

## Evaluation of Pattern of Community Engagement in District Health Care in East Wollega: Qualitative Study

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### Abstract

**Background:** Community engagement enables development of strong health care system and comprehensive use of health services resources. However, in primary health care there are inconsistencies in levels of engagement of the community that hinder much gain from the social capital and that cause unrealistic expectations from the health system. There is little research finding on the level and pattern of community engagement in primary health care unit level in East Wollega zone.

**Methods:** Community based qualitative study was employed from April to May 2016 with sample size of 30 in-depth interviews and 6 focus group discussions. Six districts were identified with simple random sampling method. Data analysis started at field and responses were transcribed, translated and systematically analyzed in themes.

**Results:** Community engagement in the primary health care units was very constrained and mainly through labor and material contributions. The trust of the community on the primary health care level is frail and the primary health care unit level is not responsive enough and had limited capacity to deal with the demands of the community health. Certainly the Community lacks opportunity and power of decision making in setting service standards and health service and resources utilizations. Community based health care structures like Health extension workers and health development armies are not uniformly and regularly supported to enhance engagement of the community and demonstrated sluggish progress and political bias.

**Conclusion:** The community is not empowered and engaged in the decisions of health system management and utilization at the primary health care unit level. The local political and health system administrators should work on behavioral change communication models and objective community mobilizations in the way the community can own the health care system.

**Keywords:** Community engagement; District health care; East Wollega

### Introduction

#### Concept of community engagement

Primary health care is expected to be first level of contact of the community with the health system assuring universally accessible health care which is closer to populations. Primary health care is integrated care with economic and social development through community engagement in decisions at different levels. Local communities must be engaged in health care development to build social capital that builds and maintains health systems [1].

Health and diseases have roots in the society and there are different socio-economic determinants of health and disease. Thus health promotion and social well-being is unattainable without social empowerment. Best solutions for the community health improvements should come from the social perspectives and actions [2].

Community participation had many concepts among different groups of populations: educated and literate, urban and rural, professional and non-professional terms. The degree to which the community participates in health care programs is also obviously

different. On study on meaning of 'community involvement', in Natal, participants perceived community participation as the way of helping each other for instance, when there is someone who is in shortage of food or hungry to supply food. In similar way others put as having a representative committee of the community in health care system. The rural community perceived it as the concept is more than mutual assistance and they are part of the problem and solutions of health issues and they should also have a formal community representing structure to reflect their concerns. As to the side of health professionals, community involvement was perceived as collaboration of the community in all process of health interventions and communicating the health needs of the community.

#### Outcome of community engagement

Health affects all and the responsibility of all. It is not confined to individual and institution level interventions and all should be concerned with the health services deliveries. The community should be empowered to its own health care. Community empowerment enhances the responsiveness of the health system and the community for the health problems of the larger community and sustains the impacts to the generations. It builds the sense of responsibility and accountability among the community for their health problems [3].

As to the global study in addressing the compressive health care to the population in need, which has been the promise of PHC strategy since 1978, there have been many improvements among the global community. Compressive health care should be addressed through equitable distribution of health care, community empowerment in health care, addressing socio-economic determinants of health and intersectoral collaborations. As finding shows there are promising improvements in past times overall the world like engagement of trained community health workers to access health care for the marginalized community, effective mechanisms of community, advocacy in community engagement and social system transformations [4,5].

According to quasi experimental study in Kenya, on Community Health Strategy on health outcomes, participatory community planning based on household information drives improvement of different health indicators. As the study implies, community health strategy, through intensive engagement of the community in health care issues and interventions is effective approach to improving health outcomes of the community. This was basically through provision of adequate health information which enables the households to make health decisions in health matters [6].

