackbart, 2013, p.1). EU Health strategy emphasizes on health in the Europe 2020 considering health spending is a growth friendly expenditure. A sustainable health systems and healthy population are decisive for economic development. Investing in sustainable health systems means structural reforms, sound innovation and cost-effective spending can bring secure health outcomes and efficiency. Investment on people's health boosts economic growth by enabling individuals to remain active longer and better health. Finally, investment on health reduces health inequalities and contribute to poverty reduction as well (Seychell & Hackbart, 2013, p.2).

Since 1980s, EU gradually developed a number of activities where health promotion was one significant one. The economic and fiscal crisis raised the urgency to put effort by EU towards economic growth in Europe 2020, promoting social cohesion and sustainability. In order to reach that target through focused action and coordination, the commission takes a cycle of economic policy coordination (European Commission, 2020). EU didn't

find any short-term solution. Rather that EU has focused on sustainable long-term financing for health care.

Acknowledging these development, EU adopted a new policy framework on 20 February 2013 linking EU health and social policies to Europe 2020: the “Social Investment Package for Growth and Cohesion” including a paper on “Investing in Health”. (European Commission, 2013)

EU has taken a significant number of financial mechanism to support these initiatives. The EU’s Structural Funds and Cohesion Policy are also powerful tools that foster indirectly or directly through transport, urban regeneration, environment, social inclusion, employment and housing (Seychell & Hackbart, 2013, p.2). “Investment in Health” by EU explains how it’s action in the area of health helps to reach Europe 2020 objectives given the interplay between macroeconomic outcomes and health. Sound health is a prerequisite for inclusive and sustainable growth. Good health influences people how much they can active in working and social life. This investment initiative argues for a combination of investment in sustainable health systems, in reducing health inequalities and in people’s health. These three fields are important to achieve positive health outcome which indirectly or directly turn economic outcomes (Seychell & Hackbart, 2013, p.5).

Evidence shows from European Union that the public sector plays significant role in the financing of health care service which is more than 70 percent. Though in 2011 it was only 15 percent and not all EU countries have consistency on it. Earlier evidence reflects the relationship between health outcomes and healthcare expenditure is not liner. However, it is not only how much spend but also how to spend that should be taken in consideration. Therefore, present budget limitation should be used as a scope to improve the effectiveness of healthcare expenses.

The Economic Policy Committee and the Commission have identified a number of fields where efficiency gains and structural reforms could improve the overall health system. Such as:

1. Encouraging use of health services and more cost-effective provision
2. Ensuring a mix balanced of staff skills
3. Reducing the unnecessary use of hospital care and specialists
4. Disease prevention and better health promotion
5. Improving data collection
6. For decision-making process using health assessment more systematically
7. Assure the cost-effective use of medicines and information availability for healthcare staff and patients. Such as improving provider competition and patient's choice, giving guideline for target and good practice, inspection and audit system, reforming provider payment system etc. (Smith, 2012).

The member states of the commission worked together to identify more efficient ways of investing in health aiming to end by 2013. To support these, Commission set up independent and multi-sectoral expert panel to advise on efficient ways of investing in health and tasked a number of research on forecasting EU the economics of healthcare financing, reimbursement process of medical products, external reference pricing pharmaceutical expenditure, pharmaceutical expenditure (European Commission, 2010).

It seems that proper Health Strategy taken by the EU have been compounded by not only economic crisis but also an ageing population, expensive technological progress, greater healthcare demand, rise of chronic diseases etc. Getting more value for money through investment and reform is crucial. EU shows that investment in health can drive not more spending rather smarter spending. It may take distinct forms, like change in the management to improve efficiency to improve health outcomes, prevent diseases, initiative to promote sound health, investment in staff of healthcare and equipment and training. The avoidable mortality and morbidity underlying inequality of health service represent a misuse of human capital that is assessed to reduce. Universal access to high quality, efficient healthcare services, safe, cooperation between healthcare and social sectors and fruitful public health strategy to prevent chronic disease can create a

significant contribute to social inclusion and economic productivity. EU aims that through these mentioned investments, cost-effecting innovation should be foster to complement the reform and to achieve better health outcome within the context of Europe 2020 (Seychell & Hackbart, 2013).

Furthermore, empirical evidence from Uganda shows that they reduced their health care suffering by monitoring local health care providers (Bjorkman & Svensson, 2009). As rural people in Bangladesh face this problem hugely, they can use this mechanism to ensure doctors presence regularly for health care service. Local people can work as pressure group on doctor in this regard. As the 'learning perspective' public accountability can enhance the effectiveness of government also (Bovens et al., 2008, p.232). Bovens et al. (2008) assert that 'public accountability provides public office-holders and agencies with feedback-based inducements to increase their effectiveness and efficiency'. As a feedback based mechanism, health committee can work that will enable local community to reveal their dissatisfactions and complaints. In addition, it will be a good platform to negotiate and consult with doctors to better health service delivery.

Serra (2011) asserts that without proper reporting system, only monitoring is not sufficient to change health service provider's attitude. Following Serra's perspective, this paper suggests to conduct one meeting every month between supervisory authority and health committee.

Empirical evidence from Zambia about strengthening community involvement examining the role of FBOs (Faith-Based Organizations) in delivering a specific health service (HIV) to the population can be taken in consideration about possible problem and solution in this regard (Lentz, 2010). In Zambia, there was a fight against HIV where FBOs had large role to deliver health care service by involving community people and they enhancing relationship with international partner and Zambian government. There were some cultural, economic and social problems that compounded the spread of AIDS. This evidence identifies problem that influence the implementation of community

participation of strategies and offer recommendations to develop continuous community relationships and strengthening partnership (Lentz, 2010).

The first problem was funding cycles which was often very small amount for small service givers who operate on limited capital. There was often a long wait for the funding and FBOs had no preconception about when funding would arrive or funding is coming. The recommendation came in this regard was deliver payments in a timely way and if possible ensure multiyear budget allocations to enhance sustainable monetary relationships with FBOs. Specially individuals should get more flexibility considering financial allocations when funds distribute (Lentz, 2010).

The second problem -criticisms came were mismanagement, corruption, incompetence and lack of transparency to NGOs and small FBOs due to untrained management capacity. This skills shortage hinders their capacity to formulate transparent reports to the donors for grants. Therefore, there was a badly need of HRM training for sustainable co-operation. The recommendation came in this regard was donors from multinational should assist agencies to increase administrative capacity by providing them training assistance to use technology and computers effectively (Lentz, 2010).

The third problem was due to social restriction on HIV, people were afraid to test HIV. They believed that if it is positive then they will be avoided by communities. The recommendation was all stakeholders or partners should work together to lower the stigma of AIDS.

The forth problem was found that shortage of HIV testing and other types of medical equipment. The recommendation came in this regard was facility shortage could be enhanced if donors stimulate their relationships and enhance co-operation by providing health clinic equipment, trained staff and medications.

The fifth problem was found about shortage of trained nurses and physicians. The recommendation came with five ideas. First, brain drain should be stopped through better

working environment and higher salaries from donors and MOH. Second, include HIV-positive personnel to practice their job if it is not hard for them, third, non-physician clinicians should have continuous care routine and training. Fourth, medical students can be included to health service delivery and fifth, corporation can adopt a health center or hospital with equipment (Lentz, 2010).

Italy adopted DBFMO or design-build-finance-maintain and operate Anglo-Saxon model to build new hospital (Vecchi et al., 2020). However, this model has proved as non-transparent, rigid, unaffordable and non-value for money.

In Malaysia, there is an increase trend of Public Private Partnership to deliver public infrastructure, particularly in health sectors. Government has taken facilities management (FM) initiative with hospitals in this regards (Hashim et al., 2019). This FM functions are divided in three categories, like- 1. Formulation strategies, 2. Determine service requirement and 3. Communication. Though there are some inadequacy in this partnership, it is considered as a vital initiative to deliver effective health service delivery in Malaysia (Hashim et al., 2019).

Evidence from Veneto region, Italy suggests that institutional PPPs allow national health service to obtain significant benefits when introduced as a supplement to the regular public-service provisions for a determined set of goals and services. (Cappellaro & Longo, 2011). On the basis of four area analysis, the study on Veneto region tried to find out what managerial and governance features are important to build appropriate actions for public health service provisions and what reasons drive to adopt this. Those four areas are institutional aim, governance structure, administrative procedures and relationship with the purchasing authority. We can see the same successful example from Community Care Network (CCN). It showed another good example public-private partnership in USA (Gloria J et al., 1997). A wide range of public and private sector institutions were included within their partnering organizations. CCN speaks about four principal goals through their partnerships: 1. A focus on the health status of communities, 2. A seamless continuum of care, 3. Management within fixed resources, 4. Community accountability.

These goals indicate that local coalitions and service delivery networks is necessary to advancing these goals. These broad-based partnership goals provide a unique opportunity to CCN program for understanding the types of collaboration strategies and actions that are being performed (Gloria et al., 1997).

Torchia et al. (2013) conducted a research based on a comprehensive literature of PPP in health care services focused on the United States and United Kingdom where PPPs for health care service took first place. In their research, they provide some guidelines that any PPPs for health service needs to focus. They believe that though PPPs can provide a method for achieving the relative advantages of private and public sectors in mutually concerned ways, various issues are critical here that need to be carefully examined when implementing a Public-Private Partnerships in health service delivery. For effective PPP, government should play the role as regulator where the accountability is critical as well as public interest is at stake. Therefore, governments should continue to settle standards and record as well as monitor efficacy, quality, safety and secure that citizens have sufficient access to the service and products they need. According to Jamali (2004) Public-Private Partnerships do not entail 'less government' rather a different role. In addition, due to stronger setting of the private partner in such co-operation or partnership, more active public participation is often required (Scharle 2002). Widdus (2001) asserts the same experiencing from developing countries that one of the major fields requiring special attention is the lack of efficiency of the pharmaceutical distribution system. Therefore, it seems that such partnership demand some innovative ways combining different resources and skills from both public and private parties for effective health service delivery. In order to be useful, the public party should continue to: set standards for products security, find fundamental research, quality and efficacy and promote a system whereby people have sufficient access to health service and products; use public resource in a cost-effective and efficient way; foster environments in which business enterprises are appropriately driven to meet the require of the whole population (Torchia et al., 2013). Another important component considered fundamental to Public Private Partnerships efficacy is the regulatory structure in which they take place (Torchia et al., 2013). Pongsiri (2002) highlights the establishment of a sound and transparent regulatory

framework as an unavoidable precursor to private party participation. It is the responsibility of regulation provider to assure to the all parties that resources are available to meet the broader policy goal (Zouggari, 2003). In addition, Public-Private Participations implementation should examine the interests of all the parties that have an attention in it. Fischbacher and Beaumont (2003) also focus the significance of decision-making and process during the implementation stage. Taking evidence from English health care program they put emphasis on nature and extent of stakeholder's involvement. Because it is seen that these affect the decision-making process, design and implementation of the PPP for health service delivery. Singh and Prakash (2010) put also emphasis on all party's strong involvement in the PPPs. They also focus that to decrease the power asymmetry between parties and to depend on informal setting of trust and coordination for effective PPP.

Blanken and Dewulf (2010) also outlined the significance of flexibility in PPPs from taking evidence on seven Public-Private Partnerships projects in Australia and England. Not only that, they assert some features of flexibility like knowledge and expertise, the contract, contractual arrangements and party's dependency to each other for successful health service delivery under PPPs.

However, though there are huge suggestions about effectiveness of PPPs in the health service delivery, there is a lack of evidence about effectiveness of Public-Private Partnerships (Torchia et al., 2013). Barr (2007) proposed some protocol that can be taken in consideration to evaluate the effectiveness of PPPs. These are: 1. The relationship between the private sectors and public sectors, 2. The nature of PPPs between private and public sector participants, 3. The financial arrangements of the Public-Private Partnerships projects, 4. The government policy legislated to promote partnership efforts, 5. Quantification and identification of PPPs outcome, 6. Assessing equity, 7. Identifying the possible weakness of the analysis. McKee and his colleagues (2006) assert that during implementation phase of a PPP, many things arise that need to be taken seriously in consideration. These are costs, quality of service, flexibility and complexity.

Considering the global cases, it can be said there is no short-cut formula to achieve success in partnership program. It always depends on many complex issues. As Widdus (2001) mentioned that effectiveness even not guaranteed always Public-Private Partnerships can be helpful but they are not a magic.

2.4 Conceptual Framework of the Study

This research has conceptualized the concept of collaboration as analytical framework to examine the nature of PPP in the study area. There is also variation in the level of collaboration as a fashion of coordination. In collaboration based partnership, decision-making and communication mechanism of parties to manage each other's requirement is significant than contribution to production by the concern parties (Alford & O'Flynn, 2012). A greater degree of collaboration can be measured by the level of empowerment among parties that they provide to each other. There are some more indicative points are there to measure the degree of collaboration, like- mutual access to knowledge or information where all parties get accessibility from each other about relevant information, consultation on the basis of all parties combined feedback and opinions, combined decision-making etc. (Alford & O'Flynn, 2012).

In collaboration effort, competitive advantage examines to distribute job responsibilities considering each party's capacity. Collaboration assists in overcoming information imbalance and knowledge gap between partners through knowledge sharing. It also helps to overcome risks through optimal risk sharing among parties. However, in Public-Private Co-operation generally involves a contractual, long term, innovative arrangements for advancing infrastructure and giving public services by private sector's expertise, fund that are generally the responsibility of public sector. There are many types and forms of public-private cooperation in flowing between public and private parties. The essence of such cooperation is risk sharing between parties. On the other way, collaboration helps in engineering program, that wouldn't possible with cooperation effort only. Trust is the crucial essence of such collaboration based partnership between parties. It also focuses on protection of property right, balance and equitable relationship

among parties, joint objectives, fair game, predictable regulatory and business environment.

Alford and O'Flynn (2012, p.116) asserts - "The point is that collaboration between governmental and non-governmental organizations will usually require the public sector agency to cede some power to external providers. They need to do this not because collaboration is a nice idea, replete with friendly, harmonious overtones, but because in some circumstances it may be the only way to secure the benefits of externalization. Especially relevant here is the role of inter-organizational trust." A greater degree of collaboration can be measured by the level of empowerment among parties that they provide to each other. The greater range of connectedness in deliberation indicates that each party has influence and knowledge over decisions and they enjoy greater mutual empowerment. Without this collaboration, parties will not enjoy equal power.

Hence, the research will examine the nature of this partnership based on collaboration effort between parties analyzing their access in decision-making, level of empowerment, mutual access to knowledge and consultation.

Figure 2.2: Conceptual framework

Source: Developed by author

Hence, the research will examine the nature of this partnership based on collaboration effort between parties analysing their access in decision-making, level of empowerment, mutual access to knowledge and consultation. To examine the extent of community involvement of this PPP, this research conceptualized opportunity indicators from Zaman's (1984) conceptual framework of citizen participation. Opportunity indicator involves decentralization of responsibility, functional co-operation and linkage between parties and flexibility.

Chapter Three

Methodology

3. Research Methodology and Selection of the Bangladesh Case Studies

Introduction

The past two chapters reviewed the core argument of the study and conceptual theoretical framework. This chapter states the general research methodology for the fieldwork and the criteria used in selecting the case-study areas for detailed empirical investigation. The methodological features of research set the step for acting on theory and supporting empirical investigation.

Methodology is defined as a "system of explicit rules and procedures on which research is based and against which claims for knowledge are evaluated" (Nachmias & Nachmias 1992, p.14). Methodology serves some crucial purposes of research. Such as- first it eases communication between researcher and respondents. Second, it serves as a foundation for logical reasoning. Finally, it helps to establish empirical findings of other different studies and to ease replication. Whatever, there is no universal methodological prescription or ideal for research (Khan, 1998). This is always relative and influenced by distinct research topic. As there is no universally acceptable method, one rationale way to reduce the weakness of a specific method is to regulate a combination of techniques.

First section of this chapter introduces the criteria of this research areas selection. Second section will discuss about tools and techniques of this research. It narrates the methodological techniques and consideration concerning the study as well as the sources and process of data collection. Third section will focus on limitation and constraint of this paper.

3.1 The Cases and the Basis for Their Selection

Considering the research objectives, this research attempted to point out suitable empirical cases that mirrored the answers of my objectives. More specifically, this research was searching such field cases that should broadly give back the considerable

scenario of the study. In this regard, the specific field sites for study were selected on the foundation of -

1. A careful analysis of literature (government documents, publications, reports, journals etc.
2. The views and suggestions of concerned personnel.
3. Consideration of certain elements (See table 1.1)

This research has chosen three significant unions under three upazilas of Mymensingh and Feni district in Bangladesh. From Mymensingh, two unions were chosen - Radhakanai Union under Fulbaria Upazila and Char Eshordia Union under Sadar upazila. The reasons to choose these two unions are - Char Eshordia Union is under Sadar Upazila which is near to main town Mymensingh and another union is located to more remote area in Mymensingh. Two opposite unions have been chosen to get the real facts of rural health services through CCs. Another union Char Darbesh is chosen from Shonagazi upazila in Feni. Though there are nine unions in Shonagazi, this research has chosen the most remote union Char Darbesh to get exact scenario of CC from remote area. In addition, as the researcher worked Sonagazi Upazila as Chief executive officer, there was easy accessibility to get information from the respondents.

Table 3.1 The rationale of the selected fieldwork areas

Name of the Sites	Rationale and Major Points Considerations
Radhakanai Union, Fulbaria Upazila, Mymensingh	• Availability of community clinics • Possibility of observing the acting committees and community people • Opportunity to get chance to be closer to the community people and get the real picture of the scenario as it is researcher's grandmother's home village. • Notable community clinics initiatives
6 No Char Eshordia Union,	• Availability of community clinics

Sadar Upazila, Mymensingh	• Near to town to get an idea about community clinics service delivery when it is near to district hospital • Possibility of observing the acting committees and community people • Important spot as it is near to the city • Successful cases of community clinic
Char Darbesh Union, Feni	• Few community clinics • Remote area- to get an idea about community clinic's service delivery when it is far away from town. • Possibility of observing the acting committees and community people • Poor health condition in that area

Source: Based on Author's Field Work

Purposive sampling design was adopted for the current study to select respondents. A total of 225 respondents relating to the community clinics health service (beneficiaries, staffs of CCS and member of CGs & CSGs) were contracted for data collection. Data have been collected through interview, focus group discussion and case study. Besides, the 225 respondents, 12 Key Personnel were taking part in the interview session.

