ORIGINAL ARTICLE

COMMUNITY ENGAGEMENT PLATFORMS FOR COMPASSIONATE, RESPECTFUL AND CARING HEALTH SERVICE: CHALLENGES AND OPPORTUNITIES, IN SULULTA DISTRICT, ETHIOPIA

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ABSTRACT

***Background**: While evidences existed on the effectiveness of community engagement (CE) in improving outcomes and quality of health care, little is known about the best available community engagement platforms for Compassionate and Respectful Care (CRC) service improvement.*

***Objective**: To explore CE platforms to improve CRC, the facilitators and barriers to successfully implementing these platforms.*

***Methods:** Implementation research was done using phenomenological study design. An interview guideline was used to collect the data. An audio recorder was used, and field notes were also taken. Twenty Key Informants were interviewed by health experts about CE. Audio records were transcribed, and thematic analysis of the text data was performed using qualitative data analysis software Atlas-ti -v-8.*

***Results:** Six CE platforms were identified. These are: the Community Score Card (CSC), Health Development Army (HDA), community forum, women's conference, citizens' charter, and health facilities governance board. The existence of HDA, presence of a conducive cultural environment, the readiness of the community to inform service gaps, the existence of effective facilitators (individuals) to mobilize the community, and the presence of Health Extension Workers (HEWs) within a community were available opportunities explored for effective community engagement. Distortion of the public's perception toward the HDA, lack of explicit structure for CRC, and the limited attention by leadership to engage the community for CRC were some identified barriers that hindered CE for CRC success.*

***Conclusion**: Among the major CE platforms, the CSC and HDA were reported by most of the study participants. The existence of HDA, a conducive cultural environment, and the HEWs embedded within a community were identified facilitators. The public distortion toward the HDA and the limited attention by leadership to engage the community for CRC were among the identified barriers. Therefore, to effectively engage the public for the CRC improvement, it is important to use the CE platforms in a way that convinces the public, develop a clear structure for implementing CE for CRC, and avail finances and other necessary resources for CE implementation.*

***Keywords:** Community Engagement, Compassionate Respectful and Caring, Community Engagement Platforms.*

INTRODUCTION

The importance of community engagement (CE) in the delivery of health services has long been recognized. It was one of the priorities of the 1978 declaration of Alma-Ata as stated in chapter 4. "The people have the right and duty to participate individually, and collectively in the planning and implementation of their health care" (1). As it builds confidence, trust, and mutual respect among health care providers and users, CE has been recognized as best available effective types of interventions to improve quality of care (QoC) (2,3).

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The World Health Organization (WHO) in the framework of CE for quality, people-centered and resilient health services, defined CE as, "A process of developing relationships that enable stakeholders to work together to address health-related issues, and promote well-being to achieve positive health impact and outcomes"(4). With this WHO definition, the term 'stakeholder' represents a number of concepts beyond the context of the current study. we used the concept of 'community' stated by MacQueen et al; – "A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings"(5).

Previous studies showed the availability of effective mechanisms for CE in health care. For instance, in their systematic review, Glandon D et al; have identified 10 best CE approaches that they believed to successfully engage the community for strengthening the health system, improving access to and quality of health care (6).

In Ghana, an approach called the Systematic Community Engagement (SCE) has been designed and implemented since 1999 aimed to improve the QoC by building trust and confidence between the public and the health professionals (7). The SCE mainly used the existing public associations' group directed to identify health gaps and barriers of health care utilization that enables to initiate necessary corrective measures to reduce barriers and improve the QoC.

In Costarica; Morgan and Lifshay presented a tool called the ladder of community participation (8). In this approach, authors have discussed 7 strategies that can be used to engage communities that comprise health department initiates and directs action, health department informs & educates the community, limited community input/consultation, comprehensive community consultation, bridging, power-sharing, and community initiates and directs action. The strategies were laid out in steps based on the extent of community participation, decision-making, and control which enables the community to participate at a variety of levels starting from taking directions from local authorities to make their own independent decisions (7, 8).

Norton et al reported a Participatory Poverty Assessment (PPA), an approach used in Uganda to collect perceptions and feedbacks of the poor used to inform national policies and strategies for poverty reduction (9).

