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-

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 fnding shows there are promising

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

Result and Discussion

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 changes.

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

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

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. T ere is no change. T e community level willingness and participation are also low. T e health extension workers supposed to work on these issues in the community are not focusing on these problems practically. T e concerns and opinions of the community are not accepted. We have no direction for direct

institutional delivery promotion in our district. T ey 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 theree.

Conclusion

T e level of Community participation in health care activities of the primary health care units in the districts is very low and limited. T e community participates mainly through labor and material contributions for developing health care facilities like health centers and health posts. T e 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. T e health system is not open enough and has limited initiation and capacity to deal with the concerns of the community health. T e population has inadequate opportunity in participating in service standards and packages in the health care facilities. T e community structures are not uniformly and regularly supported to enhance the involvement of the community in health a f airs of their district. T e power of the community in deciding on the health service and development of the society is near to the ground. T e access and quality of health services for the majority of rural community is still low. T e

7. Kirondea S, Kahirimbanyib M (2002) Community participation in