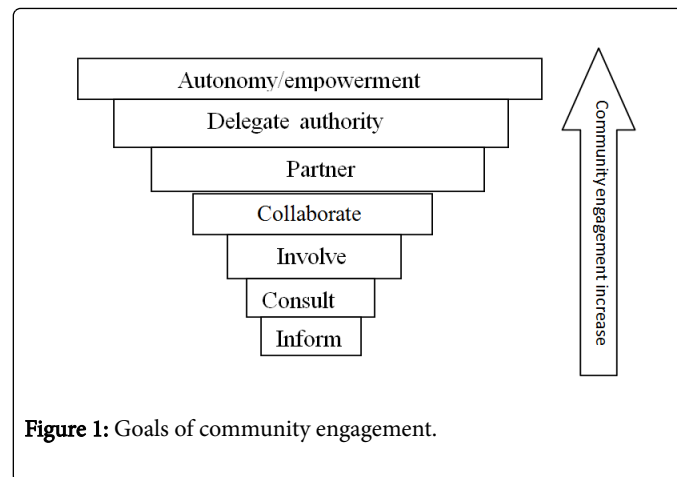
According to the scholars, community engagement should be strongly sought since it improves access and effectiveness for health care services in PHC settings. This is even critical in health resource limited settings like Ethiopia. For instance in community based study in South Africa in Tuberculosis treatment; the contribution of the community in assuring accessibility of treatment was clearly stated [7].

According to a study on primary health care in South Africa, assuring community empowerment should be among the key factors to strengthen and develop the primary health care system and a community. In other terms the strong and re-engineered primary health system is crucial for participation of the community in health system and development. This enables strong health promotion activity among different segments of population and to address variety of health problems in cost effective ways [8,9].

Multilevel study on perception and perspectives of the community on African health systems showed that the perception of the community on health care delivery is a valuable contributor for the improvement of health systems responsiveness and effectiveness of health care in Africa. Among the main concerns of the respondents of the study were shortages of medicines in the public sector and poor attitude of health workers especially during emergency [10].

Community engagement covers a wide variety of actions from simple information sharing to higher degree, community empowerment. This can be put in the form of "ladder of participation". In the lower level of the ladder there is lower level of community engagement (more passive) and on the top of the ladder the community has the power to administer its health care system (more active). Through Community engagement there is ground work for common direction, resource sharing, holding responsibilities; decision making and addressing of the concerns of the larger community. Community engagement in health care system is a process that develops and evolves over time. Community engagement needs clearly stated goals and purposes based on contexts and actual problem. The challenges, opportunities, outcomes of interventions and feedbacks should be communicated among the community and the health system through continuous evaluations and sense of responsibility. Some of the goals of community engagement in primary health care include: To

improving quality, developing Progressive Partnerships among the community, stakeholders and the health system, cultivating responsibility and accountability and ensuring Sustainability (Figure 1) [11,12].



**Figure 1:** Goals of community engagement.

In recent days WHO and other bodies are frequently reviewing the level of implementation of the PHC strategy and health outcomes. Among the reasons for the sluggish progress of the MDG in past time among the most countries of the world was low level of community centered approaches of health programs. As WHO recommended reviewing the integrated management of childhood illness, health care Delivery systems that rely solely on government health facilities must be expanded to include the full range of stakeholder and community-based approaches. This implies ineffectiveness of health programs in settings where there is low community engagement [13].

According to a study in South Africa on the level of the community participation in PHC, community participation has been implemented in broad terms and various manners. However the community had no power in decision of their health interventions and allocation of health resources for their health problems. In general there was no people centered approach and the decision making power remains to the health professionals [14].

Community participation enables recognition and comprehensive use of resources for health care system. However the level of participation has been uneven among different population groups especially in developing countries. The deep rooted sociocultural challenges and leadership cultures have made women and marginalized groups from full participation and decision making in development agendas including primary health care. In primary health care there are inconsistencies in implementation and levels of engagement of the community that hinder much gain from the social capital producing confusions and unrealistic expectations from the health system and other bodies. This undermines the role of the community in gaining and maintaining self-reliance and administration of its own health system and resources [15].

Lessons from Africa show even though there are promising positive outcomes in involving communities in health care system and projects, creating empowerment of the community have been a great challenge. In addition the level of intersectoral collaboration has been very low or sub-optimum. The community based health workers also lacked adequate training and skills in advancing and maintaining community engagement in health care projects. Usually the focus has been towards developing health professional working in the health care institutions

and there is no strong commitment in seeking the collaboration of workers from other sectors for better intersectoral collaboration. Attaining community empowerment and intersectoral collaboration goals need strong long term actions and commitments from the health global community especially in the developing world [16].

