DEVELOPMENT OF STRATEGIES TO IMPROVE HEALTH CARE SERVICES FOR YOUNG PEOPLE IN EAST GOJJAM ZONE, ETHIOPIA

by

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DECLARATION

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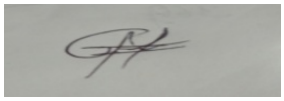
I declare that this thesis is my work and all the study sources referenced have been acknowledged by means of complete referencing.

Furthermore, I declare that I submitted the thesis to originality-checking software and that it is within the acceptable requirements for originality.

I further declare that this thesis was never submitted previously or part of it, for examination at the University of South Africa for another qualification or any institution for a qualification.



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ABSTRACT

Proper health service provision for young people aged 15-24 years (young people) remains a challenge in East Gojjam because of different factors. Literatures indicate that even though there is rapid population growth in developing nations including Ethiopia, appropriate health service provision for this ever-growing population remains challenging.

The purpose of the study was to evaluate the health care services provision for young people in East Gojjam Zone, Ethiopia, and to use the findings to develop strategies to enhance the utilisation, coverage, and quality of the health services for young people in East Gojjam Zone, Ethiopia.

To this end a convergent parallel mixed method was used as a research design. Both quantitative and qualitative methods were used to collect, analyse and interpret data. Quantitative data was collected from 418 respondents that were randomly selected from the study population. Four focus group discussions and eleven in-depth interviews were conducted to collect qualitative data from the participants that were selected purposively. There were demographic and socio-economic, socio-cognitive, and institutional variables investigated quantitatively and qualitatively. Both descriptive and inferential statistics were applied to analyse the data. The quantitative findings were triangulated with qualitative ones to ensure reliability of the research.

Both quantitative and qualitative results exhibited gaps in health service utilisation and its quality for 15-24-year-olds in East Gojjam Zone, Ethiopia. Based on these findings, strategies had been developed, to enhance the quality and utilisation of health services for young people, to overcome the challenges aforementioned. Recommendations were made to improve strategic approaches at all levels of health service delivery. From these findings, the most important recommendations were forwarded to the relevant authorities

to combat the challenges and improve the quality, utilisation and coverage of health services for young people in East Gojjam Zone, Ethiopia..

Keywords

East Gojjam Zone; evaluation; health care; health care services; health service coverage; health service quality; health service utilisation; mental health; young people.

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DEDICATION

This thesis is dedicated to my younger brother, Hailu Damtie Demeke, a hard-working farmer and a caring father of his seven children who passed away during my study period.

His untimely death is a huge loss, not only for his families, but also for the community he belonged, as he was a mentor to fellow farmers, helper to the needy and companion to the neighbourhood.

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LIST OF ABBREVIATIONS

BMI	Body Mass Index
CAC	Cognitive Accessibility
CDC	Centre for Disease Control
CMOE	Centre for Management and Organisation Effectiveness
COVID-19	Corona Virus Disease Type 9
CSA	Central Statistical Agency
CSE	Comprehensive sexuality education
EDHS	Ethiopian Demographic Health Survey
ENN	Environmental News Network
EPHS	Essential Package of Health Care Services
FGD	Focus Group Discussion
HAQ	Health Care Access and Quality
HBM	Health Belief Model
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
IPPF	International Planned Parenthood Federation
KPIs	Key Health Service Performance Indicators
MHA	Mental Health and Addiction
MPR	Multivariate Logistic Regression
OECD	Organisation for Economic and Cooperation Development
PAA	Psychosocial Accessibility
RH	Reproductive Health
SPSS	Statistical Package for the Social Sciences
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TPB	Theory of planned behaviour
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WFP	World Food Program
WHO	World Health Organization
YFS	Youth-friendly services

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

Young people constitute 19.4 percent of the total population worldwide and there is a rapid growth in Africa (United Nations Economic Commission for Africa 2020:1). According to a study by Masquelier, Hug, Sharrow, You, Mathers, Gerland and Aklema (2021:e409), 18.3% of young people aged between 15-24 years (young people) live in sub-Saharan Africa. It is a truism that giving due attention to the health of young people (15-24 years) have a three-fold advantage in advancing their wellbeing, laying foundations for their later life, and serving the next generation (Texas Leadership Charter Academy (TLCA) 2019:749). Young people are also key actors in countries' effort to achieve educational and health goals, that intend to prepare future adulthood (Republic of Kenyan Ministry of Health 2016:5).

Healthy adolescents and young people contribute to economic growth by increasing productivity, lowering health care costs, and interrupting the transmission of poverty, disease, and discrimination across generations. For every dollar spent on youth and adolescent health, the health, social, and economic benefits are estimated to be ten times greater (Lehtimaki & Schwalbe 2019:22).

Globally, young people have an 11.2% probability to die in their age between 15 years and 24 years (Masquelier et al 2021:e409). The World Health Organization (WHO) (2022:1) has reported that, an estimated 1.3 billion young adults (from the ages of 15 to 24) died worldwide, with the majority of these deaths being attributed to preventable or curable illnesses. In Africa, the mortality rate was 13 times higher in low- and middle-income countries than in high income countries, and it was more than seven times higher in young people (WHO 2018:1).

However, adolescents and youth worldwide are still facing serious challenges in their health development (Oljira 2016:14). The challenges emerge from socio-cultural barriers and poorly coordinated, unacceptably provided and unevenly qualified health services in

terms of geographic distribution and providers' skill. Moreover, perceived lack of privacy and confidentiality coupled with poor provider attitudes and lack of resource in health care facilities are additional challenges (Mulugeta, Girma, Kejela, Gebremeskel, Andargie & Zerihun 2019:1). Lack of appropriate health development for the young generation may lead to risky behaviours including exposure to Human Immuno-deficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) which can lead to drastic consequences to their lives (Akatukwasa, Bajunirwe, Nuwamanya, Kansime, Aheebwe & Tamwesigire 2019:2). Young people have a higher mortality rate due to a lack of access to a primary care physician, poor nutrition and mental health issues and disorders (Rice, Purcell & McGorry 2018:S9).

Health education is important for young people not only for today but for their lifelong wellbeing and the health of the next generation (Robard, Kang, Tolley, Hawke, Sanci & Asgerwood 2018:692).

1.2 BACKGROUND TO THE RESEARCH PROBLEM

There are nearly 2 billion young people between the ages of 15 and 24 (also called youth age) in the world and 90% of them live in developing countries (Akatukwasa et al 2019:1). Approximately 87% of the world's population is living in developing countries, and up to a quarter of the population is under 25 years of age. Many countries, particularly in South Asian countries and Africa, have a youth rate of one in three (Joseph 2016:5). The same is true in Ethiopia where young people make up to 33.8% of the country's population (Gebrie, Asrade, Tsehay, Yazachew & Dellie 2021:2).

Each year more than 1.2 million adolescent deaths are registered worldwide (Susanna & Nina 2019:3). Hence, health care services need to be available for young people in sufficient numbers and quality to ensure their wellbeing. According to Baeten, Spasova, Vanhercke and Coster (2018:39), enhancing health services' utilisation, coverage and quality promotes their accessibility, acceptability, and appropriateness for young people by applying the quality criteria for youth-friendly health services. In addition, it reduces inequalities in health services, as health service coverage varies greatly from country to country. At least 50% of the world's population does not have access to basic health services; it has no secret that the services for young people in low-income countries are highly dispersed, lack coordination, and are of poor quality (World Health Organisation

(WHO) & World Bank 2018:30). The situation in Ethiopia is not different; the overall service coverage for Ethiopian young people is low, hence, rapid scale up of promotive, preventive, and curative health services through significant investment on primary health care services is mandatory (Eregata, Hailu, Memirie & Norheim 2019:1). The study done in Southern Ethiopia by Mulugeta et al (2019:4) showed that the utilisation, coverage, and quality of health services for young people are below the WHO criteria both in quality and quantity.

1.3 STATEMENT OF THE RESEARCH PROBLEM

Youth period is a unique and critical stage of development in which young people encounter unmet health needs and exposure to risky behavioural and health- related problems that result in high mortality rates (The Society for Adolescent Health and Medicine 2017:758). Most health services are not well integrated with the needs of the youth, inadequate in access and utilisation, poor and uneven in quality and coverage; moreover, their services are limited to sexual and reproductive health (SRH), HIV, and STIs; they do not fully address the broader health problems faced by adolescents and youth (Oljira 2016:17).

According to Fite, Mohammedamin and Abebe (2018:2), the Ethiopian adolescent and youth health service utilisation, coverage, and quality level remains poor and unacceptable. The researchers further indicated that unintended pregnancy and unmet contraceptive needs among young Ethiopian women were 23.5%, 22% respectively and an annual abortion rate was 28 per 1000 women. Ethiopia has a prevalence of malnutrition among adolescents, with 29% of the population suffering from chronic under-nutrition, 3% being overweight or obese, and approximately 20% of adolescent girls suffering from anaemia. Additionally, 28% of adolescent girls have not been able to eat three meals in a day (Zelalem, Sisamo & Maru 2020:20). A survey study by Mekuriaw, Zegeye, Molla, Hussen, Yimer and Belayneh (2019:1) demonstrated that the overall prevalence of the prevalent mental disorder among Ethiopian undergraduate students (youth) was 37.73%.

According to the East Gojjam Zone report (2019, 14), the ratio of health professionals to the population in East Gojjam is much lower than the minimum standard as set by the World Health Organization (1GP:10,000 populations, and 1 Nurse: 5,000 populations). Shortage in health professionals is the main challenge in the health institutions. The report

also showed high professional turnover which further cause lack of skilled care providers. Even if there are nine hospitals and other primary health care facilities in the zone, due to different reasons, the quality of the services delivered is not good and there are some health service institutions where services for young people are not being delivered as expected. Service need of clients is not properly addressed. There is still service accessibility problems due to the institutions' distance. Even though there are some improvements, from the report, there is limitation in the quality of recording, reporting and documenting services given for the young people. It also showed that there is shortage of essential drugs and equipments, lack of units to deliver health services, and problems in timeliness and completeness of data which affect decisions to be made and give timely solution for the problems.

Apart from poor service provision and higher exposure of young people to SRH, mental (behavioural) health, and nutritional health problems, there is no comprehensive understanding about the challenges related to health care services for young people in Ethiopia in general and East Gojjam Zone in particular, as researches conducted on this area are scanty. Therefore, this study was conducted to fulfil the aforementioned gap; it attempted to evaluate the utilisation, coverage, quality, and challenges for health services to young people in East Gojjam Zone, Ethiopia.

1.4 RESEARCH QUESTION

This study answers qualitative and quantitative questions stated in the following sub-sections.

1.4.1 Importance of research questions

Focusing the study objective and purpose to a few key questions that the researcher tries to address in the study helps illuminate the issue that the researcher wishes to investigate. They provide the researcher with a a research framework, helping to structure the study by providing relevant direction and coherence; moreover, they help to sustain the researcher's concentration throughout the study period. They also define the boundaries of the study (Onwuegbuzie& Leech 2006:478). In mixed methods studies, the research questions determine the research design, sample size, and sampling strategy,

instrumentation, and statistical or qualitative analysis techniques (Onwuegbuzie& Leech 2006:475).

The researcher stated the research questions for both quantitative and qualitative phases of the research as follows:

Phase 1: Empirical phase

- **Step 1: Quantitative phase**
    - How are health care services provided for young people in East Gojjam Zone, Ethiopia?

- **Step 2: Qualitative phase**
    - What can be done to improve health care services provided to young people in East Gojjam Zone, Ethiopia?
    - What are the challenges to the utilisation, coverage, and quality of specific health services provided by the specific health care institutions in East Gojjam Zone, Ethiopia?

Phase 2: Development phase

- What strategies could be used to enhance the utilisation, coverage, and quality of the health services for young people in East Gojjam Zone, Ethiopia?

Phase 3: Validation

- How can the strategies developed to enhance the utilisation, coverage, and quality of the health services for young people in East Gojjam Zone, Ethiopia be validated?

Phase 4: Integration phase

- How can the results of the various phases of the study be integrated?

1.5 RESEARCH PURPOSE

The purpose of the study was to evaluate the health care services provision for young people in East Gojjam Zone, Ethiopia, and to use the findings to develop strategies to enhance the utilisation, coverage, and quality of the health services for young people in East Gojjam Zone, Ethiopia.

1.6 RESEARCH OBJECTIVES

Phase 1: Empirical phase

- **Step 1: Quantitative phase**
    - To evaluate the utilization of the specific Health services for young people in East Gojjam Zone, Ethiopia
    - To determine the challenges to utilisation, coverage, and the quality of services in the health care institutions in East Gojjam Zone, Ethiopia.

- **Step 2: Qualitative phase**
    - To determine the quality of the health services provided to young people by the specific health care institutions in East Gojjam Zone, Ethiopia.
    - To explore the challenges that young people experience when utilising specific health services provided by the specific health care institutions in East Gojjam Zone, Ethiopia

Phase 2: development phase

- To develop strategies to enhance the utilisation, coverage, and quality of the health services for young people in East Gojjam Zone, Ethiopia.

Phase 3: Validation

- To describe the technique to validate the strategies developed to enhance the utilisation, coverage, and quality of the health services for young people in East Gojjam Zone, Ethiopia.

Phase 4: integration phase

- To describe the way how the results of the study could be integrated.

1.7 CONCEPTUAL FRAMEWORK

Theories and models are the main way scientists put their findings into a bigger picture (Polit & Beck 2018:127). A conceptual framework outlines the relationships between concepts that are specific and relevant to the subject matter of the research (Cohen, Mannion & Morrison 2018:69). The conceptual framework below, which is adapted from Australian Association for Adolescent Health (2018), indicates the relationship between socio-demographic, socio-cognitive, institutional factors, here considered as challenges, and the quality and coverage of health services utilisation to young people. This illustrative framework was applied to explore the challenges/factors and their effects on the quality and coverage of service utilisation in East Gojjam Zone.

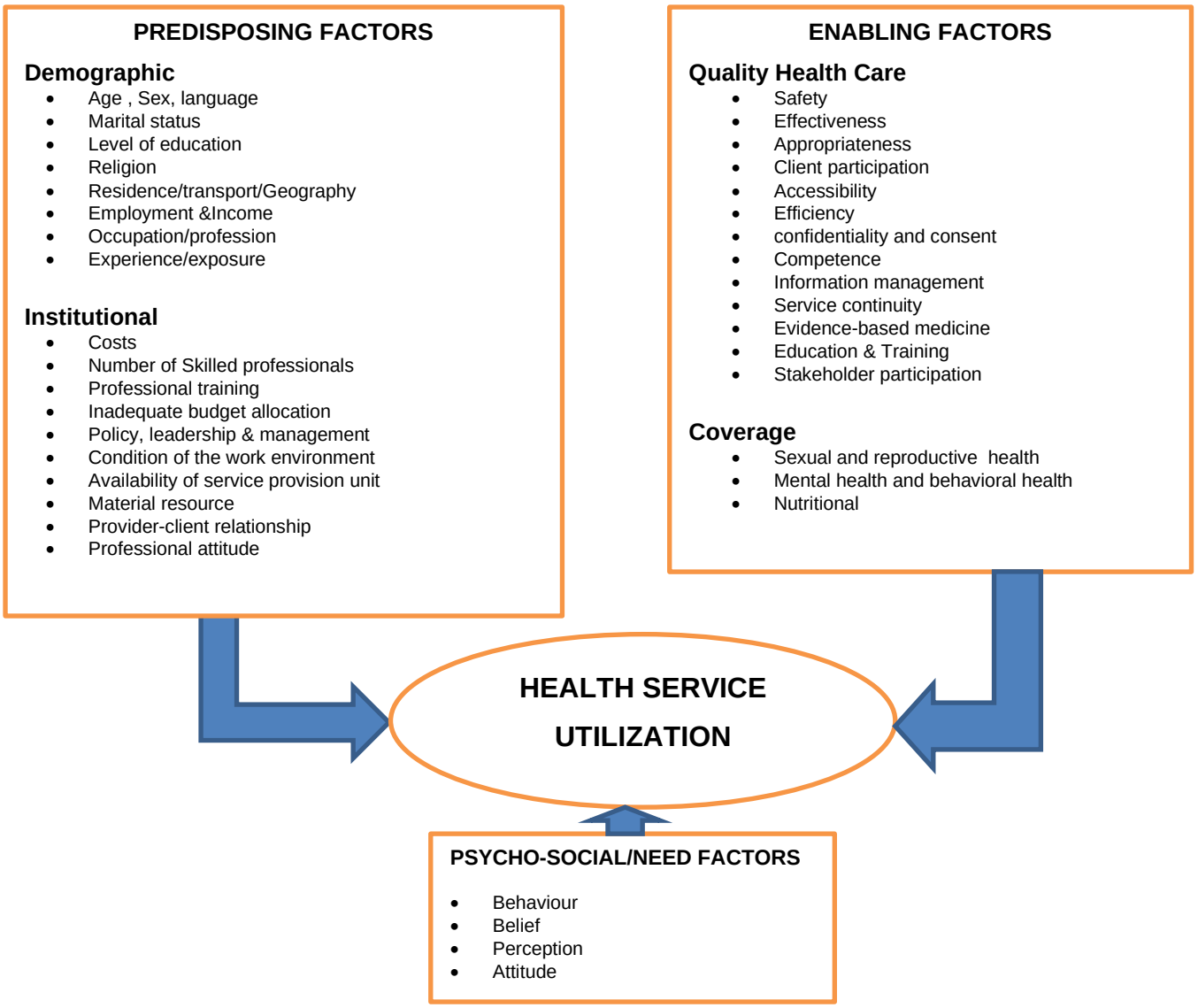

Figure 1.1 A conceptual framework illustrating health service and the challenges (factors) based on Anderson's behavioural model

1.8 DEFINITION OF CONCEPTS

Health service coverage: The extent of interaction between the service and the people for whom it is intended (Tracking Universal Health Coverage 2017:xii). In this study, health service coverage indicates to the extent the young people of East Gojjam Zone, Ethiopia; interact with the health services provided for them.

