



Assessing community members' knowledge and attitude towards Community-Based Education practices in Southern Ethiopia

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ARTICLE INFO	ABSTRACT
<p>Article history Received: 2021-04-04 Revised: 2021-12-17 Accepted: 2021-12-18 Published: 2022-03-09</p> <p>Keywords CBE Practices Community Knowledge Community Attitude</p>	<p>The study conducted by the University of Gezira in Sudan indicated that many institutions are not involving the community in the process of Community-Based Education (CBE) program evaluation. Moreover, the community feels that the program is being imposed upon them rather than being available for them. This study aimed to assess community knowledge and attitude towards university health students' CBE practices and associated factors. The community-based cross-sectional study through systematic random sampling method was conducted on 394 households. Descriptive statistics and logistic regression analysis were conducted by using Statistical Package for Social Science (SPSS) Version.23. Of the 394 individuals interviewed, 188 (47.7%) of them were found to have good knowledge and 229 (58.1%) have good attitude on CBE practices. Concerning the determinant factors, educated respondents, high-income respondents, and student and government employee were likely to have better knowledge of CBE practices than others. In addition, students and government employee also likely to have better attitude towards CBE practices than other occupations. Community members' knowledge and attitude on certain aspects of the CBE practices were still poor. Thus, the awareness and large participation of community members in the program are needed to increase the popularity of the program.</p>
<p>Kata kunci Pengetahuan masyarakat Praktik CBE Sikap masyarakat</p>  	<p>Menilai pengetahuan dan sikap anggota masyarakat terhadap pelaksanaan Community-Based Education di Ethiopia Selatan. Studi yang dilaksanakan oleh Universitas Gezira, Sudan mengindikasikan bahwa banyak institusi yang tidak melibatkan masyarakat dalam proses evaluasi program Community-Based Education (CBE). Lebih dari itu, lebih masyarakat merasa bahwa program ini dibebankan kepada mereka daripada tersedia untuk mereka. Oleh karena itu, studi ini bertujuan untuk menilai pengetahuan dan sikap masyarakat terhadap praktik-praktik CBE oleh mahasiswa universitas kesehatan serta berbagai faktor yang berhubungan. Studi community-based cross-sectional melalui sistematis random sampling telah dilaksanakan terhadap 394 rumah tangga. Statistik deskriptif dan analisis regresi logistik telah dilakukan menggunakan SPSS versi 23. Diantara 394 individu yang diinterview, 188 (47.7%) dari mereka memiliki pengetahuan yang baik dan 229 (58.1%) memiliki sikap yang baik terhadap praktik CBE. Terkait dengan factor-faktor penentu, responden yang terdidik, memiliki gaji yang tinggi, pelajar, serta pegawai pemerintah cenderung memiliki pengetahuan yang lebih baik terhadap CBE dibandingkan responden lain. Selain itu, pelajar dan pegawai pemerintah juga memiliki sikap yang lebih baik terhadap praktik CBE dibanding responden lain. Pengetahuan dan sikap anggota masyarakat terhadap aspek-aspek tertentu dalam praktik CBE masih rendah. Maka, kesadaran serta partisipasi luas masyarakat dalam program ini sangat diperlukan untuk meningkatkan popularitas program ini.</p> <p>Copyright © 2022, Haligamo et al This is an open access article under the CC-BY-SA license</p> 

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INTRODUCTION

World Health Organization (WHO) defined Community-Based Education (CBE) as a part of education which is aimed to achieve educational relevance to community needs of implementing community-oriented educational program. CBE consists of learning activities that use community extensively as a learning environment. Not only are students and teachers, which are the members of the community, involved, but representatives of other sectors are also actively engaged throughout the educational experience. CBE through contextual learning can become more meaningful for students (Kelly et al., 2014), teachers, and ultimately participative community members (Claramita, 2019). Acknowledging the crucial points community involvement in learning process, there are various studies investigated community engagement in affecting different fields such as environment (Soto-Cruz et al., 2015), nature conservation (Rathnayake, 2016; Rodríguez-izquierdo et al., 2010), heritage conservation (Rasoolimanesh et al., 2017), human conservation (Maton, 2008), language learning (Fikri, 2018), medical (Sari et al., 2018), and so forth.