Table 3.2 Visited community clinics in the study area

Char Eshordia Union, (Sadar Upazila, Mymensingh District)	Radhakanai Union (Fulbaria Upazila, Mymensingh District)	Chardarbesh Union (Shonagazi Upazila, Feni)
1. Alalpur community clinic	1. Dabardasta community clinic	1. Mangalkanti community clinic
2. Char borgina community clinic	2. Khaloypura community clinic	2. Dokhhin chardarbesh community clinic
3. Char Jawgora community clinic	3. Polastoli community clinic	3. 9 no ward community clinic
4. Char Horipur community clinic	4. Rogunathpur community clinic	
5. Char Eshordia community clinic	5. Dorduriya community clinic	
	6. Bogajan community clinic	

Source: Based on Author's Field Work

3.2 Tools and Techniques of Data Collection

The intention of this research is to find out the fact through reflections and experiences from people, therefore, qualitative method approach has been chosen. Qualitative research is based on information demonstrated words- opinions, accounts, description, feelings etc. (Williman 2006). Researcher should have explicit thinking about his/her analysis. As Robson (2002, p.459) asserts "the central requirement in qualitative analysis is clear thinking on the part of the analyst."

The research used both primary and secondary sources of data. There are numbers of empirical data collection mechanism and tools are used in this research. These are chiefly consisted of Interview (informal and open ended), Key Personnel interview, Focus group discussions, Case study and observation (uncontrolled). Purposive sampling was adopted in selecting the respondents for the interview. Reports, published materials and

government reports were used as the secondary sources. For information and ideas, a good agreement of time was spent to discuss persons and specific institutions for information and ideas. The range of people made contact with included government officials from Health Ministry at different hierarchical level, health researchers, university academics, villagers, elite people from the case study localities.

The research related documents and a selection of the vital secondary literature on PPP in the rural health service in Bangladesh were discussed as an initial step of this research. As a part of the inclination exercise, some informal discussions were taken place with key stakeholders and representatives of the health ministry.

Rigid and formal structured questionnaire weren't taken place, rather than a simple examine list of discussion points guided that interviews. A diary was used for field study where the virtually observed facts were noted. Some interviews were recorded in case of necessity with the permission of the interviewees. Respondents' body and facial expression was also observed with particular attention.

3.2.1 Interview

Interview is an attractive theme for project researcher (Denscombe, 1998). Though initially it is not seemed to involve considerable technical paraphernalia and it draws on an expertise that researcher already have the capacity to conduct a conversation. However, it is not that simple in reality. Although there is a plenty similarity between an interview and a conversation, interview is something more than conversation. Interview includes a set of understanding and assumptions about the situation which are not usually associated with informal conversation. Denscombe (1998) asserts that there should be three criteria for an interview- first, there is a consent to take part, second- interviewees' word can be treated as on the record and for the record, third- the agenda for the discussion is set by the researcher. Informal and open-ended interview has taken places in this research. Unstructured open-ended interviews are generally collected through record field noted, observation and involvement of researcher with participants of the research area (Jamshed, 2014).

For the fieldwork, the target groups included the following: selected purposive member of communities who are beneficiaries or client of the community clinics program – notably community people, staffs of CCs, local elites, member of CGs and CSGs, as well as some key personnel.

A total of 12 key personnel interview were conducted in this research. Based on experience and knowledge, they were selected to give effective input for this research. Time frame and saturation were used as the guiding basis for sample size. Alphabets including 'Respondent A', 'Respondent B' and others were used to identify the key personal respondents here. A purposeful discussion allows researchers to gather reliable and valid data to respond research objectives and questions (Saunders et al., 2009).

Table 3.3 Composition of key informant interview respondents

Category	Number	Remarks
High officials from Ministry	Respondent A Respondent B Respondent C Respondent D Respondent E	Preferred anonymity
Academic and researchers	Respondent F Respondent G	Preferred anonymity
Think Tank Representatives	Respondent H Respondent I Respondent J	Preferred anonymity
Policy maker and Political Leaders	Respondent K Respondent L	Preferred anonymity

Source : Based on Author's Work

3.2.2 Focus Group Discussion

Focus group is a type of group interview that concentrates in-depth on a specific topic or theme with an element of interaction (Walliman, 2006). People who have particular knowledge or experience about the research subject are used as such group or who have a specific interest in it. It can be slightly difficult to arrange focus group due to the difficulty of collecting a group of people at a time for a discussion session (Walliman, 2006). However, this research has explored some vital findings through focus group discussion from selected unions.

This research has taken focus group discussion in three different categories – focus group discussion with beneficiaries, focus group discussion with staffs of CCs and focus group discussion with member of CGs and CSGs. The reason of this category is the different views from their own position. It helps the research to identify their issues more clearly.

3.2.3 Case Study

Besides interview and focus group discussion, case studies play vital part to find fact of this research. Case studies focuses on one instances or just a few instances of a specific phenomenon with a view to giving an in-depth account of experiences, events, relationship or process occurring in that specific instance (Denscombe, 1998). In social research, the use of case studies has become highly widespread, specially with small scale research. Denscombe (1998) states "when researcher opt for a case study approach they buy into a set of related ideas and preferences which, when combined, give the approach its distinctive character. True, many of the features associated with the case study approach can be found elsewhere and are not necessarily unique to this strategy. However, when brought together they form a broad approach to social research, with an underlying rationale for the direction and planning of an investigation that separates it from the rationale for survey research or the rationale for experimental research." Some case studies give deep insight for this research.

3.2.4 Observation

Observation is a well-established method in social science. In this process researchers transform basic of human social activities of group behavior by a systematic method for analyzing and collection information (Angrosino, 2012). Here researcher go to the sites where people play, stay, worship, work or conduct the countless tasks of daily life. Here researcher's key task is to observe what happens naturally (Angrosino,2012, p.166). Observation is a kind of qualitative research approach which covers not only participant's observation but also research work and ethnography in the field (Jamshed,2014). Multiple study areas can be involved in observation. Data from observational data can be blended as confirmatory or auxiliary research (Jamshed, 2014). Due to time constraint, I didn't go for 'participant observation'. Instead, I took uncontrolled simple observation to grapes the real scenario of the study.

3.2.5 Secondary Source

Along with primary data, secondary data is extensively used for this research. Secondary data is information that has been recorded or interpreted from primary source (Walliman, 2006). There are plenty of sources of secondary data collection – newspaper, magazines, documentaries, news broadcasts, Internet, advertising etc. Though there are huge sources of secondary data, the quality of data depends on the method of presentation and source. It is therefore always crucial to make a careful assessment of the opinions provided or quality of the information. Along with primary data, secondary data shows different interpretation for research that has been made of the phenomenon or event (Walliman, 2006).

I relied deliberately on secondary sources of data, like reports, published materials and government reports as this information were only sources in some cases. Furthermore, they allowed me to handle broad range of conceptual matters and eased conceptual connection between my research and similar studies. In addition, this information was cost effective and easily accessible that was a vital consideration for this research.

Table 3.4 Method and Theoretical Framework

Research objectives/questions	Method of Data Collection	Theoretical Framework
1. Nature of PPP	Both Primary and Secondary sources of Data, Interview, Key personnel interview	Contemporary public governance model Collaboration based partnership
2. Extent of Community Participation	Key Personnel Interview, Focus Group Discussion, Case Study	Zaman's framework on citizen participation
3. Strengths and challenges	Interview, Focus Group Discussion, Case Study, Observation	

Source: Based on Author's Work

3.3 Constraints and Limitations

Three months were taken for fieldwork for this research. Although the given time was limited, the research was expected to expanded a general picture about the issue and deepen the comprehensive understanding of the applied or field realities. I could investigate a small number of sites in a short period. It has delimited the scope of the research. However, by using extensive secondary sources, I hoped to requite the weakness partially. Moreover, I had to work amongst major constraints of fund, time and logistic resources. In addition, the fieldwork time was not sufficient for conducting a comprehensive research. As it was a personal research, I was not entitled to get any logistic support from my office. Furthermore, the explanation and analysis of the research are incomplete as huge data were gathered to be analyse or presented here.

Chapter Four

Findings and Observations

4. Findings and Major Observations from Field

Introduction

This chapter introduces the findings of the research objectives from the selected cases in Bangladesh. It mirrors Chapter Two that reviewed vast literatures concerning the research objectives. The findings have been divided in three sections. Section 4.1 will examine the nature of PPP considering selected cases in Bangladesh. Section 4.2 will narrate the extent of community participation of this partnership. Finally, section 4.3 will examine the strengths and challenges of this program. These sections will also narrate the methodological deliberation and techniques concerning the research, including the sources of information and ways of data collection.

4.1 Nature and Current Practice of PPP: Views from the Field

This section examines the nature and current practice of community based PPP in the study areas. It mirrors chapter 2 that examined different types of PPP from vast literature along with global references and conceptualized the concept of collaboration to examine the nature of this PPP. The information of this section is taken from both primary and secondary sources of data. Interview and Key personnel interview were taken as primary sources. The objective is to find out the nature of collaboration of existing community clinic based PPP in the study area.

The next sub-sections will examine- the general pattern of this PPP, government's role as partner, community people's role as partner in Bangladesh along with field-case sites in further details. Finally, it summarizes the nature of existing PPP in the study areas.

4.1.1 General feature of this collaboration effort

Community Clinic (CC) is the revolution of government to increase primary health care service to the doorsteps of people living in the rural area in Bangladesh (CBHC, 2018). Community Clinics program is a distinctive example of Public-Private partnership where community clinics have been constructed by donated land given by community while

constructions, service providers, logistics, medicine and all other inputs are given from the government. Community owns community clinics and plays active and vigorous role for improvement of these clinics in all regards. Community clinics can be considered as one stop service outlet in respect of Health, Family Planning and Nutrition (CBHC 2018). Community Clinic is a flagship program of government. It is the lowest tier of health facility that provides health education and health promotional facilities.

The significant characteristics of PPP are sharing of risks, development of mutual services/products, costs, mutual value addition and benefits (Klijn & Teisman, 2003). It is often as a form of structured partnership between private and public actors in the planning/ exploitation of infrastructural facilities and construction in which they share costs, risks, resources, benefits and responsibilities (Koppenjan, 2005). In this existing community clinic based partnership program, as a regulatory body, finance mostly vests to the government and risks, responsibilities, maintenance vest to the both community people and government. Both government and community people avail benefits and mutual value of this program. There are varieties of potential dependencies in PPP- the need to manage risk, the need for capital, the need for maintaining flexibility for adaptation etc. (Alter & Hage, 1993). The research found that in this program, both government and community people are dependent on each other to maintain the clinics and manage possible risks.

Respondent E mentioned “There are mutual trust and dependency in this partnership effort. Community people depends for finance and supervision on the government and government depends on community people for proper maintenance of the community clinics. Both share risks as both are benefited from this initiative”.

4.1.2 Government’s role as partner

In Bangladesh, health system relies deliberately on the public sector or government for setting policies and financing and service providing mechanisms. In 1978, Bangladesh signed of Alma-Ata declaration to achieve health for all about primary health care by 2000 like other members of WHO. However, in 1998, it was found that due to

inaccessibility and unavailability of health service to the vast vulnerable and marginalized rural community, that goal was far from destination. In this context, to provide primary health care service Government of Bangladesh planned to establish these community clinics all over the country at the door steps to the pro people. Initially, government planned to build 18000 CCs. It was designed like one community clinic for 6000 population. If any ward has no community clinic, people from that ward come to near ward where community clinic is existed. From the beginning, the innovation of this unique PPP has been duly regarded and highly welcome by the rural people. All the community clinics have been exhibited on community donated land whereas medicine, instruments, equipment, construction, service providers and all logistics are from government. Management of CC is conducted by both government and community through CGs headed by local elected member. As the lowest tier of health service, the journey of CCs started in 1998 and 10000 community clinics were constructed during 1998-2001. Due to government change, this program was closed from 2001 to 2009. In 2009, after resuming the responsibility, Prime Minister Sheikh Hasina took revitalize program for closed community clinics through a project named RCHCIB or Revitalization of Community Health Care Initiatives in Bangladesh. For this purpose, government took support from JICA, TIKA and other NGOs. Rapid Assessment on CC; TA & Financial support for development of CHCP's training manual, trainer's guide, TOT, Financial support for Supervision & Monitoring; Development of documentary, Technical & financial support for best CC award, E-learning was given by world health organization. Financial support for CHCP, CG, CSG & Local Govt. representative training was given by JICA.

Respondent A opined "As a regulatory body, government has established more than 14,000 community clinics to provide primary healthcare service for disadvantage people in Bangladesh. Government plays active role to success the mission of this PPP. Sense of ownership in the essence of this unique program where both government and community people work to achieve the same goal through mutual trust and collaboration".

Monitoring of community clinics by the supervisors is a regular task of different level. Initially, WHO supported field monitoring by providing few field monitors for three years. Some partners are providing support monitoring and supervising through external facilitators. The DMCH and District Nutrition Officers (the Vaccine Alliance) have been monitoring and supporting supervision of community clinics under UNICEF. Monitoring is also being conducted from the head office of CBHC through analysing online report and mobile tracking with necessary feedback (CBHC, 2018). According to CBHC (2018) other UN agencies that provided supports (financial, technical, capacity building, monitoring and supervision, medical equipment, water and sanitation etc.) are: WHO, JICA, The Vaccine Alliance, UNICEF, USAID, TIKA, OMRON, DFID, WB and Save the Children.

Training for CHCP is conducted with the participation of GO-NGO specialists and UN agencies experts through a series of workshops and meeting. All the statisticians from different levels (Upazila, District and Division) have been trained on line reporting and reporting formats. Around 552 statisticians have been prepared on community Clinic Management Information System (MIS). There is first line supervisor also of both Health and Family Planning who are provided workshop and meetings with the involvement of GO-NGO stakeholders. Around 19154 local governments representatives have been given training. There are also provision of overseas training for managers and health officials as incentives. 1517 female CHCPs have been trained as CSBA. In case of complicated cases medical officers and SACMOs visit clinics periodically and give services. Internet connection and laptop is given to all the community clinics. E-health activities from community clinics (CC) to Upazila Health Complex (UHC) has been introduced in some locations.

In 2018, to serve primary health service through community clinics by the co-operation with social organization, private person or institution, government declared a law for community clinic health co-operation in more effective manner. It is called ‘Community Clinic Health Co-operation Trust Law 2018’ (Bangladesh gazette, 2018). After implementing this law, government has established a Community Clinic Co-operation

Trust. This trust can build community clinic anywhere in Bangladesh and existing all community clinics will vest under this trust. It's main head office in Dhaka but government can place its branch anywhere in Bangladesh. The main goal of this trust will be ensured community participation in health service and provide primary health care to all rural communities. To achieve this, trust will establish a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society. There is a trust adviser parishad. Prime minister is the chief of this parishad. One minister from health ministry, one minister from finance ministry, one minister from planning ministry, Secretary of health ministry, secretary of health service division and one person referred by prime minister consisted this parishad. This advisor parishad advices and guide to trust board. Trust board is formed with representative of all trust adviser parishad. In addition, director general of health department, director general of family planning department, secretary of Bangladesh medicine industry and three referred persons by government whereas at least one member is lady doctor. The managing director of trust is the member secretary of this board. The main duty of this trust is to fund collection, maintenance of all properties, engage community people and donors, decentralization of power to community group, co-operate community group, support and enhance the activity of community support group, ensure digital health service in the community clinics and some other works addressed by advisors and government. Trust board can establish more committee or sub-committee in case of necessity. Every three month, board will conduct a Meeting. Decisions are by the majority of board members. Trust board will submit budget report to the government in every financial year. Health service department, health department, district civil surgeon, Upazila health and family planning officer are responsible to conduct the activities of community clinics. All workers involved with these clinics under this fund are responsible to the managing director for their work. Deputy commissioner of all districts and upazila nirbahi officers of concern upazila will monitor the service of community clinics. It is found that as representatives of central government, there are many stakeholders from government are responsible to monitor and supervise of the CCs. Health service department, health department, district civil surgeon, Upazila health and

family planning officer are responsible to conduct the activities of community clinics. Moreover, the main goal of this community Clinic Co-operation Trust is to ensure community participation in health service and provide primary health care to all rural communities. That means community empowerment is one of the main goals of this Trust. To achieve this, trust is working to establish a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society to overcome financial constraint.

The research found that as regulatory government took this initiative as commitment to ensure health to all. No doubt, the structure of this PPP is totally unique where clinics establish on donated land by community and medicine, instruments, equipment, construction, service providers and all logistics are from government. Management of CC is conducted by both government and community through CGs headed by local elected member. Certainly there is mutual trust between parties unless this combined management was not possible. This is not any profit oriented PPP, rather goal is to ensure primary health care with cost effective manner for both parties. Moreover, community empowerment is one of the main goals of government.

Respondent B opined “One of the main goals of this PPP is not only attain primary health care to all but also empowering people through decentralization of power. To achieve this, as regulatory body government has established already a Community Clinic Co-operation Trust. The major goal of this Trust is to strengthen community empowerment and establish a working relationship with other stakeholders of government. The ‘Trust will also collect donation from social institutions or donor agencies to overcome financial constraint to ensure health to all”.

4.1.3 Community people’s role as partner

Community owns community clinics and assign to play an active and vigorous role for improvement of CCs in this regards. The involvement of community people in this program in two ways- first, staffs of community clinics are member of community

people, second- member of community group and community support group to monitor the activities of CCs are also from community.

Respondent F stated “The community engagement of this program in two ways- staffs of community clinics and community support group. Obviously, it is a great initiative to engage community people to serve their own community. This is one of the best example of community engagement.”

Management body of community clinic is called community group (CG). All they are from community. In each community group, there are 13-17 members where at least one third members are women and adolescent boy/girl. Central committee consists with General Secretary (who is basically any elected member, Assistant secretary-1 (who gives the land for community clinic. He is usually a life member), Assistant Secretary-2 (Teacher from High School), Koshadhakkha, A freedom fighter (Compulsory) and Member Secretary – CHCP. This community group is headed by UP member who is an elected body of that locality. Land donor or his representative is considered as life member and senior vice president of community group. Out of vice president and president at least one is female. CHCP is considered as member secretary in place FWA/HA (CBHC,2018).