Service evaluation: An assessment of how well a service is achieving its intended aims (Twycross & Shorten 2014:65). In this study, service evaluation refers to an assessment

of how well the health services of East Gojjam Zone, Ethiopia, meet health needs of the young people within the area.

Health service quality: A multifaceted concept with three main dimensions: effectiveness (service coverage that results in the desired health gains), patient safety, and responsiveness/people-centeredness which respond to individual preferences, needs, and values (WHO 2017). In this study, health service quality refers to the effectiveness, patient safety, and responsiveness of the health services in East Gojjam Zone, Ethiopia, to the young people within the area.

Health service utilisation: When people are given medical services for their health needs, it is referred to as use or utilisation (Yakob et al 2019:726). In this study, health service utilisation refers to when the young people of East Gojjam Zone, Ethiopia, get health care from the health services within the area.

Quality: The term refers to the extent to which the standard service delivery procedures are implemented (Yakob et al 2019:726). Quality is defined the same way in this study.

Young people: People of age 15-24 years (World Health Statistics 2018:8). Young people refer to the same age group in East Gojjam Zone, Ethiopia in this study.

1.9 SIGNIFICANCE OF THE STUDY

The findings provided the latest information about the utilisation, coverage, quality, and challenges of health service provision for young people in East Gojjam Zone, Ethiopia. The findings were used to develop strategies to enhance the utilisation, coverage and quality of health services to young people East Gojjam, Ethiopia.

1.10 SCOPE AND LIMITATIONS

This study was done in East Gojjam Zone in Amhara Regional State, Ethiopia. Young people (15-24 years) were the target population of the study, and registered young people's data in the health institutions and health service providers was the sources of information gathered for the study.

Due to incomplete registries about young people's service in the health institutions, there could be issues not addressed in the study. There could be selection and response biases. There was no guarantee that the opinion of the participants of the focus group is honest as well as all the questionnaires would be responded to and come back for analysis. Only the sampled respondents could be interviewed so the study could not address all young people.

1.11 STRUCTURE OF THE THESIS

This thesis comprises of eight chapters.

Chapter 1: Orientation of the study

The researcher introduces the study and takes the reader through the conceptualisation of the study, briefly touching on the research problem, questions, objectives, purpose and methods used. Laying a foundation for chapter 3 regarding the methodology.

Chapter 2: Literature review

In this chapter, the researcher describes the literature appraised in relation to the topic under discussion. Paving a way for understanding the phenomenon under study from various perspectives, those in agreement and those negating the study.

Chapter 3: Methodology of the study

The researcher takes the reader through the research methods used to undertake the study. Putting bare a paper trail for other researchers in similar contexts to emulate.

Chapter 4: Analysis, presentation and description of quantitative findings

In this chapter, the researcher describes the data collection process and the data analysis processes for the quantitative component of the study. Collected data is analysed and findings described.

Chapter 5: Description of qualitative data result

The researcher briefly touches on the data collection and analysis processes. Findings are described with the support of verbatim quotes from the data.

Chapter 6: Integration, interpretations and discussions

This chapter integrates, interprets and discusses the quantitative and qualitative conclusions of the data collected in the Phase 1 (quantitative) and Phase 2 (qualitative) studies.

Chapter 7: Development and validation of strategies to enhance the utilization of health services by young people in East Gojjam, Ethiopia

The purpose of the study is to evaluate health services to young people in East Gojjam Zone, Ethiopia; in order to develop strategies to enhance the utilization, coverage and quality of the health services to young people in East Gojjam, Ethiopia. In this chapter, the researcher describes the development and validation of the strategies.

Chapter 8: Conclusion, limitations and recommendations of the findings

Chapter 8 makes concluding remarks about the study findings and the developed guidelines, the validation outcome, study limitations and recommendations to policy makers, and for further research.

1.12 SUMMARY

Health service utilisation for young people needs integrated effort in coping up with challenges and bringing them to the desired state. The quality and coverage of the services should also be critically evaluated. Responding to demographic, psychosocial and institutional influences properly ensure that health services are youth-friendly.

Young people suffer from a variety of health issues, including inadequate nutrition, sexually transmitted diseases, substance misuse, and mental health issues, as well as a lack of health services and a higher mortality rate. Collaborative efforts should therefore be pursued to enhance the uptake, coverage and quality of health care services for young people.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review summarizes existing evidence regarding a topic and outshines the significance of the new study (Polit & Beck 2018:171). Therefore, it is taken to be a foundation for all areas and stages of the research in question: purpose, foci, research questions, methodology, data analysis, discussion and conclusions (Cohen, Manion & Morrison 2018:181).

This chapter discusses the utilisation, coverage, quality, and challenges associated with the use of health services among young people. It helps to decide whether the topic is worth studying. This chapter also provides insight into how the researcher can restrict the scope into the field of study (Creswell, 2017:40). The purpose of this chapter is to provide a summary of the main conceptual and theoretical issues arising from related literature and to serve as a reference for the study as a whole.

The researcher conducted a systematic review of a selection of articles published in a variety of indexed journals related to the subject matter of the research. The search engines were books and journals included in PubMed, Scopus (Scopus Plus with Full Text), Ebsco Host, Jstor, University of Chicago Press, Sage Journal, and the National Academy of Science. The search strategy was based on the key words or terms and subjects: health service, health service for young people, health service utilization, health service coverage for young people, quality of health service, and factors associated with youth health services.

In the search engines, a total of 2002 sources were found and of which 342 were journal articles, 763 were theses, 597 and others were books. Most articles were duplicated and only 43 articles were used for the study. For the empirical part of the analysis, the researcher searched full-text research papers conducted between 2016 and 2020 using qualitative, quantitative, or mixed-methods. However, for the theoretical aspect of the research, the researcher searched back to 1990 for a better understanding of the

theoretical framework and the sample size determination for the quantitative and qualitative methods in this study. Each publication was assessed for relevance, and supporting or challenging the quality of the health services provided to young people in Ethiopia. The legislative documents yielded supporting information on the quality, coverage and use of health services to young people in Ethiopia.

2.2 HEALTH SERVICE UTILISATION (COVERAGE AND QUALITY) FOR YOUNG PEOPLE

Researches conducted both globally and in sub-Saharan countries have highlighted the vulnerability of young people to a variety of health issues, as well as social and economic hardships. In many African countries particularly, it has been reported that it has been difficult to persuade young people to participate in health services. (Hoon, Pham, Beilby, & Karnon 2017:1). Many African countries have reported difficulties in convincing young people to participate in health services (Nkosi, Seely, Ngwenya, Mchunu, Gumede, Ferguson & Doyle 2019:2). The same is true in Ethiopia. While progress has been made on access to essential health facilities, young people still face a number of health challenges, including lack of sexual and reproductive health (SRH) services, malnutrition, HIV/AIDS infection, substance abuse (mainly chat, tobacco and alcohol, but also drug use) and persistence of gender inequalities (Organisation for Economic Cooperation and Development [OECD] 2018:2). Furthermore, the utilisation of preventative and therapeutic services remains low, which presents a major public health challenge and impacts efforts to enhance health outcomes by scaling youth-friendly services (YFS) which have yet to yield the desired results (Nkosi et al 2019:1).

It appears that holistic youth health services improve their involvement and understanding of the health system. This engagement addresses one of the biggest threats to youth health and well-being: the negative perceptions of health services, such as worries about confidentiality, shame, and inadequate service delivery in relation to the needs of the young person (Whitehead, Amot, Armour, Scott & Reid 2018:11). The transition to adult health care has been the subject of increased research and policy attention over many years. However, the unmet needs of adolescents and young adults continue to be documented and universal implementation has yet to be realised (Farre & McDonagh 2017:77). This is supported by the fact that 214 million women wanting to delay or abstain from becoming pregnant are not using modern methods of contraception

around the world. This highlights the limited reproductive and sexual health rights of women of childbearing age (Guttmacher Institute 2017:3).

According to Khumalo, Mabaso, Makusha and Taylor (2021:9), it has been observed that adolescents aged 13 to 18 years have a low level of access to and use of campus health services due to a variety of factors, such as a lack of knowledge and awareness, preconceived notions, lack of privacy, and negative experiences. Furthermore, it has been found that adolescents have a higher degree of belief in the provision of health services and the associated costs (Aalsma, Gilbert, Xiao & Rickert 2016:140). Adequate parental involvement, the promotion of health-related self-efficacy or satisfaction, and participation in various teams have been strongly associated with improved health outcomes in adolescents (Colver, McConachie, Le Couteur, Dovey-Pearce, Mann, McDonagn, Pearce, Vale, Merrick & Parr 2018:1).

In this research, the focus is on the utilisation of health services, as well as the coverage and quality of health services. Furthermore, the coverage of health services is also addressed, including the use of sexual, reproductive, substance use, mental health, and nutrition health services.

2.2.1 Health service coverage

Universal health coverage (UHC) is a set of health services that are designed to ensure that all individuals have access to the necessary preventive, preventive, and treatment-based health care, rehabilitation, and palliative care. The WHO defines UHC as “ensuring that all individuals have sufficient quality health services to be effective” (Perehudoff, Demchenko, Alexandrov, Brutsaert, Ackon, Durán, El-Dahiyat, Hafidz, Haque, Hussain & Salenga 2020:54). Universal health care is characterised by three primary characteristics: coverage, quality, and avoiding poverty due to expenses, which are not commonly attained in the health of adolescents and young people (TLCA 2019:749). Around the world, the shift towards UHC has been linked to the goal of making health care more accessible and affordable, but UHC efforts are often initiated in response to a socio-economic or political transformation (Reich, Harris, Ikegami, Maeda, Cashin & Araujo 2016:811). The World Health Organization (WHO) and the World Bank (1919:8) have indicated that it is in the hands of our political leaders to choose the appropriate

economic, financial, and social factors to attain UHC by focusing on primary health care investments.

The essential package of health care services (EPHS) in many countries does not include some essential services of human health (SRH) services, including safe abortion and reproductive services, which are already limited in accessibility (Ravindran & Govender 2020:1). The availability of high-quality services offered by district health systems across the country as a “close-to-patient service” and the expansion of financial protection are two of the primary factors contributing to the prevalence of SRH disparities between the wealthy and the poor, as well as between urban and rural areas (Panichkriangkrai, Topothal, Saengruang, Thammatach-aree & Tangcharoensathien 2020:37).

According to the WHO (2021:1), at least 50% of the world’s population does not have access to essential health services. The situation is even worse in sub-Saharan countries such as Ethiopia. Health service coverage indicators are indicators that measure the extent to which individuals in need are receiving essential health services, such as reproductive, mental, behavioural and nutritional health care (Federal Ministry of Health 2017:12). Ethiopia’s overall service coverage in 2015 was low and the country urgently needs to enhance the provision of preventive curative and related services through increased investment in primary health care (Ergeta et al 2019:1).

The scope of health service coverage can differ based on different factors, including demographic, epidemiological, and technological developments, as well as user preferences (Perehudoff et al 2020:54). According to Ravindran and Govender (2020:6), lack of international and domestic funding, political and legal obstacles, restrictive gender stereotypes and gender-based inequalities hamper the provision and availability of quality SRH services, for example, during the national COVID-19 lockdown in New Zealand, young people with higher socio-economic disadvantage had an unmet sexual health need (Rose, Garrett, Mckinlay & Morgan 2021:1).

Despite the purposes of offering the services that are right to the population need to ensure the universal access to reproductive and sexual health services, the health services package that is typically included in UHC in many developing nations does not adequately address a wide range of SRH concerns and is not cognisant of the unique

needs of adolescents who face particular difficulties as reported by the International Planned Parenthood Federation (IPPF) (2017:5).

2.2.1.1 Sexual and reproductive health service utilisation

As teens go through puberty, a lot of questions come up about their sexuality and gender identity, and some of them come up earlier than others (National Academies of Sciences, Engineering and Medicine 2019:49). Young people often sought out sexual and relationship health services for reproductive health care and contraception; however, often found to be uncomfortable due to a lack of privacy and a perception that the services were only available to married couples. Additionally, those who attended YFS were more likely to come for SRH advice and testing when they experienced symptoms of sexually transmitted infections (STIs). In many cases, pharmacies provided access to contraception and emergency/abortion pill options, but limited or no counselling was provided (Thongmixay, Essink, Greeuw, Vongxay, Sychareun & Broerse 2019:10). Young people may find it not easy to come to terms with their sexuality and gender identity if they are not provided with the necessary support (Russell & Fish 2016:65).

The sexual behaviour of young African adults poses major public health challenges, partly because of high prevalence of STIs among the young people, the lack of adequate family planning services, and low condom effectiveness (Mutumba, Wekesa & Stephenson 2018:430). The situation in Ethiopia is analogous to it. Young people in the country face a multitude of reproductive and sexual health issues, with gender inequality being a major factor, as well as sexual coercion and early marriage. Other issues that must be addressed include unplanned pregnancy, abortion, STIs, and AIDS (Haile, Shegaze, Feleke & Glag 2019:3). Despite the fact that the legal marital age in Ethiopia for women is 18 years, early marriage is still a problem. The prevalence of early marriage is highest in Amhara Region, with 73% [95% CI 71.38, 74.62] (Aychiluhm, Tesema & Tadesse 2021:3).

A survey of 588 adolescents between the ages of 15 and 24 revealed that the majority (68.1%) had not used any form of contraception (Ethiopian Demographic Health Survey [EDHS] 2016:26). The contraceptive prevalence rate is currently 9%, and the unmet need among adolescent girls (15 to 19) is 30%, making it one of the lowest rates in Sub-Saharan Africa. This is due to a lack of in services accessibility that are suitable for

adolescents and young people, such as family planning, which leads to a high incidence of unintended pregnancies (EDHS 2016:7). According to a study done by Ayehu, Kassaw and Hailu (2016:1), SRH services for young people are underused and need to be addressed urgently where, if not addressed, young people may engage in harmful sexual behaviours. The study also found that 771 young people between the ages of 15 and 24 had never visited a health facility for sexual and reproductive services (SRH). Only 66 of them (8.6% of the total population) had ever visited a facility for SRH (Tilahun, Bekuma, Getachew & Seme 2021:1). A research project conducted in East Ethiopia by Assha, Bosho and Jaleta (2017:110) revealed that more than half of young people in the region were not utilising family planning, voluntary counselling, and testing services due to a scarcity of reproductive health resources, outdated practices, a lack of confidentiality, and inconvenient hours of operation.

On a global scale, the rate of condom use at the time of the most recent high-risk sexual activity in the preceding 12 months was significantly lower for young women between the ages of 15 and 24 in 31 countries, and in 18 countries for young men between the age of 15 and 24.In sub-Saharan Africa, between 2012 and 2017, only 34% of young boys and 28% of girls had a good understanding of how to avoid getting HIV (WHO 2018:6). According to the Global Monitoring Report, seven out of ten young women of age 15-24 years do not have better knowledge about HIV (WHO 2021:58).

The level of access to reproductive health services among young people was very low in a study conducted by Karijo, Wamugi, Lamanyishoe, Njuki, Boit, Kibui, Karanja and Abuya (2020:25). As a result, young people remain highly exposed to STIs, become diseased with HIV/IDS, and become pregnant (Sentís, Martin-Sanchez, Arando, Vall, Barbera, Ocaña, Cordón, Alsina, Martin-Ezquerra, Knobel, Gurguí, Vives, Coll, Caylá & Garcia de Olalla 2019:2). According to a study by Kerbo, Tefera, Kuti and Nur (2018:1), less than 50% of the youth in southern Ethiopia were utilising YFS. Only 47 out of 376 youth respondents (55.3%) took part in voluntary HIV/AIDS testing and counselling, and only 43 out of 376 (50.6%) used Family planning services (Abate, Ayisa & Mariam:2019:1).