There has been a popular demand that education should give service to a society. To answer this condition, a new strategy of education referred as 'Community-Oriented Education'/'Community-Based Education' was introduced to the world. The implementation of CBE is, for example, at Jimma University. It was aimed to produce competent health professionals who are responsive to the felt needs of the community through a developmental approach that contributes to improve the livelihood of society by involving the community and stakeholders in community development. It also aimed at producing professionals who are socially accountable and ensures lifelong learning in the community through training, research and services in the community (Ferede, 2015). Students opined that Community Based Learning (CBL) benefits them in terms of opportunities, inter-personal, intra-personal, and societal benefits. Many students seem to go beyond the surface, obvious gains of CBL and talk about it deeper, more subtle gains such as self-examination, reflection on one's values, and finding meaning in life. Clearly, students value CBL and its potential impact has on all domains of their functioning (Ibrahima, 2010). Interestingly, a good sociocultural approach has been proven to enable professionals, academicians, and teaching support staff to implement information literacy (Wang et al., 2011).

Community plays major role in giving feedbacks to university with regards to the usefulness and operation of community-based programs. Students tend to worry that they cannot meet community expectations or do not deserve the generous hospitality. This sometimes leads to disappointment among students which may seriously affect their interest, enthusiasm, and the excitement they experience during the first posting, and consequently may influence the attainment of course objectives (Schmidt, 1992). The programs where the community worked side by side with the health workers tend to be not effective. The relationship between communities and centers of higher learning tends to be one-sided in that communities are mostly the passive recipients of what the students offer (Bruning, 2006).

The development and maintenance of community-based interventions requires the management (Kruger et al., 2015) of numerous challenges. Conducting community assessments and coordinating the implementation of interventions in diverse communities requires cultural sensitivity, the coordination of activities with key stakeholders, the appropriate investment and acquisition of resources and systems to evaluate productivity and quality. Community based education and service (COBES) was reported as one of the factors influence students' career speciality choice and practice location. This has led students to be aware of community needs such as inadequate doctors or health professionals and the community members' right to have equal access to health. Another consequence, students are able to adapt to rural lifestyle through COBES. Living among community is also a good training for students as the real environment helps them to address an inequality or mal-distributions of doctors and other health professionals in the country and other Sub-Saharan African countries in certain circumstances.

The various information reported and published in several studies about the factors which were presumed to lead the community to be in contrary direction to plan CBE programs. The factors were lack of curiosity among students, lack of confidence among students, lack of motivation among community members, being quitter and carelessness of students as worst as lack of productiveness in repetitive works. Furthermore, the other factors were the involuntariness of health professionals working in the community to unfold what they know about CBE practices to the community members as stakeholders in collaboration with students, lack of coordination among students, and resource scarcity (Schmidt, 1992).

One of the Sustainable Development Goals (SDGs)' aims is to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all by 2030. Thus, education quality has been set as one of the priorities of the SDGs' goal. To be more detail, it aims to build and upgrade education facilities for children, disability, and gender sensitive, besides providing safe, non-violent, inclusive, and effective learning environments for all. However, in sub-Saharan African countries, 750 million adults still remain illiterate in which two-third of them are women (UN, 2016; UN, 2019). Hence, CBE is an important initiative to achieve SDGs' goal and to ensure full participation of local communities in the frame of plan and management of sustainable development as well as promoting sustainable lifestyles. The relevance of community-based non-formal education and informal learning for children, young people, and adults, especially those not in education or from marginalized or disadvantaged parts of society, must be recognized and fostered in every country in the world to meet the SDG s' goals.

There are few researches focused on students practice on CBE by putting aside the perception of the community towards the program and value of community members in program design and implementation. To the best of our knowledge, there is no scientific evidence regarding the knowledge and attitude of the community on CBE practices since no scientific research was conducted on this topic. Therefore, this study was designed to extract out the knowledge and attitude of community members concerning (CBE) practices and the associated factors, which can help universities to improve the implementation of the program. The overall objective of the study is to assess the knowledge and attitude of community towards university health students' CBE practices as considerable as the associated factors in Aleta Wondo town in Sidama Zone, Ethiopia.