Another effective CE tool in the health care literature is the Community Score Card (CSC). In Afghanistan, Edward et al. reported CSC as an effective means to identify health service delivery concerns of the community, ensure responsiveness of service providers to the needs of the community, maintain a positive relationship among providers and the public (10). A CSC has also been found to increase the utilization of health services by increasing community awareness and participation as well as by ensuring service providers' accountability (11).

In line with the existence of tools to engage the community in health care delivery, there were also various facilitators to their success which have been documented in the literature. A study from the United Kingdom found the presence of health professionals in the community as an opportunity for community participation (12). Another study from

the United Kingdom reported the use of existing social networking events of the community as an opportunity for community participation (13). Engaging the community from the design of the health program, being kind and respectful, and spending time with the community are also among facilitators for successful CE identified in the literature (14). There is also research that reported the design of context-based programs as the most effective way to engage communities (15).

On the other hand, there are also researches which indicated the CE work has been hindered by various obstacles. Limited organizational commitment, skill gap, and limited finance were amongst the main identified barriers to effective CE (16). According to some studies, competing agendas of stakeholders such as where one agenda is preferred over another, affect the relationship between community and organization, ultimately impacted CE (17,18).

In Ethiopia, the idea of participating community in health related activities has been started since 2011 during Health Sector Development Plan (HSDP-IV) (19). It was aimed to create awareness and change the behavior of the community to ensure their full participation in health policy formulation, planning, implementation, monitoring, and evaluation as well as regulation of health services and resource mobilization for the health sector and ultimately to enhance continuity and sustainability of health programs. A Women Development Army (WDA) is a pioneer CE platform designed to support health extension program (HEP) packages at the household and community level. It is a platform where women with little or no literacy are organized into 1:5 household networks and 1:30 development teams (20, 21).

Although existed evidences indicated CE platforms have led to improved health care access, outcomes, and quality of care, the evidences that show the best available CE platforms used to improve Compassionate, Respectful, and Caring (CRC) health service is lacking. This study had 3 objectives: 1) To explore existing CE platforms in the Ethiopian health system to engage the community for CRC improvement. 2) To identify CE platforms designed to improve other types of health care in the Ethiopian health system that would enable to participate the community in CRC improvement, and 3) to explore the facilitators and barriers to the successful implementation of identified CE platforms.

MATERIAL AND METHOD

Study design: This study was carried out in the Sululta district in March 2021. The study site was chosen purposely. Firstly, the Federal Ministry of Health (FMOH) decided to conduct the study in the Oromia National Regional State – one of the 11 regional administrations in Ethiopia.Then, based on the discussions with the Oromia Health Bureau, among districts in the region, it was found that Sululta district was better in terms of CE implementation. It was believed that the district could have been able to identify CE platforms for CRC, and also to learn the challenges and opportunities for implementation of the platforms. Suluta is one of the districts of the Oromia Special Zone Surrounding Finfinne, located 40 km north of the Ethiopian capital, Addis Ababa. Implementation research was done using the phenomenological study design. The study designed was used to explore CE platforms for CRC, opportunities, and challenges related to CE platforms implementation for improving CRC.

Study population: We conducted Key Informant Interviews with health staffs responsible for CE activities. Participants who are working in all level of the current Ethiopian health system, namely: from the FMOH, Regional Health Bureau, Zone Health Office Department, District Administration, District Health Office Department, Health Facilities (health center, hospital and health post) as well as from the community were invited. A total of 20 Key Informant Interviewees were participated. The composition of the study participants was as follow: 3 were CE experts composed from Zone Health Office Department, Regional Health Bureau and FMOH; 7 head of Health Centers, 2 HEWs, 2 managers from district level and 6 of the study participants were community representatives (2 kebele leaders, 3 community elders, and one kebele militia). The study participants were purposely selected. Purposive selection was made with the expectation that participants would be able to share their real-life experiences with CE platforms to improve CRC, as well as the challenges and opportunities associated with their implementation.