The Republic of Kenyan Ministry of Health's (2016:12) guideline highlighted the potential of providing adolescents and youth with access to and utilisation of quality and comprehensive SRH services to reduce the prevalence of poor health outcomes. It also

identified a number of barriers to youth access to SRH services, which are further discussed as follows:

- Structural barriers: Legislation and policies that necessitate parental or partner approval, the distance from facilities, the cost of services, the cost of transportation, the length of wait times, the hours of operation, the absence of essential commodities, and the absence of privacy and confidentiality.
- Socio-cultural barriers: Constraints and stigmas around sexuality among teens and young adults, unfair or harmful gender stereotypes, discrimination and judgment of teens and young adults by society, family, friends, partners and providers.
- Individual barriers such as: Young people's incomplete or inaccurate understanding of SRH services, including myths and misconceptions about contraception; lack of self-determination and individual agency; a lack of ability to navigate internalised social and gender norms; limited knowledge of what SRH services exist and where to find them.

Therefore, young people aged 15-19, 20-24, who have ever experienced reproductive issues, who live with a partner, who live alone, who are knowledgeable about SRH, who have a flexible working schedule for YFS, and who participate in a school club were all associated with the use of SRH services (Gebrehana, Arage, Degu, Getnet & Necho 2021:e08526). A significant proportion of STIs occur annually among individuals aged 15-24, with the majority of these individuals having never had an STI test (Cuffe, Newton-Levinson, Gift, McFarlan & Leichliter 2016:512). The two main reasons for universal SRH access are access to high-quality services and the expansion of financial risk protection (Panichkriangkrai et al 2020:34).

According to Zuma, Seeley, Mdluli, Chimbindi, Mcgrath, Floyd, Birdthistie, Harling, Sherr and Shahmanesh (2020:1058), having good health care workers, a supportive family, and close friends can help protect young people by building strong connections and making it easier for them to access care. But having a strong relationship with men, drinking and drug use, and early pregnancy can put young people in danger. The study said that policies and programmes need to be put in place that encourage healthy and supportive connections with family and friends, good social habits, and open-mindedness in clinical services. Even though the law permits women to use contraceptives without the permission of their parents or guardians, in Ethiopia, young, unmarried women who

have few children, no support from their partners, or who are less educated, do not have access to family planning services (EDHS 2016:15). When it comes to preventing teens from engaging in risky sexual behaviour, better communication between parents and teens about sex and reproductive health concerns is more important than ever (Munea, Alene & Debelew 2020:940). Despite a range of initiatives, legislation, and policies that focus on the accessibility of family planning services, the prevalence of unmet SRH needs remains disproportionately high (IPPF 2017:5). Young girls and women between the age of 15 and 24 are especially vulnerable to contracting HIV in sub-Saharan Africa (UNAIDS 2016:8).

A study in Kenya on the use of the SRH by the young people in the country by Mutua, Karonjo, Nyaberi, Wanyoike, Kausya and Mugai (2020:2437) concluded that the government should improve the utilisation of SRH services through education and promotion. The study also recommended that the government scale-up and institutionalise YFS by extensive capacity-building, and by increasing the use of SRH services. The Ministry of Health and health service providers should increase the number of users and fully implement youth health policy recommendations with effective assessment plans (Gebrehowana et al 2021:e08526).

2.2.1.2 Substance use and mental health service utilisation by young people

Even if young people face a number of mental health problems, most of them do not need help from health care providers (Lee, Ngaiman, Poon, Jalil, Yap, Abdin, Subramaniam & Verma 2019:1). Suicide and violence related to mental health disorders are often overlooked in global health efforts, yet they are a major contributor to health-related afflictions, impacting 10-20% of young people (Wonde, Mulat, Birhanu, Biru, Kassew & Shumet 2018:1). Sub-Saharan African nations have limited experience with alcohol and HIV education programmes among young people (Osuafor & Okoli 2018:79).

Suicide ideation and attempted suicide were 22.5 % and 16.2 % respectively among people in Ethiopia (Oljira 2016:25). The rise in the number of young people reporting self-harassment and suicidal thoughts resulted in an increase in the number of adolescents presenting with anxiety and depression who were still awaiting treatment (Kachor & Brothwell 2020:46). In Ethiopia, young people are exposed to chewing chat, smoking cigarette, and drinking alcohol (16.7% & 45.6%, respectively) (Alemu, Zeleke, Takele &

Mekonnen 2020:10; Oljira 2016:25). According to Rice et al (2018:S9), young men are more likely to suffer from mental health issues, such as increased rates of suicidal ideation, behavioural disorders, substance use, and interpersonal violence, than their female peers. Furthermore, their health risk profile is significantly different, emphasising the need for different types of prevention and intervention.

While there has been a lot of attention paid to mental health and the impact it has on young people, they are still not getting the treatment they need and are not taking the right medication (Li 2016:139). To make the mental health services more accessible to young people, Goicolea, Ahlin, Waenerlund, Marchal, Christianson, Wiklund, Hurting, and Sebastian (2018:1) proposed that health centres should be trusted by young people and have a multi-disciplinary team to provide the services. The primary focus should be on reaching out to young people who require mental health and substance abuse treatment (Hawke, Mehra, Settipani, Reliham, Damay, Chaim & Henderson 2019:1). Educational attainment, age, race, and income were major determinants of the likelihood of developing mental health issues; however, good physical health and a higher level of optimism were protective factors (Alemu et al 2020:11).

Despite the fact that a variety of mental health issues, such as anxiety and depression, neurosis, and substance abuse, can have a detrimental effect on an individual's capacity or readiness to seek professional assistance, two of the most prominent individual barriers are feelings of shame or inadequacy in assessing oneself and feelings of guilt when assessing whether or not an individual's behaviours or thoughts are out of control (Muris, Meesters, Pierik & Kock 2016:607). Alcohol consumption is a major contributing factor to a variety of alcohol related incidents and fatalities among adolescents, such as traffic-related crashes and fatalities, interpersonal violence and criminal activity, sexual risk-taking, HIV transmission, and tuberculosis, as well as the economic consequences of these events (Morojele & Ramsoomar 2016:551).

According to Wonde et al (2018:1), suicide and violence-related mental health outcomes are among the world’s top health threats, while mental illness-related disability affects 10-20% of young people. People between the ages of 15 and 19 in Ethiopia were more likely to think about or try to commit suicide than those who didn't. The number of people who thought about or tried to commit suicide increased by 22.5%, and those who tried to kill themselves increased by 16.2%. Youth in Ethiopia are addicted to a lot of different things,

like chat, tobacco, alcohol, with tobacco being used by 4% of young people and alcohol by 45.6% (Oljira 2016:25).

The successful implementation of mental health services interventions may lead to a decrease in the prevalence of mental disorders among young people, such as suicide, self-harassment, and substance misuse; as well as a decrease in homelessness, social exclusion, and involvement in the penal system (Herrman, Humphreys, Halperin et al 2016:1). Young people need an interesting environment with educational resources, friendly and honest staff with professional experience, a space that's easy to get to, shorter waiting times, and attractive services (Hawke et al 2019:2).

2.2.1.3 Nutritional health service utilisation by young people

The result of the study conducted by Tyrrell, Townshend, Adamson and Lake, (2016:292) to explore the environments and food behaviours of young people attending school and college in England to further understand the relationship between eating behaviours and environmental context, indicated that young people do not make themselves ready to participate in home food preparation at their age rather obtain food from outside of their home which further leads to exposure for the change of their behaviour regarding knowledge of healthy eating and food preference. Ethiopia has made significant strides and improvements in health and nutrition in the last 30 years. However, poor nutrition was a persistent problem in 2016 and 22% of women of reproductive age reported being under-nourished, 8% were overweight or obese, and 24% had anaemia (United States Agency for International Development [USAID] 2018:2).

A report conducted by the World Food Program and Central Statistical Agency (WFP & CSA) (2019:IV) showed that there was 36.1% food insecurity of households in the Amhara Region and twenty-two percent of women in the reproductive age were underweight (Body Mass Index (BMI)<18.5). Wasting in young people was found 13.0 percent in Ethiopia and it may last with future chronic health consequences (Environmental News Network [ENN] 2021:81). Even though young people with depression don't always have access to healthy food, it is still seen as a time-consuming and expensive way to prepare and use it (Bayes, Schloss & Sibbritt 2020:1). It is well-known that adolescents and young women living in low-resource environments may experience a variety of micronutrient imbalances (Baxter, Wasan, Soofi, Suhag & Bhutta

2018:103). Chronic malnourishment and anaemia are the most common nutrition related problems among Ethiopian female young people. About 36% of teens aged 15-19 with a BMI of less than 18.5 are chronically underweight, and 13% are anaemic (Oljira 2016:25).

According to Perera (2017:50), poor dietary behaviours were more common among young men than women, and food selection, body image and cost were key determinants of sustainable diets for young people. Providing young woman with the necessary information to make well-informed and healthy choices would be essential for lasting behavioural changes throughout the entire life cycle associated with dietary modifications (Baxter et al 2018:103).

2.2.2 Health service quality

Quality improvement is the process of improving outcomes, reducing costs, improving accessibility and improving care for providers and staff. Access without quality can be seen as a promise of UHC (Kilkenny & Bravata 2021:419). There should be an evaluation of national health service accessibility and quality in order to comprehend where countries can enhance their health service provision (Lancet 2018:2236). Lancet (2018) further asserted that, across the globe, the accessibility and quality of health care, as reflected in the benchmark of health care access and quality (HAOQ), has increased significantly.

In Ethiopia, the quality of health services for teens and young people was still below the WHO's 75% good quality standards. The quality of teen and youth health services was low by 58.8%, 46.4%, and 47.2%. This was due to a few factors, like not having enough and well-trained health service providers, not involving young people enough in the facility management, not having the right guidelines and procedures, not following the national youth health services guidelines, and not meeting the output quality dimensions (Gebrie et al 2021:16) and output dimensions respectively.

Hospital quality should be patient-centric and health care providers should share the right information on a regular basis, as more quality data leads to more awareness and better patient outcomes (Nemati, Bahreini, Pouladi, Mirzaei & Mehboodi 2020:1). Privacy and confidentiality are obstacles to access to quality services (Thongmixay et al 2019:10). Ensuring high-quality health outcomes for teens and young people necessitates the

systemic elimination of these barriers, as well as taking into account factors outside of the health system, such as addressing laws that disproportionately limit youth access to health and social attitudes (Health 2019:749).

High-quality health services are focused on building resilient health systems with the capacity to tackle complex problems through prevention, early detection, early response, peace-building, and economic protection, which in turn leads to improved health outcomes, reduced health disparities, and stronger economic growth (Perehudoff et al 2020:44). In health care systems, young health care providers and young patients have limited or no understanding of health policy and related topics that are important to them (WHO 2018:2). It is therefore essential to enhance the standard of health service delivery at the primary health care level in order to achieve the UHC objective (Malembaka, Karemere, Bisismwa, Balaluka, Altare, Odikro, Lwamushi, Nshobole & Macq 2020:1).

2.3 CHALLENGES IN DELIVERING HEALTH SERVICES TO YOUNG PEOPLE

The public health system is reported to have faced a number of issues at one time, such as the proliferation of services, a lack of personnel, financial and cash-flow issues, a lack of effective communication technology, inadequate information management, and a risk to the quality of patient care (management and leadership) (Malakoane, Heunis, Chikobvu, Kigozi & Kroger 2020:2).

From the socio-ecological perspectives, the researcher reviewed those factors as follows:

2.3.1 Individual (socio-demographic) factors that influence health services for young people

Health services for young people should be accessible, fair, suitable, efficient, and good for their health, but it can be hard to get them up and running due to organisational issues like bad leadership, too much workload, too many people from different places, and not allocating resources fairly (Thomée, Malm, Christianson, Wiklund, Waenerlund & Goicolea 2016:1). The lack of communication between professionals, the inadequacy of equipment, consumable materials, and certain medications can have a detrimental effect on the functioning of the facility, as well as a negative impact on its reputation, resulting

in additional expenses for patients, and a cycle of distrust and resentment, which ultimately leads to a lack of satisfactory customer service (Jaleta 2017:3).

The results of a study conducted by Cambron, Kosterman, Catalano, Guttmannova and Hawukin (2018:369), demonstrated that increased smoking was independently associated with living in more economically disadvantaged neighbourhoods, having a lower family income, having a lower overall functioning of the family, having a more lenient family smoking environment, and being associated with deviant peers.

Factors such as advancing age, gender (male), absence from school, adherence to a particular faith, and the average grade point average predicted the alcohol use (Osuafor & Okoli 2018:79). Marital status and income status were statistically positively associated with utilisation of health services (Workie, Mekonen, Michael, Molla, Abrha, Zema & Tadesse 2021:5). When it comes to health care, there are a lot of social and behavioural factors that can affect young people's decision to use services. These include how people view health care providers, how they view staff, what they believe in, worries about being stigmatised and gossiped about, the design and layout of the facility, limited resources, and how long it takes for the facility to open (Ngwenya, Nkosi, McHunu, Ferguson, Seeley & Doyle 2020:2).

There are some intrapersonal, interpersonal, organisational, social stigma, and policy barriers that can prevent people from accessing health care services. These include a lack of knowledge and experience, cultural and language barriers, structural barriers in health care systems, and lack of insurance coverage (Garney, Wilson, Ajayi, Panjwani, Love, Garcia & Esquivel 2021:1). Young people who had a higher family income, resided with their mothers, were involved in peer-led learning, and resided in close proximity to a health centre had a higher likelihood of engaging in and utilising services. However, those who resided with their fathers and had a lower primary level of education attainment had a lower likelihood of utilising the service (Ayehu et al 2016:1). Oldfield, Humphrey and Hebron (2016:21) revealed that young people tend to seek assistance from peers rather than from family members and are significantly less likely to be subjected to parental supervision. The utilisation of reproductive health services is affected by a variety of elements, such as age, sexual orientation, SRH service data, and prior experiences of visiting a health facility for other health services (Tilahun et al 2012:1).

The onset of substance abuse is most commonly associated with the period of transition known as adolescence, which is characterised by the onset of puberty and physical development, as well as a growing desire for autonomy (Morojele & Ramsoomar 2016:551). According to Latunji and Akinyemi (2018:52), tertiary education, lower household size, higher socio-economy class, service accessibility, and proximity were all positively correlated with good health-seeking behaviours. Using drugs and alcohol can have a huge impact on a person's finances, physical health, and mental health. It can also have a big impact on the family life that comes with living with an addicted teen (Dykes & Caskerb 2021:224). There were a lot of obstacles to getting HIV and SRH integrated, like vertical policy programming and not knowing what policies and guidelines to follow, different provider issues like not having the right training and attitude, and general health system issues like low staff and not having the right infrastructure and privacy to provide these services (Akatukwasa et al 2019:1). Law also plays an important role in ensuring that teens have access to the right services (Susanna & Nina 2019:23). According to a study by Odunayo and Florence (2019:282), the main issue with health information seeking behaviour is the tendency to make pragmatic decisions to address health problems and to seek medical treatment and care within the resources available from an individual perspective.

2.3.2 Socio-cognitive (psycho-social) influences on health services for young people

2.3.2.1 Impact of behavioural factors on young people's access to and use of health services

Latunji and Akinyemi (2018:13) define health-seeking behaviour as anything that people do or don't do when they think they have a health issue or are sick in order to find a cure. Studies show that health-seeking behaviour is closely tied to how healthy a country is and how prosperous it is. The pursuit of health is not a solitary endeavour that is solely motivated by self-interest; rather, it is an integral part of an individual's, family's, or community's identity, which is composed of a variety of social, individual, cultural, and experience-based elements (Ali & Woldearegai 2019:292).

The theory of planned behaviour (TPB) suggests that by looking at and understanding how people's beliefs can change, we can figure out what kind of interventions are needed

to help young people use services, and the socio-ecological model can help us figure out where to focus those interventions (Ngwenya et al 2020:10).

