ORIGINAL ARTICLE

THE ROLE OF COMMUNITY ENGAGEMENT ON COMPASSIONATE, RESPECTFUL AND CARING HEALTH SERVICE: PERCEIVED EFFECTIVENESS AMONG HEALTH STAFFS IN ETHIOPIA

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ABSTRACT

Background*: Even though health staffs' attitudes have been identified as a main factor in influencing the proper functioning of community engagement, evidences showed that perception of health workers about community engagement for improving the Compassionate Respectful and Caring (CRC) service is very low in Ethiopia. The study aimed to explore the health staffs' perception towards community engagement for the improvement of CRC in Sululta district, Oromia special zone, Ethiopia.*

Methods: *A phenomenological study design was used. The Key Informant Interviews and an in-depth interview were conducted with a total of 20 participants using an interview guide. A thematic analysis was done guided by ATLAS Ti-8 qualitative data management software.*

Results: *Two staffs' perspectives on the role of community engagement in improving CRC have identified. Many participants mentioned that community engagement has a role in the success of the CRC. Some of the main justifications of the participants who believed in community engagement effectiveness in improving CRC were: it enables the public to inform health service gaps, strengthened bond/trust among community and health facilities, and build a sense of ownership among the public and health facilities. On the other hand, some argued that community engagement does not improve the CRC. Participants who doubted the effectiveness of community engagements mentioned the lack of necessary infrastructure and medical supplies as the main reason.*

Conclusion: *Many participants in this study recognized the benefits of community participation for the improvement of the CRC. This study identified different ways in which the community can engage to improve the CRC services. Among the effective ways of community engagement that participant in this study believed are: 1) The community can provide constructive feedback that helps health facilities address CRC-related gaps. 2) The public can create conducive conditions for CRC improvement through material or financial contributions. 3) A sense of trust and respect can be strengthened among health care providers and clients through a series of public forums. 4) The community can monitor the health care provision by caregivers at health facilities. The findings of this study revealed opportunities to design a variety of strategies to improve the CRC through community engagement. However, it is important to address some of the challenges raised such as shortage of medical supply, and lack of basic infrastructure.*

Keywords: *Caregivers, community engagement, perceived effectiveness ,CRC*

INTRODUCTION

Positive staff attitudes toward community engagement including valuing the role of community was identified as important factors in influencing the proper functioning of health programs (1). On the other hand, resistance and professionals' negative attitudes towards community engagement were identified by literature as one of the prominent barriers to the effective community engagement (2).

There are studies that explored perspectives of health staff on the role of community engagement in im-

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proving health services. For instance, a study which was conducted in Australia examined health staffs' views on the roles of community participation found that staffs' attitudes were generally positive (1). According to this report, most health workers saw the importance of community participation as improving communication between the health service providers and the community. This studies' participant also believed that community engagement helps to get constructive feedback to improve health care. Another study which was conducted in Australia examined perceived benefits of community participation among health service staffs reported as a way in taking community feedback into consideration to design more accessible and appealing health program, raising awareness of the program through consultation, and encouraging a sense of ownership (3).

Similarly, a study which was conducted in South Africa found that health professionals had positive perceptions towards community engagement practices and that they believed community engagement plays an important role in the communication between the local community and health professionals (4).

A study finding from Tanzania reported various benefits of community engagement such as better identification of community needs and priorities, more transparency and accountability, increased communities' trust on health system, and improved the access and quality of health service(5).

Likewise, a study that explored the social accountability practices in Benin, Guinea, and the Democratic Republic of Congo among health professionals, health managers, and community members found that community engagement especially public forums can help to address patients' concerns regarding the quality of care. Furthermore, it can be used to correct misbehaved health professionals (6).

Community Engagement was a successful method in Bangladesh for increasing service utilization by ensuring community ownership and service providers' accountability (7). Another study in Bangladesh also discovered that community participation is essential for promoting community ownership, responsibility, and stakeholder involvement (8).