Data collection: The Key Informant Interview was conducted by a research team members composed from University of Gondar and FMOH. One of the members of the study team was a lecturer at University of Gondar, and two were from the Ministry of Health – a Health Professional Ethics Officer and a Health Information System professional. We used KII to identify existing and potential CE platforms, as well as the opportunities and barriers of implementing these CE platforms for CRC improvement. An audio data was taken using an interview guideline prepared in the local language. The interview guide was prepared by the research team. The guideline was reviewed three times by experts in the field of qualitative research at the University of Gondar. Besides, shortly, before the start of the actual data collection, the data collection guide was pre-tested in Sendafa district of Oromia Special Zone. We used audio recorder to record participants' voices. Field notes were also taken.

Data Analysis: Audio records collected at the field was transcribed, and text data were analyzed using Qualitative Data Analysis software –Atlas-ti-8. Thematic analysis was performed. Transcripts were repeatedly read, and synthesized. Codes were generated and categorized into sub-themes, and main themes were emerged from sub-themes . The transcription, translation and data analysis tasks were done by all research team members.

RESULT

The findings of the study were divided into three main themes: community engagement platforms for CRC, opportunities of CE for CRC and challenges and barriers to CE to improve CRC. Similarly, six CE platforms were identified: Community Score Card (CSC), Health Development Army (HDA), community forum, women's conference, citizens charter, and health facilities governance board. Furthermore, the existence of HDA, presence of conducive cultural environment, readiness of the community to inform service gaps, presence of effective facilitators (individuals) and existence of HEWs residing within a community were identified as good opportunities for CE. On the other hand, lack of explicit structure for CRC, funding shortages; poor infrastructure and limited resources, lack of dedication among frontline health staffs, and

shortage of health professionals were identified as main barriers that hindered CE for CRC success.

Community engagement platforms for CRC

A Community Score Card: A CSC is a mechanism in which the community evaluates health facilities' CRC, discusses the results of the evaluation, and provides feedback to health facilities. According to our key informant interview data, CSC is one of the formal community engagement tools, but it has different CRC related indicator. All of the six health facilities included in our study used this tool. It was identified that the CSC is a way that help health facilities to know the publics' reflection about their CRC service status.

> *'We are using CSC extensively. There is an indicator that directly asks about CRC. In this way, when the community becomes a mirror and shows us our problems, we understand the problems and we try to improve.'* – Health manager

The CSC evaluation is conducted quarterly by a committee called a 'client council' which is composed of a variety of community members. It is a platform that enables health facilities to plan and act based on community feedback to improve CRC.

> *The evaluation [CSC] is done by client counsel, groups of people composed of youth, elderly, religious leaders, and school directors. Evaluation results which are collected from different kebeles under the specific health center are taken and the identified gaps are reported to the health center. Then, the health center management with client counsel prepares an action plan.* – CE expert.

One of the reasons for the intensive use of the CSC is that it was designed to be user-friendly considering clients/patients as being unable to read and write. It is a way for people to express their feedback in the language they understand. Participants are able to use different color cards to evaluate the health facilities' performance of CRC services.

> *'For example, when asked the public feedback on CRC and If their feedback is positive, they will give us a green card. A yellow card indicates good service, and there is also a chance to get a red card.'* - Head of the health center

According to the study participants, if CSC has a discussion session after evaluation, it can help providers who violate the CRC principles, to identify mistakes, learn from their mistakes, and change their behaviors using community feedback from evaluation.

> *'We allow the community to evaluate our health center to check whether or not health services are provided with compassion and respect. If there is a problem with the service delivery, it is possible to identify the problem by discussing it with the community and advise the professional to adjust his/her behavior.'* – Head of the health center

Health Development Army: Study participants revealed that the HDA is another platform that can be used by health facilities to engage the community for CRC improvement. The HDA is a network of women organized at two levels in the community: the smallest group composed of 1 to 5 members, and the largest group composed of 30 to 40 members. Each group has its own leader that organizes a regular discussion in every 1 to 5 and 1 to 30 groups. The HDA leaders regularly discuss with HEWs, which

helps to identify concerns of the community regarding CRC. As each HDA group have its own health plan and expected to report their performance to the HEWs, the HDA leaders have a chance to regularly discuss community concerns with HEWS.