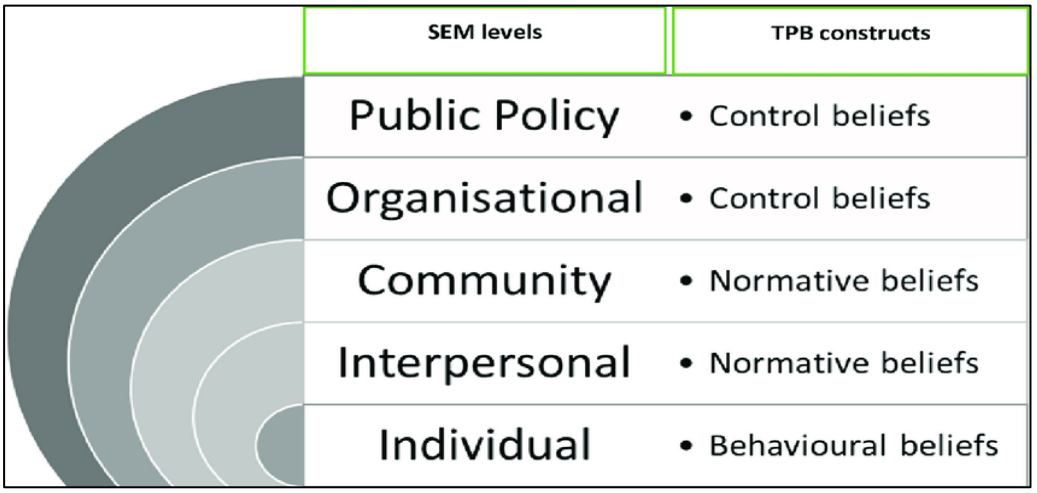

Figure 2.1 Determine social and ecological levels of impact with the related theory of thought patterns of planned behaviour

(Source: https://doi.org/10.1371/journal.pone.0231080.g003)

Adolescents' health-seeking behaviours are affected by a variety of factors, such as the negative outlook of nurses and the local community, peer pressure, a lack of access to medical care, a lack of services available on weekends, long waiting times, remote locations, and a lack of understanding. Common reasons for seeking health care include family planning and prenatal care (Mboweni & Sumbane 2019:67). The EDHS's (2016:13) report showed that young people with physical impairments are frequently, but mistakenly, assumed to be sexually abstinent, drug or alcohol dependent, and at low risk for abuse, violence or rape.

Young people are prone to a lot of health issues, like stress, not getting enough sleep, not having enough sex, not eating right, not getting enough exercise, smoking, drinking, and taking drugs. Plus, they have certain behaviours that affect how they look for health care and how they use health information, and there are some social and professional obstacles that can stop them from getting care (Tran & Silvestri-elmore 2020:1). In addition, alcohol and drug use have been linked to increased risk of promiscuity among young people, which is now a leading cause of HIV/STI transmission (EDHS 2016:8).

2.3.2.2 Beliefs, perceptions and attitudes about health services for young people

Some scholars described perception as a set of inner sensational cognitive processes of the brain at the subconscious cognitive function layer that detects, relates, interprets and examines internal cognitive information in the mind (Agbabiaka & Omisore 2016: 1-5). Utilisation of healthcare services may be largely predicated on how the users perceive the quality of service delivery. A healthcare facility may be available, accessible and even affordable, yet, patients may not utilise it if there is a negative perception of the quality of service. In other words, perception affects utilisation. Perception also affects clients' attitude towards healthcare service delivery and their level of satisfaction with the services available (Sari, Suslu, and Ayaz. 2020: 16-21).

Young people's health is often put at risk due to a lack of respect for their privacy and confidentiality, as well as bad provider practices and a lack of resources (Mulugeta et al 2019:1). Cognitive accessibility (CAC) and psychosocial accessibility (PAA) were identified as the primary barriers preventing young people from accessing sexual and reproductive health services. The cognitive accessibility barriers were low sexual literacy and lack of knowledge about services. The psychosocial access barriers were fear of parents finding out about pre-marital sex and feelings of shame and embarrassment due to negative cultural attitudes (Thongmixay et al 2019:8). There are a lot of social and behavioural factors that come into play when it comes to health providers, like how people view them and think they do not have the right skills, what people believe in, fear of being judged, and gossip (Ngwenya et al 2020:2). The researcher evaluated the perception and attitude of young people towards the services for the young people.

2.3.3 Organisational challenges/factors on health services for young people

In the foreth coming sections the researcher addressed different organisational factors based on the litratures he read through.

2.3.3.1 Health service delivery (intervention approaches and policies, leadership, cost of service, professionals' skill, accessibility, availability of service and resources such as equipment, supplies and drugs)

Interactively applied health services achieve the objectives of physical, psychological and social cares which are met through a multi-disciplinary approach (Howard, Scott, Ju, McQueen & Scuffham 2018:5). In a review by Garney et al (2021:1), organisational or structural barriers in health care systems are leadership related that hinder young people from receiving services. There are a lot of obstacles in the health care system, like bad staff morale, long wait times, dirty places, running out of medicines, not having enough infection control or a bad atmosphere, and a lack of safety and security for both patients and staff (Malakoane et al 2020:1).

Health teams in the institution should provide services needed by the youth in the way that safeguard their life (Oliphant, Veale, Macdonald, Caroll, Harte & Stephenson 2018:16). The professionals should also be skilled enough to effectively respond to the needs of the young people through breaching inappropriate approaches such as lack of confidentiality, having a negative attitude towards sex, drugs, and other substances, as well as being judgmental and intolerant, can lead to discrimination (EDHS 2016:17). Even though being trusted by the client is very important to collaborative service delivery to young people, caring for them with high needs is complex and challenging (Morgan, Pullon, Garett & Mckiniay 2018:1). The service should also pay attention to their requirements, such as evaluating the potential risks associated with drug and alcohol use, sexual health, and mental health issues (Oliphant et al 2018:16).

Lack of availability of the service, Lack of privacy, and inconvenience of the service hours were all reasons for not taking advantage of the service (Ansha, Bosho and Jaleta 2017:110). Shame and fear from health providers, limited information, negative attitudes from health providers, misunderstandings about the services, and lack of privacy were the main challenges preventing young people from using SRH service (Watara, Mumuni, Zuwera, Edward, Iddrisu & Margret 2020:17). The two most significant institutional obstacles were the lack of geographical accessibility and, in particular, the lack of access to youth-specific health services (Thongmixay et al 2019:8).

The results of the study conducted by Mayhew, Sweeney, Warren, Collumbien, Ndwiga, Mutemwa and Lut (2017:iv67) indicated that structural elements, such as the availability of resources, the allocation of personnel and workload, and the rotation of personnel, could influence the delivery of integrated care. Other major expenses for the youth include the cost of medicines and medical tests, as well as other out-of-pocket costs like travel expenses to health care facilities (Kalseth & Halvorsen 2020:435).

2.3.3.2 Mass-media and social-media programmes

Mass media is one way of communication to reach the community to get information (Gashu, Yismaw, Gessesse & Yismaw 2021:2). Mass media campaigns increase knowledge and awareness about issues and behavioural activities like smoking by young people (Stead, Angus, Katikireddi, Hindis, Hilton, Lewis, Thomas, Campbell, Young & Bauld 2019:1). Health service communication through mass media could potentially improve the utilisation of health services for young people (Yaya & Bishwajit 2022:94).

Thornicroft (2018:616) said that mass media can be used to improve understanding of mental health and to change health behaviours such as seeking help. On the other hand, media advertising for mental health and psychiatric care services can have a detrimental effect on the behaviour and utilisation of health care (Cheng, Benassi, De Oliveira, Zaneer, Collins & Kurdyak 2016:e303). The digital age has revolutionised the way people around the world access information, and this has had a significant impact on the perception of health care, the pursuit of information, and the search for the most effective approach to health, particularly among young people (Odunayo & Florence 2019:283).

Young people can get health-service related information through social media from the perspective of developing new and more effective health promotion interventions such as tele-health (Third, Bellerose, De Oliveira, Lala & Theakstone 2017:6). Among the different communication modalities as sources of information; text, e-mail and video chat are important for the young people for using their smartphones to directly contact their care givers to ask a quick question instead of physical visit (Saberi, Siedle-Khan, Sheon & Lightfoot 2016:254). Young people are major users of phone-based internet as a source for sexual health information (Sherifali, Ali, Ploeg, Markle-Reid, Valaitis, Bartholomew & Fitzpatrick-Lewis & McAiney 2018:1). According to a study by Yasine (2020:1), young people who were aware of YFS used them 9.7x more than those who

weren't aware of them. A study by McNamee, Mendolia and Yerokhin (2019:1) found that spending more than 4 hours a day on social media was associated with significantly lower levels of emotional well-being and more behavioural issues.

2.3.3.3 School health programmes (as source of information for young people)

School health programmes can also be referred to as health-promoting schools (Kolbe 2019:446). Schools can potentially act as a source of information for the community, providing precise data regarding the use of substances such as cannabis, alcohol, tobacco, and other drugs, so that educators and parents can continue to deter young people from using these substances (Donnelly & Young 2018:693). Health education and outreach campaigns to promote preventive services are focused on creating a sense of vulnerability and vulnerability among young people (Luquis & Kensinger 2018:1). In addition, communities considered the close connection between health and nutrition interventions and education to be beneficial, as it was increasing the chances of children benefitting from education (Keating, Tadesse, Dejene, Yard, Appleby & Cardwell 2019:11).

Ten interactive elements are included in contemporary school health programmes:

- Education in nutrition
- Ecology services
- Medical services
- Guidance
- Social and psychological services
- External environment
- Emotional and social climate
- Family involvement
- Employee wellness
- Community involvement (Kolbe 2019:443)

Comprehensive sexuality education (CSE) programmes have not been successfully implemented on a large basis, and little progress has been made in educating the most vulnerable young people (EDHS 2016:14). According to Shabani, Moleki and

Thupayagale-Tshweneagae (2018:1), awareness of available health services is a key factor in determining how often young people use them. Young people have low levels of mental health literacy (MHL), which makes it difficult for them to recognise mental disorders and the risk factors, protective factors, and underlying causes that may contribute to them (Hart, Mason, Kelly, Cvetkovski & Jorm 2016:34).

2.4 SUMMARY

This chapter focused on how youth in Ethiopia and other countries perceive health services. This chapter also discussed the utilisation, coverage, quality of health services to young people and the challenges related to the services in the globe at large and in Ethiopia in particular. In doing so, relevant literatures were discussed. The intensive and extensive discussion of related literatures revealed similarities in factors relating to the utilisation, coverage, and quality of the health services to young people.

CHAPTER 3

METHODOLOGY OF THE STUDY

3.1 INTRODUCTION

Chapter 2 discussed the literature pertinent to development of strategies to improve health care services for young people. It addressed the views of other researchers about the utilisation and challenges of health services for young people.

This chapter provides an overview of research design and methods involved in the study to evaluate the specific health services and to explore challenges for health care services provision for young people. It also addressed the broad range of data collection methods available and organizes them according to their predetermined or emergent nature, whether they are closed-ended or open-ended, and their emphasis on numerical versus non-quantitative data analysis (Creswell 2017:34).

3.2 RESEARCH PARADIGM

A paradigm refers to a set of common rules and ideas about how a researcher perceives reality, known as ontology, or how a researcher understands reality, known as epistemology, or a combination of different methods used by scientists to investigate different situations, known as methodology. (Creswell & Poth 2018:35). Pragmatism is a way of looking at things that gives researchers the freedom to pick the methods, techniques, and procedures that work best for them and their goals. This is what the researcher used to carry out the mixed method research (Creswell 2017:30). Pragmatism uses both induction and deduction to explore the many, multiple perspectives on the issue and the questions asked in the research (Cohen et al 2018:532).

The researcher employed the pragmatism lens to assess and recognise the difficulties associated with the provision of health services to young people, as well as to provide methods to comprehend their impact on the endeavour. The researcher tried to cope with the psychological risks by giving all the information they needed with detailed explanations about what they were doing and why they were doing it.

3.3 STUDY APROACH

Research approaches are the plans and procedures for research that progress through the stages of conceptualisation (broad presumptions), data collection and analysis, interpretation, communications and reporting. A mixed methods approach incorporates quantitative and qualitative data into a single study and offers benefits in terms of completeness, practicality and increased credibility (Polit & Beck 2018:309).

Mixed methods involve combining qualitative and quantitative techniques in each of the five stages of a research study (planning, designing, collecting data, sampling, analysing, and drawing conclusions) (Creamer 2017:49). In this study, we used mixed methods to frame the data (in both words and figures) and design the questionnaire (both open-ended and closed-ended).

3.4 RESEARCH DESIGN AND METHODOLOGY

A research design, based on the principle of ‘fit for purpose’, is a methodology or approach designed to structure and facilitate research, so that research issues can be addressed using a rationale and evidence framework (Cohen et al 2018:173). The research design establishes the relationships between the objectives, goals, data and results of the research, as well as the evidence necessary to support the objectives, goals and questions of the research (Cohen et al 2018:175). Research designs and types of inquiry can be divided into three main categories: qualitative, quantitative, and mixed method approaches, which provide concrete guidance for research study activities (Creswell 2018:56). The best way to design a study depends on a few things, like if it's feasible, what kind of people you're looking at, how much money you're looking to spend, and how long you want your study to last. (Eyler 2021:10).

3.4.1 Mixed methods research

A Convergent mixed methods approach combines qualitative and quantitative data collection and analysis at approximately the same time, combining the results and incorporating the information into the interpretation of the overall results (Creswell 2017:181). Most of the time, the answers to the questions in the quantitative data are closed-ended, while the questions in the qualitative data are open-ended and don't have a set answer (Creswell 2018:51). Therefore, stronger understanding about the problem or the question is best addressed with mixing or integrating of data than in qualitative or quantitative method alone (Creswell 2018:294). In this research, the researcher employed a convergent parallel mixed method approach to resolve research queries and determine if the quantitative and qualitative outcomes concur or contradict one another (Creswell 2017:181).

3.4.2 Phases to conduct the research

3.4.2.1 Phase1: Empirical phase

Quantitative component

Cross-section designs are great for collecting data all at once and they are really cost-effective (Polit 2018:225). Cross-section designs provide indirect indications regarding the nature and frequency of alterations in physical and cognitive development of samples, however, they may not be appropriate for the investigation of developmental trends and causal relationships within cohorts (Cohen et al 2018:348).

The researcher applied cross-sectional design to collect quantitative data to evaluate the practice and identify challenges regarding the health service for young people in East Gojjam, Ethiopia.

Qualitative component

Theoretically, phenomenology is a methodology used to comprehend human life experiences and investigate subjective phenomena, with the conviction that fundamental truths about the world are grounded in human experience. According to Polit (2018:276),

the four stages of descriptive phenomenology are bracketing, intuition, analysing, and describing. The researcher employed descriptive phenomenology for the Qualitative strand of the study to illustrate the difficulties young people face in accessing health care services in East Gojjam, Ethiopia.

3.4.2.2 Phase 2: Strategy development phase

The strategy development process includes analysing the process and results of data, as well as making systematic changes to improve performance by setting national objectives, creating a service quality definition, and incorporating situational analysis into a big stakeholder engagement process. The objective of the process is to build capacity and promote advocacy in order to enhance the quality of service and foster a culture of excellence throughout the health system (Lehtimaki et al 2019:15). According to Centre for Management and Organisation Effects (Centre for Management and Organisation Effectiveness [CMOE] (2020:2) says that the process of strategy development includes collecting objective data, looking at the current strategy, looking at what needs to be changed, finding new strategy tools, coming up with a tailored strategy development process, setting the groundwork for the process, getting the results you want with the help of experts, and setting up accountability teams and success metrics.

In this study, the current national health guidelines presented in the health institutions to deliver health care service for young people were examined, the needed changes were reviewed and the strategy tools for the development process were identified. Public health expert team was established to achieve the desired result and finally the result was measured through key health service performance indicators (KPIs).

3.4.2.3 Phase 3: Validation of strategies

In order to validate the strategies, the Delphi technique was employed. The Delphi methodology involves a group of experts who are tasked with completing multiple rounds of questionnaires that focus on their assessment of a particular subject matter through multiple interviews (Polit & Beck 2018:319).

The researcher applied the seven steps of the Delphi technique to verify the usability of the strategies.

Step 1: Choose a facilitator. The first step is to choose a facilitator. The researcher facilitated the Delphi data collection.

Step 2: Identify your experts. The researcher used the public health experts from the Health Districts in East Gojjam Zone, Ethiopia. A sample of twenty managers from health districts and health care institutions that did not take part in the study were purposefully selected and asked to participate in the Delphi technique to validate the strategies.

Step 3: Define the problem. What is the problem or issue you are seeking to understand? The researcher explained the problem to the experts and explained the process to follow in validation of the developed strategies.

Step 4: Round 1 − questions were asked, to seek the initial response from the experts.

Step 5: Round 2 − questions. To seek clarification / probe the responses given in round 1.

Step 6: Round 3 − questions. To seek the way forward regarding the recommended solutions in round two. Because a full consensus reached at second round, only the first and second rounds were conducted in the study.

Step 7: Act on the findings. Comments and suggestions from the experts were considered to finalise the strategies during the validation process. Once the consensus was reached, the researcher considered the strategies to be published.

3.4.2.4 Phase 4: Integration phase

The integration phase can be either side by side (presents first one set of the finding & then the other), transformation (transforming qualitative codes into quantitative) or joint display (use of table or graph) to merge the two data sets (Creswell 2017:182). After independent quantitative and qualitative analysis, the integration or merging occurs at the interpretation and reporting stage, which is the combination of the results of both qualitative and quantitative findings (see Creswell, 2017: 182). According to Creswell, there are several methods of merging results: Side by side comparison: where the researcher reports either quantitative or qualitative results first and then compares

whether the results support or contradict each other. Qualitative code or theme transformation: transforming or changing the code or theme into a quantitative variable and then combining it with the other quantitative variable. Joint display or merging: where two data sets, such as a table or a graph, are presented together. In the present research, qualitative codes were converted into quantitative variables, and both quantitative variables were merged.