For better community engagement, there is another support group called community support group. Around every functional community clinics, there are three communities support group. It is consisted having 13-17 members where one-third member is woman. Community support group consists with Ahbayak (1) and other 16 members are appointed by Ahbayak. There are three support groups in each ward. There are 1-15 members in each support group where one-third is women. It was expected that only givers will be in the committee but practically it is not happen. This Community Support Group helps Community Group for proper community clinic management. It also creates awareness among community about community clinic service and health message (CBHC, 2018). Training manual for Community Group (CG) and Community Support Group (CSG) members & trainer’s guide have been developed through a series of meetings, workshops with the contribution of GO-NGO experts and specialists of UN

Agencies. It is about 12 weeks basic training for CHCP where 6 weeks for theoretical class and 6 weeks hands on. It was finalized in a national workshop with the participation of MOHFW, DGHS, DGFP, UN Agencies, field managers & other stakeholders. Around 170799 Community Group members and 560388 Community Support Group members have been given training (CBHC 2018). The role and responsibilities of these two community groups in this program are to create a social movement of health care in their own community through community clinics to bring health highest outcomes. To monitor and supervision of community clinics activity and give valuable advices are also their job concern.

Another significant community involvement of this program is CCs staffs. They are generally from the same community or they can transfer by their choice to another community clinics. Respondent C mentioned "Employees of the community clinics are recruited by the government through both written and viva exam. Initially, selected participants are posted in his/her own area. Then there is a transfer system considering their own interest by government's demand. Girls who are appointed through exam are allowed to work both parent and father-in-law's area. But for boys – its goes only father's area not father-in-law's area. Their job as health provider in community clinics is transferable"

There are three staffs provision in each community clinic. Training for Community Health Care Provider(CHCP) is conducted with the participation of GO-NGO specialists and UN agencies experts through a series of workshops and meeting. It is about 12 weeks basic training for CHCP where 6 weeks for theoretical class and 6 week's hands on. CHCP gets training for three months from upazila. Family Planning officer(FPO) gives service three days at community clinics and three days he works in the field. Health assistant provides service in community clinics for three days. One day he/she goes to home to home for motivation and two days he gives EPI vaccine. There office time is 9am to 3pm. Health assistant provides service in community clinics for three days. One day he/she goes to home to home to motivate people about health issue and two days he gives EPI vaccine.

4.1.4 Extent of collaboration between parties

The research found that the existing community clinic based PPP is a unique example of PPP blending with different notions. As it is mentioned already in chapter two that any of the criteria of PPP are not certainly mutually exclusive. They sometimes overlap to each other. It is applicable for existing community clinic based PPP. This PPP is followed by contemporary public governance model where goal is not only cost reducing good designed contract mechanism but also a standard of mutual trust and collaboration between parties. It is a distinctive pattern of PPP where community clinics have been constructed by donated land given by community people while construction, service providers, logistics, medicine and all other inputs are given by government. Both government and community are responsible for management these clinics through community group. Community owns community clinics and plays active and vigorous role for improvement of these clinics in all regards. Millions of people are taking services from community clinics and it has become an essential part of health system. In this community clinic based PPP, government depend on community to maintain the clinic effectively and manage risk. On the other hand, community groups depend on government for capital and resource allocation. Therefore, it is seen that there is a mutual dependency and trust between government and community people in this program.

This PPP is not long period infrastructure projects of development projects that take place under a long-term contract where the role of government stuck with scope of business, target, output, specific priority with competitive incentive opportunity. In this community clinic program, business is not the objective. This community based PPP is not an instrument to promote privatization through infrastructure based public service provisions. One of the major goals of this program is cost reduction through collaboration between parties. A collaborative relation may include elements of complementary, parallel or contractual arrangements when such a union is mutually undertaken for advancing the common shared objectives. The suitable arrangement depends on the scope, risk and nature of the project. The research found the collaboration effort is blending of some other elements that is found in other PPP arrangements. As Alford and O'Flynn (2012) mentioned that in collaboration effort, government often vests some

power to other party as this is the best option for government. In existing community clinics program, it is found that it is a difficult job for government to provide health care service to this huge population and appoint specialized doctor at every corner of the country. Rather, government initiated this community clinics projects that is run by community people. Therefore, this is not pressure on government to take all responsibilities by own. This decentralization helps government to provide health to all.

Respondent D mentioned “The journey of this PPP is not so long. Still there are long way to go. Every time it is evolving with new ideas and initiatives. For example, Community Clinic Trust is a new step taken by the government to strengthen community empowerment and effective implementation of CCs. Our goal is to ensure quality health service through collaboration and set this initiative as an example for other developing countries”.

In chapter two, it was discussed that in collaboration based Partnership, there is a variation in the level of collaboration as a fashion of coordination (Alford & O’Flynn, 2012). Here, decision-making and communication mechanism of parties to manage each other’s requirement is significant than contribution to production by the concern parties (Alford & O’Flynn, 2012). A greater degree of collaboration can be measured by the level of empowerment among parties that they provide to each other. There are three indicative points in this regards (Alford & O’Flynn, 2012). First, mutual access to knowledge or information where all parties get accessibility from each other about relevant information (Alford & O’Flynn, 2012). The second important thing is consultation on the basis of all parties combined feedback and opinions about latter’s actions and plan. The third element is combined decision-making where all parties enjoy the right to determine and deliberate issues in the relationship (Alford & O’Flynn, 2012). The greater range of connectedness in deliberation indicates that each party has influence and knowledge over decisions and they enjoy greater mutual empowerment. Without this collaboration, parties will not enjoy equal power. Generally, the non-government parties have less money, information, legislative authority than government organization. It is also true for voluntary agencies/non-profit organizations than private firms. Alford and

O'Flynn (2012, p.116) asserts "The point is that collaboration between governmental and non-governmental organizations will usually require the public sector agency to cede some power to external providers. They need to do this not because collaboration is a nice idea, replete with friendly, harmonious overtones, but because in some circumstances it may be the only way to secure the benefits of externalization. Especially relevant here is the role of inter-organizational trust."

However, existing 'Community Clinic Co-operation Trust' doesn't involve both party's equal involvement. Though this trust is consisting with government officials from concern sector. It doesn't ensure involvement of community representative yet. Respondent H opined "As a regulatory body, this is government's duty to find out way to ensure community engagement in every possible field. Without greater range of connectedness, greater mutual empowerment is not possible." He suggests that government should include community representative in this Trust board.

The research found as there is no provision of direct communication mechanism with central government with community people, mutual access of information is limited in this regard. There are provisions of information exchange between CGS and CCs staffs. However, information exchange from bottom layer to higher authority passes through a proper channel. For example, staffs of CCs inform to Thana Health and Family Planning Officer(THFPO), then THFPO deliver it Civil Surgeon. Then Civil Surgeon delivers it to the ministry. Respondent B stated "Any information regarding health issues or decisions pass to the community member through proper channel. Again, community member conveys their message through proper channel to the central government. But there is no provision of direct involvement of community representative in decision-making yet."

From focus group discussion, the research found that there is a knowledge gap between parties. Community people are often not aware about their right and responsibility. From government side, it is also found that there is limited effort from government to build knowledge and expertise to community member and staffs of CCs.

The second indicative point is consultation. There is always a monthly meeting held with higher authority of Upazila Health Complex and CCs staffs. There is also a regular consultation provision among community group and community support group with CCs. They provide their valuable opinion, plans and feedback to the higher authority. Yet, community representative provision is absent in monthly Trust board meeting. It indicates, community member's engagement is limited in this program.

The third indicative point is joint decision making. Major decisions are taken by Trust Advisory Parishad regarding any important issues. However, community member enjoy flexibility in decision-making in their own area. For major decisions, the solely depend on higher authority. Sometimes staffs of CCs convey their message through proper channel to the higher authority. However, major decision is still vested to community co-operation trust. From focus group discussion, respondents expressed their frustration about their limited access in consultation with central government. They mention that this program is structured by involving community people but very limited scope to contribute. In some cases, respondents don't know that community empowerment is one of the main goals of this PPP.

Respondent C also mentioned "The structure of this program about community involvement is one of the unique examples of community empowerment. Government has given highest emphasis on empowering community people in this existing partnership. However, joint decision-making still a challenge from central level to periphery. That's why CGs and CSGs are there to make it easier". Respondent I opined "Without mutual access to information and decision-making, community engagement will not be effective in partnership program. Government should emphasis to mitigate this gap and ensure mutual access to knowledge and consultation."

Though key respondents from ministry mentioned that community empowerment is one of the significant goals of this mission, members of community groups expressed their frustration about limited faculty to contribute in focus group discussion. They mentioned though they are assigned to monitor and supervise CCs activity, they have very limited

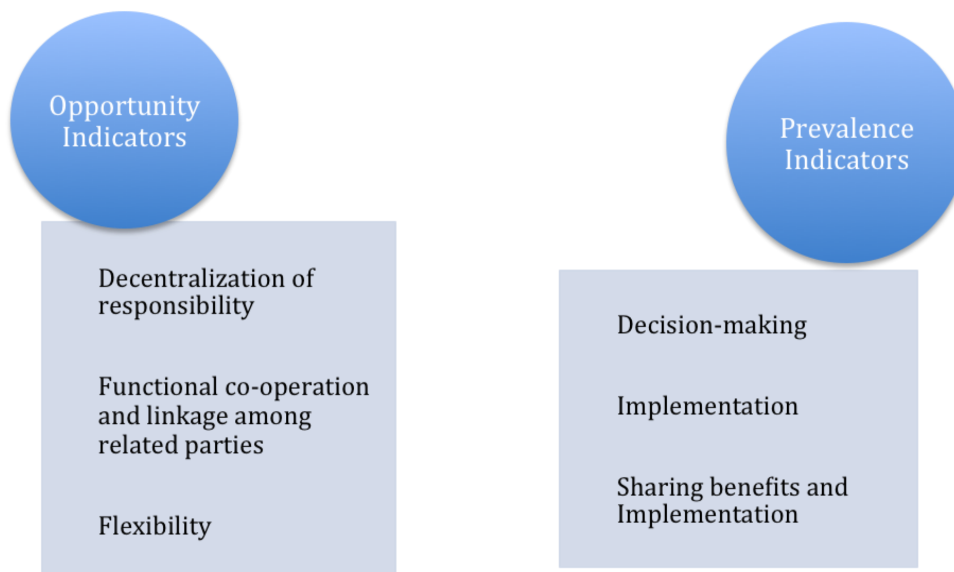
power in decision-making and implementation. Respondent F opined "Though this PPP is considered as a great example of collaboration through empowering community people, still there is significant gap. As a regulatory body, government should innovate some policy instruments to ensure both parties reasonable access in information exchange, decision-making and implementation. To attain flexibility in collaboration, government should mitigate the knowledge gap between parties".

4.2 The Extent of Community Participation: Views from the Field

This section examines the nature of community participation of this PPP in the selected areas. While chapter two reviewed the theoretical framework of Zaman's Citizen Participation model, this deliberation concentrates on the specific case study areas.

This research has conceptualized the opportunity indicators of Zaman's (1984) Citizen Participation framework to examine the extent of community participation of the selected sites. These indicators include decision-making, sharing benefits and implementation. Through the indicators a researcher can measure the extent of community participation in concern project.

Figure 4.1 Zaman's Framework of Community Participation



Source: Based on Zaman's (1984) citizen participation framework

The next sub-sections review the extent of community participation in the selected areas through the light of opportunity indicators of Zaman's theoretical framework of citizen participation. First sub-section will examine decentralization of responsibility of community people and sustainability of their engagement in this program by the light of plethora of logics. Second sub-section will examine functional co-operation and linkage between parties and third sub-section will measure of flexibility of community involvement in this program. Information of this chapter is taken from both primary and secondary sources of data. Interview, focus group discussion and case study were used to find out the answers.

4.2.1 Decentralization of responsibility

This section examines the decentralization of responsibility and sustainability of this community involvement in this PPP. This study analyses a set of expected results that decentralization contributed to as an initial step in developing a structure for assessing sustainability through community empowerment to improving service delivery in this program. Sustainability is a major issue closely connected to any community based intervention. It is experienced in many cases in the past that such interventions align to community empowerment failed to sustain with the abolition of support from development partners or national level. The main ground for this failure are lack of ownership and involvement of the community (Normand et al., 2002).

All over the world, many social scientists are searching means and ways around obstacles that hamper successful program and project in developing countries (Gonzalez, 1998). In this regard, community participation has been advising since mid-1970 as a miracle remedy. Development experts believe that decentralization is the solution in a highly centralized bureaucratic system towards development. The problem of executing plans through a centralized administrative approach guide to a call for a more decentralized bureaucratic approach. This study examines the extent of community involvement by Cheema and Rondinelli (2008) defined plethora from a decentralized development point of view along with sustainability of community involvement. This logic has been discussed elaborately already at Chapter 2.

Plethora of logics shows that decentralization can be a method of overcoming the limitations of centralized administrative system by delegating substantial authority for development management and planning to the field official who are closer to the problem. It can reduce the negative impact of red tape in bureaucracy and it minimizes the concentration of authority, power and resources from the center of government in the state capital. Thus, central government officials get chance to involve with local level. It enhances their sensitivity and knowledge to local problems to be solved. The research found that this community participation in this PPP is a notable initiative of decentralization of power where community clinics have been constructed by donated land and construction, service providers, logistics, medicine and all other inputs are given by the government. Both government and community are responsible for management these clinics through community group. Community owns community clinics and plays active and vigorous role for improvement of these clinics in all regards. It is a good example of decentralization of power. The study found that through decentralization, central government officials get chance to involve with local level that enhances their knowledge and sensitivity to solve local problem in more effective manner. In this community based PPP, health service department, health department, district civil surgeon, Upazila health and family planning officer are responsible to conduct the activities of community clinics. They can get chance to know the views of community people through this collaboration. Deputy commissioner of all districts and upazila nirbahi officers of concern upazila will monitor the service of community clinics. Health service department, health department, district civil surgeon, Upazila health and family planning officer are responsible to conduct the activities of community clinics. Upazila Health Complex is monitoring authority of CCs from local level. Respondent A mentioned "Community clinic is a wonderful example of decentralization of power from bureaucratic concentrative authority to local government who are closer to the problem. This PPP has ensured smooth health service without bureaucratic complexity. Community Clinic is the bottom tier of health service in Bangladesh and government gives highest priority to community involvement. Therefore, it has minimized the concentration of central government and has involved community people and local

government through decentralization. Such decentralization is obviously a useful tool towards sustainability of such partnership program".

Decentralization allows central government officials get chance to involve with local level and permits better administrative and political penetration of central government plans into places remote from national capital. That enhances their sensitivity and knowledge to local problems to be solved. The research found that this decentralization of power through this PPP allows community people to share their opinion and involvement for their betterment. Respondent E mentioned 'Community people have own traditional knowledge to solve many problems. This involvement allows them to share their views to authority. That helps both parties.'

It is also pointed that decentralization allows greater representation for religious, political, tribal and ethnic community in the decision-making process of development that lead to substantial equity in the allotment of investments and government resources. This logic also assumes that decentralization creates opportunity of alternative ways of decision making by involving influential elites as their involvement enhances the scope of policy implementation. It leads to more innovative, creative and flexible administration. Decentralization of development management and planning allows local leaders to take active role in planning and implementation development plan through strong involvement and participation. The research found such equity in the formation of Community Groups and Community Support Groups. In the structure of community group and community support group this equity is visible. Community group is leaded by an elected member and involve representative from different group from the society. In a poor legal system, local people feel vulnerable to raise their voice about doctors or any person who hold a superior position (George,2003). However, from focus group discussion as elected members are also included in Community Support Group, they don't feel that vulnerability to raise their voice over any suggestions.

Management body of community clinic is called Community Group (CG). All they are member of community. In each community group, there are 13-17 members where at least one third members are women and adolescent boy/girl. Central committee consists with General Secretary (who is basically any elected member, Assistant secretary-1 (who gives the land for community clinic. He is usually a life member), Assistant Secretary-2 (Teacher from High School), Koshadhakkha, A freedom fighter (Compulsory) and Member Secretary – CHCP. This community group is headed by UP member who is an elected body of that locality. Land donor or his representative is considered as life member and senior vice president of community group. Out of vice president and president at least one is female. CHCP is considered as member secretary in place FWA/HA (CBHC,2018). For better community engagement, there is another support group called Community Support Group (CSG). Around every functional community clinics, there are three communities support group. It is consisted having 13-17 members where one-third member is woman. Community support group consists with Ahbayak (1) and other 16 members are appointed by Ahbayak. There are three support groups in each ward. There are 1-15 members in each support group where one-third is women. It was expected that only givers will be in the committee but practically it is not happen. This Community Support Group helps Community Group for proper community clinic management. Around every functional community clinics, there are three communities support group in each ward. It is consisted having 13-17 members where one-third member are women. Community Support Group helps Community Group for proper CC management. It also builds awareness among community about community clinic service. (CBHC,2018). In focus group discussion with members of CGs and CSGs, they think there is proper balance of community involvement in this program that involves representative from different group of the society. Respondent B stated “All member of the CGs and CSGs are from community to foster the activities of this program. For example, elected member and freedom fighter are there who have influential role in the society. On the other hand, the land giver is also play important role in the committee as a community member. One of the main purposes of this program is to empower community people, more specifically handover responsibility to the community as they are the main beneficiaries”

Decentralization increases the efficiency and effectiveness of central government and enhances greater capability of administration to focus on function that is not generally performed well by central government. It can plan a structure through which tasks of several central government agencies and ministries involved in development could be harmonize more efficiently with each other. It also provides structure of activities to local leaders and nongovernment organizations. To institutionalize the participation of community people, a decentralize government form in essential in development management and planning. The study found that to serve primary health service through community clinics by the co-operation with social organization, private person or institution, government declared a law for community clinic health co-operation in more effective manner. It is called community clinic health co-operation trust law, 2018 (Bangladesh gazette, 2018). After implementing this law, government has established a community clinic co-operation trust. This trust can build community clinic anywhere in Bangladesh and existing all community clinics will vest under this trust. It's main head office in Dhaka but government can place its branch anywhere in Bangladesh. The main goal of this trust will be ensured community participation in health service and provide primary health care to all rural communities. To achieve this, trust will establish a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society. There is a trust adviser parishad. Prime minister is the chief of this parishad. One minister from health ministry, one minister from finance ministry, one minister from planning ministry, Secretary of health ministry, secretary of health service division and one person referred by prime minister consisted this parishad. This advisor parishad advices and guide to trust board. Trust board is formed with representative of all trust adviser parishad. In addition, director general of health department, director general of family planning department, secretary of Bangladesh medicine industry and three referred persons by government whereas at least one member is lady doctor. The managing director of trust is the member secretary of this board. The main duty of this trust is to fund collection, maintenance of all properties, engage community people and donors, decentralization of power to community group, co-operate community group, support and enhance the activity of community support group, ensure

digital health service in the community clinics and some other works addressed by advisors and government. Trust board can establish more committee or sub-committee in case of necessity. Every three months, board will conduct a Meeting. Decisions are by the majority of board members. Trust board will submit budget report to the government in every financial year. Health service department, health department, district civil surgeon, Upazila health and family planning officer are responsible to conduct the activities of community clinics. All workers involved with these clinics under this fund are responsible to the managing director for their work. Deputy commissioner of all districts and upazila nirbahi officers of concern upazila will monitor the service of community clinics. One of the main goals of community clinic co-operation trust is to ensure community participation in health service and provide primary health care to all rural communities. To achieve this, trust establishes a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society. Respondent C stated 'Such Trust can be considered as institutionalization of this PPP through decentralization of power. This trust leads to more innovative, creative and flexible administration. It enhances the number of public services and efficiency at lower cost by minimizing diseconomies of scale. It is already observed that the way community clinic program is formed involving community people and other elites from the rural community, it is very much flexible to administer this program.'