Since 2005, community engagement has been one of Ethiopia's strategic initiatives used to promote quality and equitable health services (9). Much effort has been made on some community engagement mechanisms such as the Health Development Army (HDA) and the Community Score Card (CSC). The HDA, in particular, has been shown to be effective in engaging the public for health services access improvement (10, 11).

In recent years, Ethiopia has set goals aimed to improve the quality of health care and designing four major agendas that believed will transform the health sector (12). A movement toward Compassionate, Respectful, and Caring (CRC) health professionals is one of the four agendas, which runs concurrently with the transformation of health care quality and equity, woreda transformation, and information revolution.

The health workforce density in Ethiopia is 0.96/1000 population (13) which is far below the World Health Organization's (WHO) threshold of 4.45/1000 population seated for 2020 (14). So, to promote CRC in Ethiopia, it is plausible that the limited number of health professionals in the country needs the full participation of the community. Before inviting the public to engage in improving CRC, it is

important to understand the perspectives of health professionals toward community engagement in improving CRC. To the best of literature search, authors in this study did not find a single study showing perception among health workers about the role of community engagement for improving the CRC. Therefore, this study invited study participants from different levels of the Ethiopian health system, and explored health staffs' perception towards engaging the community for improving the CRC in Sululta, district of Oromia Special Zone, Ethiopia, 2021.

METHOD

Study context and design: The study was conducted in Sululta district, Oromia region, Ethiopia, in early march, 2021. The district is located 40 KM in the north of Addis Ababa, the capital of Ethiopia. We selected the district because of: i) the recommendation from the Ethiopian Ministry of Health to conduct the study in the Oromia region, ii) The Oromia region reported that the district has better community engagement in the health sectors, and iii) we believe the health care providers might have better experience and understanding about community engagement in the health care delivery. There are six health centers, one primary hospital and 23 health posts in the district. According to a 2021 population projection, the district's population was 175,705. We used the phenomenological study design to explore the perception of health staffs' on community engagement in improving CRC.

Study population: A total of 20 participants were recruited. Participants were invited from the Ministry of Health, Oromia Health Bureau, Zonal health office department, Sululta woreda level, health centers, hospitals, and community representatives from the community level. Regarding the composition of participants by their roles, three were community engagement experts, two woreda level managers, five health center heads, two deputy health center heads, two Health Extension Workers, two kebele (community) administrators, three community elders, and one kebele militia.

Sampling procedure: We purposively invited health staffs who involved in community participation. Participants who we believed would have the experience and understanding of community engagement to improve CRC were enrolled through discussions with health leaders at all data collection points. Community engagement program coordinators, woreda health office heads, and heads of the health center suggested participants from the health facilities level. Rather, participants from the community levels are recommended by kebele administrators.

Data collection: The Key Informant Interview (KII) and an in-depth interview have been conducted. The KII was conducted with CE experts at health institution (departments) level. An in-depth interview was conducted with participants from various health centers and community levels. The interview was conducted using an interview guide by three data collectors who were recruited from the university of Gondar and Federal ministry of Health. The data collectors were experienced in qualitative research and fluent in both Amharic and Afaan Oromoo languages. The guide was prepared by the study team and reviewed by a group of qualitative research expertise from the University of Gondar, and also it was pre-tested prior to actual data collection. We used a voice recorder to gather audio data from par-

ticipants, and we took a field note. The audio was recorded after asking the participants' language proficiency: Ten interviewees were interviewed in Afan Oromoo language and ten were interviewed in Amharic.

Data Analysis: The audio data collected in the field was transcribed into Afaan Oromoo and Amharic languages, and translated into English. We have reviewed and repeatedly read the transcript and conducted a thematic analysis after understanding the content and meaning of the information. Participants' quotations were coded, and codes were categorized into themes. The data was analyzed using qualitative data management software –Atlas.ti-8. Transcription, translation, and analysis were done by members of the study team who participated in data collection.