In this study the quantitative and qualitative data were analyzed separately and were transformed to mix the results at interpretation and reporting phase (Cohen, Manion & Morrison 2018:314).

3.5 STUDY SETTING, TARGET POPULATION, STUDY POPULATION, SAMPLING AND SAMPLE SIZE

3.5.1 Study setting

The study setting plays a critical role in a research study, encompassing the characteristics, context, environmental conditions, and logistical aspects of the study environment and having an impact on the conduct of the research study (Majid 2018:3). It is where the research takes place (Creswell 2017:158).

In the scope of this study, nine hospitals were included in the study setting. According to East Gojjam Administrative Zone Communication Affairs Office (2018), the geographical location of East Gojjam Zone is 300 km from Addis Ababa. East Gojjam is one of 11 Zones in the Amhara Regional State. East Gojjam Zone consists of 16 Districts and 4 Administrative Towns. It has a population of 2,397,876 of which 2,123,101 lives in rural areas and 274,775 in towns and of which 49.6% are females and 50.4% are males with annual projection of 1.8% per year. From the total population 47% are young. The hospitals cater for secondary services and rehabilitations. The health centres cater for the primary health care services, mainly preventative and promotive health services (East Gojjam Zonal Health Bureau 2019:3).

3.5.2 Target population

Asiamah, Mensah and Oteng-Abayie (2017:10) defined target population as a subset of individuals or groups with particular characteristics of interest and significance. The target population of this study comprised all young people in East Gojjam.

3.5.3 Study population

The part of the population that is available to the researcher, referred to as the accessible population or study population (Polit & Beck 2018:243). The present research had different study populations for two phases based on the methods of data collection used for the two strands. The data collected from the populations in the two strands were transformed (transformed qualitative codes into quantitative or jointly displayed using table or graphs) to mix the results at interpretation and reporting phase (Cohen et al 2018:314).

Quantitative strand

For the Quantitative strand, young people who were coming to the health institutions to get the health care services were the study population for the survey and health institutions were the study population for the observation questionnaires.

Qualitative strand

For the qualitative strand (interviews), the study population was composed of young individuals.

3.5.4 Site of the study

The population sites of the survey, the focus groups and the individual interviews were public health institutions in East Gojjam Zone.

3.5.5 Sampling

The process of sampling involves the extraction of a subset from a selected sampling frame or a sample of a population in order to make inferences about the population or to generalise the results in relation to existing theories (Taherdoost 2017:4). As both quantitative and qualitative sampling techniques were employed in this study, both probability sampling methods and non-probability sampling methods were employed.

3.5.5.1 Sample size for quantitative strand

The study area, East Gojjam Zone, was randomly selected using lottery method from a total of eleven zones in Amhara region. There are nine governmental hospitals in the zone. The hospitals were taken purposefully for their client flow and variety of services they provided for the young people which made the evaluation of the services and the gaps more descriptive than in the other public and private health institutions.

The process of systematic sampling involves taking the population size and dividing it by the desired sample size to determine the sampling interval, from which each k^{th} case is selected from a list to draw a random sample (Polit & Beck 2018:247). The researcher randomly chose the people to answer the questions using probabilistic sampling.

An estimate of an average monthly young people's flow, taken from six consecutive months' registry, in nine public hospitals was 678 (East Gojjam Zonal Health Bureau 2019:5).

Total (study population) size=678x9=6102

Sample size formula for quantitative strand using Cochran's equation (Glenn 1992:3) is as follows:

$$n = \frac{(z_{\alpha/2})^2 p\,(1-p)}{d^2}$$

Where: n=sample size; p=health service prevalence for young people taken from previous study by Kerbo et al (2018:1)=46.9%; d=degree of accuracy expressed as proportion (0.05).

Based on the above formula: $n= (1.96)^2 0.469 (0.531)/(0.05)^2 =383$.

To fill the gaps in non-response or ineligible rate during the actual survey, the researcher increased the sample size by 10% contingency. Then n became 383+10% (383)=383+38.3=441 and it was equally allocated to the nine hospitals; 441/9=49 sample units to be taken from each hospital.

3.5.5.2 Inclusion and exclusion criteria for Quantitative strand

Criteria for the inclusion and exclusion of study subjects include features that sample units have to be incorporated in the accessible population (Gray, Grové & Sutherland 2017:331).

Only purposefully selected health institutions were included.

- Young people of age 15-24 years who came to the hospitals were included.
- Respondents who were not able to respond due to critical illnesses were excluded.

3.5.5.3 Sampling for qualitative strand

Qualitative methods are informed by purposeful sampling, and the goal of qualitative research is to deliberately select participants or locations (documents or visuals) that will best serve the researcher's understanding of the issue and the research question (Creswell 2017:158). Purposeful selection of participants was also applied in the present research to address the questions and obtain insights into the phenomenon studied. Participants for the four focus group discussion and eleven in-depth interviews were taken from clients coming to the health institutions who fulfil the inclusion criteria.

Table 3.1 Distribution of FGD and in-depth interview participants across the study setting

Group	Pseudo name (codes for each participants)	Sex	Age	Residence	Education level
Group 1	P1	F	18	Urban	Level-4
	P2	F	19	Rural	12 complete
	P3	M	23	Rural	Grade 10
	P4	M	18	Rural	Grade 9
	P5	M	24	Urban	Level-4
	P6	M	23	Urban	Grade 6
	P7	F	24	Rural	College
	P8	F	18	Rural	1st Degree
Group 2	P1	F	18	Urban	Level-4
	P2	M	19	Rural	12 complete
	P3	M	20	Rural	Level-4
	P4	F	19	Rural	Grade 9
	P5	M	21	Urban	Level-4
	P6	F	22	Urban	Grade 5
	P7	F	16	Rural	College
	P8	M	19	Urban	Level-4
	P8	F	18	Urban	1st Degree
Group 3	P1	M	19	Rural	Level-4
	P2	F	18	Urban	12 complete
	P3	M	21	Urban	Degree
	P4	F	19	Rural	Grade 11
	P5	F	20	Urban	Level-4
	P6	F	21	Urban	Level-4
	P7	M	18	Urban	College
	P8	M	18	Urban	Level-4
	P9	M	20	Rural	12 complete
	P10	F	19	Urban	1st year BSc nursing
Group 4	P1	F	19	Urban	12 complete
	P2	F	20	Urban	12 complete
	P3	M	24	Urban	Degree
	P4	M	19	Urban	Grade 11
	P5	F	20	Urban	12 complete
	P6	M	19	Urban	Level-4
	P7	F	18	Urban	12 complete
	P8	M	20	Rural	Level-4
	P9	F	20	Urban	12 complete
	P10	M	18	Rural	Level-4
Indepth-Interview	I1	23	F	Urban	Grade 10
	I2	22	F	Urban	2nd year midwifery
	I3	21	F	Rural	Degree
	I4	20	F	Urban	12 complete
	I5	18	F	Urban	Level-4
	I6	20	F	Urban	Grade 7
	I7	20	M	Urban	12 complete
	I8	20	F	Rural	Level-4
	I9	21	F	Urban	Level-4
	I10	18	F	Rural	12 complete
	I11	18	F	Urban	Grade 7

3.5.5.4 Sample size for qualitative strand

Creswell (2017:158) proposed two ways to figure out the size of a qualitative sample. The first is that there are some rough estimates of sample size from qualitative research studies, ranging from 3 to 10 for phenomenology. The second approach focuses on the concept of saturation, which is the point at which data no longer provides new insights or reveals novel characteristics. To assess and report data saturation accurately, a minimum of 13 study participants were selected, 10 interviews and 3 additional interviews to demonstrate that there were no new themes emerging from the data) (Francisa, Johnston, Robertsona, Glidewella, Entwistlec, Ecclesd & Grimshawe 2010:1229-1245). Focus group interviews involve a group of people, usually between 5 and 10, who are asked questions about their thoughts and experiences at the same time (Polit & Beck 2018:297). The researcher employed four focus groups with a total of 36 participants, and eleven in-depth interviews. The researcher adhered to the principle of saturation, so that no additional data was collected for the FGD and for the in-depth interviews (Polit & Beck 2018:103).

3.5.5.5 Inclusion and exclusion criteria for qualitative strand

- Purposively selected participants of age 15-24 years who were voluntary to sign a consent form to participate in the focus group discussion (FGD) and in-depth interview were included.
- Telephone participation was excluded for fear of the incompleteness of the information due to network problem of the nation and their geography of residence.
- Document analysis was excluded, as it cannot suits with this strand.
- Participants who terminated the participation due to any reason were excluded.
- Youth under 18 years of age who did not have the filled parental assent forms were excluded.

3.5.6 Variables in the study

Two set of variables were used in this study:

3.5.6.1 Independent variables

- **Predisposing factors**

  - **Demographic factors**

    - It includes age, sex, and language, level of education, marital status, religion, residence or transport access, income, occupation, and experience or exposure of the respondents.

  - **Institutional factors**

    - It includes costs, number of skilled professionals. Professional training, inadequate budget allocation, policy, leadership & management, condition of the work environment, availability of service provision unit, material resource, provider-client relationship and pprofessional attitude.

- **Psycho-social factors**

  - It includes behaviour, belief, perception and attitude to the services.

- **Enabling factors**

  - Quality health care including safety, effectiveness, appropriateness, client participation, accessibility, efficiency , confidentiality and consent, competence, information management, service continuity, evidence-based medicine, education & training and take holder participation.
  - Coverage of health service including sexual and reproductive health, mental health and behavioral health and nutritional health services

3.5.6.2 Dependent variable

- Health service utilisation

3.6 DATA COLLECTION METHOD(S) AND PROCEDURE

The researcher collected both data types at the same time, with help from research assistants, and used the data to make sense of the results. Any discrepancies or unexpected findings were explained (Creswell 2017:34).

3.6.1 Quantitative component

In this phase, the researcher collected quantifiable and structured data (Polit & Beck 2018:250). Self-administered questionnaires were used as an economical approach to conduct a survey for the Quantitative strand (Polit & Beck 2018:318). Considering the advantages and its fitness to the design selected for quantitative strand, an agreement with WHO for standardised tool had been achieved and the researcher modified and used the tool to fit the context. The researcher also developed a survey checklist for the quantitative data. Pilot testing was held for the 22 questions (13 knowledge and 9 attitude-based) on 10 young people of age 15-24 (young people). The pilot test was done in July 2022 and its purpose was to evaluate the readability of the questionnaire, to identify typographical issues, to evaluate the usability of the proposed time frame, and to evaluate the reliability of the questions using the Cronbach's test. There was no correction made on the questions and all passed the test with Cronbach's alpha value 0.823, which is statistically acceptable because it was greater than 0.7.

Through single day training conducted on 08 July 2022 in Debremarkos town, two data collectors were adequately prepared about the purpose, objectives, and how to take corrective measures on problems during the data collection process. Close supervision was done by the researcher during the data collection procedures and challenges faced were corrected soon.

3.6.2 Qualitative component

Qualitative research involves the collection of data through qualitative observation, qualitative interviews, qualitative documents, and qualitative audiovisuals and materials (Creswell 2017:158). Descriptive phenomenology is a way of looking at people's day-to-day lives and mainly focuses on what we know about ourselves (Polit & Beck 2018:276).

In this study the researcher, through a descriptive phenomenology approach for both in-depth interview and FGDs from the young people, collected qualitative data with the aid of an interview guide. Pilot testing was applied to test the guides. An Amharic version of the tool was delivered.

Demographic data (sex, age, resident and educational background) were obtained from the FGDs and in-depth interviews. The participants were selected purposefully. The qualitative data was collected from four hospitals. The hospitals were purposively selected from the Zone. The total average time taken for the FGDs was 49 minutes. The minimum amount of time was 40 minutes, and the maximum was 58 minutes. For the in-depth interview, the total average time taken was 47 minutes. The minimum duration was 43 minutes, and the maximum duration was 1hour. Ethical principles were ensured through-out the courses. Those who did not sign the consent and/or assent forms did not participate. Those who were voluntary to be audio-recorded were allowed to engage. Participants presented their experiences in the form of responding to open-ended questions. Data collectors were adequately prepared for the one-on-one interviews and the role they could assume in the data collection process. The focus group discussions and interviews were recorded with audio recorders as well as the in-depth interview. Field workers helped out with handing out the info sheets, getting people to sign them and taking notes. The audio was saved to a laptop computer and ready to reduce the probability of losing data and to put them as a backup file. The collected information was transcribed and later translated into English language by linguistics. The moderators supervised the overall data collection process.

3.7 DATA ANALYSIS METHOD

3.7.1 Data analysis for quantitative strand

Data was cross-checked for completeness, cleaned, coded and cross-checked for accuracy. Where data was missing, the average score of total number of answers was used to address the missing data. The descriptive statistics including frequencies and cross-tabs for the items were calculated by computer and presented in Tables and Graphs. Descriptive multiple logistic regression was performed with a p-value <0.05 to establish statistical significance. The data were evaluated using Statistical Package for the Social Sciences (SPSS) Version 28. Odds ratios and 95% confidence levels were

estimated to assess the strength of the association between study variables through multivariate logistic regression (MPR). Statistical significance was declared when p-value <0.05.

3.7.2 Data analysis for Qualitative strand

The researcher analysed the qualitative data supported by Atlas-ti software with manual assistance and following the seven steps in Colaizzi's data analysis method for descriptive phenomenological study (Morrow, Rodriguez & King (2015:643).

- The researcher thoroughly reviewed all participant accounts multiple times in order to gain a comprehensive understanding of the data (familiarisation).
- The researcher determined that all statements are directly pertinent to the subject matter of the study (identifying significant statements).
- The researcher identified meanings pertinent to the phenomenon that resulted from a thorough examination of the relevant statements. The researcher retrospectively "wrapped" his prior assumptions to adhere to the experience of the phenomenon (formulating meanings).
- The researcher grouped the meanings found into common themes across accounts. Again, it was important to bracket pre-positions, particularly to avoid being influenced by existing theories (clustering themes).
- The researcher wrote a complete and comprehensive explanation of this phenomenon, including all the topics mentioned in step 4 (developing an exhaustive description).
- The researcher has condensed the comprehensive description into a concise, succinct statement that outlines only those elements that are considered necessary for the conceptualisation of the phenomenon (producing the fundamental structure).
- The researcher then sent the basic structure statement back to all participants to determine if it accurately reflected their experience and if they could go back and revise previous steps in the analysis (seeking verification of the fundamental structure).

3.7.3 Delphi method analysis

The health managers answer multiple rounds of questions, and their answers were summarised and distributed to the group after completing each round.

3.8 ENSURING RIGOUR

Doing social research with rigour is an ethical issue (Iphofen & Tolich 2018:361). The objective of rigorous research techniques is to reduce or eliminate any bias in order to guarantee data quality (quantity and validity of measures) in quantitative research and transferability, as well as credibility, dependability, and conformability in qualitative research (Polit & Beck 2018:121).

3.8.1 Quantitative strand

Validity: The researcher increased the validity of the study through piloting and training the data collectors, stating the independent variables accurately to produce the observed effect and focusing on matching the evaluation result to the goals and objectives (to increase internal validity). In addition, the researcher made clear explanation of independent variables to increase external validity. The criterion validity of the instrument was ensured if its scores correlate highly with scores on criteria. Three substantive experts were consulted to assess and document the content of the questionnaire. Construct validity was achieved by correctly handling the variables of interest.

Reliability: In order to ensure the reliability of the instrument, the researcher applied three measures: conducted chi-square reliability test, ensured that definitions of the variables measured were precise through pilot test so that they were clear, unbiased and were to be accurately measured and translated the questionnaire into the language that all participants can understand.

3.8.2 Qualitative strand

In order to conduct this study, the researcher meticulously organised and conducted a series of semi-monthly interviews, taking into account the four-dimensional

trustworthiness criteria and considering a variety of ethical issues at all stages, taking into account all aspects of their application. These criteria are illustrated below:

Credibility: On average, interviewers spent 45 minutes for every FGD. The researcher verified whether the investigators had sufficient knowledge and research capabilities to carry out their tasks. He also made sure that the interviewer provided and returned the notebook. He held regular debriefings to self-correct and improve performance.

Dependability: The researcher ensured reliability by creating comprehensive draft protocols for the duration of the study, creating a comprehensive record of the data acquisition process, and quantifying coding precision and dependability.

Conformability: The researcher conducted weekly investigators meetings. The researcher will apply triangulation techniques.

Transferability: To ensure transferability, the researcher used a purposive sampling technique. The researcher also quantified operational and data saturation.