> *They [HDA members] discuss regularly in their every 1 to 5 and 1 to 30 groups. Again, they [HDA members] discuss with the health center and the health post every month. As it is all about health care, they are supposed to at least have contact with HEWs. They also report their work to the HEWs. They would have a chance to discuss with HEWs while they bring a report.'* – CE officer

Community forum: A community forum is another tool that was identified by this study that may enable the community to regularly discuss with health facilities about the health care provision. The forum is open to the public at all levels; at the woreda and health facilities levels with the participation of all eligible community residents.

> *'The second is the community forum. Community forums are held every three months by health centers and districts. Anyone in the community is eligible to participate including kebele chairmen, and militias. They discuss what we need to improve.'* – CE officer

Although the forum is broad and discusses general health service delivery, it allows the public to directly or indirectly reflect their views on CRC service delivery and enables institutions to take corrective action based on public opinion.

> *'If we want to talk about CRC what does our [health facility's] health care service look like? How is the health professional providing services from reception to discharge? If we [health facility staff] ask these questions, we [health facilities] can practice CRC. And we are having a community forum every quarter.'* – CE officer

Women's Conference: The current research identified women's conferences as another CE platform used by health facilities for CRC improvement. Participants in the KII mentioned that the conference only invites pregnant mothers, and it is held every month. It is a widely used CE tool to help pregnant women discuss why they do not want to visit health facilities, and it helps facilities to resolve problems raised during the discussion.

> *"The health center holds a women's conference every month. They [health centers] gather pregnant mothers from each kebele, and holds a conference. Our experts are working to improve maternal health services by creating opportunities for mothers to consider the health facilities as their home. The community used to raise complains. For example, they say, "we don't want to come to your health center because the midwife named 'X' is insulting us." The conference is held monthly until the mothers give birth. It is good that we work hard.* – HEW

Citizens' Charter: Although the implementation of the Citizens' Charter is not consistent, we understood that it can be one of the effective ways to engage the community for the betterment of CRC. It is a document of agreement, signed among health facilities and a community via community representatives such as kebele administrators, the managers, and the most influential people in the community. At the beginning of each fiscal year, health facilities announce the list of health services

they plan to provide to the community in the presence of community representatives so that a community can present a complaint if health facilities do not provide per the signed agreement.

'There is Citizens' Charter. We will sign with the kebele leadership and HEWs. We plan to include CRC there.' – Head of the health center

Health facilities governance board: Another method of CE tool which was identified in our current study was the health facilities governance board. The board is composed from a variety of members. One of the board members is a community representative who is expected to quarterly attend boards' meetings to review the performance of health facilities.

'Exactly! There is a board member who is selected from the community. He participates in quarterly board meetings and presents what he has as a participant.' – Health Manager

During the quarterly discussion on the performance of health facilities, the board can identify various problems including the CRC and setup administrative solutions.

'We discuss improving the problem. In our board meeting, when we review the works, we discuss it [CRC] as an agenda. We have made them [health facilities] improved.' – health manager

Opportunities

The existence of HDA: Recognizing the impacts of previous changes on the success of health services, many of our study participants noted that strengthening HDA is crucial and a best available opportunity for CE to improve CRC. According to informants' opinion, the HDA is not only a good way to engage the community, but also serves as a bridge to other CE strategies' effectiveness.

'We have no questions there [on strengthening HDA]! By the way, HDA is the backbone of the health system…. We have seen a lot of decrease in maternal and child mortality. The HDA is a good opportunity for CRC, for all health services.' – CE Expert

'For all our [Health facilities'] work, whether to conduct a community forum or a CSC, we get the community through HDA. So, , there is no doubt to strengthen it (HDA). Strengthening HDA is critical to all of our work.' – Deputy Head of the Health Center

Presence of conducive cultural environment: This study revealed the presence of a conducive cultural environment in the health facilities which is considered as one of the opportunities to successfully implement CE platforms in improving CRC –a coffee brewing ceremony that held regularly at the women's health conference. We found it as a helpful way in strengthening the bond and trust between professionals and clients/patients. The underlying concept for the success of the coffee ceremony event as per some study participants, "A coffee is a popular cultural drink in the community, brewed and hosted for guests. Hence, while attending a conference held in the coffee program, mothers would feel honored at the conference, allows them to enjoy the discussion and can actively participate.'