Alma-Ata declaration (WHO, 1978) promised the essential health care access to the in need of health care through self-reliance of the community and participation of the community. However, intense challenge is facing many countries in implementing the community engagement approach at different levels of health care, predominantly in less developed countries causing challenges in delivering health services and poor health outcomes.

In Ethiopia, community engagement approach in health care has been attempted in past times especially since primary health care strategy adoption in early 1980s. In the current health care system of Ethiopia decentralized health care is among the priority policy concerns. The health care delivery structure is nearer to the community to assure enhanced engagement and empowerment of the community. Around 2002/03 the government of Ethiopia has designed health extension program for enhancing the local community engagement in its own health care. Although there have been tremendous improvements in the health care utilization of the community and health status, the pace of the program is not as expected in empowering the community in decision making and leadership of the health system.

In Ethiopia, though there are routine government health reports on the implementation of the health extension program, there is limited literature on the level and pattern of the community in health care system in at primary health care level in the districts. In my study area there is no research result showing how the community participates in health care. The evaluation also presented evidences on the perception of the community on health care in primary health care units.

## Objectives

### General objective

Evaluation of level and pattern of community engagement in district health care in east Wollega from April to May 2016.

### Specific objectives

- To illustrate pattern of community engagement in district health care in East Wollega from April to May 2016.
- To examine perception and expectation of community on the district health care in East Wollega from April to May 2016.
- To identify strengths and pitfalls in community engagement in district health care in East Wollega from April to May 2016.

## Methods and Materials

### Study area

East Wollega zone is located in Western Oromia, Western Ethiopia and its capital city is Nekemte. Based on 2007 Census of Ethiopia, this zone has a total population of 1,213,503 among which about 7.72% are urban inhabitants. The zone is situated on 12,579.77 square kilometers area. Almost 90% of the populations are Oromo in ethnicity.

**Study period:** This study was conducted from April to May 2016 G.C

**Study design:** Community based Cross sectional study design was used with qualitative data collection approaches.

**Source population:** All adult population in East Wollega zone.

**Study population:** Adult population in East Wollega zone who are included in the study.

**Inclusion/exclusion criteria:** Adult population (18-65) who are residents in the east Wollega zone at least for 6 months were included in the study. Individuals who cannot provide adequate information (seriously ill) were excluded from the study.

### Sample size determination

The sample size was not determined in strict manner initially. The nature of qualitative study requires the actual sample size to be determined based on the information saturation on the field work. Accordingly 20 in-depth interviews and 6 focus group discussions were used from 6 districts in the zone.

### Sampling technique

To identify the districts in the zone, simple random sampling method was used. Purposive sampling technique was used to find study participants from each district for in-depth interview and FGDs. The health extension workers in the local health posts supported the data collection process.

### Data collection procedure

A semi-structured open-ended interview and FGD guide questions were adapted from different sources to collect qualitative data. The guiding questions were designed in English and translated to Afan Oromo by persons with a good background in both languages. Interviews and group discussions were conducted by the local language (Afaan Oromoo). The data collectors were 6 Bsc health workers. Data was collected by electronic records and later transcribed and translated. In addition key notes have been taken during the interviews and group discussions.

### Data quality control

Data collection process was extensively supervised. The data collectors and supervisors had 1 day training on standardizing the procedure and for common understanding. The quality of the data will be checked at each step during data collection. Peer reviews and professional consultations among the investigators and supervisors to enhance research output quality.

### Data analysis

Data analysis started at field. The responses transcribed, translated and were systematically organized in themes. Narration of concepts of interview responses and discussions was made to explore the level and pattern of community engagement in the health care in the district. The original responses of individuals were also presented as it is appropriate.