3.9 ETHICAL CONSIDERATIONS

3.9.1 Permission to conduct the research

The researcher requested for the permission letter from Amhara Regional Health Research and Technology Directorate Director and the zonal health department in order to conduct the research at the health institutions (Annexure D). The researcher also asked permission from the specific institutions based on the letter written from the directorate (Annexures E-N).

3.9.2 Avoiding harm to participants

Ethical considerations in all research studies involve protecting human participants through the use of appropriate ethical principles. Ethical considerations are particularly important in a qualitative study because of the detailed nature of the study (Creswell 2017:88).

3.9.3 Ensuring informed consent

Informed consent means alerting participants to the nature of the study and formally soliciting their volunteerism in participating in the study (Yin 2018:126).

The College Ethics Committee of the University of Southern Africa (UNISA) has given its approval for the study to be conducted (Rec-240816-052 Number: CREC Reference #: 46340262_CREC_CHS_2022) (Annexure A). Additionally, a letter of authorisation has been obtained from the Regional Health Research and Technology Directorate of Amhara (Annexure D), as well as the Eastern Gojjam District Health Department, to carry out the study (Annexure F).

Written assent form for the guardians of the participants and informed consent for all 15-24-year-olds participants were provided with the questionnaire in Amharic version (Annexure R). They were provided with sufficient time to comprehend the concept and were informed that the stored data would be used for future purposes if necessary. After a comprehensive explanation, only the volunteers voluntarily signed and took part in the process (Annexure P). Furthermore, they were informed that they could withdraw at any time without any inconvenience (Annexure O).

3.9.4 Ensuring privacy and anonymity

The most secure way to protect your information is to remain anonymous. This means that any information you provide will not be published in a way that makes you visible to the public and will not be disclosed to third parties (Polit 2018:267).

In this research, there was an agreement with statistician and co-coder to keep the data and the overall process confidential (Annexure X, Y,). Confidentiality binding agreements with field workers (research assistants) also was signed to keep the information obtained during data collection confidential (Annexure Z).

Confidentiality was maintained; the FGDs and in-depth interview were scheduled and conducted based on mutual agreement; appropriate COVID-19 protection principles were applied before, during and after data collection and no further harm was anticipated. The researcher attempted to handle the psychological threats/increase the participants'

confidence by providing information through intensive explanations about the aim and the purpose of study. Psychological help or arrangement for referral was set for those participants who might be distressed. Confidentiality also was ensured in such a way that the questionnaire did not have a space to fill their participants' names and only was possible through numerical codes. Focus groups and interviews were conducted at secured settings.

Anonymity was ensured in such a way that the questionnaire does not have a space to fill their participants' names and only was marked through numerical codes. Possible data protection effort was applied for its confidentiality. Research assistants signed the agreement. This data was used strictly for the purposes of the study (Annexure Z).

3.9.5 Risks in the study

The study involved direct human participants. As stated in risk category 3, minor discomfort or inconvenience occurred, and it did not pose a risk above the everyday norm. Confidentiality of the information was ensured. The participants did not receive direct benefit from participating in this study, but through their participation, they were equipped in identifying factors that affect their psychosocial wellbeing, and in doing so they were able to cultivate better support systems when addressing health services delivered to young people.

3.9.6 Information to the parents and the young people

Participants and their parents feared for leak of their personal information. Therefore, the researcher followed the following steps provided both in English and Amharic versions:

Firstly, the researcher informed them to be confident enough and not to be disturbed by such psychological stressors which stroke their mind.

Secondly, the trained data collectors helped to offer support or counselling to participants if distressed during the data collection process.

Thirdly, safe storage arrangement of data took place so that there was no fear of information leakage.

Fourthly, pre-arrangement with the emergency department or unit of the institution was made if in-case, unexpected event occurs, to alleviate the cause and let the participant come to the initial status.

The study did not involve invasive procedures on psychological assessment. Thus, no harm was expected. The researcher made prior arrangements with the site, for participants to be referred to the psychology department of the health institution for counselling in case of emotional distress.

Because of a low economic status of the participants, non-availability of online connectivity and gadgets, face-to-face data collection methods was applied. Therefore, all COVID-19 related prevention measures were adhered to by the researcher, participants and co-researchers, to prevent cross infection during data collection:

- Information on prevention including distancing, transmission, sign and symptoms and management of COVID-19 for data collectors was provided.
- Distancing was ensured during transportation by using non-public transport and conducting the interview/ discussion outside in open space.

3.9.7 A description of the procedure for obtaining consent from participants

The researcher requested permission from Amhara Regional Health Research & Technology Directorate Director and from the Head of East Gojjam Zone Health Department to conduct the research in the study areas. The researcher also requested the permission to access the patient registers within the specific institutions (Annexure C).

For the quantitative and Qualitative strands, the researcher obtained the written consent and/or assent through the following process:

The researcher addressed the recruitment letter/letter for participation to the participants' and parents. Then, the researcher clearly explained all the risks and benefits of participating in the study and did get their voluntary response. In addition, the researcher frequently assessed the prospective participants' understanding by asking appropriate

questions and allowed them ample opportunity to read and ask questions if not clear. No incentive was given to participants.

3.10 SUMMARY

This chapter focused on the research paradigm, the study approach, the research design, the research methods, the target population and the study populations, the sampling, the data collection techniques and procedures, the data analysis techniques and the rigour and ethical aspects of the study.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF QUANTITATIVE FINDINGS

4.1 INTRODUCTION

Chapter 3 discussed the methodology in detail. This chapter focuses on the analysis of quantitative data. The quantitative data was collected through questionnaire from the young people who came to the hospitals during the data collection time. The Amhara Regional Health Research and Technology Directorate, the East Gojjam health department and district offices gave permission to the researcher to conduct the study (Annexures D - N).

4.2 QUANTITATIVE APPROACH

This research was done in the East of Gojjam in Amhara province, Ethiopia at nine hospitals. There were 423 survey questionnaires given to the respondents and completed after careful instructions given by the data collectors. But, due to different factors which affect the response rate for survey research (Nayak & Narayan 2019:31), only 418 questionnaires were returned. The response rate was 98.8 % in this study, and it is considered very well. Data was entered, cleaned and analysed using SPSS Version 28 software.

Descriptive and inferential statistical analysis was applied in the study.

4.2.1 Descriptive statistics

4.2.1.1 Descriptive presentation for quantitative results for the sampled participants

In this section, the socio-demographic information of the participants, including their gender, age, place of residence, marital status, level of education, religion, ethnicity, and participation in religious activities, is described.

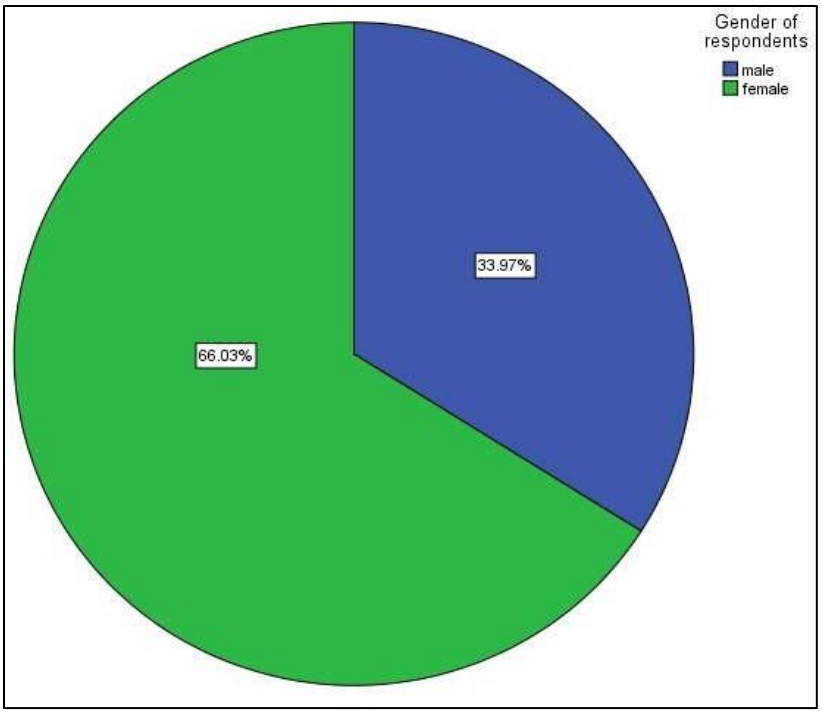

Figure 4.1 Participants' gender (N= 418)

As shown in the above figure, most of the participants in the study were females. They account 66.03% (n=276) of the total sample whereas the males were 33.97% (n=142).

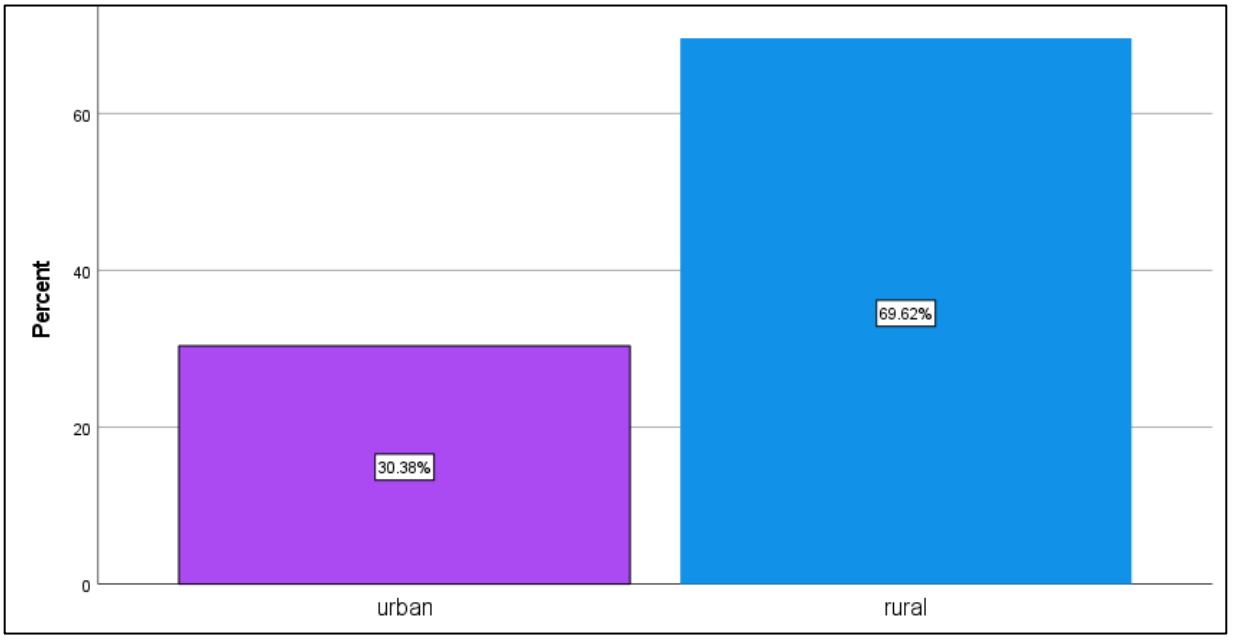

Figure 4.2 Participants residence (N= 418)

As shown in the above figure, majority of the participants, 69.62% (n=291), came from rural areas and the remaining 30.38% (n=127) were from the urban parts of the Zone.

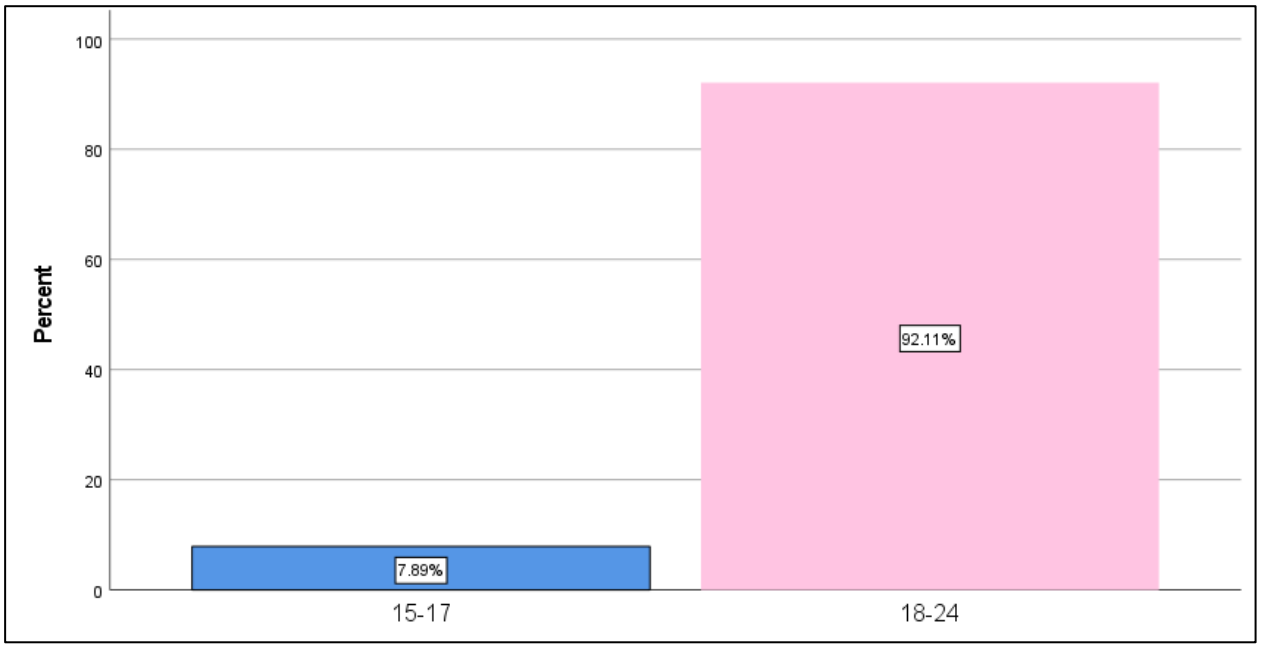

Figure 4.3 Distribution of participants by their age category (N= 418)

The aforementioned graph revealed that the majority of participants, 92.11% (n=385) were between the ages of 18 and 24 and that just a small percentage, 7.89% (n=33) were between 15 and 18-years-old. The participants' average age was 21.62, with a standard deviation of 2.465.

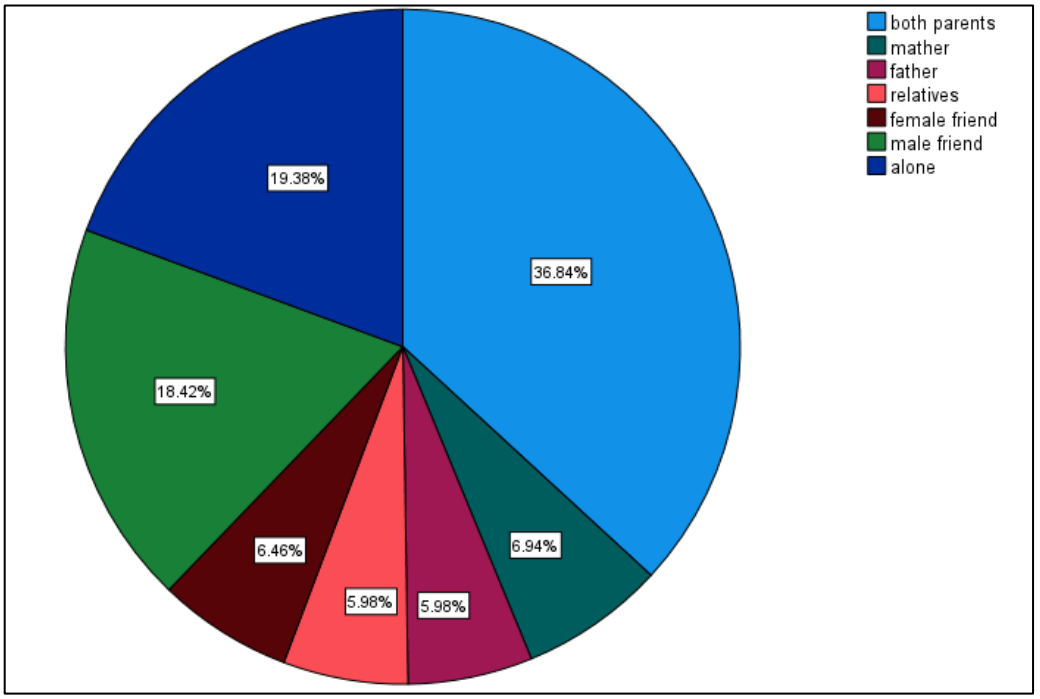

Figure 4.4 Percentage of young people with whom did they live (N= 418)

The above figure showed that from the total 418 respondents, 36.84% (n=154), were living with both parents; 6.94% (n=29), were living with their mother; 5.98% (n=25), were living with their father;5.98% (n=25), were living with relatives; 6.46% (n=27), were living with female friend; 18.42 % (n=77), were living with male friend and 19.38% (n=81), were living alone.