The main target was to empower community people through shifting power from central government to local community to ensure the highest outcome. They believe that such decentralization is working very effectively from government to community people to deliver primary health care. It was asked to the respondents about their opinion considering local leader's involvement in this partnership. Majority of community people agreed that there is satisfactory involvement of elected leader in this partnership program through committee and sub-committee. Such decentralization also helps to policy implementation. Local leaders can take active role in planning and implementation through strong involvement and participation.

It was asked to the respondents from community group and community support group what they think about their involvement to the decision-making in this partnership program. The respondents from all three unions expressed that though they have notable involvement in this program but with limited decision-making power. They can exercise their decisions with limited capacity. Respondent I opined that there should be more power vested upon community group with sufficient resources allocation. Respondent L mentioned "Member of community groups should have proper education and training to contribute more for the society in this regard. Though this is an excellent structure of decentralization, in practice community people have limited access in consultation and decision-making. Government should overcome this limitation through effective policy guidelines".

Moreover, one of the main goals of SDG is to reduce financial hardship of medical expenses. Respondent C stated "One of the core missions of government is to enhance the capacity of community clinic to attain UHC on time. In this regard, ensure cost effective primary health service through this program can be a good attempt to attain SDG". Respondent B mentioned that "This partnership program reduces not only financial burden from pro-people but also works as a bridge to build strong relationship between service provider and community people. Therefore, service provider can take attempt from common understanding to solve any health-related problem. This partnership also enhances governance and accountability in health service delivery." It is hoping that community clinics will be able to contribute effectively in achieving Sustainable Development Goals (SDG) and health for everyone will be ensured (CBHC,2018).

Considering the discussion of sustainability of community participation in this partnership program through the light of decentralization concept, it is observed that though such decentralization is a sustainable attempt by the government as it enhances greater capability of administration to focus on the function that is not generally performed well by central government alone, there is some gap in practice. Though it increases the efficiency of central government by decentralizing power as well as reduces

the financial hardship to the communities, community people have limited access over information, decision-making and implementation.

4.2.2 Functional cooperation between parties

Community Clinic is a distinctive example of Public-Private partnership where community clinics have been constructed by donated land given by community while construction, service providers, logistics, medicine and all other inputs are given by the government. Both members of Community Groups and Staffs of Community Clinics are member from the community. It is already discussed in previous chapter about the structure of this PPP is a good example of decentralization of power. The structure of CG and CSG can be seen in this table.

Table 4.1 Size and Job Description of CG and CSG

1 Community Group (CG)	3 Community Support Groups (CSG)
13-17 members (HCP*, local leaders, local govt.local elites)	13-17 members (local govt, community leaders, community from all SES**, adolescent; 1/3rd female members)
Headed by Union Parishad member (of ward where CC located)	Headed by Union Parishad member to help CG in CC management
Responsibilities: • CC's daily operations • M&E • Stakeholder coordination • Fund generation	Responsibilities: • Assist CG in managing CC (M&E, fund generation etc) • Raise community awareness

Source: Mahmood, 2018, p.1

As CGs and CSGs are consisted from the community member, they have very significant role of this program. In addition, staffs of CCs are also taken from community in this PPP. Respondents from Radhakani union stated that they feel these clinics as their own where they can go for any primary health problems. As health service providers are from their own territory, it gives them different closeness to those community clinics. Both members of CGs and CSGs and staffs of CCs are from community who are responsible to maintain the CCs. Such involvement of community people is a great example of decentralization of power. This involvement gives them an opportunity to work for their own community. They can work for their community with more devotion knowing what is better them.

Generally functional co-operation between parties occurs at different levels. Functional cooperation requires joint activities and service sharing to achieve unity and reduce cost of the service. Community Clinic Co-operation Trust was established in this regard. The main goal of this trust will be ensured community participation in health service and provide primary health care to all rural communities. To achieve this, trust will establish a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society. The main duty of this trust is to fund collection, maintenance of all properties, engage community people and donors, decentralization of power to community group, co-operate community group, support and enhance the activity of community support group, ensure digital health service in the community clinics and some other works addressed by advisors and government. Decisions are by the majority of board members. Health service department, health department, district civil surgeon, Upazila health and family planning officer are responsible to conduct the activities of community clinics. All workers involved with these clinics under this fund are responsible to the managing director for their work. Deputy commissioner of all districts and upazila nirbahi officers of concern upazila will monitor the service of community clinics. One of the main goals of community clinic co-operation trust is to ensure community participation in health service and provide primary health care to all rural communities. To achieve this, trust establishes a working relationship with union

health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society.

The structure of this partnership shows that there is interdependency in both parties. From focus group discussion with members of CGs in Char Eshordia Union, they express about their ownership feelings for CCs. They feel CC as their property. As a member of community group, they always want to give their best for their community. They expressed that they always feel a sense of responsibility for the better service of that community clinic. They mentioned that it's applicable for other members too. They feel strong involvement with this program. 'It feels that it is ours'- they concluded. However, they expressed their limitation over decision-making and consultation in this program.

However, some respondents from CGs and CSGs in Radhakanai Union mentioned that they should have more power in decision-making and need some budget to execute in case of emergency. Both CGs and CSGs helps staffs of CCs tproviding their suggestion and support. In case of serious issue, they take the issue to Upazila health complex officer. In focus group discussion, members of Radhakanai Union expressed that to deliver any message to the higher authority they need to wait to convey that message through proper channel. From focus group discussion, it is found that the functional linkage between parties is not sufficient to strengthen the program.

Respondent J opined "knowledge gap between parties is often a barrier to joint decision-making and consultation. In that case, government should take necessary initiatives to mitigate this knowledge gap. Thus, community people can contribute more effectively in this partnership". As a feedback based mechanism, CGs and CSGs in the community clinic program work that enables local community to reveal their dissatisfactions and complaints. In addition, it is a good platform to negotiate and consult with health staffs to better health service delivery. Respondent F mentioned "This community involvement helps to establish accountability of government to service delivery through effective community engagement. Thus, government should ensure the best way to implement this engagement".

Mulgan (2003, p.12) mentioned 'by making government answer to their ultimate owners, the people, accountability encourages public deliberation and participation, key aspects of democratic citizenship.' From the scenario of Bangladesh health sector, it is proved that accountability is one of the crucial factors to ensure effective health service delivery. It enables clients, beneficiaries and citizen participation directly in the service delivery procedure. Therefore, they get the scope to deliver their ideas and views for better service delivery to the government (Mulgan, 2000). Citizen or client participation is widely popular in health sector to control and monitor the activities of health workers through various public accountability mechanism like report card, health committee, patient's right charter etc. This public accountability mechanism empowers democratically legitimate persons like community leaders and local politicians to monitor and assess executive performance in in accordance to their preference (Bovens et al., 2008).

Table 4.2. Process of CSC (community score card) Implementation constituted of four basic phases

Phase 1 Planning and preparation	
Phase 2 CSC with community (CSG)	CSC with providers (CG)
Phase 3 Interface	Action Plan Setting
Phase 4 Action plan implementation	Monitoring and Evaluation

Source: Mahmood, 2018, p. 2

The research found that the design of community participation in this program is a great example of decentralization of power, there is poor monitoring and supervision over the program. The research found that though the functional linkage between parties is well organize, in practice there is some gap that can be mitigated by useful mechanism of government. Respondent K mentioned “As it is hard to control supervision from central to periphery, therefore, community participation is a good effort of decentralization of power by empowering community people. But government should set up useful mechanism to mutual engagement in all aspects and assess the performance. Unless this decentralization might be useless”.

4.2.3 Flexibility

Staffs of community clinics have opportunity to work in their preferable service station. Staffs of CCs are recruited by the government through both written and viva exam. Initially selected participant is appointed in his/her own community. Then there is a transfer system considering their own interest or by government’s demand. Girls who are appointed through exam are allowed to work both parent and father-in-law’s area. But for boys – its goes only father’s area not father-in-law’s area. Focus group discussion of the staffs of CCs, they shared that it is very convenience for them to work at their own territory. They think it is very economic also to work near to their house as it reduces cost of their living. Respondent C mentioned “Employees of the community clinics are recruited by the government. Initially, selected participants are posted in own area. There is flexibility to transfer considering their own interest or sometimes demand of government”. Woman who are appointed through exam are allowed to work either at parent or father-in-law’s community.

Box: 4.1 Case Study on Dabardasta ward no. 1, Radhakanai Union, Fulbaria Upazila, Mymensingh

Rahima Khatun is a health provider in 1 no Dabardasta ward Radhakanai Union, Fulbaria Upazila, Mymensingh. Initially after selected as CHCP, she was appointed another union where her parents live. But after getting married, she transferred to present ward where her in laws live. She said that such flexibility of participation is the strength of this community clinic program and it encourages many women to work here. She mentioned that this flexibility of work encourages others to work in this health service program. She concluded that there is always a sense of satisfaction as she works for her own community.

Besides recruitment flexibility of staffs, members of CGs and CSGs also avails flexibility in this program in their meeting and decision-making at own community. Moreover, doctors often feel uncomfortable about interference of local unqualified people in their service that might influence the relationship of local community people and government (Mosquera et al., 2001). In this regard, community people can share their problem easily to the trained health care providers by their own language. Respondent L opined "Most of the doctors are unwilling to work in country side, in this regard, trained health service providers from local territory have become dependent sources of health service to the villagers". Beneficiaries enjoy opportunity to share everything without any hesitations to the health care providers from their community. Respondent K mentioned that this community involvement not only ensures community health service but also an effective tool of value for money to the government. Respondents from community people also expressed their satisfaction about this cost-effective health service by community clinics. In addition, Community clinic co-operation trust can build community clinic anywhere in Bangladesh. The main goal of this trust is to ensure community participation in health service and provide primary health care to all rural communities. To achieve this, trust will establish a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. It will also take donation from social institution or donor from society.

Family planning officer of community clinic gives three days service at community clinic and other three days they work in the field. It also gives opportunity to build strong connection with community people. Everyday around 50 to 60 patients come to each community clinic. As health service providers are also member of the community, community people can talk about their problems without any hesitation. Respondent D mentioned “Though major decisions of CCs are vested in community clinic co-operation trust, within own territory community group and staffs of community clinic are flexible take their decisions. Such flexibility makes this program unique.” Most of the respondents from CGs and CSGs mentioned that there is no rigid timeframe about our communication. They do it considering their own convenience and necessity.

From focus group discussion it is found that some CCs take 2-5 taka from per patient. They do it by their own decision. They use this money as salary of the cleaner of CC. There is no government budget for this purpose. There is a Sonali bank account for every community clinic. The money they take from each patient is saved there. After paying the money for the cleaner’s salary that money use for any extra cost of community clinic like banner or program arrangement or emergency poor patient. In case of any emergency, patient from concern community can use that extra money from the bank. If any patient need emergency support, they refer patient to Upazila Health Complex (UHC).

Though major decisions are taken from higher authority, member of CGs and staffs of CCs enjoy the flexibility to take minor decision in their territory. In some cases, they consult with UHC in monthly meeting. Health service department, health department, district civil surgeon, Upazila health and family planning officer are responsible to conduct the activities of community clinics. The research found, members of community group and community support group provides their valuable opinion, plans and feedback to the concern authority. However, decision-making isn’t easy with central government from bottom layer. Any decision from bottom layer passes through a proper channel. For example, community clinic health providers inform to Thana Health and Family Planning Officer (THFPO), then THFPO deliver it Civil Surgeon. Then Civil Surgeon delivers it to

the ministry. Respondent F mentioned “Members of community group and community support group need more training and education to play more active role in this program. Respondents from Char Eshhordia CGs members opined that there should be more awareness program and more active involvement they need to run this program efficiently. In focus group discussion with member of CGs and CSGs, they mentioned that without prompt decision, implementation is often hard. They can’t take that quick decision from their limited capacity. Fischbacher and Beaumont (2003) also focus the significance of decision-making and process during the implementation stage. Taking evidence from English health care program they put emphasis on nature and extent of stakeholder’s involvement. Because it is seen that these affect the decision-making process, design and implementation of the PPP for health service delivery. Singh and Prakash (2010) put also emphasis on all party’s strong involvement in the PPPs. Respondent J mentioned “Though government’s intention was to empower community people but still there is some gap- like community group member have very limited power over the program. There is often lack of necessary medicine that is solely depends on higher authority. They have nothing to do with budget allocation”.

However, many respondents from member of CGs expressed their dissatisfaction about flexibility in decision-making and financial limitation. In many cases, they depend on higher authority to take decisions. It often hampers prompt action in case of emergency. Respondent H mentioned “Member of community group are not always well educated which is crucial to maintain proper communication with higher authority”. Respondents from community group and community support group in Char Eshordia Union, Mymensingh expressed that there is a frustration among group members that they need to depend often on higher authority to solve emergency problem. Respondents from Chardarbesh Union, Shonagazi Upazila, Feni also expressed that there should have more flexibility to take decision by community group. They mentioned often community group depends on higher authority in emergency cases. In case of medicine shortages and other demand, community group or community support group hold very little power over it.

Table 4.3 Flexibility in decision-making of CG & CSG (Q. Do you think you can take decisions easily regarding any issue of CCs?)

Sites	Affirmative %	Negative %	No-comments %
Char Eshordia Union	16	84	0
Radhakanai Union	10	80	10
Chardarbesh Union	15	72	13

Notes: *Affirmative = members think that they have access to decision-making; Negative = members think that they have no access to decision-making.
Source: Based on Author's Work

Most of the members of CGs and CSGs expressed that they have very minimum access in decision-making. As a result, in case of emergency it's tough to take any prompt action. They also mentioned they there should be a fund for them that they can use in emergency. One member from Radhakanai Union said in this regard "it is like dhal-nai, taloar nai, nidhiram sorkar". That indicates- though they are responsible and involve to maintain the CCs, they have very limited power over it. It is experienced in many cases in the past that such interventions align to community empowerment failed to sustain with the abolition of support from development partners or national level. The main ground for this failure are lack of ownership and involvement of the community (Normand et al., 2002).

Table 4.4 CGs & CSGs' opinion about separate fund for emergency (Q. Do you think there should have a separate fund for you in case of crisis?)

Sites	Affirmative %	Negative %	No-comments %
Char Eshordia Union	92	8	0
Radhakanai Union	90	10	0
Chardarbesh Union	88	10	2

Notes: *Affirmative = members think that there should have a separate fund; Negative = members who think that they should have a separate fund.
Source: Based on Author's Work

Respondents from all three unions mentioned that there should be more flexibility in decision-making for community group and community support group. Respondent G opined that flexibility in decision-making will provide more sense of empowerment to the community group. It will easier to achieve desire outcome, he concluded. The structure of health committees and the recruitment procedures of health care providers in community health clinic indicate the nature of involvement of community people in this partnership program. The research found that there is an orderly contact by regulation among all stakeholders of this program as it is priority project of Prime Minister. However, functional-linkage should be more strengthened by frequent communication with higher authority. Moreover, without proper reporting system, only monitoring is not sufficient to change health service provider's attitude (Serra, 2011). Respondent H suggested "At least one meeting should be conducted every month between supervisory authority and health committee. He added "There should be specific report and monthly evaluation provision also". The research found that both trust board and committee conduct meeting in regular basis. Though there is inspection chart to monitor the activities of CCs, there is no provision for regular evaluation.

4.3. Strengths and Challenges: Major Observations from the Field

This section examines the strengths and challenges of this PPP in the selected areas. The nature of this PPP and the extent of community participation of this program have been discussed already in sections 4.1 and 4.2. Information of this section is taken mainly from primary sources of data. Interview, case study and focus group discussion were used to examine the process. Some information was taken from secondary sources of data. This section has been divided in two subsections – first strengths and then challenges.

4.3.1 Strategic Analysis of PPP: Strengths

The objective of this section is to find out the strengths and challenges of this partnership program in the selected areas. Considering nature of PPP, relevance of government's goals, equity, effectiveness, values for money, this paper will examine the strengths of this PPP.

Barr (2007) proposed some protocol that can be taken in consideration to evaluate the effectiveness of PPPs. These are- the nature of PPP, relevance with government's goals, equity assess, effectiveness, value for money or financial arrangement, possible weakness assess etc. Monitor (1996) also identified that efficiency, effective management, cost effectiveness can be considered as successful PPP for health service delivery. A report by the Asian Development Bank Institute (2000) identified some objectives of ideal health service delivery in PPP. Those are also aligned with these mentioned features by Barr (2007). Considering these features, this paper examines the strengths of this PPP.