METHOD

Study setting

This study was conducted in Aleta Wondo Town, Southern Ethiopia. Aleta Wondo town was bordered with Sheyicha and Gidbo in the North, Bultuma in the East, Wotona Kebele in the South and Titira in the West. It is located 333 Km of South of Addis Ababa capital of Ethiopia and 64 Km from Hawassa capital of SNNPR. The town has a total population of 52,604. Of those, 27,731 are male and 24,873 are females. Among the total population 17,486 are found in Mesalemiya Kebele, 18,927 in Chefe Kebele and 16,191 in Dela Kebele. There are around 10,521 households found in the Aleta Wondo town. Among those, 3,497 are located in Mesalemiya Kebele, 3786 in Chefe Kebele and 3,238 in Dela Kebele.

Study design and sample size

Community based cross sectional study was employed to assess the knowledge and attitude of community towards university health students' CBE in Aleta Wondo Town in Sidama Zone, Ethiopia. The sample size was calculated by using single population proportion (Formula 1).

$$n = \frac{(Z_{\alpha/2})^2 (p)(q)}{W^2} \quad n = \frac{(1.96)^2 (0.5)(0.5)}{(0.05)^2} \quad n = 384 \quad (1)$$

where: n is sample size; Z is standard normal distribution (significance level at $\alpha = 0.05$) (95% CI) ($Z=1.96$); W is margin of sampling error tolerated (5%); P of 50% proportion is considered; The non-response rate of 10% (38.4) was considered; and A total sample size of 423 (384+38.4) was calculated.

Sampling method and procedure

Systematic sampling technique was applied in order to include respondents for data collection in the town from households. The data was collected using pretested English version questionnaire through face-to-face interview. The questionnaire was translated in to Ethiopian official language, Amharic. This questionnaire prepared in English and Amharic was then interpreted to the language the respondents knew. The data were collected from households that were incorporated into the sample. If the respondents were absent then the researcher repeatedly checked for three days.

Research tool

The research tool, in term of questionnaire, used for this study were developed based on questionnaire development methods (Günap, 2017; Kabadayi, 2019). Hawassa University Community based education coordinator Mr. Derese Daka and My advisor Dr. Bekam Kebede played as the main role in providing information and helped the researcher in developing a tool used for this study. Some parts of the questions were taken from research done by Gizra University (Schmidt, 1992). The tool was also checked by the department of environmental health at Hawassa University before and after community survey.

Data analysis

The data collected were categorized and checked for its completeness before the analysis was carried out. The data gained were analyzed using Statistical Package for Social Sciences (SPSS) version 23. Bivariate and multivariate logistic regression analyses were done in order to identify the presence of associations and strength of that association between dependent and independent variables. Descriptive writings and statistical tables were used to describe the study variables.

Ethical approval

Ethical clearance was obtained from Hawassa University Ethical board committee. Permission letter was also obtained from Aleta Wondo Town's administration, and the informed consents were obtained from respondents. The right to participate or to refuse was clearly explained and respected for respondents; as a result, only those who consented to

participate were included in the study. The privacy and confidentiality of the respondents relating to their information was kept.

Operational definitions

The operational definitions are: 1) community members are people who were living in the study area and receiving the service from CBE practices; 2) knowledge instrument is a research instrument which comprised of 11 questions prepared to assess the knowledge of community towards CBE practices in which each correct answer was given one mark and no mark was given for ineffectual answers. An individual with mean score of 0.5 was considered as knowledgeable; 3) attitude instrument is the instrument comprised of 15 statements prepared to assess the attitude of community towards CBE practices with the same five choices at each question. These five alternatives presented as choice were Likert scale agreement options to measure the attitude level of a given individual that were given from 1-5 mark. The attitude score was then divided in to two levels that were good attitude and poor attitude using the mean attitude score value.