Table 4.1 Other demographic characteristics of participants in the study (N=418)

Demographic characteristics	Attribute of variables	Frequency	Percentage
Marital status	Married	134	32.1
	Unmarried	195	46.7
	Widowed	89	21.3
Educational level	Illiterate	137	32.8
	Primary	98	23.4
	Secondary	65	15.6
	College and above	118	28.2
Religion	Orthodox	364	87.1
	Muslim	43	10.3
	Protestant	11	2.6
	Catholic	0	0.0
Religious participation	More than two times per month	147	35.2
	Up to two times per month	116	27.8
	No participation	155	37.1
Importance of religious participation	Very much useful	254	60.8
	Useful	87	20.8
	No use	77	18.4
Ethnicity	Oromo	50	12.0
	Amhara	337	80.6
	Other	31	7.4
Participation in day/night party	Yes	234	56
	No	184	44
Getting money	Yes	208	49.8
	No	210	50.2

As shown in the above table, from the total respondents, 134 (32.1%) were married, 195 (46.7%) were unmarried and 89 (21.3%) were widowed. Regarding the educational level of the participants, 137 (32.8%) were illiterate; 98 (23.4%) were primary, 65 (15.6%) were secondary and 118 (28.2%) attended college and above. Most participants 361 (86.4%) were Orthodox Christian. Regarding the religious participation of the respondents, 147 (35.2%) did participate more than two times per month, 116 (27.8%) did participate up to two times per month, and 155 (37.1%) did not participate at all. Most participants 254

(60.8%) also believed that religious participation was very much useful for young people. From the total respondents, 234 (56%) participated in the day/night party but the rest 184 (44%) did not. Half, 210 (50.2%), of the respondents did not get money.

Table 4.2 Sexual activity, RHS knowledge and health worker contact (N=418)

Description	Response N (%)	
	Yes	No
a. Sexual activity (N=418)		
• Sex with multiple sexual partners (>2) (N=418)	157 (37.56)	261 (62.44)
• Sex with one partner (N=418)	146 (34.93)	272 (65.07)
• No sex (N=418)	115 (12.92)	303 (72.48)
b. Forced sex (N=303)	74 (24.42)	229 (75.58)
c. Utilised contraceptive methods (N=303)	99 (32.68)	204 (67.33)
d. Having information about any reproductive health services (N=418)	151 (36.1)	267 (63.9)
e. If the answer is yes for above, then having SRH service knowledge about (n=151)		
• Contraceptive methods	53 (35.1)	98 (64.9)
• Treatment for sexually transmitted infections (STDs)	53 (35.1)	98 (64.9)
• Voluntary counselling and testing (VCT) for HIV/AIDS	86 (57)	65 (43)
• Safe abortion care services	45 (29.8)	106 (70.2)
• Post abortion care services	45 (29.8)	106 (70.2)
• Antenatal care	50 (33.1)	101 (66.9)
• Postnatal care	32 (21.2)	119 (78.8)
f. Source of information for the SRH services (n=151)		
• Parent talk	42 (27.8)	109 (72.2)
• Teacher (schools)	88 (58.3)	63 (41.7)
• Health workers	94 (62.3)	57 (37.7)
• Friend	34 (22.5)	117 (77.5)
• Newspaper	38 (25.2)	113 (74.8)
• Posters	29 (19.2)	122 (80.8)
• Mass media	55 (36.4)	96 (63.6)
• Social media	29 (19.2)	122 (80.8)
g. Knowledge about where the service is given (n=151)		
• Contraceptive methods	83 (55)	68 (45.0)
• Treatment for sexually transmitted infections (STDs)	47 (31.1)	104 (68.9)
• VCT	58 (38.4)	93 (61.6)
• Safe abortion care services	38 (25.2)	113 (74.8)
• Post abortion care services	18 (11.9)	133 (88.1)
• Antenatal care	10 (6.6)	141 (93.4)

Description	Response N (%)	
	Yes	No
• Postnatal care	33 (21.9)	118 (78.1)
h. The consumption of alcohol, chewing *chat*, or the taking of any medication can have an impact on the refusal to utilise reproductive health (RH) services (condom, pills, etc.) at time of sex	331 (79.2)	87 (20.8)
i. Watching movies or television programmes prompt me to use contraception during sexual intercourse	295 (70.6)	123 (29.4)

From the above table, most participants, 303 (72.5%), had at least one sexual partner and they experienced sex. From those who had sex experience, 157 (51.82%) had multiple partners. From those who experienced sexual practice, 74 (24.42) were forced, and 204 (67.33) did not utilised any contraceptive method. Most of the participants 267 (63.9%) did not have information about any reproductive health services until the study period. From those participants who did have information 151 (36.1%), only 53 (35.1%) did have knowledge about contraceptives, and similarly 53 (35.1%) did have knowledge about VCT for HIV/AIDS. However, most participants106 (70.2), did not have information on safe abortion care services, and the same number of participants 106 (70.2%), did not have information on post abortion care services. The number of participants who did not have information on antenatal and postnatal services was 119 (78.8%) and 116 (76.8%) respectively.

The major sources of information for those participants who did have information on the RH services were teachers (schools) 88 (58.3%), and health workers 94 (62.3%). But parents 109 (72.2%), friends 117 (77.5%), newspapers 113 (74.8%), posters 122 (80.8%), mass media 96 (63.6) and social media 126 (83.4%) were not found to be better sources of information about RH services.

However, regarding their knowledge about where the service is given (n=151), only 83 (55%), did know where they could get the contraceptive methods, but more than half of the respondents did not know where the services for the STDs treatment 104 (68.9), for voluntary counselling and testing (VCT) for HIV/AIDS 93 (61.6%), for safe abortion care 113 (74.8%),for post abortion care133 (88.1%),for antenatal care 141 (93.4%),and for postnatal care services 118 (78.1%) did not where they could get the services till the study period. According to 331 (79.2%) of the respondents, consumption of alcohol, chewing *chat*, or the taking of any medication can have an impact on the refusal to utilise

RH service (condom, pills, etc.) at time of sex. Moreover, 295 (70.6%) respondents answered watching movies or television programmes prompt to the use contraception during sexual intercourse.

Table 4.3 Classification of participants' agreement level (N=418)

Descriptions	Level of agreement n (%)				
	Strongly agree	**Agree**	**Neutral**	**Disagree**	**Strongly disagree**
Rh service is important for youth	104 (24.9)	98 (23.4)	95 (22.7)	121 (29.0)	0 (0.0)
Every youth person should understand the significance of RH service	104 (24.9)	98 (23.4)	95 (22.7)	121 (29.0)	0 (0.0)
Young people have harder time than adults to use RH service	108 (25.8)	72 (17.2)	76 (18.2)	129 (30.9)	33 (7.9)
Being judgmental makes an RH service unlikely	113 (27)	50 (12)	55 (13.2)	139 (33.3)	61 (14.5)
The longer waiting time mages RH service unlikely	161 (38.5)	109 (26.1)	43 (10.3)	56 (13.4)	29 (11.7)
If the providers are unfriendly, the service will become unlikely	239 (57.2)	53 (12.7)	24 (5.7)	63 (15.1)	39 (9.3)
If service is not confidential, the service will become unlikely	161 (38.5)	74 (17.7)	41 (9.8)	66 (15.8)	76 (18.2)
If the cost is expressive, the service will be unlikely.	70 (16.7)	87 (20.8)	51 (12.2)	161 (38.6)	49 (11.7)

From the above table, 29.0% (n=121) participants disagreed that RH service is important. Only 24.9% (n=104) participants strongly agreed that each youth should be aware of the use of RH services, but 29.0% (n=121) disagreed the idea. From the participants, 25.8% (n=108) strongly agreed that young people have harder time to get RH service than adults, but 30.9% (n=129) disagreed with it. A considerable number of participants, 33.3% (n=139), disagreed that being judgmental makes an RH service unlikely. More than one-third of the respondents 38.5 % (n=161) strongly agreed that the longer waiting time makes RH service unlikely. Most participants, 57.2% (n=239), strongly agreed that the use of RH service is unlikely if the providers are not friendly. Most participants, 38.5% (n=161), strongly agreed that the use of RH service is unlikely if the service is not

confidential, and *38.5%* (n=161*)* disagreed that If the cost is expensive, the service will be unlikely.

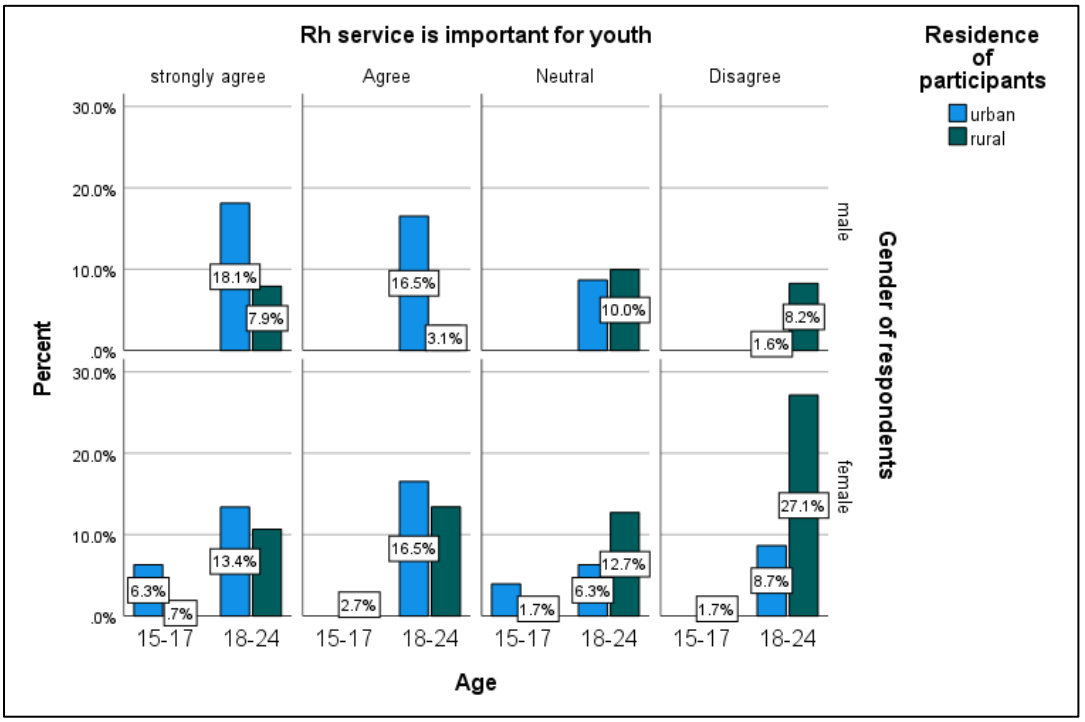

Figure 4.5 Participants' agreement level on the importance of RH services for young people by residence, gender and sex (N=418)

As shown in the figure above, 18.1% (n=26) male respondents of age 18-24 years from urban area strongly agreed with the importance of RH service for youth. However, 27.1% (n=75) female respondents of age 18-24 years from the rural area strongly disagreed with it.

Table 4.4 Participants' agreement level on importance of RH services by age, marital status, education level, religion and ethnicity

Characteristics	Levels of agreement on importance of RH services					Total
	Strongly agree	Agree	Neutral	Disagreed	Strongly disagree	
Age						
15-<18	10	8	10	5	0	33
18-24	94	90	85	116	0	385
Total	**104**	**98**	**95**	**121**	**0**	**418**
Marital status						
Friendship	30	32	37	37	0	136
Married	37	34	35	28	0	134
Unmarried	23	12	10	14	0	59
Widowed	14	20	13	42	0	89

Characteristics	Levels of agreement on importance of RH services					Total
	Strongly agree	Agree	Neutral	Disagreed	Strongly disagree	
Total	**104**	**98**	**95**	**121**	**0**	**418**
Education level						
Illiterate	30	25	35	47	0	137
Primary	23	33	21	21	0	98
Secondary	21	22	14	8	0	65
College and above	30	18	25	45	0	118
Total	**104**	**98**	**95**	**121**	**0**	**418**
Religion						
Orthodox	80	93	72	116	0	361
Muslim	18	5	17	1	0	41
Protestant	4	0	4	3	0	11
Catholic	2	0	2	1	0	5
Total	**104**	**98**	**95**	**121**	**0**	**418**
Ethnicity						
Oromo	17	21	7	5	0	50
Amara	85	70	82	100	0	337
Gurage	2	7	6	16	0	31
Total	**104**	**98**	**95**	**121**	**0**	**418**

As seen from the above table, 24.88% (n=104) respondents strongly agreed with the importance of RH services and of which 90.38% (n=94) were 18-24-year-olds, but 28.95% (n=121) respondents and of which 95.87% (n=116) of age 18-24 years disagreed with it. Regarding their marital status, from those strongly agreed, 28.85% (n=30) respondents were at friendship and 35.58% (n=37) were married. From those respondents who disagreed with the service, 47 (38.84%) were illiterate and 37.19% (n=45) were college and above in their education level. Most, 95.87% (n=116) of the respondents' who disagreed with the importance of the RH services were Orthodox Christians, and82.64% (n=100) were Amhara in their ethnicity.

4.1.1.2 Descriptive presentation for quantitative results of observation in the hospitals based on global standards for health services for young people

Nine hospitals were evaluated for their services, based on eight international standards for quality health services. These standards included health literacy for young people, community-based services, the right package of services, the providers' skills, the facility's features, equity and non-discrimination, data and the involvement of young people.

Table 4.5 Observation in the hospitals showing measurable criteria of global standard for quality health care services for the young people (young people' health literacy; standards-1 for N=9)

Observation in hospitals	Yes	No
Input criteria		
Operating hours are indicated on the health facility's signboard.	7 (77.8)	2 (22.2)
In the waiting area, the health facility has the latest information, training and communication materials specially designed for young people.	4 (44.4)	5 (55.6)
Providers of health-related services have the skills to deliver health education to young people and to communicate he information. (including health, and other services).	4 (44.4)	5 (55.6)
Outreach workers got training to educate young people.	3 (33.3)	6 (66.7)
There is outreach plan in the facility to promote young people.	3 (33.3)	6 (66.7)
Process criteria		
Health care professionals offer age and developmental health education and guidance to young people and make sure they know where health, social and other services are available.	4 (44.4)	5 (55.6)
Health facilities carry-out outreach activities to improve youth health and increase service utilisation by young people.	2 (22.2)	7 (77.8)
Output criteria		
Youth are conscious about services.	2 (22.2)	7 (77.8)
Young people know what health services are available, where they are available, when they are available and how to access them.	2 (22.2)	7 (77.8)

As shown in the above table, lower than the average number of hospitals had been found fulfilling the input, the process and the output criteria the young people' health literacy standard. Only the signboard that mentions operating hours was observed in 7 (77.8%) hospitals. Five (more than 55%) of hospitals did not have the health facility like latest information, education and communications materials specially designed for young people in their waiting area. Most 6 (66.7) hospitals did not have trained outreach workers to educate young people.

Table 4.6 Observation in the hospitals showing measurable criteria of global standard for quality health care services for the youth (community support; standards-2 for N=9)

Observation in hospitals	Responses	
	Yes N (%)	No N (%)
Input criteria		
Health care providers have the skills and resources to talk to parents, guardians, other community members and organisations about the importance of providing health care services to young people.	2 (22.2)	7 (77.8)
Health facility has an active list of agencies with which it collaborates to boost community support for young people.	4 (44.4)	5 (55.6)
Outreach activities and/or outreach worker involvement are planned to boost gatekeeper support for young people's use of services.	2 (22.2)	7 (77.8)
Process criteria		
Process criteria are met. Health facility partners with young people, gatekeepers and community organisations to create health education and communication strategies and materials that focus on behaviour and plan service delivery.	1 (11.1)	8 (88.9)
Parents/guardians who visit the health facility are informed about the importance of youth health service.	6 (66.7)	3 (33.3)
Health care providers share information about youth health services with parents and teachers during school meetings.	3 (33.3)	6 (66.7)
Health care professionals and/or outreach staff disseminate information to young people and other community members regarding the importance of health services to young people.	4 (44.4)	5 (55.6)
Output criteria		
Gatekeepers and community groups promote the delivery and use of health services by young people.	3 (33.3)	6 (66.7)

As indicated in the above table, only 2 (22.2% of hospitals) had health care providers who have the skills and resources to communicate with families, other community stakeholders and organisations on the values of youth services. The majority (77.8%) of hospitals (7) did not have an outreach strategy and/or did not involve outreach workers in outreach activities to improve gatekeeper support for youth use of services. Only 1 (11.1%) of hospitals demonstrated a commitment to collaborating with youth, gatekeepers and community organisations in order to create health education and communication strategies and resources, as well as a plan for service provision. The health care professionals from 6 (66.7%) hospitals did not inform parents about the services available to the young people.