4.3.1.1 Nature of PPP

To know the effectiveness of this PPP, first this research has examined the nature of this PPP. It is already examined in details in section 4.1. The research found that this community clinics based PPP is a distinctive example of Public-Private partnership. This PPP is followed by contemporary public governance model where goal is not only cost reducing good designed contract mechanism but also a standard of mutual trust and collaboration between parties.

As it is mentioned already that any of the criteria of PPP are not certainly mutually exclusive. They sometimes overlap to each other. As Alford & O'Flynn (2012) assert that PPP may comprises with diverse and various combinations. It is also applicable for existing community based PPP. It is not like contracts governed public-private partnership that tends to be complex, long, highly specified and legalistic. It is a combination of various arrangements where community clinics have been constructed by donated land given by community while construction, service providers, logistics, medicine and all other inputs are given from government. But both government and community are responsible for management these clinics through community group. Community owns community clinics and plays active and vigorous role for improvement of these clinics in all regards.

Existing public private partnership is vastly similar to Alford and O'flynn's (2012) collaboration based partnership. It is mentioned already that there can be variation in the level of collaboration. In the existing public-private partnership it is observed there is variation of collaboration. Empowerment is one of the core elements of collaboration partnership (Alford & O'flynn, 2012). In Bangladesh, we see government has given highest emphasis on empowering community people in this PPP. Such collaboration is found between government and community people considering decentralization of power and trust. Therefore, it can be said, though there is no single arrangement or specific nature of this PPP program, this partnership program reflects similarity with O'flynn defined collaboration-based partnership. Alford and O'flynn (2012) stated that this kind of collaboration arrangement is a model for developing countries for effective health service delivery.

Respondent H opined "This community based PPP can be considered as an effective framework to achieve universal health coverage for Bangladesh. Here the relation with the party is collaborative and trust based. The arrangement gives community people a sense of ownership. Land of CCs is donation by community people and members - responsible for this CC are also from the same community. Therefore, there is huge

opportunity to get highest outcome of this PPP by ensuring effective empowerment of community."

4.3.1.2 Relevance with government goal

Community Based Health Care has been positioned with national policies. Moreover, Bangladesh is committed to accomplishing both universal health coverage and SDG by 2030. In this regard, the CBHC program, especially Community Clinics project is a distinctive tool having the prospective to contribute to the attainment of both goals. The effectiveness of this PPP can be also measured by assessing the relevance of this initiative with the government's goal. This is constitutional commitment of Bangladesh to remove inequalities in acquire to health in rural areas. Bangladesh has joined in the global community also in committing to attain UHC by 2030 under the Sustainable Development Goals (Joarder et al., 2019). After 29 years of its independence, Bangladesh adopted its first National Health Policy (NHP) that was revised again in 2011. It stated that 'Every citizen has the basic right to adequate health care. The State and the government are constitutionally obliged to ensure health care for its citizens'. National health policy marked most of the things pertaining to country's health care service system including health care expenditure and health care financing. Freshly adjusted National Health Policy suggested a considerable increase in budgetary allotment for health care delivery and services system. As a result, to National Health Policy, government assumed health care financing scheme 2012 to 2032 with the aim of grating more funds in reducing out-of-pocket payments and health to 32% by 2032. (Fahim et al., 2018). Bangladesh has to achieve the policy of 'Multisectoral Action Plan for Prevention and Control of Non-Communicable Diseases' by 2025. WHO expects to achieve Universal Health Coverage (UHC) for all people without financial hardship and warned already to keep the word that was promised about it. Along with this expectation, UN also set of SDG where the health target is access to essential and quality healthcare service to all. Therefore, it can be said the goal of National policy, goal of WHO to achieve UHC and the goal of UN to achieve SDG go hand in hand. UN also emphasizes on achieve Universal Health Coverage for Bangladesh. SDG's another significant is to ensure equity in health service.

In Bangladesh, CBHC services have been positioned with national policies. The early focus was conducting health services closer to pro people. Eventually the focus altered to improving utilization and access of services and securing the facilities of ESP 2016. The present focus is to build up health service system with quality, efficiency, equity and gender equality in access to health services to attaining universal health coverage. Various government structures, like Directorate General of Health Services (DGHS), Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP) were involved in policy implementation of CBHC for better co-ordination. Domiciliary services incorporated by Upazila health system (UHS) through satellite clinics to selected health facilities at Upazila, union and ward levels. Rural dispensaries/union subcentres and Union Health & Family Welfare Centres (UH&FWCs), under the DGHS were operating at the union level. At the ward level, Community Clinics was the lowest level health facility. With limited capacity, initially the Community Based Health Services (CBHC) program step by step built up ties within the Upazila health system (UHS). With some constraints, UHC was gradually taking the coordinator role of UHS. Before that there was less effectiveness in co-ordination of Upazila structures between family planning and health. Since the inception of CBHC, national and international NGOs arranged substantial support to Bangladesh Government for the execution of CBHC policies, including reinforce to Community Clinics. Community health workers (CHWs) for several decades, all over the world have participated in the facilities of primary health care. Experience has revealed that CHWs are capable to contribute remarkably to efforts in upgrading the health service of the population (including child mortality rates and reducing maternal rates), specially in places with the shortage of sufficient health professionals. CHWs offer a broad variety of preventive, curative and encouraging services across countries. However, to achieve Millennium Development Goals, overall progress and coverage of these initiatives is recorded as low and differs across countries. Each country has unique features of CHBC program than other countries. Overall the Community Based Health Care (CBHC) has been applicable to the health care needs of the people of Bangladesh. By reducing expenditures on medicine/drugs at Community Clinics, this program has alleviated the

financial burden from pro people. The Community Clinics and CBHC approaches have the latent to contribute to achieve both universal health coverage and sustainable development goals (Independent Evaluation of Community Based Health Services in Bangladesh, 2019).

Respondent A opined that over the years the Community Based Health Care have been positioned with national policies. Primary focus was to provide services closer to the population, specially to pro people with the establishment of Community Clinics. Eventually, the focus changed to utilize and access of services. The present focus is to build up efficient health system with equity, gender sensitive and quality of care. Bangladesh is committed to accomplishing both universal health coverage and SDG by 2030. In this regard, the CBHC program, specially Community Clinics project is a distinctive tool having the prospective to contribute to the attainment of both goals. Efficient and effective operation of Community Clinics is required to understand this potential.

"It is our national priority to strengthen primary health service to achieve sustainable development goal. To ensure health service for all, Government of Bangladesh has already built up more than 13,000 community clinics in this regard. Our target is to establish 14,890 functioning community clinics by 2022. By 2030, we hope to attain universal health coverage. Even though many challenges and constraints in both national and local level, we have observed through variety national reports- [National Institute of Preventive and Social Medicine (NIPSOM), National Institute of Population Research and Training (NIPORT), Implementation Monitoring and Evaluation Division (IMED)] high level customer satisfaction to community clinic services."- Respondent D

Respondent E opined "Bangladesh government took the lead to start community clinic to deliver Primary Health Care (PHC) at the door steps of pro people who were deprived of necessary health care. One clinic for every 6000-8000 population, who are grass root people live in remote, isolated and hilly places. Since 1998, this project had to conquered different types hurdles under the leadership of MOHFW. Thousands of rural people are

enjoying free health service from the close by community clinics. They own their Community Clinics and love their ownership. Community Clinics program has been acknowledged as role model by the global community for primary health service, particularly for developing countries. It has provided significantly in achieving Millennium Development Goals (MDGs) and is giving for Sustainable Development Goals (SDGs)".

Respondent L mentioned that 'Bangladesh already advances on reaching SDGs health indicators with significant development on under-5 mortality. It decreased to 16 from 20 per one thousand live birth in 2018. This success has achieved due to government's distinctive initiative of community clinics and others. World Health Organization is also committed in supporting us to achieve universal health coverage in this regard.' Respondent K mentioned that 'Government is trying to ensure primary health care to all citizen as their right, not privilege. In this regard, government has established this trust based PPP with community people to establish an equitable and sustainable health service. Community Clinic program is aligned with government's vision and health policy to achieve UHC.'

4.3.1.3 Equity

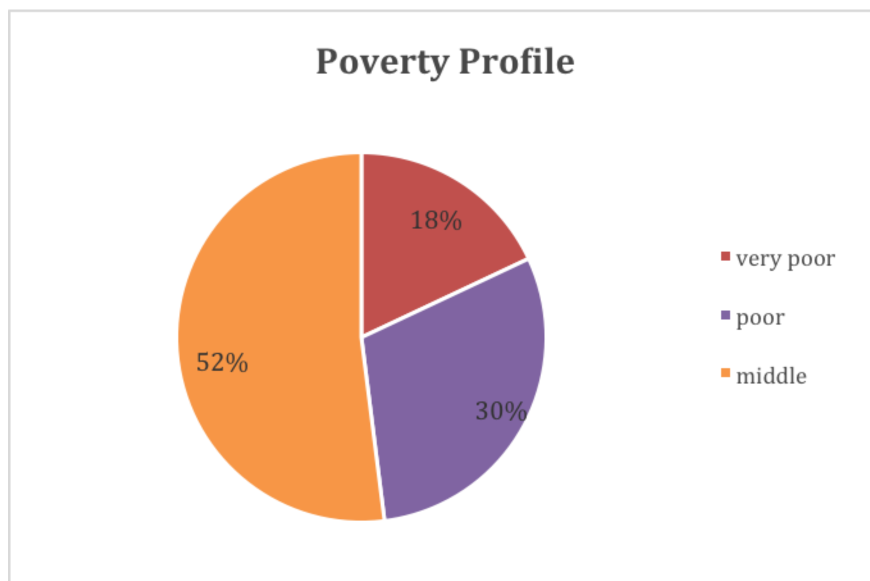
Ensuring equity in access to health care is another prime part of effective health service delivery. Rural people from different age group come to take service from community clinic. 48% of beneficiaries are poor or extremely poor. 77% beneficiaries are women in community clinics (Morol, 2019). Different age group take health service from community clinics. Mostly 42% people, age group 30 to 59 both men and women come to take health service. Age group above 60 years are 17% (Morol, 2019).

Independent Evaluation of Community Based Health Services in Bangladesh, 2019 reported 90% CCs users live close to Community Clinics. In this research, it also found that users don't feel any geographical barrier. Most respondents from three unions mentioned that they live nearby their community clinics. 85 % respondents from Radhakani union, 90% respondents from Char Eshordia Union and 80% Respondents

from Char Darbesh union mentioned that they don't feel any geographical barrier abour community clinics.

Independent Evaluation of Community Based Health Services in Bangladesh, 2019 also showed that all age groups were represented in this program. Older than 30 was majority which was 59%. All income quintiles also were represented. The study showed half being poor (48%) to very poor. Below five years of age were13%, below 20 years of age was 23% and 60 years old were around 17%. Female users were more than male which is around 77%. Another study shows 48% of beneficiaries are poor or extremely poor. 77% beneficiaries are women in community clinics (Morol, 2019).

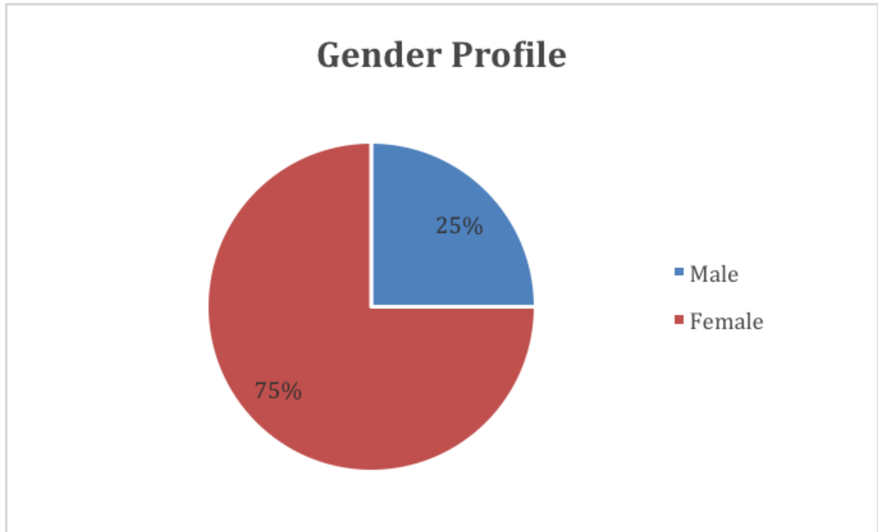
Figure 4.2 Poverty Profile



Source: Author's field work

It is demonstrated on the figure that the socioeconomic status of users of three unions are- 52% belong to middle class, 30% poor and 18% very poor.

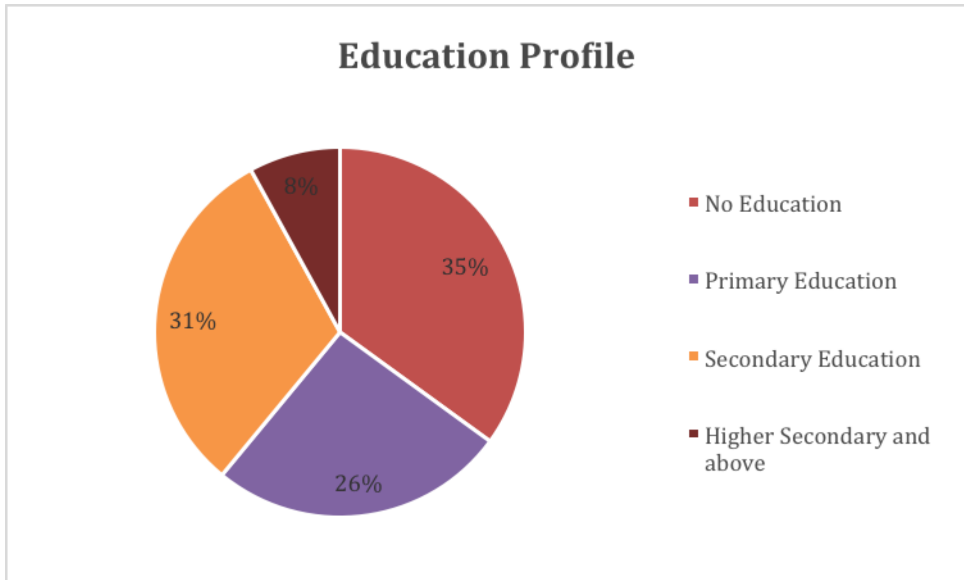
Figure 4.3 Gender Profile



Source: Author's field work

It is demonstrated on the figure that 75% users are female and 25% users are male in those community clinics.

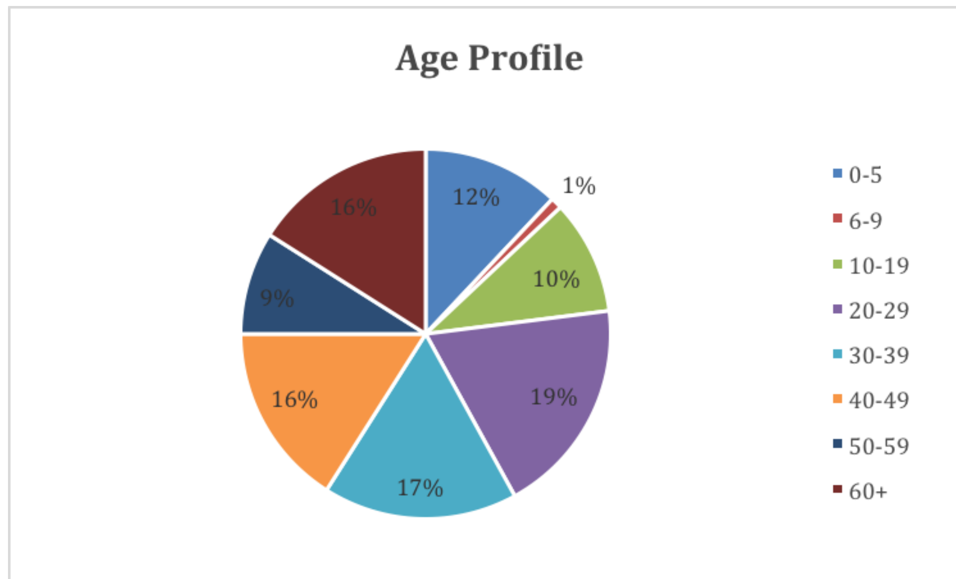
Figure 4.4 Education Profile



Source: Author's field work

It is demonstrated on the figure that among users, 31% had attained secondary education, 35% had attained higher secondary education, 26% had attained primary education and 8% had no education.

Figure 4.5 Age Profile



Source: Author's field work

It is demonstrated on the figure that 16% users were 60+ age, 9% users were 50-59 age group, 16% users were 40-49 age group, 17% users were 30-39 age group, 19% users were 20-29 age group, 10% 10-19 age group, 1% was 6-9 age group and 12% users were below 5 years age group.

This research also found while taking interview of users of CCs from different background that patients are taking health service from all religious, age, ethnic, gender and socio-economic background. Respondents from Char Eshordia mentioned that as Sadar hospital is near to their union, most people prefer to take health service from there. Because they can visit specialize doctor with minimum cost there. On the other hand, respondents from Radhakanai union and Chardarbesh Union mentioned that poor people prefer to take service from CCs than district hospitals. In case of critical cases, they take service from UHC. Equity is found in CGs and CSGs. As member from all diversified

groups of society involve there. There were some components in favours of Community Clinics addressing equity question. Free health service from Community Clinics is a great thing for poor. The gender and age profile of users reflected probably the cultural inclination. Overall observation- there is no imbalance considering age group, gender or education group. However, more study is needed to one step ahead understand the equity feature of Community Clinics.

4.3.1.4 Effectiveness

According to CBHC (2018) "From 2009-2015 about 460.88 million visits were conducted to community clinics for health service of which 9.071 million complicated and emergency cases were referred to better facilities for proper and acceptable management. Among the health service seekers, there are 80% are children and women. Per month average 9.5-10 million visits are in community clinics and per day 38 visits per community clinics. Community clinic is the one stop service provider for family planning, health and nutrition. It is the lowest tier of health facility that provides health education and health promotional facilities. All the community clinics are outreach places for routine NID and Immunization. It provides limited screening of NCD-Hypertention, curative care, Diabetes, complicated cases and identifying emergency with referral to higher provision. In a notable number of community clinics, normal delivery is being conducted which is depend to the availability of expertise manpower, proactive CG and committed local health management. In case of emergency, patients within a short time can be referred to Upazila Health Complex (UHC)."