RESULTS AND DISCUSSION

From a total sample size of 423, about 394 households were participated in this study with a response rate of 93.1%. The mean age for the study subjects was 30.58 in which the majority (215 or 54.6%) of them were within age of 30 years and above. Among the respondents, the majority (207 or 52.5%) were males and 302 (76.6%) were literate. The marital status of respondents indicates that 256 (65%) were married and 116 (29.4%) were single. The largest number of the respondents 166 (42.1%) were household head followed by spouse 128 (32.5%). 280 (71.1%) of the respondents were followers of protestant Christianity followed by orthodox which accounts 57 (14.5%). Regarding their ethnic group, 269 (68.3%) of them were from Sidama followed by Oromo which accounts 56 (14.2%) of the study participants. Out of total respondents, 56 (14.2%) were government employees and 18 (32.1%) of them were health professional. Occupation of most respondents (88 or 22.3%) were housewife and followed by the same value for students. The family size status of the respondents shows that most of the respondents have family size ranges from five up to eight (231 or 58.6%). Out of total subjects, around 216 (54.8%) have income above 2500 Ethiopian birr (see [Table 1](#)).

Table 1. Socio-demographic characteristics of respondents in Aleta Wondo town, SNNPR, Ethiopia, 2017 (N= 394)

Characteristics	Frequency	Percentage (%)
Age		
15-19	56	14.2
20-29	123	31.2
30-39	163	41.4
40-59	52	13.2
Sex		
Male	207	52.5
Female	187	47.5
Marital status		
Married	256	65.0
Single	116	29.4
Divorced	6	1.5
Widowed	16	4.1
Ethnicity		
Sidama	269	68.3
Oromo	56	14.2
Amhara	45	11.4
Others	24	6.1
Family size		
1-4	75	19
5-8	231	58.6
9-12	75	19
13-16	13	3.3
Relationship		
Head	166	42.1
Spouse	128	32.5
Son/daughter	85	21.6
Relative/non relative	15	3.8
Educational status		
No education	92	23.4
Primary	134	34.0

Characteristics	Frequency	Percentage (%)
Secondary and Preparatory	75	19.0
More than primary and secondary	93	23.6
Occupation		
Government Employee	56	14.2
Merchant	80	20.3
Student	88	22.3
Housewife	88	22.3
Farmer	61	15.5
Others	21	5.3
Religion		
Protestant	280	71.1
Orthodox	57	14.5
Catholic	14	3.6
Muslim	41	10.4
Others	2	0.5
If government employee		
Health professional	18	32.1
Manager	7	12.5
Accountant	10	17.9
Others	21	37.5
Monthly income		
Below 1500	55	14
1500-2500	123	31.2
2501-3500	102	25.9
3501-4500	67	17
More than 4500	47	11.9
Kebeles		
Mesalemiya	131	33.2
Dela	120	30.5
Chefe	143	36.3

The proportion of respondents with good knowledge was 47.7% (188) with 95% confidence interval of 47.3 to 57.1%. Further analysis of the questions on knowledge revealed that the majority (76.4%) of the respondents knew that community problems are solved through CBE practices. Out of total respondents, around 95.9% knew that CBE practices can contribute to the development of a country. Contrarily, only 2.3% of respondents did not hear about CBE practices before. On the other hand, 50.1% of the respondents have not observed any problem in their community solved by university health students based on CBE practices (see Table 2).

Table 2. Knowledge of respondents on CBE practices in Aleta Wondo town in Sidama Zone, SNNPR, Ethiopia, 2017

Knowledge on CBE practices	Number of subjects with correct answer	Percentage (%)
Have you heard about CBE practices that University health students are practically working on, before this day in your community?	385	97.7
Have you contacted with any University health student who is working on CBE practices in your community before this day?	357	90.6
If yes, is there anything you did with them?	245	62.2
Do you know how University students are conducting CBE practices?	234	59.4
Do you know University health students can solve problems of a community through CBE practice?	375	95.2
Do you know what problems are solved by university health students through CBE practice?	301	76.4
Do you know how they can solve the problems?	326	82.7
Is there any problem you know that was solved by university health students in your community?	177	44.9
Do you know anyone who told you about CBE practice of university health students in your community?	51	12.9
Do you know CBE practices have many positive social, economic and health impact for a community?	382	97
Do you know CBE practices can contribute to the development of a country?	378	95.9