'Most of the time, when we have women's conferences, the community wants to brew coffee. Because of our culture, they love coffee. We host a coffee ceremony at the conference. To make them not feel bored. It helps them forget about their own homework and focus on the conversation. We

see them as our guests. In our culture, coffee is brewed for guests. That way, they sit down and talk. Here it can bring the community closer to us.' – HEW

Readiness of the community to inform service gaps: Many participants agreed on the existence of committed and motivated community to inform identified gaps related to the CRC which is another available good opportunity to participate community for CRC success.

'They [community] are very interested to provide feedbacks about services related with CRC, and about how both hospitals and health centers greet patients. It means they have interest to evaluate health facilities a soon as they saw problems related with care provision at health facilities.' – HEW

Presence of effective facilitators (individuals): Some participants stressed the need to use the various audacious individuals existed in the community to engage the public in a wide range of forums. Because these influential individuals would speak directly to the health service about the delivery problem without hesitation or fear.

For instance, one of the participants stated that these prominent people can have a role in the CSC:

'The CSC and the community forum want key participants from a community. If religious leaders, and influential members from the community are invited in these discussions, they [influential people] will tell you directly without any fear of what they should say. They are representatives of the community. We will be effective if they [influential people] participate in all community forums' discussions and CSC evaluation.' – Kebele administrator

Presence of HEWs residing within a community: In our current study, we also found the existence of HEWs who live in the community as one of enablers for effective CE as well as to improve CRC. According to some participants, the continual presence of these HEWs in the community is helpful in bringing the community and the providers together, making them closely related and know each other well. As it brings them closer, it strengthens their relationship. This in turn makes it easier for the public to inform the health facilities about the CRC and other health service gaps.

'Around the health post, HEWs are residing in the community. It [the existence of HEWs and community together] is like a family. When they [HEWs] are within a public, their [HEWs and community] communication will be easier, and service will be better.' – Health manager

Barriers: Although there are many platforms outlined in this report that might enable the public to play their part in improving CRC services, our KII data revealed that they are not being implemented as much as they should be at the moment. Many barriers to CE have been identified in this study. These barriers are can affect all CE platforms. Of these, the major barriers stated by many participants are distortion of the public's perception toward the HDA, lack of explicit structure for CRC, funding shortages, poor infrastructure and limited resources, lack of dedication among health staff, and shortage of health staffs.

Distortion of the public's perception toward the HDA: On the contrary to the hope on HDA in facilitating CE, we found that the public participation in HDA was not as desired and that its success was declining. The main reason voiced by many

participants for this was a distortion of the public's perception toward the HDA as many perceived that HDA is designed for the benefit of others rather than to benefit the community in health care. Realizing this, one participant stated that the health authorities were reorganizing, and renovating the HDA and that the name itself had been changed from HDA to a 'neighborhood organization'.

> *'Man, when you talk about HDA, it looks like you're talking about politics. When you enter a community to talk to people about health or agriculture, they [Community] say that they came for politics. It [HDA] had a political spirit, and I think it [Distortion of the public's perception toward the HDA] could have been a challenge …. That's why we changed the name [HDA] to 'Ijaarsa ollaa' – a neighborhood organization.'* – Health Manager

Lack of explicit structure for CRC: The findings of this study revealed that CRC program lacks attention at all levels, and its monitoring and evaluation was interrupted. It was what many of the participants reported as a prominent challenge to effective CE. The lack of a clear structure and ownership made the program difficult to run. Per these participants' opinion, although the CRC has been set up as one of the 4 major agendas designed to transform the health sector in Ethiopia, the emphasis for CRC was not good from managers at all levels. For instance, one of our study participants compared the emphasis of managers to CRC vs other transformation agendas. He said:

> *'One is the structural problem. For example, the information revolution is under the planning directorate. They [staff working on information revolution] will review it [information revolution related works]. They [staff working on information revolution] planned it [information revolution related works], reviewed and evaluated at each level. Quality and equity services have also a clear structure that directly related to the Oromia Regional Health Bureau. The same is true of Woreda transformation. However, CRC has no structure or owner.'* – CE Expert

Funding shortages: Funding shortage was another challenge which played a negative role in the success of community participation for CRC. Many participants agreed that the existing health-care system does not adequately fund community engagement and CRC activities.