Table 4.5 Status of important services of CC from 2009-March, 2016

Sl	Service	Visit of patients	Remarks
1	PHC (Health, FP & Nutrition)	483.20 million visits	On average 39 visits/CC/day
2	Referred from CC	11 million emergency & complicated patients	Most of the cases have been referred to UHC
3	Normal Delivery (ND)	28160	Normal Delivery is going on in 1008 CC & is increasing
4	Supply of Medicine	Medicine worth Tk. 8270.50 million	Medicine supplied by EDCL & CMSD

Source: CBHC, 2018, p.1. Adopted from http://www.communityclinic.gov.bd

Community Clinics were supposed to provide primary health service to 80% of the rural people living within thirty minutes walking interval from Community Clinics. ESP health coverage included IMCI, EPI, health education, family planning, nutrition, treatment of common diseases- fever, pneumonia, skin diseases, cough and peptic ulcer, diahria, virus related diseases, cold, weakness, alsar, constipation, pain, breathing problem, dengue etc.

Respondent A mentioned "Community based primary health care drive is considered as one of the sensible and logical strategies in delivering the universal health coverage across the world. In Bangladesh, community clinics, a population supported grass-root level primary health care delivery system has framed a model of expanding access to primary health care with a remarkable advancement in equity about community involvement and service. Although there are limitations of primary health care in all developing countries, community clinic is a sustainable effort to do our best with limited resources. I hope this research will provide some recommendations on the further improvement of Community Clinics in Bangladesh."

We already came to know by a report from Asian Development Bank Institute (2000) about some objectives of ideal health service delivery that may be explained differently by private and public sector health providers. First of all, it focused on delivering quality health care facility. This is the benchmark of a successful health care system. Private and public health service providers may be motivated and inspired by different incentives and have different idea and perceptions about 'good quality' health care service. It will affect the essence of health outcomes.

Respondent D opined "CCs have become a reliable place for primary health care services in the remote areas in Bangladesh. Besides Diarrhoea, cold and other diseases, Pre and post-delivery health care for mother, family planning, reproductive health, nutrition, immunization, health advices and information services are given there. As proper health service is negligible to poor in Bangladesh, CCs are providing more than thirty types of medicines free of cost as per need of pro people. Selected community people are the member of community group and community support group and they are responsible of the proper maintenance of the CCs in their territory. This PPP has become a role model for many other developing countries as cost effective mechanism."

It was asked to the respondents about their opinion about quality health service about primary health care. The outcome was most of the respondents show satisfaction about primary health care from community clinic service.

Figure 4.6 Client Satisfaction

Source: Author's fieldwork

It is demonstrated on the figure that 92% respondents expressed their satisfaction about the service of CCs. 65% are satisfied and 27% are very satisfied. 6% expressed that the service of CCs average satisfactory to them. Only 2% expressed they are unsatisfied about the service of CCs.

Box: 4.2 Case Study on Dabardasta Community Clinic, Radhakanai Union, Fulbaria Upazila, Mymensingh District

Ambia Begum (4o) lives in Dabardasta village. She is from poor and conservative family background. She said that her pregnancy wasn't easy. She faced huge complications during her pregnancy. She expressed her profound gratitude to the health service providers of community clinic. She mentioned that she gave birth her two sons after five miscarriages. Her pregnancy was a life risk event in her life. She thinks that without the support of health provider of community clinic it was really hard to give birth her two healthy sons. She said her family was not capable to spend money in hospital. Community clinic became a blessing for her.

" ami sharajibon kritoggo thakum ai clinic-er apa'r kase. Tar jonno ami shuso vabe

duita shustho baccha jormo dite parchi”- she mentioned.
(She mentioned that she will be grateful forever to community clinic as she was able to deliver to health children by getting support from CC.)

Respondent B opined that “The remarkable reduction of maternal and child mortality over last two decades correspondent with the development of these community level health care interventions.”

The reasons that have driven health success in Bangladesh are- first, it’s history (Ahmed et al., 2013). After liberation war, social transformation took place rather than fancy policy. It encouraged pluralistic reform instead of idealized policy framework. Second, research. Research provided authentic knowledge for health structure strengthening (Arifeen et al., 2013). Third, equity. The innovation of community-based approaches and partnership enabled Bangladesh to provide better health service than many other Asian countries (Das & Horton, 2013).

Box: 4.3 Case Study on Alalpur community clinic, Char Eshordia Union, Sadar Upazila, Mymensingh District

Aysha Akter (37) from that union shared her own recovery story. She mentioned that she and her family used to get primary health care from that community clinic as it is nearby their house. Once she came to that clinic with severe pain in her stomach. First community health provider gave her primary health care service to recovery. But unfortunately the first-aid treatment from community clinic did not work for long. As her situation became worse day by day, community clinic sent her to Mymensingh Medical College Hospital for emergency. Then she needed a surgery and got well. After coming back home she was closely monitored by the community clinic health provider. She mentioned that community clinic health providers not only suggest about advance treatment (if needed), but they also monitor after recovery.
“ami khub shontusto tader chikitshai. amar ba amar bacchader kisu hoile ai

community clinic-e amader prothom vorosha" – said Aysha.
(Aysha said she is satisfied enough of the treatment of CC. For her kids she can depend for treatement on CC entirely.)

The research found that most of the beneficiaries in the selected areas are satisfied about the given primary health care service of CCs. Das and Horton (2013) stated though there are some challenges, Bangladesh has established some unusual success in health service delivery through public-private partnership. Karim et al. (2016) assert that it is evident that through community clinics, people perceived quality health services in rural areas, Bangladesh. After analysis health structure in several Asian countries- India, China, Pakistan and some other countries, Balabanova (2013) point out that Despite spending less on health care than several neighbouring countries, Bangladesh has made huge health advances and the lowest infant and under-5 mortality rates, the lowest total fertility rate and now has the longest life expectancy in South Asia.

4.3.1.5 Value for money

Ensuring sustainable financing of health care is another core objective of effective health care service. Moreover, it is directly linked to the sustainable development goal of health issue. Thus, getting more value for money through investment and reform is crucial. EU shows that investment in health can drive not more spending rather smarter spending. Evidence shows from European Union that it is not only how much spend but also how to spend that should be taken in consideration. Therefore, present budget limitation should be used as a scope to improve the effectiveness of healthcare expenses.

Community Clinics are basically giving free primary health service. In some community clinics, they take 4-5 taka as fees from every patient to maintain the clinic. Because there is a cleaner whose salary doesn't come from government. Community Clinics use that fees as salary to the cleaner. Most of the respondents think that this money doesn't matter for them. Even for special consultation with specialist doctor, they can take free help from Shastha batayon. Shastha batayon is an initiative by National Health Service to provide primary service through mobile phone. It can be considered as tele medicine or

E-medicine. It was initiated in 2015 by health department which is known as shastha batayon. DG, health department said that it was initiated so that people can get free health service. Besides this the mission was that poor people will be safe from fraud doctor. DG thinks that they are successful in this initiative. Director General of Health Department expressed his hope to connect shastha batayaon to community clinics to boost confidence of health providers of community clinics. There are 80 trained doctors in that shastha batayon who receive phone in 16263 number from all over the country (Morol, 2019). An IT company named Synesis taking charge of this shastha batayaon on behalf of government through tender competition. If anyone takes service from here an auto message of prescription delivers to the patient automatically. Besides primary health care, ambulance service is also provided by this project. To ensure accountability it is used (Morol, 2019). This project is trying to connect with all community clinics throughout country.

It is observed in EU that by investing in health can drive not more spending rather smarter spending. Getting more value for money through investment and reform is crucial. It may take distinct forms, like change in the management to improve efficiency to improve health outcomes, prevent diseases, initiative to promote sound health, investment in staff of healthcare and equipment and training. The avoidable mortality and morbidity underlying inequality of health service represent a misuse of human capital that is assessed to reduce. Universal access to high quality, efficient healthcare services, safe, cooperation between healthcare and social sectors and fruitful public health strategy to prevent chronic disease can create a significant contribute to social inclusion and economic productivity. EU aims that through these mentioned investments, cost-effecting innovation should be foster to complement the reform and to achieve better health outcome within the context of Europe 2020. (Seychell & Hackbart, 2013). Existing community clinic program can be said such reform which promote cost effective primary health care through smarter ways to the door steps of community people.

Delivering health care services effectively and efficiently is another significant part of proper health service. As there are always budget constraints, therefore using limited

resources in an effective manner is of prime importance. Private and public health service providers often have different cultures that drives them resource allocation in different ways and utilize those resources effectively. Due to such different intervention of costs, health outcomes are often affected. Delivering health care services effectively and efficiently is another significant part of proper health service. As there are always budget constraints, therefore using limited resources in an effective manner is of prime importance. Private and public health service providers often have different cultures that drives them resource allocation in different ways and utilize those resources effectively. Due to such different intervention of costs, health outcomes are often affected. It was asked to the respondents about the degree of cost effectiveness of health service delivery in their concerned unions. About 98% users mentioned that it is cost effective health care initiative.

Respondent A opined "Bangladesh is one of the rare countries that provides free health and medical services for community through many public health facilities. No doubt that community clinic program has become a financially feasible initiative by the government. It has reduced extra cost from not only government budget but also from beneficiary's pocket.".

Respondent C stated that "This Community Clinic Project was launched under the MOHFW in 2011. The present Health, Population and Nutrition Sector Development Program 2017-2022 outlines the Community Clinics as the primary unit for Upazila Health System. CC is the lowest tier of primary health care in Bangladesh. It is a 'one stop' health care outlet focused on health promotion and prevention. Across the South-East Asia, this initiative has become a role model. To overcome the financial hardship from both government and pro people, it is a revolutionary attempt by government."

Independent Evaluation of Community Based Health Services in Bangladesh (2019) stated "The result of the cost-benefit analysis showed that total accrued benefits outweighed total costs and, hence, the net-benefit of BDT 1511.51 million (USD 18.00 million) was a substantial figure. The benefit-cost ratio was 1.23, which implied that BDT 100 (USD 1.19 USD) investment in CCs generated a benefit of BDT 123 (USD

1.46) which was higher than any conventional investment. Thus, investment in CCs can yield 23% financial benefit subject to equipping the CHCPs with adequate medical training and necessary equipment."

Most of the respondents expressed their satisfaction about their free medical care and medicine from the CCs. In focus group discussion, member of CGs and CSGs also mentioned this service is cost effective for pro people. The research found that 96% community clinics are located in easy to reach areas for community people. Therefore, most of the cases they don't need any transportation cost to get health service. As medicine and consultation is free, they don't have any financial burden to get primary health care. Government doesn't spend extra budget for security purpose as community member are responsible to ensure security of CCs. From Key Personnel interview in Health Ministry, they mentioned that this initiative is a cost-effective mechanism for government to ensure health for all. As there is no specialized doctor, government don't need to spend huge money for staffs of CCs. Rather involvement of community member work as an accountability mechanism for the government.

Therefore, it is found in this PPP both government and community people are benefited considering value for money. The land is donated to build Community Clinic. Both government and community people maintain the CCs. Such structure is economically feasible for government. On the other hand, community people are getting almost free health service and medicine. Therefore, it is cost effective for them also. Respondent E opined 'Low budgetary allocation is one of the big problems in Bangladesh for quality health service. As a cost-effective mechanism and to ensure primary health care for all, government has taken this community clinics initiative for pro people. To achieve UHC within time frame, it was needed to strengthen our capacity to health service delivery with a cost-effective manner. I hope community clinics will help to achieve its goal if we can ensure effective use of this PPP.'

4.3.2 Strategic Analysis of PPP: Challenges

This section examines the challenges of this program in the selected areas. Considering geographical location of CCs, equipment, medicine, budget, unavailability of CCs staffs and their skills, monitoring and supervision, this paper will examine the challenges of this PPP.

4.3.2.1 Geographical Position of Community Clinics

Though community plays active and vigorous role for improvement of these clinics, there is one community clinic for every 6000 populations. If any ward has no community clinic, then people from that ward come to near ward where community clinic is existed. It’s obviously a pressure for the existing community clinics. The research found from the focus group discussion of respondents at Char Eshordia Union that though most CCs are near to their house, there is poor road and lack of transport for some beneficiaries. They think CCs should be build considering these issues also. Focus group discussion of respondents in Radhakanai Union mentioned also that geographical barriers isn’t the issue but remote areas often a problem. Focus group discussion of respondents in Chardarbesh Union mentioned that socio-cultural barrier also a big problem for them. As Feni is a place of conservative religious culture, often female users face problem to go CCs by themselves and sometimes pregnant women feel uncomfortable to talk with male staff. 90% of respondents of all three unions mentioned that they live close to Community Clinics but still remote areas, poor road conditions, lack of transport and in some cases socio-cultural barriers are issues, that need to be overcome. Morol (2019) also mentioned that remote area, social and religious taboo, inconvenience of vehicle and poor road condition is often a barrier to get service from CCs.

In focus group discussion beneficiaries of Char Chardarbesh Union mentioned “Community clinics should be placed in walking distance as women and children are the important users of community clinics.” Respondents from Char Eshordia union and Radhakanai Union expressed the same opinion about next placement of CCs.

The placement of community clinic is not always in very good position regarding accessibility. Sometimes it is in remote place where people face difficulty to reach there. Sometimes land is given considering it in mind that their ancestor will get a job in the community clinic. Most of the staffs of CCs mentioned that the numbers of visits are increasing gradually in CCs. Independent Evaluation of Community Based Health Services in Bangladesh (2019) showed that from 2014 to 2017 it increased in 57%. Most of the respondents think that majority who take service from CCs are those who live nearby of the community clinics. Respondent G mentioned that to avoid this issue, Government needed to place community clinic by acquiring land instead of gifted land by community people. Due to this 'donation' provision, community people often donate land that is not very convenient for others. Respondent H opined that instead of donated land government could acquire the land for CCS from the community people. There are many community clinics to be built yet. Members of community think government should take in consideration of these issue to establish new ones.

4.3.2.2 Limitations of CCs Equipment, Medicine and Budget

Financial constraint is one of the crucial problems to ensure effective health service delivery in Bangladesh. In some cases, community clinics program is facing the same challenges regarding budget allocation properly. A survey of BBS shows that half of the population in Bangladesh can't get proper medical care whenever they sick (Morol, 2019). Because after getting sick most of the people don't go to certified MBBS doctor. This BBS survey was conducted in 2016. It shows that around 16% patients take health care service from community clinics, 26% from private hospitals and some goes abroad for medical care. This survey shows that there are some reasons for why patients are not taking medical care here. 57.77% think that their problem is not major issue to go for doctor. 16.73% people think that treatment is an expensive process. 5.14% people don't get anyone to go to doctor. 5.05% can't go due to ignorance of decision makers from family, 1.84% can't go due to distance, 1.45% never goes due to fear of major diseases. O.94% doesn't know where to go. This survey also shows that among 1000 people 170 are sick somehow. This scenario said that a large portion of people are not getting proper health care in Bangladesh (Morol, 2019).

BDHS survey of 2017-18 shows that child mortality rate is not decreasing in Bangladesh (Morol, 2019). Child mortality is an indicator to measure socio-economic condition and life standard of a country. This survey shows- though at past it decreased but last five year it is stagnant. 30 infants out of 1000 died before age 28 days (Morol, 2019).

Table 4.6 Child mortality per thousand (before age 28 days)

2007	2011	2014	2017
37	32	28	30

Source: BDHS 2017-18. Adapted from Morol, 2019, p.1

Letest Niport report shows that health institutions are not ready to provide sufficient health service that might be a challenge to achieve SDG goal (Morol, 2019). Information around 1,524 institutions were taken for this survey in 2017 from community clinics, union health center, union health and family planning center, mother and child welfare center, District hospital and medical college hospital. This report shows that the overall scenario about medicine supply and delivery related facilities have decreased compared to 2014.

Table 4.7 Basic Medical Equipment

2014	42%
2017	38%

Source: NIPORT Report, 2017. Adapted from Morol, 2019, p.1

Table 4.8 Basic Medicine

2014	42%
2017	33%

Source : NIPORT Report, 2017. Adapted from Morol, 2019, p.1

Table 4.9 Equipment

Medical Equipment	2014	2017	2018
Thermometer	98%	91.6%	87.5%
Stethoscope	91%	93%	100%
B P machine	80%	82%	100%
Light source	33%	46.8%	25%
Glucometer			75%

Source: Morol, 2019. P.1

The significance of these finds has been addressed in the media ("Prothom-alo", 2018). These three surveys are conducted by National Institute of Population Research and Training (NIPORT). Last year a survey result was published in a hotel about maternal death and health service by health ministry. It shows that maternal death rate is increasing that is 196 among 100000 presently that was 194 in 2010 among 100000. Though it was a great achievement of government, appreciated by Nobel winner economist Amarta Sen also, it is declining according to last survey. There were 3,21214 women took part in this survey. It shows that among five pregnant women, one don't get health service. Even not get any health service before, after or during pregnancy. According to BDHS (Bangladesh demographic health survey) 2017-18, the infant mortality rate is also increasing. The average fertility rate is also stagnant for last eight years. The means the uses of contraception use is not increasing.

Morol (2019) shows that the number of beneficiaries in CCs is not increasing expectedly over the years. Since 2016, the numbers of beneficiaries are almost stagnant.

Table 4.10 Number of Beneficiaries over the Years

Year	Beneficiaries
2014	5,55,00000
2015	8,47,00000
2017	8, 82,00000

Source: Morol, 2019. P.1

To improve the scenario of CCs, some facts should be taken in consideration. The research found that in many cases there is shortage of equipment, medicine and other necessary drugs issues in community clinics. In separate three focus group discussions in three unions, staffs of CCs expressed that often there is shortage of medicine that often creates disappointment to the beneficiaries. They said in case of crisis period, they have nothing to do as there is no separate budget for that. In focus group discussion with members of CGs and CSGs mentioned that though they are responsible to maintain CCs, they have very limited power in case of emergency. They should have separate budget to handle crisis situation. It is found in some CCs that they don't have necessary equipment for primary health service. In some cases, new equipment need to replaced but due to budget constraint, they cannot do it. Furthermore, it is observed that there is a lacking of logistic support like vehicle in case of emergency, unavailability of medicine and other limitations that make them less motivate about their work. According to NIPORT (2011) the problems of supplies and logistics contribute to the limited capacity to deliver services, and the lack of motivation of staff. Without drugs, staffs feel helplessness to provide services with limited means.