## Result and Discussion

### Level of community engagement

As this study revealed, the culture of participation of the community in health care activities in previous times has been very weak and the community was not considered as a main concerned body in all aspects of health care activities. The governments, nongovernmental and private health service delivering organizations were providing health services with the dimensions and concerns of their own organizational capacity and interest. There is increasing demand of the community for adequate and quality health care delivery that centers the health care seekers interest. For attainment of such demand, the participation of the community in all steps of health care activities must be a reality in all areas and contexts. Although the previous decades the level was very low now there is a moderate change especially in addressing health information to the community. But still the uniformity and all-inclusiveness of the population is a challenge. The ownership of the community towards its health is not attained and the disease burdens are still enormous. The health problems like communicable diseases and nutritional deficiencies which can be controlled with the house hold and community level interventions are still the leading causes of morbidities and mortalities in community. The community participation in the primary health care unit level health activities in the study area is not satisfactory with the community's view.

However the community members believe an improving pattern of community participation and access of to the health care. A 34 years old male respondent says, "I can say the extent of participation of the community is better than previous times in which there was no understanding of the community for the health of the society. Now you will hear health information here and there. The health extension workers, the media and health care facilities are disseminating knowledge to the community."

In recent times there are many efforts from the side of the government and other health care and related bodies working on disseminating health information to the massive population. Health post which is the first level of the government health system structure is stuffed by the health extension workers since 2002/3. To focus of the health extension program has been mainly enhancing the community's awareness on different health care issues focusing to house held and environmental sanitation, and MCH services. In the study area, almost all rural households have access to the health post near to their residency or community.

### Pattern of community engagement

It is expected that the community and service users participate adequately and in fairways in the health care matters. The health system without the community's adequate participation will not be effective and efficient in addressing the actual needs of the users. As to the community members' perception, the adequacy of forms and level of the participation of the population is very low. There are no clear practical means for the involvement of the community in services delivered by the facilities. The primary health care level is the base of the health system and close to the society. The different segments of the community members should have access in planning, interventions and evaluations of the health care activities. High degree level involvement of the community is desired and the community should be empowered on their own health care system. The health care system

at primary health care level is functioning without enough contribution and support of the local community.

The community has no clear understanding on the health service packages given at different facilities in the primary health care units. The service standards are also not known by the community members. The health care access and quality improvement activities do not basically consider the community. The community has no information on the health care resources allocated and utilized. The main way through which the community meets the health system is during seeking health care during illness. There is no way to utilize the local level knowledge and power of the community in strong and consistent way. The simple health information disseminated with health extension workers and other bodies is not adequate to enable the community to utilize its full potential in health promotion and disease prevention.

The technical skills required and enabling factors like access of technologies is not adequate enough to transform the health system of the primary health care units. The 37 years old community member stated it in the following manner: "I don't think the community has adequate participation in matters of their own health. It is usually low. The main reason for this is low awareness and understanding of the community." Another respondent from the community said: "We can have some health information or discussions on general meetings of the community. They also ask us some contributions of money and materials for health facilities buildings. The participation is to this level. I don't know other specific ways they are involving the community in health care issues. We usually visit the health facilities during illness".

Head of health centers in rural district also puts it this way: "The level of community participation is interestingly increasing than the previous times. Still there is no expected extent and acceptance of participation in health issues. For example there has been a sanitation improvement activity in the community through health extension program and other means. However still there is a challenge for full coverage of latrine and its facilities. The acceptance and reaction of the community is slow". On the other side 42 years old male, head of district health office puts it in the following way: "There are 1 to 5 groups in the community and they freely raise issues even to the point of rising organizations or individuals rendering the services. Sometimes we also call them for participation in material contributions e.g. materials for food of delivering mothers at facilities. However the participation of the community is not uniform, regular and as expected. There are community fatigues in some areas like malaria and HIV control activities. The community could not own health issues and they want to refer to the health professionals or other organizations. It needs strong work".

The remote and rural areas are the ones which are not acquiring such deep level and changing in knowledge and interventions consistently. The health workers mostly focus on clinical activities at health care facility levels. The community level activities are rigorous and needs very motivated workers, adequate resources and willingness from the general population. However our primary health care units lack strength in such aspects. The health care activities at community level are very shallow and not in the best demand of the local society. The community is not well convinced and accepted the health care plans and projects before interventions.

A 32 years old female participant on involvement of community in health care issues said this: "Yes we have moderate level involvement in health issue in the community. Commonly they tell us about family



planning and environmental sanitations. There are female health practitioners who sometimes visit the community. But it is not regular. No strong work on the participating community and health service users on the concerns of the users on health services. You don't observe change".