RESULT

Characteristics of the Study Participants: The majority(17) of the study participants were males while 3 were females. Regarding educational level, 7 of the participants had a bachelor's degree, 3 had diplomas, 3 had masters, and 7 were below diploma. The majority(9) of participants were between 30 and 40 years old, six between 25 to 30, two between 40 to 50, and 3 were above 50 years old. Concerning the job position, most (9) of the participants were health facility managers, 3 community engagement experts, 2 HEWs, and 6 were community representatives. Participants' work experience was averaged 7.25 years with a standard deviation of (6.07). (Table-1)

Table 1: Characteristics of the study participants, Sululta district, Ethiopia, 2021

Characteristics	Category	Frequency (n)	Percentage (%)
Sex	Male	17	85
	Female	3	15
Educational level	Diploma	3	15
	Degree	7	35
	Masters	3	15
	Others	7	35
Age category	25 to 30	6	30
	30 to 40	9	45
	40 to 50	2	10
	>50	3	15
Job position	CE experts	3	15
	Health facility managers	9	45
	HEWs	2	10
	Community participants	6	30
Work experience (Mean, SD*)	7. 25(6.07)		

* Standard deviation

Two perspectives of staffs on the role of community engagement in improving CRC have been identified. Many acknowledged that community engagement has a role in the success of the CRC. However, some claimed that community engagement doesn't improve the CRC in the absence of necessary infrastructures and medical supplies.

Community engagement can improve CRC: Participants who believed in community engagement effectiveness in improving CRC presented five main justifications: Enables the public to inform health service gaps, allow the public to collaborate to improve CRC, strengthen bond/trust among community and health facilities, build a sense of ownership among the public, and increase public awareness of their rights.

Inform health service gaps: Many participants reported that the CRC can be strengthened by community engagement as it helps the public to provide constructive feedback that enables health facilities to correct health service gaps. They also mentioned that if a health care professional does not have CRC traits, community participation might be helpful in detecting and encouraging behavioral change.

'The feedback from the community is a great input for us. We have taken disciplinary action based on community complaints. There is a professional that fired from his job based on community complaint.' (head of the health center).

There were experts who shared their practical work experiences on how to improve CRC by engaging communities. Many health facilities were implementing a community engagement mechanism to collect feedback from the community by allowing the public to visit and assess the convenience of different departments for CRC service.

'I believe it [community engagement] can improve CRC. We have seen many improvements with it[community engagement]. They [Community] come and visit our health center…. Based on their[Community] feedback, we reported the matter to the board of the health center. The board allowed us to work if it was a public opinion. I'm telling you that community shows us our gap' (Health facility manager)

Allow the public to collaborate to improve CRC: Some participants from both health facilities and the community levels believed that a community can collaborate with the government and other stakeholders in solving CRC-related issues. They pursue that a community can play a role in creating a conducive environment for CRC. Some emphasized that the public can work together with other stakeholders to create appropriate condition for CRC improvement through material or financial contribution.

'For instance, …, community participation can help us to buy ambulances. It is a people who bought two of the four ambulances in the district. We realized that there was a problem after we discussed it with the people. We reduced our [communities] grievances with the ambulance because the community donated money to buy an ambulance. We are working together' (Health facility manager).

Strengthen bond/trust among community and health facilities: Findings from this study revealed that community engagement can improve CRC by strengthening a relationship between the community and health institutions. Respondents mentioned that community engagement platforms, such as the Women's Conference and Community Forum, create a sense of mutual trust and respect between health care providers and clients.

'If a mother does not want to give birth at the health facility due to the lack of care, we will bring the mother, and providers to a conference together. We try to make discussion between both and solve the problem.In this way, the womens' conference improves CRC' (HEW).

Build a sense of ownership among the public: Respondents from the community believed the public is responsible for monitoring and supervising the health care provision by caregivers at health facilities.

'The public must monitor the services provided daily…. The owner of the health facility is the people and we are expected to follow them. We

are the ones who should encourage our experts. To be served on time according to the available supply and to make them do not sit idle. If there is a shortage of medication on a regular basis, we need to monitor and notify them.' – (Community elder)

One way to increase the public sense of ownership reported by respondents was community mobilization to build health facilities with their own material and financial contributions.