From focus group discussion, the research found that there is poor condition of internet service, amenities (water, toilets, electricity), infrastructure in some CCs. Staffs of Alalpur community clinic mentioned that they take 2-5 taka from patients as there is no

separate budget from government for cleaner. They use that money as salary of that cleaner. Health staff of Dabardasta community clinic expressed the same. They take very small amount of money to maintain the cleanliness of community clinic. However, the research found that 75% of users did not pay any fees to get the service. 25% of users paid 2 to 5 taka but they think, it is not a big issue for them. Majority of respondents mentioned that they get medicine almost free. From focus group discussion, it is found that availability of primary equipment is a basic thing to run any CCs properly but there is a limitation. However, in case of emergency patients, it's often a challenge to provide health service by their limited means. Even focus group discussion with member of Community Group mentioned the same frustration. The think government should allocate more funds considering budget issue. Though most of the community people are satisfied about their service, still there is huge floor to improve the condition of CCs. A big problem uttered by both community people and staffs of CCs is unavailability of medicine. Members of Community Group opined that if government allocates more budgets to this purpose and if they get more freedom to exercise their power, this problem will be solved. Some users complained that they often don't get medicine due to unavailability, due to shortage of sufficient medicine in the community clinics. In that case they need to wait until medicine come. Some respondents think there should be specialized doctor in the community clinic. Barman and Nayeem (2019) state that community people expected hospital with sufficient logistics support. But in reality, a small clinic with poor logistics often demoralised them. However, as CC is a cost-effective mechanism to serve primary health service, specialized doctor provision might not be economically feasible right now- mentioned Respondent E.

Respondent H opined that he Upazila health complex (UHC) has significant role over the Upazila health system (UHS). To support the function and operation of CCs, UHC plays important role through capacity building of staffs, supervision, medicines distribution, monthly meeting etc. Therefore, capacity building of UHC is also important with resources and sufficient staffs. Integration of both DGFP and DGHS is also required to monitor and supervise of their activities. To achieve the most outcomes of Community

Clinics, government should place more emphasis on these constraints through monitoring.

This research found that proper financing is one of the crucial challenges to achieve the goal of this program. Though empowerment of community people is one of the core goals of this program, due to financial limitation, member of community group often demotivated to take any initiative by their own. However, in case of emergency patients, it's often a challenge to provide health service by their limited means. Furthermore, in case of unavailability of medicine shortage, they face blaming of mismanagement. One member of CG, Radhakanai union mentioned that our situation is often "dhal-nai, taloar nai, nidhiram sarker." (A police man without arms). Staffs of Mangalkanti community clinic, Chardarbesh Union mentioned that good collaboration with Upazila authority or NGO could be a good source for this expenses.

From focus group discussion, it is found that availability of primary equipment is a basic thing to run any CCs properly. Even focus group discussion with member of Community Group mentioned the same frustration. The think government should allocate more funds considering budget issue. Though most of the community people are satisfied about their service, still there is huge floor to improve the condition of CCs. A big problem uttered by both community people and staffs of CCs is unavailability of medicine. Members of Community Group opined that if government allocates more budgets to this purpose and if they get more freedom to exercise their power, this problem will be solved. Some users complained that they often don't get medicine due to unavailability, due to shortage of sufficient medicine in the community clinics. In that case, they need to wait until medicine come. Ireen et al. (2018) mentioned that ensuring uninterrupted supply of medicines, logistics to the functional facilities; facility of health staff and community workers should be the urgent priorities. That is absent in existing CCs program.

There are three types of services available in the CCs- Curative, promotive, preventive services. The research found curative service are available compared with other two services in the CCs. In focus group discussion, respondents mentioned that in case of preventive services, it depends on availability of FWAs and family planning

commodities. Respondent F opined that diagnostic service provision is crucial to identify diseases. He suggested that some basic diagnostic service provision can foster the capacity of primary health care service in community clinics. Majority of the respondents also think that diagnostic provision will be a great option for them to get the best service. Respondent F opined 'Primary diagnostic service provision should be promoted to ensure efficient primary health service in community clinics.'

To achieve SDG, government should allocate more budgets to ensure efficient primary health service. Independent Evaluation of Community Based Health Services in Bangladesh (2019) shows that the GoB budget was BDT 6373.7 million for the fiscal year 2017-2018 for the Community Based Health Care (CBHC) program of which 95% was spent. For capital components the total budget was BDT 1313.4 million, which was fully spent. At a time, these constituted about 3.84% of the health budget and 0.21% of the national budget in 2017-18. For allowances and salary for Community Based Health Care (CBHC) half budget was allocated whereas for medicine expenses it was 30% of the budget. Budget allocation for training was less than 6%, whereas 23% prevailed unspent in 2017-18. The budget spending and share on maintenance and repairs (1%) and monitoring and supervision were very low (0.22% and 0.21%, respectively). Moreover, that study showed from cost-benefit analysis that as government budget allocation over the last five years has been doubled (BDT 3917.80 to BDT 7687.10) to the CBHC, therefore quality service, equipment, adequate and availability of medicine, proper maintenance should be ensured in return. In addition, in case of any staff's absence, uninterrupted service delivery should be ensured. Government should place more emphasis on monitoring and supervision over this program to achieve the highest outcome of this PPP.

Respondent F opined 'Though government is increasing budget for CCs gradually in Bangladesh, there should be smarter use of allocated budget. As a regulatory body of this PPP, government should take efficient steps to smooth the journey of this PPP. Otherwise this program cannot be useful for pro people.'

4.3.2.3 Unavailability of CCs staffs and their skills

The research found that most of the community people are aware about the existence of the CCs in their locality. However, only 20% aware the exact availability of HA and FWA at the community clinics. From focus group discussion it is found that often staffs of Community Clinics are not available to provide service. There is a provision for CHCP, Health assistant (HA) for vaccination and FWAs for family welfare assistants in CCs. However, in focus group discussion of both Radhakanai Union and Chardarbesh Union, they mentioned that sometimes there is problem of unavailability of health staff at community clinics. They mentioned there should be strict opening and ending hour of every CCs. They also mentioned that though CHCP should be available six days in a week, in reality this is not happen actually. Moreover, community people often fail to reach to the Health assistant (HA) or Family planning assistant (FPA). However, regarding this issue, staffs of CCs mentioned that beneficiaries of community clinics are often not aware of their right and timing of CCs staffs. They think there should be more awareness program to build consciousness among beneficiaries. Users should know which day Health assistant and Family welfare assistant (FWA) are available, they added. Users also often feel that there should be a medical doctor in CCs. Some HAs informed that often they get barrier to get leave as there is no alternative staff there. This is mentioned by some FWAs also in focus group discussion. 10% of community clinics health provider post is vacant now (Morol, 2019). That means in whole Bangladesh around 1,400 community clinics is running without health provider who is the key person in a community clinic (Morol, 2019). Even in some clinics, other two posts are also vacant. Due to such lack of service providers, many people cannot get service from community clinics consistently. Though most of the clinics have CHCP, not all CCs have regular HAs and FWAs. Many cases they work at part time basis. This part time staff is not sufficient to provide hundred percent effective health services. This discontinuity sometimes hampers the health facilities in CCs.

Box: 4.4 Case Study on Khaloypura community clinic, Radhakanai Union, Fulbaria Upazila, Mymensingh District

Aleya (21) from this union shared her terrible pregnancy story. She said that her house is located with Khaloypur community clinic. She mentioned that FWA wasn't available during her pregnancy. She had complicated pregnancy that demanded special care. However, neither CHCP nor FWA were available whenever she became very sick. Such unavailability droved her family to take her in UHC first. Though her in laws were not interested to take her there due to both poverty and conservativeness. She mentioned that if the staffs of the CC were available for her service it could be a big help. She added she needed primary health care since her first trimester. If she could, she might avoid such complexity. However, her situation became so worst and then she was transferred to the Mymensingh medical college hospital. She expressed her frustration about the unavailability of community clinics health providers. She said "ami ba amar shontan mara jete partam! Jodi shuru thekei guidline petam hoyto eto kharap obostha hoto na."
(We might die in that worst situation. If we got proper guidance from CC from the begging, situation could be different.

Tobe et al. (2019) mention "Although achieved development goals on maternal and child health, in the era of Sustainable Development Goals (SDGs), Bangladesh still needs to promote skilled attendance at birth as well as a continuum of care for mother and babies. How to implement effective interventions by strengthening the community health system also remains as a crucial policy issue".

Respondent H opined that more educated, contractual arrangements for health staffs in the vacant posts in CCs can be an option to avoid unavailability of health staffs. He added government can consider more qualification for health staffs in CCs. He also suggested incentive or additional benefits provisions for staffs in CCs for better performance.

In Focus group discussion with member of Community group (CG) in Radhakai Union also mentioned that the part-time and shortage presence of FWAs and HAs are often a problem for continuity of health services at the Community Clinics. They think their timing should be more strict and long for the sake of beneficiaries. Often in case of emergency, users from remote places feel disappoint for the absent of staffs in CCs. Though most of the users are satisfied about the service from CCs, the discontinuity or unavailability of staffs often hamper the service, mentioned the respondents of focus group discussion of Radhakai Union and Chardarbesh Union. Committees are often not working as per their job duties. Many beneficiaries, even in some cases committee members are not aware about community group's responsibilities. As a result, the objectives of this program often hinder. Respondent I opined that CCs should promote more advance facilities for pregnant mother and child birth care so that they can take entire support from CCs than go to UHC or district hospital

Focus group discussion in Radhakanai and Chardarbesh Union, respondents mentioned that staffs of community clinics don't open office regularly. The service often depends on particular employee instead of full team. In many cases, employees don't treat patients in positive ways- complained some beneficiaries. It often depends on individual caregiver's personality trait – mentioned members of CGs in Chardarbesh union. The most important fact is community clinics staffs don't open the community clinics in regular basis.

Some respondents mentioned that due to unavailability of staff and lack of necessary equipment, emergency patients often not attend community clinic, rather they prefer to admit nearby hospital directly. It increases the cost of medical expenditure for them. Some health staff also agreed in focus group discussion that not well-maintained and poor infrastructure is really a barrier to provide efficient health service. Respondents in Chardarbesh Union mentioned that adolescent girls are often uncomfortable to take health service from male staff. The research also found that in some places community people are not fully aware about the health service of community clinics. Respondent I opined that 'Government can take massive initiative to awareness build program about CCs service. Members of CGs and CSGs should work to build that awareness among pro people. There should be an incentive provision for that to the member of CGs.'

Another important aspect is skill and training of CCs staffs. There are three different staffs in Community clinics and the duration of their training is also different. CHCP receives 12 weeks basic training where 6 weeks for theory and 6 weeks for practical. The eligibility for this training is higher secondary certificate with computer literacy. Majority of the respondents mentioned though their basic training is good enough to perform their job, they think (CHCP, HA, FWA) more training could help them to perform at their best. Respondent J opined that management skills, communication skill, record keeping and reporting are crucial to make staffs more smart to maintain the CCs. He also mentioned that they need more detail and specific job description and training. Focus group discussion with CC staffs mentioned that the training they are getting is sufficient for their job but they feel bit longer training is needed to respond to the updated health program and their capacity assessment. Respondent J mentioned that the job description of CC's staffs are not fully aligned with the Community Clinics concept. He added that other developing countries are providing longer training program in that situation. The given table shows the duration of health worker's training program in different countries.

Table 4.11 Community Health Workers in Different Countries

Country CHW scheme	Duration of Training	Tasks for CHWs	Strength of supervision	Strength of health system
Uganda Village Health Teams	10 days	Prevention and basic curative	Relatively strong	Weak
Pakistan's Lady Health Workers Program	15 months	Promotional, preventive and basic curative	Relatively strong	Weak
Ethiopia Health Extension	3 months	Preventive and basic curative	Relatively weak	Weak

Program				
Mozambique Agentes Polivalentes Elementares	6 months	Preventive and basic curative	Relatively weak	Weak
Bangladesh CHCP	3 months	Promotional, preventive and basic curative	Relatively weak	Weak

Source: Independent Evaluation of Community Based Health Services in Bangladesh 2019, P. 16

This table is a clearly indication that training program is not sufficient comparing with others. Respondent K opined that 'The group size of community group and community support group should be 10 to 12, instead of 17 for better management. Considering their educational background their training should be designed for capacity building'. Respondent J opined 'Government should utilize the staffs of CCs with most efficient and effective manner to achieve the highest outcome of this CCs. Availability of staffs should be ensured as well as well-trained health service providers for quality health service. Training of CCs staff must be reorganized in this regard'.

4.3.2.4 Monitoring and Supervision

The research found that there are two types of monitoring and supervision in community clinics. First, monitoring by community groups and second monitoring by higher authority. Regarding community group are two groups are working to monitor and supervision of the activities of CCs - Community group (CG) and Community support group (CSG). Members of these two groups are considered to provide support for the management and operation of their community clinics. However, comparing with CG, community support group found less visible in the areas. Limited monitoring carried out by them, though it is their main duty in this program. It is found that to the service provision, community engagement is limited for member of CGs and CSGs. A well-

functioning community group with a good working relationship with the staffs could work excellent. But in reality, it is absent in some cases. Another important issue is in some cases, members of community groups are not aware about their role of responsibilities. Some respondents from Radhakanai union said in focus group discussion, members of CSGs are often absent in monthly meeting. They said that often this absence due to no monetary facilities from this duty. Key Respondent H opined that government can promote incentive provision for better performance among members of CGs and CSGs.

Majority of respondents think regular supervision is essential to quality control of these CCs. Respondent I mentioned that there is no alternative but systematic quality supervision from government to monitor the program. He opined that there is a lack of systematic supervision in this implementation. The research found that though the supervision of Health Assistant (HA), Community Health Care Provider (CHCP) and Family Welfare Assistant (FWA) are conducted by several cadres, there is a lack of coordination among the supervisory authority. Though one of the major role of community group to supervise CCs, the research found that it is not always done properly as mentioned. More research should be done in this regard.

There is a monthly meeting conducted every month at the Upazila Health Complex (UHC) involving all CCs staffs in their concern localities. Overall activities of CCs are discussed in that meeting. The research found that there is a lack of frequent meeting regarding all problems of CCs in some cases. Community clinics frequently referred patients to UHC or district hospital for higher treatment. Though in case of emergency or advance treatment, it is acceptable but when CCs are required to provide the specific primary service, it is not expected. HAs and FWAs sometimes work in the field. As many beneficiaries are not aware about the accurate timetable of CCs staff, they often prefer to take service from UHC or district hospitals. Respondents of focus group discussion in Char Eshordia mentioned that 'proper monitoring and supervision can build strong link between CCs and beneficiaries'. They think if they need to go UHC or district hospital for primary health care, it will undermine the objective of this program. Respondent K

opined 'Government should enhance the quality of monitoring and supervision of the service delivery of PPP to attain UHC on time'.

Majority of respondents think regular supervision is essential to quality control of these CCs. Respondent I mentioned that 'there is no alternative but systematic quality supervision from government to monitor the program. There is a lack of systematic supervision in this implementation, that is crucial to success this program'. The research found that though the supervision of Health Assistant (HA), Community Health Care Provider (CHCP) and Family Welfare Assistant (FWA) are conducted by several cadres, there is a lack of coordination among the supervisory authority. Though one of the major roles of community group to supervise CCs, the research found that it is not always done properly as mentioned. Respondent H mentioned that 'To achieve the most outcome from Community Clinics, government should place more emphasis on monitoring and regular supervision taking evidence from successful community engagement program.'

The research found there is a lack of coordination among supervisors as this is the lower tier of health service delivery to pro people. Key informant F opined that there should be a team from Upazila Health Complex to monitor and supervise the activities of CCs in own territory. He mentioned that from central government this is really difficult to monitor the works of health staffs (CHCPs, HAs and FWAs) in CCs. Though member of CGs are assigned to monitor the CCs, they have limited capacity in decision-making and implementation. Though there are checklists for primary supervision, the visitors from higher authority neither assess the competence of staffs nor provide necessary feedback to improve. Respondent G opined "There should be a functional relationship among staffs of CCs, member of CGs and CSGs for better coordination. They all need coaching to do better team work to identify problem and solutions jointly. Prioritizing services and addresses the actions should be systematically solved through their combine effort".

The Future Direction of the Research

These finding should be further tested as the time constraint didn't allow me to check on whole scenario of other community clinics. A study must be done to discover the degree of decentralization of this partnership program. Further, new studies are needed to initiate specific data to assist in point out how the delivery mechanisms of community clinic can be mobilized for the speedy and sustainable success of this PPP in a broader spectrum. Therefore, the results obtained in this study can be an acceptable basis for the developing another tool in the next level of research.

Chapter Five
Conclusions and Recommendation

5. Conclusions and Recommendation

5.1 Conclusion

An effectively performing health care system is crucial in improving the public's health providing shelter against health-associated financial threat and strengthening the health care sector's responsiveness to client needs. Though achieving universal health coverage is one of the key preferences of the Government, health care service is a daunting challenge of the Bangladesh's healthcare arrangement. Resource allocation is insufficient in health sector to ensure health service for all. World Health Organization states that only 3.4% is spent on health sector in Bangladesh. Though health care services should be free in the government hospitals, there are huge unseen cost involved with the total process. This cost involvement in public hospitals is a great obstacle to the disadvantaged and poor people. Briefly, there is a big gap between practice and principle in public health care facilities where poor are often deprived from proper health care. Growing resources limitations have increased the demand for and willingness of organizations to work together. As a result, public-private partnerships have become a familiar method to health care problems globally. World Health Organization (WHO) encouraged and welcomed partnerships between the market and state in provisioning, researching and financing health care (Baru and Nundy 2008). In addition, due to rapid change in health care provision like medical-technological developments, ageing population and policy changes, there was a huge health care costs as well as decreasing governmental budget that had to face by governments all over the world (Torchia et al 2013). In this dynamic scenery, the role of the governments evolved and moving away from the straight provision of service delivery towards the arrangement of partnerships in community health arrangement at enhancing community health. As a result, to National Health Policy, government assumed health care financing scheme 2012 to 2032 with the aim of grating more funds in reducing out-of-pocket payments and health to 32% by 2032. Bangladesh is also trying to improve its health service system that emphasizes on quality

health care through organizational restructure and reform. As a result, community clinic based PPP takes place as a reform aiming cost-effective, responsive and sustainable to client needs. Community Clinic is the revolution of government to increase primary health care service to the doorsteps of people living in the rural area in Bangladesh.