> *'It would better if a budget is allocated. You need a budget to do something. Woreda transformation now has a budget. The health information revolution also has a budget. They [Woreda transformation and information revolution] are being implemented. The same goes for quality and equity service. Other health services have been improved. We failed on CRC. I think we can make a difference if we work hard on CRC. '*– CE Expert

Poor infrastructure and limited resources: The current study found that one of the barriers to community participation in CRC improvement was lack of infrastructure. Lack of transportation in particular, prevented the health workers movements to the community to discuss. On the other way, it limited the community's visiting of health facilities. As we observed in our data collection field visit time, we came to realized that road problem was a natural barrier that prevented the effectiveness of CE.

> *'We have a road problem. Summer is full of rivers. We find it very difficult to take sick and pregnant for treatment. It was a bridge we built for*

ourselves rolling a stem. The flood took it…. Every summer we get into the same problem. The experts here and there cannot get each other to communicate. Here is our main problem. If it is not fixed, everything you are asking about has non-sense.' – Community elder

Lack of dedication among frontline health staffs: Another significant challenge revealed by key informants was the existence of staff in some health facilities who are not truly committed to engaging in CE activities. It was the participants from the community who came up with this opinion, and according to their view, the employees of some health institutions are unfaithful and lack intentions in engaging in the CE activities. Rather, as CE activities are among their expected deliverables and are one of the criteria for their performance evaluation, these professionals pretend to work to deceive their superiors by producing manipulated reports. For instance, although the type and number of participants required to participate in the CSC are setout in the guideline, some health workers indiscriminately select individuals from the community to fill out the checklist and compile a report. As one of the kebele administrator complained:

''If a health care provider gives someone a checklist to fill out simply for the purpose of being evaluated, two concerns may arise. For example, when evaluating using this CSC by the community…, Let me give you an example. If I am the kebele chairman, and they made me fill the evaluation checklist, what did they want then? They want what they want. Their percent! They want to say our health center performed well.'

Shortage of health staffs: Our data showed that shortage of health professionals is another barrier to CE. Some of the experts involved in the study reported that it was difficult to go to the community if there are not enough staffs, especially since the health workers have a duty to work within the health center, and not only to engage the community.

'The main obstacle is the shortage of professionals in our institution. If you do not have enough professionals, you will not be able to go and discuss with the community as you would like. If you do not have an expert, you will miss the appointment that you made with community for the meeting. Then, the public crowd may get disappointed.' – head of health center

DISCUSSION

Among the identified CE platforms for CRC health service improvement by this study, the CSC and HDA were echoed by many of the study participants. Facilitators and barriers to effective CE implementation for CRC service were also been identified. The presence of HDA, a conducive cultural environment, and the presence of HEWs in a community are some of identified facilitators. The barriers are mainly related to the lack of attention by the leadership to engage the community in CRC services.

As research finding, many health facilities regularly and extensively used the CSC as a way to engage the community for CRC works. What sets CSC distinct from other CE platforms is that its formal inclusion of CRC indicator that allows health facilities to be directly evaluated by the community on their CRC services. The evaluation is carried out by committee members selected from the community so that the

community can actively monitor, evaluate, and control the health facilities' CRC status which in turn encourages health facilities to take corrective action by identifying existing problems based on communities' feedback provided from the evaluation. The basis of the CSC is beyond evaluating health facilities. It is a means that allows the community to participate in action plan development for concerns identified on evaluation, also to play a part in the implementation process and feel accountable to address the identified problems. The Malawi study that reinforces this finding was reported that CSC is a mechanism that allows negotiation between health facilities and the community, and it is a vital means of community empowerment and accountability (22). Another finding from Afghanistan also stressed CSC as a way of enhancing a voice of the public to ensure responsiveness of service providers to the needs of the community, strengthen clients and providers relationship, hold a discussion to identify service delivery concerns of the community, and develop a shared plan on the way to solve healthcare-related gaps (10).