### **Community level awareness is low**

One of the hindering factors for full participation and ownership of the health care system in the districts was the awareness gap of the general population. Even though there has been much improvements in the dissemination of health information, the behavioral change towards health promotion and development is still not as expected. The view of the community members and health care providers in the districts share this issue as one of the challenge to improve health status of the community. The health information provided to the society is not focused on behavioral change communication. The rural community which has poor accesses to basic infrastructures and opportunities of learning has little understanding on individual, household and community health issues. The change of the health status of the general populations is impossible without the change and attitude of the community on health care issues. The effort so far made in enhancing of knowledge awareness of the community is small. The work done through health extension workers in this regard has been very encouraging even though the existing health problems and community level changes are beyond their potential and skill. As to the 40 years old male community member, "The knowledge of the community to health care issues is still very low. The community has also no adequate money and resources to utilize the available health services. There are also different political and other structures that confuse the community. There is no good coordination and mobilization. The practical involvement of the population in the improvement of health services is negligible." 30 years old female health professional says "the problem is the capacity of the community to deal with these all health agendas. The behavioral change expected is still low. For example the utilization of family planning methods is low and the rural community is having many children that can increase the health problems and poverty. The cultural and modern ways of community structures are not strong now and the participation of the community in the way that can influence the health system and the local development agendas is not adequate. Everything seems messed up".

### **Forms of community participations**

There are different mechanisms of community involvement in health care system. In the district health system in the study area the main ways of community participation are visiting health facilities during illness, contributions of materials for constructions of health posts and health centers, contributions of money for maternal health care, discussions during general meetings, through small group structure (1 to 5), labor contributions and implementation of health extension packages (mostly sanitation and family health issues). In recent years the forms and extent of community level involvement are various and there are some opportunities for participation. The challenge has been the depth, regularity and continuity of the programs and support for the community and health care providers. The participation of the community is not in all types of health problems. The participation is not uniform among all community members.

Forty three years old female from the community: "We have 1 to 5 group structure in the community. Even though not well functioning this time on regular basis, we discuss on health issues especially house hold and environmental sanitation, institutional delivery utilization and related issues." 33 years old male community member from FGD says, "The participation pattern of the community in health care issues is usually through idea generation and contribution materials and money. The community is also requested to contribute labor forces for health care activities. There are issues like HIV/ AIDS gender and maternal health care on which the community is frequently involved. The government and nongovernmental bodies focus on these topics and there is access for such information. Students and adolescents also have training opportunities".

27 years old male in the community on FGD responded: "Community is large structure. It may be difficult to fulfill the interests of all individuals in the district. However there should be openness of the system for the comments of the community. The community should also know the service options and plans of the health services of the district. If we observe this trend it is very poor. The system has no clear direction and structure to deal with the communities concerns".

A 48 years old male in community presents the concern in this way: "The community level health problems are huge and numerous. The population usually shouts in the meetings prepared by the local administrators. However there is no change. The same thing will again be an agenda in others time also. The concern of the community is not practically solved. For instance safe water access is a problem we have since long time. This problem has been discussed many times. However we still are suffering with diarrheal diseases because of unsafe water".

### **Community structure for participation is not uniform**

The structure of the local community should be appropriate and clear to develop the health care seeking behavior and development of the society. The existing health care system is not providing equal opportunity for all. The rural areas are the most disadvantaged. The community participation structures focus political views as a center and the participation level of the community is highly dependent on this. The local leave administrative structure is not open enough to all community members. In some nongovernmental organizations there is a problem of considering local values. 34 years old male: "There are no clearly identified community members to deal with health issues of the population. The kebele leaders are the ones who usually work on these issues. Sometimes such activities have benefit for the participant and they don't want to involve the community members openly. 35 years old male: "I don't know any committee or structure of the community working on development of the health system. I thing population have no direct involvement in short and long term actions in the district on health issues. It could have better progress if so". 25 years old male: "There are committees some times on some specific issues. But the committee can't influence the existing system easily. Since there is no quick and appropriate response the committees are discouraged. The community has no such strong power. Another 32 years old female participant said; "There is wide opportunity for all the community to enhance their participation. There are community members who are considered members of the government party. They are frequently involved in discussions and meetings. Otherwise you are not considered for participation and your view has fewer acceptances. We don't have equal access for health information".