This research aimed to identify the nature of this partnership program and extent of community participation in this PPP. In addition, this paper directed to recognize the strengths and challenges of this program. A qualitative research approach was used for the purpose of exploring into the research objective. Review of secondary literature, focus group discussion, key personnel interview, case study, interview through an open ended and semi-structured questionnaire and a personal observation were used as the research tools.

The literatures on these subjects were vast, therefore the review had to automatically selective. The theoretical foundation of Public-private partnership has come to the consideration of scholars in a diversity of research domain as potential tools for channelling collaboration in long-established public sectors. The first stream research has originated PPP as an instrument for promoting the privatization of the functions of government through infrastructure based public service provisions. On the other hand, sociological methods to partnership have marked the significance of PPPs as a contemporary public governance model to boost the effectiveness and efficiency of public service delivery. That means, their functioning demands not only a cost reducing good designed contract mechanism but also a standard of mutual trust and collaboration between parties. (Cappellaro & Longo, 2011). On the basis of public and private party's resources, risks, cost, reward, benefits, common objective and responsibility, there are various forms of PPP in the health sector. Collaboration based partnership is one of them. There is also variation in the level of collaboration as a fashion of coordination (Alford & O'Flynn, 2012). In collaboration based partnership, decision-making and communication mechanism of parties to manage each other's requirement is significant than contribution to production by the concern parties (Alford & O'Flynn, 2012). A greater degree of collaboration can be measured by the level of empowerment among parties that they

provide to each other. There are some more indicative points are there to measure the degree of collaboration, like- mutual access to knowledge or information where all parties get accessibility from each other about relevant information, consultation on the basis of all parties combined feedback and opinions, combined decision-making etc. (Alford & O'Flynn, 2012).

Over the last few decades, community participation is widely used in the public administration literature to health service delivery. Regarding models, operational challenges, definition to community participation, there is always debate among researchers. Development practitioners and governance embrace community empowerment and community participation as a basic means of building capacity to local people towards improving health service delivery at local level. Zaman's citizen participation concept is a conceptual framework designed to explain how to measure the extent of community involvement in a program using some indicators. Zaman's (1984) framework provided a general understanding about the character of citizen participation in this research.

Views from selected global cases it is observed that there is no liner conclusion. There are different dimensions of PPP in different zones in the world that are combating to health challenges. A comprehensive literature of PPP for health care services took place by scholars that provided some guidelines for others to follow. They showed that for effective PPPs government should play the role as regulator where the accountability is critical as well as public interest is at stake. Therefore, governments should continue to settle standards and record as well as monitor efficacy, quality, safety and secure that citizens have sufficient access to the service and products they need. Therefore, it seems that such partnership demand some innovative ways combining different resources and skills from both public and private parties for effective health service delivery. Another important component considered fundamental to Public Private Partnerships efficacy is the regulatory structure in which they take place (Torchia et al 2013). Establishment of a sound and transparent regulatory framework as an unavoidable precursor to private party participation (Pongsiri, 2002). It is the responsibility of regulation provider to assure to

the all parties that resources are available to meet the broader policy goal (Zouggari 2003). The European Union has placed a good example of an integrated and consistent policy framework to respond to common challenges in the area of health that combines cooperation, legislation and financing. They showed that investing in sustainable health systems means structural reforms, sound innovation and cost-effective spending can bring secure health outcomes and efficiency. Investment on people's health boosts economic growth by enabling individuals to remain active longer and better health. Finally, investment on health reduces health inequalities and contribute to poverty reduction (Seychell & Hackbart, 2013). It is found that some countries focus on long-term sustainable financing to solve health service problem, EU has been a best example of such sustainable financing through structural reform and sound innovation.

Reviewing vast literature, the research conceptualized the idea of collaboration to examine the nature and extent of collaboration in this existing PPP. Furthermore, to examine the extent of community involvement, this research conceptualized the opportunity indicators from Zaman's (1984) conceptual framework of citizen participation that focused on decentralization of responsibility, functional linkage between parties and flexibility.

The existing community based PPP is a distinctive example of Public-Private partnership where collaboration plays major role. It is mentioned that any of the criteria of PPP are not certainly mutually exclusive, they sometimes overlap to each other and comprises with diverse and various combinations. It is found that existing PPP is also a combination of various arrangements where mutual trust and collaboration plays vital role between parties. This PPP is followed by contemporary public governance model where goal is not only cost reducing good designed infrastructure based contract mechanism but also a standard of mutual trust and collaboration between parties. This is not any profit oriented PPP, rather goal is to ensure primary health care with cost effective manner and ensure value for money. Community clinics have been constructed by donated land given by community people while construction, service providers, logistics, medicine and all other inputs are given by government. Both government and community are responsible for

management of these clinics. Government depends on community people to maintain the clinics effectively. On the other hand, community people depends on government for finance and resource allocation. Therefore, it is seen that there is a mutual dependency and trust between parties in this program. Community owns community clinics and plays active and vigorous role for the improvement of these clinics. Moreover, community empowerment is one of the main goals of this PPP. Government has established already Community Clinic Trust to strengthen this community engagement in this regard. The research found that government has given highest emphasis on empowering community people in this existing partnership. Financial constraint was also a crucial driving force of this alliance. Therefore, this collaboration effort was taken considering both party's win-win opportunity and mutual dependency considering risk, capital and maintenance through decentralization of power. Community people depends for resource on the government and government depends on community people for proper maintenance of the community clinics.

This research examined the extent of collaboration of this PPP in the light of O'flynn's theoretical framework of collaboration-based partnership. Though it was expected that a well-designed collaboration should be going through information exchange, consultation and combined decision-making between parties, there are some gaps in practice. One of the crucial goals of government in this PPP is to empower community people. However, their access is limited in decision-making and implementation. Furthermore, knowledge gap was also found between parties that is barrier also for successful collaboration. Though the design of this PPP based on empowering community people through decentralization of power, in practice, there is lacking of mutual connectedness regarding information exchange and consultation.

This research examined the extent of community participation in this PPP in the light of opportunity indicators of Zaman's theoretical framework of community participation. It investigated that there is a well-built structure of community involvement in this program by empowering community people through decentralization of power. Undoubtedly this decentralization through community participation is a sustainable attempt by the

government. It is observed that this PPP through decentralization of power is a viable attempt by the government as it can enhance greater capability of administration to focus on the function that is not generally performed well by the central government alone. It increases the efficiency of central government to primary health service as well as reduces the financial hardship to the communities. It is found that as a feedback based mechanism, CGs and CSGs enables local community to reveal their dissatisfactions and complaints about this program. In addition, it is found as a good platform to negotiate and consult with health staffs to better health service delivery. As a result, such community involvement fosters the accountability of government's service delivery. It enhances greater capability of not only to central government but also it has provided structure of activities to local leaders and creates opportunity of alternative ways of decision making by involving influential elites. There is a strong functional linkage is also found in this program as government has already established a 'Community Clinic Co-operation Trust'. The main goal of this Trust is to ensure community participation in this PPP and ensure primary health care to all rural communities through fund collection and other necessary actions. To achieve this, trust is trying to establish a working relationship with union health complex, upazila health complex, district hospital, specialized hospital and other medical colleges. Above all, its main goal is to empowering community people through decentralization and participation.

However, though the structure of this program is designed to achieve the expected outcome of CCs through decentralization of power, in practice, there were some limitations. Though the staffs of CCs and member of CGs and CSGs are responsible to look after the CCs, there was budget constraint and limited power over decision-making and implementation. As sustainability is a major issue closely connected to any community-based intervention, such issue demands more attention by the central government. Moreover, it is felt that members of CGs need more awareness and training to understand the significance of their involvement and objective of this program. It is found that there was a lack of awareness among CGs and CSGs to take sensitive and sympathetic plan for their community.

Analysing the third research question, the research found that this PPP has been positioned align with constitutional commitment, national policies and others government agenda. Moreover, Bangladesh is committed to attain UHC by 2030 under the Sustainable Development Goals. In this regard, this PPP is a distinctive tool having the prospective to contribute to the attainment of both goals. The research found that there is a collaboration-based mechanism working in this PPP that is considered as effective framework for effective health service delivery for developing countries. Regarding equity issue, the research found that patients are taking health service from all religions, age, ethnic, gender and socio-economic background. However, more study is needed to one step ahead understand the equity feature of Community Clinics. It is observed that the degree of satisfaction about primary health care from these CCs is satisfactory to most of the beneficiaries. It is also found that this PPP is a cost-effective mechanism for both parties to attain value for money.

Scrutinizing challenges, there are some constraints were found in this program. There is only one community clinic for every 6000 population. As CCs are built in donated land, therefore not all CCs position are convenient for the users. If any ward has no community clinic, people from that ward goes to near ward where community clinic exists. It's obviously a pressure for the existing community clinics. Geographical barrier isn't the only issue but also remote areas create problem for the users. In some cases, remote area, social and religious taboo, inconvenience of vehicle and poor road condition hinder the accessibility to take primary health service from CCs. Moreover, though government fund is increasing for this program, the research found- still there is a lack of effective use of the budget. There is a shortage of equipment or unserviceable equipment in many CCs. Moreover, medicine shortage is a common problem in CCs. It is found that there is a lacking of logistic support like vehicle in case of emergency, unavailability of medicine and other limitations that make them less motivate about their work. There is no separate budget that can be used in case of emergency to the community group or staffs of CCs. The public financial management arrangement is still outdated, coupled with demand-faction barriers. Therefore, the goal of community empowerment is hurdle to achieve yet. Furthermore, it is found that in some cases there is unavailability of CCs

staffs. Though CHCP is comparatively regular, other two staffs (HA & FWA) are often irregular in CCs. There are some vacancies even in some CCs. Unavailability of staff, medicine shortage, lack of necessary equipment often drives emergency patients to UHC or nearby hospital. It hampers the mission of this program. Community people are often not aware about accurate visiting hours of health staffs. Besides this, compare with other developing countries, staffs of community clinics get lack training that undermine their quality. Though there are three services provisions- Curative, promotive, preventive services, the research found curative service is available compared with other two services in the CCs. There is no incentive provision yet for better performance of this program. In addition, the monitoring and supervision is not much stronger as expected. There is lack of strong systematic monitoring and supervision mechanism over the program. There is lack of enthusiasm found among community group and community support group to perform their job as their power is limited and there is no incentive provision for them yet. Such ignorance often undermines the objective of such participation in this program. Enriching monitoring system through community participation can enhance accountability and transparency of the health service provider and proper accountability mechanism ultimately drive to better health service delivery. These challenges need to address to achieve the best outcomes of this PPP.

However, though there are some challenges, community clinic is considered as role model for many developing countries. As a cost-effective initiative, this PPP plays significant role for rural people in Bangladesh. Moreover, this PPP is aligned with government's policy and developmental goal. However, one thing need to remember that effectiveness even not guaranteed always Public-Private Partnerships can be helpful, they are not a magic (Widdus, 2001). Government needs to be careful about policy instruments in this regard. Context-specific and customized policy adjustment require to be incorporated for advance towards UHC. Finding out potential solutions of those challenges, Bangladesh can attain its goal successfully towards SDG and UHC. As a regulatory body, Bangladesh Government should settle standards and record as well as monitor efficacy, quality, safety and secure that citizens have sufficient access to the service and products they need. Because Public-Private Partnerships do not entail less government rather a different role of government.

5.2 Recommendation

As a partnership program, community clinic carries a phenomenal position to play in expanding, sustaining and strengthening role in our health care service system that unlocks a new perspective in terms of securing primary health care service as an ideal to the rest of the world. No doubt that it is an excellent attempt by Bangladesh government to ensure health service delivery to all through decentralization of power. However, Bangladesh is marginally behind expected development in health care service though continued development of new technologies, community-based master plan of health service delivery and innovation are needed to foster health care service to achieve sustainable development by 2030. In addition, health experts warn that global warming, rise in temperature, pandemic and some other diseases will increase in future. It may increase sufferings of immense population as well as economic burden of health cost. In this regard, more emphasis and importance on research-based adaptation action and programming should be in place. Past experience should lead further efforts to mark raising public health affair for Bangladesh. To achieve the goals of this community based PPP, the following recommendations are proposed:

5.2.1 Operational Level

1. Allocated budget should be used with efficient manner to overcome the constraints of equipment, medicine and other issues.
2. Develop a regular stock management technique for medicine kept at community clinics.
3. Sufficient fund need to be ensured to provide available and modern equipment with primary diagnosis opportunity for patients.
4. The availability of staffs should be ensured in every CCs. Proper balance between outreach work and facility-based work should be initiated for the staffs at the community clinics.
5. Job description of CCs staffs should be more specified and upgraded.

6. Community Clinics should be open six days per week to ensure accessibility for users to get health service without any suffering in a timely manner. It will reduce the dependency on Upazila Health Complex or district hospital.
7. Some awareness program should be taken for community people about the service provision of CCs and their rights as beneficiaries.
8. Awareness program should be taken for CGs and CSGs based on their education to capacity building as they are often not aware about their role and goal of this program. To play effective role and strengthen ownership, CGs and CSGs need resources and flexibility to work. Because the relation between the community and CC is the key to success of this program.
9. Staffs of CCs and members of CGs should have some logistics power and flexibility to work in case of emergency cases.
10. The coordination between Upazila health complex (UHC) and community clinics (CCs) need to be strengthen. Strong functional relation need to be built for capacity building of staffs, supervision, medicines distribution, monthly meeting etc.
11. An action plan provision should be developed for managing a functional monitoring and supervision structure to assess the outcome of this program.
12. Standardize procedure should be invented through up-to-date data to foster the development of this PPP. Many smaller scale and nationwide surveys over the years, research and surveillance have been conducted in Bangladesh to know the health care system. Collected data- both raw and gathered should be analysed, managed and disseminated systematically to facilitate decision-making and prompt actions by the appropriate authority. Because weak health information is a big barrier to set comprehensive health care plan.

5.2.2 Policy Level

1. Conduct an in-depth research to review the configuration and outcome of this community based PPP as the bottom layer of primary health service. Because insights about field realities can assist government towards next comprehensive understanding of the scenario that is crucial to achieve SDG.
2. Government should ensure mutual access to information, consultation and decision-making through sensible policy framework.
3. Develop a consistent strategy covering the functions and role of government in order to give greater confidence to the community people that regulatory decisions are made on a consistent, impartial and objective ground, without improper influence or bias or conflict of interest.
4. All barriers- like remote area, social and religious taboo, inconvenience of vehicle, poor road to reach community clinics need to be taken in consideration to ensure the highest outcome of this PPP.
5. Not only curative service, preventive and promotive service needs to be taken in consideration seriously in CCs. Quality services and careful analysis should be ensured through specific policy guidelines to achieve the highest outcome of this program.
6. To motivate staffs and members of CGs, incentive provision should be promoted.
7. In developing regulatory standard, give consideration to all applicable international frameworks and measures for co-operation and quality service.
8. Government should continue to settle standards and record as well as monitor efficacy, quality, safety and secure that citizens have sufficient access to the service and products they need.
9. A specific monitoring and supervision policy and guidelines should be promoted through co-ordination mechanisms among related stakeholders for better implementation.
10. This reform need to be rearranged to ensure skilled staffs, well-functioning health information system, effective health service delivery, adequate number

and properly distributed workforce, equitable access to medical technologies and products through good governance and adequate financing.

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Appendices

Appendix 1. Bangladesh: A Profile of Basic Information

Geographic location	Lies in the north eastern part of South Asia between 20 34' and 26 38' north latitude and 88 01' and 92 41' east longitude.
Land area	56,977 sq. miles or 1,47,570 sq. k. m.
Climate	Bangladesh enjoys generally a sub-tropical monsoon climate with six seasons.
Physiography	Bangladesh consists of fertile and plain land. Some hilly regions are in the south-east, north-east and few in the northern part.
Population	149.77 million (approx.)
Per capital income	$1,909
Administrative set-up	Parliamentary form of government, with Prime Minister as the chief executive.

Source: Statistical Yearbook of Bangladesh, 2019

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Appendix 2. A Selection of Possible Areas on Community Based PPP (as Suggested by the Book)

This table summarizes some of the prospective areas of research on community based PPP for rural health service delivery. Some of the questions are partly concerned by this paper and the rest provides clues for future investigation. However, the following list of research areas is by no means exclusive and indicative.

Suggested areas	Probable nature of enquiry: Few examples
1. Nature of PPP	• What is the structure of this PPP? • Is it infrastructure based or sociological method based? • How does central government link to community?
2. Role of government as partner	• What about the functions of government in this program? • Does government play authoritative role?
3. Role of community people as partner	• What about the functions of community people in this program?
4. Linkage between parties	• What about the communication mechanism of parties? • How parties are dependent on each other? • What about the decision-making mechanism between parties? • How they exchange information?
5. Extent of community participation	• What about the structure of

	decentralization? • How community group form? • How community support group form?
6. Functional-cooperation between parties	• To what extent parties have functional-co-operation? • Is there any board/committee for this? • How often their meeting conduct? • How they monitor and supervise the program?
7. Flexibility to work	• Do community people enjoy flexibility to play their role? • Do community people play active role in decision-making? • How much access community people have on budgetary issue?
8. Strengths of this program	• How much effective this structure to provide health service delivery for pro-people? • What about the relevance of this PPP with government's goal and national policy? • Does this program ensure equity in health service? • Does this PPP effective to provide health service? • Are clients satisfied from this service? • Is it ensured value for money for

	both government and beneficiaries?
9. Challenges of this PPP	• Is geographical position barrier to beneficiaries? • Are budget, equipment and medicine sufficient to serve the purpose? • Are health service providers available to community clinics? • Are health service providers being skill enough? • Is there strong monitoring and supervision over CCs?

Appendix 3 Photographs:

Photo 1. Rural people are taking health care service from community clinic

Photo 2. Beneficiaries are getting out after taking health service from community clinic

Photo 3. Community clinic building

Photo 4. General structure of community clinic