The proportion of respondents with good attitude was 229 (58.1%) with 95% confident interval of 53.8 to 62.9%. For the individual questions, it was noted that there was a good response to the statement “we need CBE practices in our community” where 90.9% of the respondents agreed on. On the other hand, 61.4% of the respondents were not satisfied by CBE practices in their community (see Table 3). This results are in line with several previous studies that the existence of community, including its environment, gives considerable effect on students’ attitude (Sata et al., 2015). Cheng (2018) reported that CBE has motivated students in learning community health care.

Table 3. Attitude of community towards CBE practices, Aleta Wondo town in Sidama Zone, SNNPR, Ethiopia, 2017

Statement	Strongly disagree, disagree and neutral	Agree and Strongly agree
University health students CBE practice is necessary for a community.	14(3.6%)	380(96.4%)
We need University health students CBE practice in our community.	36(9.1%)	358(90.9%)
I believe that University health students work on CBE practices can solve problems in a community.	28(7.1%)	366(92.9%)
I believe that material, manpower and information support for the students on CBE practice plays a great role in solving problem problems.	85(21.6%)	309(78.4%)
I acquire knowledge and skill from the students CBE practice.	53(13.5%)	341(86.5%)
I can develop a confidence through participating in CBE practice that can help me to solve problems by myself in our community.	53(13.5%)	341(86.5%)
CBE practices have a health benefit for a community.	5(1.3%)	389(98.7%)
University Health Students are confident at CBE practices in a community.	161(40.9%)	233(59.1%)
I am satisfied by CBE practices that University health students are giving.	242(61.4%)	152(38.6%)
CBE is a systematic activity that can increase the capacity of the community to solve problems by themselves.	71(18%)	323(82%)
I believe that I can get more benefit from CBE practices when I participated actively than that of students.	139(35.3%)	255(64.7%)
For the CBE practice to be acceptable and beloved by the community, students should be active in the practice.	8(2%)	386(98%)
I believe that CBE practices are always beneficial for a community.	28(7.1%)	366(92.9%)
I believe that I can involve in the world of invention and be creative through actively participating in CBE practices.	148(37.6%)	246(62.4%)
I believe that CBE practices can contribute to the development of a country.	26(6.6%)	368(93.4%)

The results of multiple logistic regressions (Table 4) show that compared to non-educated respondents, those educated respondents were 28.965 times more likely to have good knowledge on CBE practices [AOR 28.965 (9.721, 86.309)]. In the same way, compared to respondents whose monthly income was less than 1500, those with income greater and equal to 1500 were 3.330 times more likely to have good knowledge on CBE practices [AOR 3.330 (1.567, 7.078)]. In addition, based on respondents’ occupation, student and government employee were 12.943 times more likely to have good knowledge on CBE practices compare to another occupation [AOR 12.943 (3.885, 43.124)]. Meanwhile, compared to respondents who were other, those household head and spouse were 7.154 times better in CBE practices knowledge [AOR 7.154 (2.105, 24.310)]. On the other hand, compared to Chefe Kebele, the respondents from Dela Kebele were less likely to have good knowledge on CBE practices [AOR 0.239 (0.115, 0.496)]. Similarly, compared to Chefe Kebele, those respondents from Mesalemiya Kebele were less likely to have good knowledge on CBE practices [AOR 0.519 (0.271, 0.991)]. In accordance to occupation, student and government employee were 2.400 times have better attitude on CBE practices compared to others [AOR 2.400 (1.230, 4.685)]; and the respondents from Dela Kebele have better attitude on CBE practices compared to those who were from Chefe Kebele [AOR 1.872 (1.087, 3.223)].