### **Community mobilization is not strong**

Mobilization of the community enables coordination of efforts and pooling of resources for health care services. Primary health structures are not in a strong stand to mobilize the community in the way to develop the health system and population health status. The activities at the household and community levels are not well organized and supervised. The health care resources and finance are almost covered by the government itself and the contributions of the community is nil. The population has no strong initiation and motivation for health care activities at the community level. The existing community structures have no adequate technical and material supports for ensuring empowerment of the community. Majority of the respondents don't have information and awareness to the community based health insurance scheme on the way to enroll the community recently. A 34 years old community member said: "No strong mobilization of the community. They (health workers) are okay with working in the health facilities. You don't find much work in the community by the health workers. You don't reach in the remote areas. Previously the health extension workers were visiting the community, but know they are not active as before".

### **Health extension workers are not focusing on community**

The health extension program is a local community health tool in which local individuals from the village who have completed grade 10 are enrolled and trained on basic community health care issues for at least a year. The health extension program since initiated around 2002/3 G.C has been a priority issue in the health policy of the country. The attempt of the program has been addressing the rural community with essential knowledge and skill on household and community health matters. The achievement in the health extension program in enhancing the communities understanding on health care has been a lot. However the pace of change of the health status at community level was not as it was promised and expected by the government. The influence of the program in the community mobilization on health of the population was very limited. There was relatively better initiation and actions on community health in early times of implementation of the program. The willingness and action of the health extension in the community health interventions are lessening from time to time. The health extension workers practically are not bold enough to solve the community level health care. The capacity building and developing the working environment was not focused. They usually practice with the limited training obtained during initial training and the on job trainings given from time to time are shallow. Despite this all challenges the community believes as the health extension workers are useful and supportive for the community. The communities have a question of adequacy and quality of care and support they provide to the community. A 40 years old female community member says: "Yes they have a lot to help the community understand and participate in health care. For example if you take child immunization, the health extension workers address almost all children through campaigns and other means. Health education provision on Maternal cares like ANC and institutional delivery are also the focus areas of the health extension workers. However this time it seems there is no strong drive on community health level interventions". A 32 years old male community member: "The health problems at the community level are beyond the capacity of health extension workers. The health extension workers usually work in the health posts and the community level interventions are not that much. The family planning service and child immunizations are better attempted with them and there are changes

observed. This time they also prefer special settings like schools and meetings of the community for health education. The involvement and influence to household level interventions are not strong".

A health center head in one of the districts, male 32, says: "HEW is the main policy issue for the nation and PHCU too. However the change so far is little and the pace of their involvement in the community is very slow. Honestly speaking the practical implementation of the HEW program is challenging. For example, the coverage and utilization of the latrine and waste disposal issues are still poor in many areas despite of the existence of the health extension workers. The other challenge is they work in very poor setting. Some services were given for them without adequate training and facility. For example delivery service was attempted to be given by the HEW in the absence of facilities like water access, sterilization, disinfectants and in poor sanitation conditions. In the same manner the insertion of long term acting family planning services were without adequate training and are not able for the removal of it when desired. Therefore I highly recommend the government to revise the health extension program".

### **Responsiveness to the concerns of the community is less**

The concern to the community and responsiveness of the primary health care units to the questions and expectations of the population is very challenging. The health care facilities and structures at district health system are not responsive enough to the increasing demand of the service users. Even though there are some opportunities for the population to raise questions and complaints on the existing health services and intervention in the community, there is no adequate readiness and response to the populations needs. The expected change is less and the health care facilities perform routine activities. Unless there is a push and policy action to reform and change to the health care at the primary health care level, there is no situation for change and improvement through continuous assessment and improvement of health service standards and qualities. The primary health care structure is not empowered with the resources and actions on community level health interventions. The structure seems structurally decentralized. However the access of health care and community participation and empowerment is not much decentralized. The huge population is still with a challenge of obtaining basic health care and participating in its health system at the district. A 35 years old male community member puts it this way, "This is less true. Nobody cares for your concern. They provide the health service at the health facilities. How the communities can have access to present the concerns? They don't consider the ideas of the community valuable. They don't even hear you".