Another CE platform that our study found to be effective in engaging the community for CRC services is the HDA. Most participants in our study spoke about the success of the HDA from their experience that it significantly played in the success of various health-related activities. In fact, since its inception, there have been research findings on the success of HDA in Ethiopian health care delivery. Among the existing CE tool, HDA has served as a bridge between the community and health institutions, and that strong community ownership has been achieved over the past three decades through this women's development organization (23, 24).

One potential opportunity this study identified for effective CE to improve CRC was the existence of the HEWs that have made their residence in the community. The HEWs' being part of the community allows them to get closer and live as a family together which helps a community to communicate easily about the CRC or any health-related issues. This finding is similar to a study which was conducted in England that stated the presence of staff within the community as a crucial factor for successful community participation (12). According to this study, the presence of locally embedded dedicated staff in the community led to a significant increase in CE due to the fact that the number of residents felt these staff as part of the community.

Besides, we explored the presence of a conducive cultural environment in the health facilities as another opportunity for effective CE. The coffee ceremony event that is held regularly at women's conferences could enable the community to actively participate and discuss the issues of service delivery concerns including the CRC. The underpinning concept of the coffee brewing ceremony relied on the fact that it allows pregnant mothers to bring their felt health care issues to the forefront of the conference just as they do when they are having a coffee with their families at their home. If used properly, we understood that it is a means that can play a significant role in the CRC success, particularly in building a bond and trust between a community and health professionals. Another study carried out in England that examined the barriers and challenges of CE reported a similar approach called 'World Cafe' which was an effective method of CE (13).

Among the major barriers identified by the current study, lack of leadership attention and limited organizational commitment for CRC were the pertinent

barriers that affect the success of CE. Lack of clear organizational structure for CRC, the absence of a focal person assigned to the CRC at all levels of the health system, lack of supportive supervision and monitoring were also the main identified barriers. Although the CRC had been set as one of the four health sector transformational agendas, lack of managerial attention, financial and other resources limitations were hindered the overall program's activities as well as CE. There is evidence that showed the lack of commitment and neglect of leadership as the main obstacle to CE (17, 18).

Although HDA can be used as an effective means to CE; many participants in this study shared the view that the public's confidence in the organization was declining, and its effectiveness is questionable onward. People's lack of trust is most likely due to competing stakeholders interests undermining HAD's original purpose of improving public health services. Previous studies have also shown that the presence of competitive agendas between different stakeholders has created tensions, and undermined effective community participation (16-18).

Because there is still an evidence gap about available CE platforms for improving CRC, this study's strength lies in its exploration of platforms, opportunities for successful use of these platforms, and barriers. Policymakers, programmers, managers as well as non-governmental organizations that existed at the national and various levels of the health system can use the findings of this study to develop strategies for effective public engagement to improve the CRC. However, as our study is qualitative, the findings in our report are reflections of participants' views which may not be relevant to generalize for the wider community.

CONCLUSION

There are platforms for successful CE to improve CRC services. The CSC is the only identified CE platform that formally incorporated CRC-related indicator. Although opportunities exist, there are challenges to the successful implementation of the identified platforms for the CRC service improvement. While the presence of HDA is a great opportunity for CE, it lacks public trust for successful implementation. In addition, the limited attention by leadership at all levels, lack of explicit structure for CRC in the current health system, and inadequate resources allocation for CE has hampered the community's participation in CRC services. So, based on the findings of the current study, incorporating the CRC related indicators into the identified CE platforms, effectively using platforms such as HDA in a way that convinces the public, developing a clear CRC structure in the health system, and allocating finances and other necessary resources for CE implementation are vital for participation of the community in a way toward the CRC success.

Declaration

Ethical approval and consent to participate: The research team obtained ethical clearance from the Institutional Ethical Review Board of the University of Gondar (R.NO/V/PRSC/05675/2021). Interviewees provided written consent before data collection, and they had the right to participate, refuse to be interviewed or to withdraw from the interviews at any point in the interview time. Personal data of interviewees were also coded in such a way that all personal identifiers were removed. The research teams were again honest and objective in reporting the findings of this study.

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