'There is a health post that we plan to build with community participation. If a community constructs a health post with its own participation and believes it belongs to them, they may feel a sense of ownership and be satisfied with the care they will receive.' (head of the health center).

Study participants mentioned some community engagement approaches that can help to promote a sense of ownership among the public. For example, there was a community engagement approach that participants named 'maternity food': used in many health facilities to raise funds from the community for birth preparedness. A regular donation of 10 Ethiopian Birr/per eligible household in the community is made in advance to prepare food for any pregnant woman residing in a catchment who later gives birth in the health facility. Hence, when mothers give birth later and having maternity food service, they feel that they are being served on their own property.

'Regarding maternity feeding, we are in the process of collecting 10 Ethiopian birr from each household…. That will help to prepare food for those mothers during childbirth, such as porridge… and oatmeal. Mothers are happy to have this'(head of the health center).

Increase public awareness of their rights: Some respondents believed that community engagement could allow the public to be aware of their right, and it allow them to work for their unfulfilled needs. According to them, to criticize the gap and quality of health services, the public must first be aware of the kind and content of the service provided. So, the community engagement mechanisms can help the public to understand the nature of these services in advance so that a culture of health need inquiry can be enhanced among the community. With the same concept, if there is a successful community engagement approach for raising community awareness about CRC service, there may also be a culture of demanding for health services improvement to meet CRC standards among the public.

'For example, if we take Health Extension Program(HEP), if they [community] know about 16 health extension packages, they [community] would fight for their right to get these packages accordingly. Likewise, the community needs to be aware of CRC. If they [community] are aware, they will get empowered to ask for the CRC service. '(community engagement expert).

Community engagement cannot improve CRC: With this view, we presented two types of participants' perspectives. Some pointed out that certain prerequisites that must be availed for community participation to play its part in CRC improvement. Others argued that the CRC is determined by inherent professionals' character rather than community participation.

Perceived prerequisites for community engagement effectiveness: Participants with this view believed that CRC can only be achieved if and

only if professional behavior (patient management) and necessary supplies are reconciled. According to these study participants, the priority for CRC services is the enhancement of patient care character among service providers. They also asserted that shortage of supplies and infrastructure such as medicine, electricity, and water need to be considered in parallel with provider conduct.

> *'In my opinion, there is not much we can change by involving the community. It does not mean that a community will solve the problem [lack of supplies and infrastructure]. I think the community can help us by discussing with us in order to improve our service delivery. But, I don't think it (community engagement) will solve the problems [lack of supplies and infrastructure] I just described. I do not expect that from them [community]' (*Deputy head of the health center).

CRC is determined by inherent professionals' character: The finding of this research indicated the presence of health professionals who perceived that CRC depends only on the inborn personality of health professionals.

> *'I believe that what matters is the personality of the professionals. What is important is that a person must have inborn CRC characteristics. People with a lack of such behavior cannot perform CRC miraculously. But if people are inherently respectful of others, respect the elders ....' (*head of the health center).

DISCUSSION

This study showed the effectiveness of community engagement in CRC implementation by allowing the public to inform health services gaps, strengthen the relationship between the community and health facilities, and build a sense of ownership among the public. On the other hand, some contradict answers were given from the participants in which they proposed a prerequisite must be fulfilled for improving the CRC through community engagement.

This study's findings showed that many participants have a positive attitude toward community engagement. The main reason for their optimism to it is that community participation can help to identify gaps in service delivery that are directly or indirectly related to the CRC which allows health facilities to fill the gaps based on public feedback. This is possible because as a matter of fact, from experience while served, the public can present the complaints such as encountered shortage of the medical supply which in turn can lead health facilities and the relevant local authority to take corrective action. Previous study has also demonstrated that community participation may be utilized to collect public feedback, which can then be used to help institutions design programs to enhance health care delivery. According to a study conducted in South Africa, health professionals believe that community participation increases the possibility of meeting local community health service needs (4). Besides, a public can point out the health professionals who have deficient in the provision of CRC services so that to enable them correct their behavior. A study that included three countries' participants' perspectives from Benin, Guinea, and the Democratic Republic of Congo reported a related finding which revealed the health professionals' behavior was one of the main agendas discussed on the community forum (6).