A 42 years old female, says: "No adequate concern for the reception of the clients. They are not surprised with anything that happens. The facilities lack interest to serve the community. You will come from long distance to seek health care and they see it as easy thing".

In the similar way, 32 years old male said: The health institutions are less reactive to health care needs of the society even when we seek health care during illness. We acquire limited care and not adequately assured on the care. Health workers are not well cooperative. They dishonor us and sometimes insult the patients. I am not happy with their service and administration. I think there is no means to monitor the health workers in the health institutions. Obviously the workers have less motivation towards helping patients".

Furthermore, a 40 years old female explores it: "I think there is no adequate care for community health services in our district. There are

many health problems that should be addressed. For example, this living and surrounding has many solid and liquid waste problems. Nobody is working on this. There is no change. The community level willingness and participation are also low. The health extension workers supposed to work on these issues in the community are not focusing on these problems practically. The concerns and opinions of the community are not accepted. We have no direction for direct involvement in health care issues. We may raise health service issues in the general meetings of the community. I think the initiative is less. The community also lacks cooperation”.

On clinical health care at primary health care units 32 years old female participant responded like this: “The health care workers are too busy. They don’t even give much time for the individual patients during treatment. The problem starts from the record or card room. Those people are not having adequate knowledge and commitment to serve the patients. They usually are disinterested in their work. Even the health professionals have no passion to serve us”.

### **Community is not empowered to make decisions**

The decision making power of the community in the primary health care unit level health care service is not ensured in the study area. The planning, interventions and evaluations of health services at the district are not with the full participation and decision of the population. The people have no option for access of health care in the districts. In addition there is no adequate opportunity and exercise of power to the health services in the community. The population is forced to access the health care from the government health facilities because of limited access and capacity to acquire health care from other options. As to the responses of the participants, there is no belief of the community on the ownership and decision making on health services issues of the population. The varieties of idea and actions are not learned and practiced at the district health care level.

A 35 years old male participant responded as: “We visit health care facilities when there is illness among the population. They also teach us occasionally on health matters. But I don’t believe that the community has part in decision making of health issues.” Another 34 years old male responded as: “The community has no power to make decisions. The government officials work on every matter as they like. They are not responsive to the questions of the community. The leaders are not selected with the interest of the community. Totally we don’t have any form of decision making on health care in our district. “We don’t have opportunity for this. I haven’t ever heard the practice of the community in planning related issues. The leaders themselves determine the activities and they ask as for some contributions occasionally.” Other 35 years old male participant says: “The kebele leaders and some politically arranged teams have access in such tasks. Even more educated and helpful people are not considered for adequate participation. The system does not trust all community members; there is no way for planning and evaluation of health care activities of the district. I can’t say the populations are deciding on their own health issues. Nobody is concerned for the community. They provide health services as they think enough. To the community level actions, there were actions on sanitation. Now it seems people are bored and the health extensions are not active”.

### **Health care access and adequacy to the community**

A 35 years old male from semi urban area: “As to my view really we are happy with the health care activities in our district. The health care

facilities are easily accessible for the population if there is interest. For example the brother of my wife has been on treatment in the health center with in these 2 weeks. We could access necessary health care near to our compound. I consider the health center as my property, which I can utilize when there is need. However there are some problems like access of drug which expose us to the private sources”. In the same way 32 years old male: “The health care quality and type given to the society at the district level has been very sub optimal. Now there is hospital (primary hospital) in the district and the service condition is improved. This is very good thing and benefits the large population. The government should strengthen the service package at district level.” A 38 years women in semi Urban are says: “It is good. There are health facilities near to us and we can access health care at the desired time. However the accesses of drugs and specialized services have been a great challenge to the population seeking services. Another serious problem is the access of adequacy of care for the emergency conditions. Only labouring mothers get ambulance service. There should able an ambulance service for such conditions. There are no adequate readiness and care for emergency conditions at district health care. They usually refer to the higher levels and money and transport are very challenging condition in this regard”.