A good knowledge of CBE practices will, somehow, leads the community to support the students offered by students. Nasela et al. (2019) stated that a multilevel cooperation in community was succeed to prevent, detect, and manage hypertension. This, in turn, will give health university students meaningful experience (Kruger et al., 2015) as well as opportunities (Moodley & Singh, 2018).

Table 4. Factors associated with knowledge of community members on CBE practices in Aleta Wondo town, Sidama Zone, SNNPR, Ethiopia, 2017

Characteristics	Knowledge of respondents		COR (95% CI)	P<0.05	AOR (95% CI)	P<0.05
	Good	Poor				
Age						
15-39	190(55.6%)	152(44.4%)	2.812 (1.503, 5.261)	0.001	*1.946 (0.760, 4.983)*	0.165
Above 40	16(30.8%)	36(69.2%)	1.00		1.00	
Sex						

Characteristics	Knowledge of respondents		COR (95% CI)	P<0.05	AOR (95% CI)	P<0.05
	Good	Poor				
Male	116(56%)	91(44%)	*1.374 (0.924, 2.043)*	0.117	*1.303 (0.765, 2.218)*	0.330
Female	90(48.1%)	97(51.9%)	1.00		1.00	
Educational status						
Educated	202(66.9%)	100(33.1%)	44.440 (15.861, 124.513)	0.000	28.965 (9.721, 86.309)	0.000
Non educated	4(4.3%)	88(95.7%)	1.00		1.00	
Relationship						
Head and spouse	147(50%)	147(50%)	* 0.695 (0.439, 1.100)*	0.120	7.154 (2.105, 24.310)	0.002
Other	59(59%)	41(41%)	1.00		1.00	
Monthly income						
1500 ETB+	191(57.4%)	142(42.6%)	4.125 (2.215, 7.683)	0.000	3.330 (1.567, 7.078)	0.002
Below 1500 ETB	15(24.6%)	46(75.4%)	1.00		1.00	
Occupation						
Government employee and student	107 (76.4%)	37(23.6%)	4.411 (2.808, 6.929)	0.000	12.943 (3.885, 43.124)	0.000
Others	99(39.6%)	151(60.4%)	1.00		1.00	
Kebele						
Mesalemiya	68(51.9%)	63(48.1%)	*0.617 (0.380, 1.000)*	0.050	0.519 (0.271, 0.991)	0.047
Dela	47(39.2%)	73(60.8%)	0.368 (0.223, 0.607)	0.000	0.239 (0.115, 0.496)	0.000
Chefe	91(63.6%)	52(36.4%)	1.00		1.00	

where: CI-Confidence interval; COR-Crude odds ratio; AOR; Adjusted odds ratio

Based on this study, 188 (47.7%) respondents were found to have good knowledge and 229 (58.1%) had good attitude on university health students' CBE practices. Educated respondents, respondents with high monthly income, and student and government employee were more likely to have good knowledge on CBE practices. Also, students and government employee were more likely to have good attitude on CBE practices. This is presumed that government has a good socialization of CBE program as there are many opportunities provided by government for students to implement their health care skills.

Based on the research conducted at Gezira University in Sudan, 90% of the participants answered that Gezira health students were dedicated and hard workers in a community of Community Based Programs (CBP) (Schmidt, 1992). It is higher than the result of this study in which 59.1% of respondents answered that the university health students are confident and hard workers on CBE practices in community. The research conducted at Gezira University also indicated that 33% of participants answered that CBP raises community awareness on the prevention and cure of common diseases. This percentage is lower than the result of this study in which 82% of respondents answered that CBE practices are a systematic activity that can increase the capacity of the community to solve problems by themselves. Research of Gezira University also indicated that 87% of respondents answered that CBP can increase community understanding on Gezira University objectives and strategies. This percentage is slightly lower than the result of this study in which 97% of respondents answered that CBE practices have positive social, economic and health impacts in community which was one among many objectives of universities CBE programs.