Participants in this study also believed that one of the benefits of community engagement is that it can strengthen the bond between the public and health

professionals. This is plausible in particular if public forums on health issues are frequently held. Regular discussions might increase the chances of intimacy between health professionals and the public which build a sense of families among health professionals and clients/patients. With this, a study from Tanzania reported a concurrent idea that indicated trust between communities and health workers has improved due to increased community participation (5).

Respondents also perceived that community engagement can bring a sense of ownership to community members. Community participation can develop a sense of ownership in a variety of ways. According to our current findings, a sense of ownership was developed as the community contributes financially or materially to support health services. However, even if the community does not contribute money or materials, if the community and health facilities are in regular contact, a sense of public ownership can be built in the process. The study from Bangladesh indicated that ensuring community engagement tools such as CSC enabled an effective discussion between community and health institutions, helped the community to be aware of their roles in improving health service delivery, and in the long run it will have a positive impact on building community ownership and accountability (8).

As the finding of this research showed, the community members feel responsible to monitor, supervise and control health facilities and correct their shortcomings. Having a motivated community with a sense of responsibility to address any aspects of service delivery challenges is one of the best opportunities which can play a significant role in solving CRC-related issues. So, enabling the community to make their own decisions, and allowing them to have greater involvement on health service delivery is one of the most successful community engagement approaches cited by literature (15). Also, an idea of communities' ability to decide and control issues related to their own health – the so-called 'community empowerment' by previous literature is at the top of the ladder of community engagement (15, 16).

Despite many participants recognized the benefits of community participation for the improvement of CRC, some questioned its effectiveness. It's plausible that the participants mentioned a lack of supplies and basic infrastructure as a prerequisite to community participation.

Lack of supply such as medication can easily lead patients/clients to raise complaints. In addition, shortage of basic infrastructure including water, electricity, and transportation can negatively influence the CRC service. Evidences that indicated lack of infrastructure as one among the prominent barriers to community engagement effectiveness are available. (17).

The strength of this study was that it included the participation of a wide range of participants, from the Ministry of Health to the community level. This could help to get the realities of existing perceptions among health staffs regarding community engagement effectiveness in improving CRC. However, the research was limited to a single district. Therefore, anyone wishing to use the findings should consider that this study does not represent the opinions of health staffs beyond the scope of the study site.

CONCLUSION

Many participants in this study recognized the benefits of community participation for the improvement

of the CRC. Community participation can improve the CRC through the variety of ways which include: informing health facilities about health service gaps, strengthen the relationship between the community and health facilities, and build a sense of ownership among the public. The finding of this study also revealed that the community can monitor the health care provision by caregivers at health facilities. The study indicated opportunities to design and implement a variety of strategies to improve the CRC through community engagement. However, we can conclude that the strategies designed should be focused on the challenges that the participants raised such as shortage of medical supply, and lack of basic infrastructure.

Declaration

Ethical approval and consent to participate: Ethical clearance was given from the Institutional Ethical Review Board of the University of Gondar (R.No.V/P/RCS/05/675/2021). The study participants were consented before data collection. Respondents also had the right to participate, refuse to be interviewed or to withdraw from the interviews. Personal data of interviewees were also coded in such a way that all personal identifiers were removed. Participants' identity information has been coded throughout the data collection, transcription, and analysis phases. The research teams were honest and objective in reporting the findings of this study.

Consent for publication: Not applicable

Availability of data and materials: Data will be available upon reasonable request from the corresponding author.