The community is not getting what they expect and like in terms of health care. Even though the possibilities for the health care are improving than before in the districts, the degree of concern to the community is low. The facilities are reaching the households even in rural communities. But the quality issue remains in all health facilities in the primary health care unit. As to the communities view, the accessibility of health care from the recently introduced primary hospitals in the district also solved cost of transport and other services that was a challenge to seek zonal level care.

### **New concept: health development army**

Health development army is a new structure in the Ethiopia in which different parties from the community, government/political officials and other relevant bodies are represented. The army is expected to improve the involvement of the community in health care issues and transform the health care system and socioeconomic development of the society. The structure enables these parties to periodically discuss and act on local health problems in the existing situations. The structure is established with the government at the district level and among the populations. The health development army is formed from the representatives or leaders of 1 to 5 groups among the population. The government claims the army as a tool to enhance community participation and social development. However others consider this 1 to 5 and health development army structures in the community as a tool to manipulate the community for political purposes. As observed from the study areas, the functionality of the health development army was found to be minimal. There is no strong monitoring and support to such structures to function for the promised purposes.

32 years old, male and head of health center says: “It is there. It is good attempt to involve the community in the health care process. However practically there is no action. The members are people selected from the local community’s 1 to 5 structures. They were trained with the work conditions of enhancing community health issues but no M and E mechanisms. We can’t say it improved community participation. I can say it only a beginning.” In the same way, 25 years old worker on district health office says “Health development army/HDA is very essential. They contributed a lot in

institutional delivery promotion in our district. They also helped the health system with mobilization of the community for contributions of money and cereal for the maternal care at health facilities for the mothers delivering at health facilities during their labour and delivery time. With simple training given and with continuous support they can sensitize the community for more and better change. Indeed there is monitoring gap over there'.

## Conclusion

The level of Community participation in health care activities of the primary health care units in the districts is very low and limited. The community participates mainly through labor and material contributions for developing health care facilities like health centers and health posts. The trust and belief of the community on the primary health care level services in the districts in addressing the need and concern of the community is very low. The health system is not open enough and has limited initiation and capacity to deal with the concerns of the community health. The population has inadequate opportunity in participating in service standards and packages in the health care facilities. The community structures are not uniformly and regularly supported to enhance the involvement of the community in health affairs of their district. The power of the community in deciding on the health service and development of the society is near to the ground. The access and quality of health services for the majority of rural community is still low. The ideas, values and potentials of the local communities are not exploited and used for the development of the health system in the districts. However there is improving trend of participation of the community in the district health care system in the past few years and there are attempts of enhancing community participation through health development army and other community level structures.

## Recommendations

- The government of Ethiopia should strengthen the knowledge and skill of the HEWS and also consider staffing the health posts with at least diploma level health professionals.
- The community level health interventions should focus on behavioral change communications to improve knowledge and skills of the community on health and community development.
- The government should establish health care quality improvement measures in the district health system and the health care facilities should be equipped and supplied with appropriate materials and supplies.
- The Community should be empowered and participate in planning, implementation and evaluation of district health care through mobilization and utilization of community potential and resources.
- The community members and structures should be participated and involved in community health care and development issues with all inclusive approaches.
- The health care facilities at district health care level should be responsive to the concerns and questions of the community at both community and health care facility levels.
- Community level interventions and participations should be strengthened with strong practical community development models and demonstrations.

- The district health care projects and activities should be integrated and creative by collaboration of government and government organizations to avoid community fatigue.
- The local government and higher officials should strengthen health development army and other community development structures with appropriate supervisions and capacity buildings.

## Declarations

### Ethical considerations

A formal letter of research ethical clearance was obtained from Wollega University. Administrative bodies of East Wollega zone and selected districts were officially contacted through letters. After the purposes and the procedure of the study were explained, verbal consent was obtained from all respondents. Confidentiality of the responses was assured to the respondents by keeping individual responses as it is used for research purposes. Names and personal identifications were not exposed to the public.

### Consent to Publish

Verbal consent was obtained from each participant of the study to publish the result and summary findings of the study as appropriate keeping confidentiality.

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### Authors Contributions

All of the authors were involved in generating the research question, developing proposal, supervising data collection process, analyzing data and preparing research report.

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