CBE programs are all aimed at producing changes in community. However, the question, then, of course is to what extent these changes contribute to the well-being of community. Based on this research finding, 98.7% of the respondents agreed that CBE practices have health benefit for the given community. Moreover, out of the total respondents, 95.2% of them knew that CBE practices can solve community problems. Hence, the community members knew as the program is better and beneficial in many ways. However, 61.4% of the respondents were not satisfied by CBE practices which were implemented by university health students in community. In relation to the utilization status of the program, 55.1% of the respondents have not observed any problem solved by health students in their community. This might be a main factor that can force the community to be in contrary direction to the program. Thus, universities have to work a lot since community members expect special things daily.

Community support and mobilization have been reported as the key enabling factors for the success of Community Based Interventions (CBIs) for HIV prevention since they require a culturally sensitive approach (Carlson, 2012). In relation to this report, our study also indicated that 78.4% of respondents believed that material, manpower, and information

support were needed for students on CBE practices which play a great role in solving community problems. The majority of the community knew that support is needed for students working in the community in solving problems.

Based on our result, education is the main contributing factor that affects the knowledge of community members towards CBE practices. Compared to non educated people, those educated respondents have better knowledge. The main reason behind this was the encouragements of primary and secondary school students on the program practices mostly during the time of university health students working on CBE practices were searching to find and solve problems of the school environment. Learners tend to share their knowledge and doing peer review in many subjects, including CBE program (Michaels et al., 2017), managing (Kruger et al., 2015), making evaluation on it (Bailey et al., 2016), and even finding the solution for the issues arise (Dreyer et al., 2016; Ndateba et al., 2015). Therefore, it makes sense that students tend to have better knowledge in CBE practices. The other reason is that the educated people who are working in different offices knew about the program and wanted to involve in their community program together with the university health students.

The second factor affecting knowledge but not attitude was the monthly income of households. Those community members with low-income level were most of the time forced to isolate themselves from the program due to two main reasons. First, they fear when someone can enter their home to ask them something and present with unexpected false response that was “no household member here we are from the neighbor”. Furthermore, they want to be involved in something that came with payment in their community. Hence, they were not simply getting an opportunity to involve. The two reasons were not the same to all households with low-income level. But the majority of them were following this matter.

The third factor was occupation that was identified to affect on both knowledge and attitude of the community towards CBE practices. This is due to the fact that students and government employee are most of the time exposed to CBE practices given by university health students. The higher the amount of their knowledge the higher curiosity they have about certain topic. It is also proven that a good knowledge has drives learners to be more open-minded (Ramadianto et al., 2015). As the consequences, students and government employee will always adding their comprehension about CBE. So that students and government employee have both good knowledge and attitude on CBE practices.

The fourth factor affecting the knowledge of respondents was relationship of the respondents in their family. Since in most houses, mothers and fathers can invite someone coming from outside, so that the spouse and household head were identified as having better knowledge on CBE practices than others like son, daughter, relatives, and other non-relatives. In some ways, family has been identified as the determinat factor for individuals’ health (Rahman et al., 2018; Shahhosseini et al., 2012; Tomayko et al., 2021) and education (Smith, 2010). Considering this matter, possessing good knowledge about many aspects are possibly associated with family condition.

The last factor identified as having effect on the attitude of the community was Kebele of the respondents. This was due to the reason that students conducting CBE practices are mostly selecting a Kebele purposively for community diagnosis to identify problem and to give intervention to the problems they have prioritized. Due to this reason, there is knowledge and attitude variations among respondents from different Kebeles on CBE practices. Our finding indicated that respondents from Dela Kebele have better knowledge compared to the respondents from Chefe Kebele.

CONCLUSION

According to this study, three out of five respondents were found to have good attitude on CBE practices and slightly lower than half of the study participants had good knowledge. Community knowledge and attitude toward certain aspects of students’ CBE practices were still poor. Educational status, occupation, family relationship, as well as monthly income significantly affect community knowledge of CBE practices. Respondents’ occupation and Kebeles (village) affect community attitude towards CBE practices significantly. In addition, cultivating community awareness about CBE practices as well as their encouragement in participating the practices are needed. Thus, community will be easy to share knowledge and skill or to transfer information in every CBE practice.

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