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REFERENCE

1. Nathan S, Johnston L, Braithwaite J. The role of community representatives on health service committees: staff expectations vs. reality. Health expectations : an international journal of public participation in health care and health policy. 2011;14(3):272-84.
2. Daykin N, Evans D, Petsoulas C, Sayers AJE, Policy: A Journal of Research D, Practice. Evaluating the impact of patient and public involvement initiatives on UK health services: a systematic review. 2007;3(1):47-65.

3. Freeman T, Baum FE, Jolley GM, Lawless A, Edwards T, Javanparast S, et al. Service providers' views of community participation at six Australian primary healthcare services: scope for empowerment and challenges to implementation. The International journal of health planning and management. 2016;31(1):E1-21.
4. Zwama G, Stuttaford MC, Haricharan HJ, London L. Rights-Based Training Enhancing Engagement of Health Providers With Communities, Cape Metropole, South Africa. Frontiers in sociology. 2019;4:35.
5. Kamuzora P, Maluka S, Ndawi B, Byskov J, Hurtig AK. Promoting community participation in priority setting in district health systems: experiences from Mbarali district, Tanzania. Global health action. 2013;6:22669.
6. Lodenstein E, Mafuta E, Kpatchavi AC, Servais J, Dieleman M, Broerse JEW, et al. Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees. BMC health services research. 2017;17(1):403.
7. Hanifi SMA, Hossain A, Chowdhury AH, Hoque S, Selim MA, Mahmood SS, et al. Do community scorecards improve utilisation of health services in community clinics: experience from a rural area of Bangladesh. International journal for equity in health. 2020;19(1):149.
8. Mahmood SS, Rasheed S, Chowdhury AH, Hossain A, Selim MA, Hoque S, et al. Feasibility, acceptability and initial outcome of implementing community scorecard to monitor community level public health facilities: experience from rural Bangladesh. International journal for equity in health. 2020;19(1):155.
9. Federal Democratic Republic of Ethiopia Ministry of Health.. Health Sector Development Programme IV 2010/11 – 2014/15, Final Draft [version 19 March]. October 2010. [cited 2021 12/22/2021]. Available from: https://www.healthynewbornnetwork.org/hnn-content/uploads/HSDP-IV-Final-Draft-October-2010-2.pdf
10. Karim A, Fesseha N, Shigute T, Emaway D, Dagnew S, Solomon F, et al. Effects of a community-based data for decision-making intervention on maternal and newborn health care practices in Ethiopia: A dose-response study. BMC pregnancy and childbirth. 2018;18.
11. Admasu K, Balcha T, Getahun H. Model villages: a platform for community-based primary health care. The Lancet Global Health. 2016;4(2):e78-e9.
12. FMOH. Health Sector Transformation Plan. Addis Ababa: Federal Ministry of Health (FMOH). 2015. [cited 2021 12/22/2021]. Available from: https://www.medbox.org/dl/5e148832db60a2044c2d40f6
13. Haileamlak A. How Can Ethiopia Mitigate the Health Workforce Gap to Meet Universal Health Coverage? Ethiopian journal of health sciences. 2018;28(3):249-50.
14. WHO. Health workforce requirements for universal health coverage and the Sustainable Development Goals Human Resources for Health Observer - Issue No. 17. Geneva; 2016.
15. Attree P, French B, Milton B, Povall S, Whitehead M, Popay J. The experience of community engagement for individuals: a rapid review of evidence. Health & social care in the community. 2011;19(3):250-60.

16. WHO. Community engagement: a health promotion guide for universal health coverage in the hands of the people. 2020. [cited 2021 12/22/2021]. Available from: https:// apps.who.int/iris/rest/bitstreams/1304287/ retrieve

17. Harden A, Sheridan K, McKeown A, Dan-Ogosi I, Bagnall A-M. Review 5: Evidence review of barriers to, and facilitators of, community engagement approaches and practices in the UK. 2016.[cited 2021 12/22/2021]. Available from: https://www.nice.org.uk/guidance/ng44/ evidence/evidence-review-5-community-engagement-barriers-and-facilitators-pdf-2368403681