Table 4.7 Observation in the hospitals showing measurable criteria of global standard for the quality of services for the young people (appropriate package of services; standards-3 for N=9)

Observation in hospitals	Yes N (%)	No N (%)
Input criteria		
There are policies in place that set out what kind of health information, advice, tests, treatments, and care services are needed and can be provided.	6 (66.7)	3 (33.3)
Health facilities have policies and procedures that determine which health services are offered in the facility and which are offered in community settings like schools.	6 (66.7)	3 (33.3)
There are policies and processes in place that the referral system for both in-house and out-of-house services, including transitional care for young with the chronic conditions.	6 (66.7)	3 (33.3)
Process criteria		
In accordance with policies and practices, health care providers deliver the necessary suite of the information, counselling, diagnostics, treatments and care in facilities and community settings.	3 (33.3)	6 (66.7)
Service providers ensure that young people are referred to the appropriate services and level of care in accordance with local regulations and practices, and adhere to transition care policies.	6 (66.7)	3 (33.3)
Output		
The health facility offers a comprehensive range of health services to meet the requirements of all young people, both with the facility itself and/or through referrals and outreach.	1 (11.1)	8 (88.9)

As shown in the above table, most hospitals, 6 (66.7%), had policies and procedures regarding the services for the young people which is considered to be basic part of the package. However, only 3 (33.3%) hospitals provided the service based on the policies and procedures. Therefore, most hospitals, 8 (88.9%), did not fulfil the needs of the young people.

Table 4.8 Observation in the hospitals showing measurable criteria of global standard for high-quality health care-services for high-quality health care-services for the young people (providers' competencies; standards-4 for N=9)

Observation in hospitals	Yes N (%)	No N (%)
Input criteria		
Providers and personnel with the profile requirements ready in place.	9 (100)	0 (0)
Providers of health-related services possess the necessary technical capabilities to deliver the desired set of services.	2 (22.2)	7 (77.8)
Providers of health care services have been sensitised to the importance of safeguarding the rights of the young persons' access to data, privacy, and confidentiality, as well as the health care they receive in a courteous, non-judgmental, and non-racist manner.	3 (33.3)	6 (66.7)
The health facility clearly outlines the responsibilities of providers and the rights of young people.	1 (11.1)	8 (88.9)
As part of the service package, decision support tools (guidelines, protocols, algorithms) address clinical care topics.	2 (22.2)	7 (77.8)
A supportive oversight framework is implemented to enhance the performance of health care providers.	2 (22.2)	7 (77.8)
In order to guarantee lifelong learning, a continuum of professional training programme is implemented, which includes a component for adolescent health care.	6 (66.7)	3 (33.3)
Process criteria		
A continuum of professional training programme with young people's health-related component is implemented to guarantee lifelong learning.	2 (22.2)	7 (77.8)
Providers and support staff interact with young people in a positive manner and respect their privacy, confidentiality, rights, non-discriminatory treatment, and care.	1 (11.1)	8 (88.9)
Output criteria		
Health care providers and support staff communicate with youth in a positive manner and respect their privacy, confidentiality, data protection, non-discrimination, and treatment rights.	2 (22.2)	7 (77.8)
The services provided to young people are provided in an open, welcoming, and respectful manner that is non-discriminatory and non-judgmental, and they are aware of their health care rights.	1 (11.1)	8 (88.9)
Young people are given accurate, age-appropriate and clear information so they can make an informed decision.	5 (55.6)	4 (44.4)

As shown in the above table, in all hospitals 9 (100%), there was a documented profile of professionals and support staffs. However, only 3 (33.3%) of hospitals trained professionals and only few, 2 (22.2%), did have competent health care givers. Moreover, only 1 (11.1%) hospital did clearly display the rights and obligations of young people' in

the health facility. Above half of the hospitals, 7 (77.8%), did not have supportive tools and supervision system regarding the services for the young people. Furthermore, most hospitals, 8 (88.9%) did not provide non-judgmental and non-discriminatory supportive youth services.

Table 4.9 Observation in the hospitals showing measurable criteria of global standard for quality health care services for the young people (facility characteristics; standards-5 for N=9)

Observation in hospitals	Yes N (%)	No N (%)
Input criteria		
A policy is in place, including a shared responsibility between providers and support staff, to foster a hospitable and clean atmosphere, shorten waiting times, and offer flexible operating hours and scheduling of appointments.	6 (66.7)	3 (33.3)
The facility is equipped with essential services such as electricity, water, hygiene and waste disposal.	5 (55.6)	4 (44.4)
Privacy policies and procedures are in place to protect the personal and confidential data of young people. Health care workers and support staff are aware of these policies and procedures, and they know their roles and responsibilities.	2 (22.2)	7 (77.8)
A procurement and inventory management system is in place for the drugs and supplies needed to provide the package of services.	7 (77.8)	2 (22.2)
There's a system in place for getting the equipment, keeping track of it, keeping it clean and making sure it's used safely to provide the services you need.	7 (77.8)	2 (22.2)
Process criteria		
With or without an appointment, health care providers offer consultations at a time that is convenient for young people in your locality.	2 (22.2)	7 (77.8)
Providers of health care and support personnel shall adhere to policies and procedures designed to safeguard the privacy and confidential information of young people.	2 (22.2)	7 (77.8)
Medications and supplies are available in sufficient amounts without shortages (stocks) and are used in a proportionate manner.	0 (0)	9 (100)
The tools needed to deliver the right package to young people are in place, functional and used in the right way.	2 (22.2)	7 (77.8)
Output criteria		
The health facility has easy-to-use hours, scheduling and waiting times that are kept to a minimum.	3 (33.3)	6 (66.7)
The overall atmosphere of the health facility is warm and inviting.	1 (11.1)	8 (88.9)
At every step of the consultation process, young people get private and confidential health care.	3 (33.3)	6 (66.7)
The facility is equipped with the necessary tools, pharmaceuticals, equipment and technology to provide the necessary services to young people.	3 (33.3)	6 (66.7)

As shown in the above table, there was a policy in place for most hospitals, 6 (66.7%). However, care givers and support staffs in only 2 (22.2%) hospitals did know their own responsibilities regarding the services to young people. Although most hospitals, 7 (77.8%), had a system for procurement and inventory of medical supplies related to young people' services, there was no adequate supply of drugs and medications for the services in all hospitals,9 (100%). Moreover, there was no clean and welcoming environment in most hospitals, 8 (88.9%).

Table 4.10 Observation in the hospitals showing measurable criteria of global standard for health services (Equity and non- discrimination; standards-6 for N=9)

Observation in hospitals	**Yes N (%)**	**No N (%)**
Input criteria		
Facility policies and procedures specify that facility personnel must provide services to all young people regardless of their financial capacity, age, gender, marital status, educational background, racial/ethnic origin, sexual orientation or any other characteristic.	7 (77.8)	2 (22.2)
For services that are offered for free or at an affordable price, there are policies and procedures in place.	5 (55.6)	4 (44.4)
Providers and support staff are familiar with the policies and procedures mentioned above and know how to apply them.	2 (22.2)	7 (77.8)
The health facility's political promise to treat all young people equally and to take corrective measures when needed is reflected in the facility.	5 (55.6)	4 (44.4)
Health care professionals are familiar with the groups of young people at risk in their local community(ies).	3 (33.3)	6 (66.7)
Process criteria		
Health care professionals and support staff show the same welcoming, non-judgmental, and respectful attitude towards all young people, no matter their age, gender, marital status, sexuality, culture, ethnicity, disability or any other.	2 (22.2)	7 (77.8)
Providers of health care services do not discriminate against any group of young people, in accordance with relevant laws and regulations.	1 (11.1)	8 (88.9)
The health facility engages vulnerable groups of young people in the planning, monitoring and assessment of health services, and in certain aspects of the provision of health services.	0 (0)	9 (100)
Output criteria		
Regardless of income, age, gender, marital status, educational background, ethnic background, sexual orientation or any other characteristic, all young people experience similar levels of care.	1 (11.1)	8 (88.9)
Young people who are in vulnerable situations are involved in helping to plan, track and assess health care, as well as some other parts of health services.	0 (0)	9 (100)

Most of the hospitals, 7 (77.8%), had policies and procedures which stated the obligations of health care givers regarding the services to young people based on their age, sex, marital status, and other factors. However, only 2 (22.2%) hospitals had health care givers and support staffs who were aware of the policies and procedures on equity and no-discrimination of the services to the young people. Moreover, those health caregivers in most hospitals, 7 (77.8%), did not demonstrate a friendly, non-judgmental and respectful attitude to the young people. The result also showed that all hospitals, 9 (100%), did not involve vulnerable young people in their management functions.

Table 4.11 Observation in the hospitals showing measurable criteria of global standard for quality health care services for the young people (data and quality improvement; standards-7 for N=12)

Observation in hospitals	Yes N (%)	No N (%)
Input criteria		
A system is implemented to facilitate the collection of data on service utilisation that is broken down by age, gender and other relevant socio-demographic profiles.	6 (66.7)	3 (33.3)
Health care providers receive training on data collection and analysis to support quality improvement efforts.	1 (11.1)	8 (88.9)
There are tools and systems in place to self-monitor the quality of youth health services,	2 (22.2)	7 (77.8)
There are also follow-up mechanisms to link support supervision with areas of improvement identified during standardisation.	4 (44.4)	5 (55.6)
There are also systems in place to reward and recognise exceptional health care professionals and support staff.	3 (33.3)	6 (66.7)
Process criteria		
The health facility also collects age and gender-based data on service use and performs periodic self-assessment of quality.	1 (11.1)	8 (88.9)
Health care providers and staff use data on how often services are used and how well care is done to plan and put into action quality improvement plans.	1 (11.1)	8 (88.9)
Providers and support staff receive on-the-job training in areas identified by self-assessment.	3 (33.3)	6 (66.7)
Individuals who demonstrate excellence are acknowledged and rewarded accordingly.	2 (22.2)	7 (77.8)
Output criteria		
In its reports to districts, the facility provides data on the cause-specific use of services by young people, aggregated by age and gender.	2 (22.2)	7 (77.8)
The focus of the facility's quality of care reports to districts is on youth.	4 (44.4)	5 (55.6)
Health facility personnel experience a sense of empowerment from their supervisors and a drive to meet the requirements of the standards.	2 (22.2)	7 (77.8)

As shown in the above table, 6 (66.7) hospitals had a system to collect data about the young people' service utilisation. However, only 1 (11.1) hospital had trained care giver, collect and analyse data on young people' health service and use the result for planning and evaluation.

Table 4.12 Observation in the hospitals showing measurable criteria for health service quality (young people' participation; standards-8 for N=9)

Observation in hospitals	Yes N (%)	No N (%)
Input criteria		
The governance of the facility involves the involvement of young people.	7 (77.8)	2 (22.2)
A policy is in place to involve young people in the planning, supervision and evaluation of services.	3 (33.3)	6 (66.7)
Youth are well-versed in the laws and regulations that help them make wise choices, and they understand the process of giving consent is made clear in the policies and procedures of the facility, which are in line with the law.	2 (22.2)	7 (77.8)
Process criteria		
Youth are familiar with the laws and regulations that assist them in making informed choices, and the consent process is clearly outlined in the facility's policies and procedures, in accordance with the relevant laws and regulations.	3 (33.3)	6 (66.7)
Health care professionals give clear and specific details about what the illness is and what treatment options there are, and they take into account the teen's decision on what to do next.	2 (22.2)	7 (77.8)
The health facility undertakes activities to develop the skills of young people in certain areas of health-related services.	5 (55.6)	4 (44.4)
Output criteria		
Health services are planned, monitored and evaluated by young people.	1 (11.1)	8 (88.9)
Young people are actively involved in making choices about their own care.	1 (11.1)	8 (88.9)
There are several ways in which youth are involved in the service delivery.	3 (33.3)	6 (66.7)

The above table shows that 7 out of every 9 hospitals (77.8%) had a governance structure that included young people in planning, tracking and evaluating services. However, health care workers in only 2 (22.2%) hospitals were aware of laws and regulations and few hospitals, 3 (33.3%), involve young people in planning, monitoring and evaluation regarding their need identification and their expectations. Moreover, health care workers in most hospitals, 7 (77.8%), did not provide accurate information on young people' medical conditions.

4.1.1.3 Descriptive presentation for quantitative results for other specific institutional services to young people of age 15-24 years

The results observed for nutritional and mental health service in the health institutions addressed their assessments with separately prepared units and assignment of professionals for each service as follows:

Table 4.13 Nutritional, mental and behavioural health services for young people (observed result)

Observations in hospitals	Yes N (%)	No N (%)
Nutritional health-related services		
Is there nutritional assessment for young people?	4 (44.4)	5 (55.6)
Mental and behavioural health		
Is there Mental Health or psychiatric screening, counselling and treatment unit in the organisation?	7 (77.8)	2 (22.2)
Is there an up-to-date guideline/procedural policy for Mental Health & Behavioural Health services?	3 (33.3)	6 (66.7)
Is there properly registered book/list in each unit?	4 (44.4)	5 (55.6)
Is there trained professional assigned in the unit?	3 (33.3)	6 (66.7)
Is there screening and counselling service for risky behaviour like smoking, alcohol use, khat use, violence?)	1 (11.1)	8 (88.9)
Is the information secured/does anyone except the respected professional, not access it?	1 (11.1)	8 (88.9)
Are there appropriate and sufficient drug supplies in the institution?	3 (33.3)	6 (66.7)
Are principles of distancing for prevention of communicability of diseases especially COVID-19 on action?	2 (22.2)	7 (77.8)
Are there enough amounts of provisions (sanitiser, mask and other personal protective equipment in the institution?	1 (11.1)	8 (88.9)
Is there a system/programme/to give health education for young people regarding prevention of COVID-19?	2 (22.2)	7 (77.8)

As shown above 5 (55.6%) of the hospitals did not have nutritional assessment services. Regarding mental health and behavioural services, most of the hospitals, 6 (66.7%), did not have an up-to-date guideline/procedural policy. Moreover, 8 (88.9%) hospitals did not have screening and counselling service for risky behaviour like smoking, alcohol use, *chat* use, and violence among the young people. Moreover, in above half of the hospitals there were no principles of distancing for prevention of communicability of diseases especially COVID-19 on action, enough provisions and systems/programmes to give health education for young people regarding prevention of COVID-19.

4.2.2 Inferential statistics

In inferential statistics, values are compared using inferential queries or inferential hypotheses using various tests that are related to variables or group-to-group in relation to variables so that conclusions can be made from the sample into a population (Creswell 2018:257). The inferential part of result of the present study is expressed as follows:

Table 4.14 Chi-Square test of association between respondents' character and utilisation of RH services

Characteristics	Utilisation of RH services		
	Chi-square	Degrees of freedom (df)	Asymp. Sig (2 sided)
Gender Male Female	0.476	1	0.490
Age 15-17 18-24	5.895	1	0.015
Residence Urban Rural	30.31	1	<.001
Marital status Married unmarried Widowed	37.86	2	<.001
Level of education Illiterate Primary Secondary College and above	33.18	3	<.001
Religion Orthodox Muslim Protestant Catholic	16.82	2	<.001
Frequency of religious participation No participation Up to two times per month More than two times per month	23.21	2	<.001
Religious importance Very much useful Useful No use	11.50	2	.003

Characteristics	Utilisation of RH services		
	Chi-square	Degrees of freedom (df)	Asymp. Sig (2 sided)
Ethnicity Oromo Amhara Other	26.92	2	<.001
Living with Both parents Mother Father Relatives Female friend Male friend Alone	19.25	6	.004
Day/night club participation Yes No	6.49	1	.011
Frequency of day/night club participation Every week Every two weeks Every month Twice a months Once in three months	6.49	1	.011
Getting money Yes No	8.87	1	.003
Having information about SRH service Yes No	4.81	1	.028

According to Table 4.14, age, residence, marital status, educational attainment, religiosity, frequency of religiosity, importance of religion, ethnicity, living with, attending day/nightclubs, getting money from parents and having information about any reproductive health services were all associated with reproductive health services use. However, gender and frequency of day/night club participation did not have any association with utilisation of reproductive health.

Table 4.15 illustrates the outcome of the analysis, indicating that age of respondents [AOR=8.64; 95%CI 2.79,26.73], urban residence [AOR=5.32; 95%CI 2.87, 9.88] are significantly associated with the utilisation of RH services. Regarding the marital status, unmarried & widowed young people are significantly associated with RH services utilisation with

[AOR=0.43; 95%CI 0.24,0.7], and [AOR=2.57; 95%CI 1.16,5.71], respectively. Level of education and getting money are also significantly associated with the utilisation of RH services. The respondent's level of education has significant association with the utilisation of the RH services with [AOR= 0.29; 95%CI 0.14, 0.58, AOR=0.19; 95%CI 0.09, 0.46, and AOR=0.47; 95%CI 0.23, 0.94] for the primary, secondary and college and above respectively. Getting money also has significant association with [AOR=1.83; 95%CI 1.09, 3.06] in the study. Although up to two times religious participation per month showed significant association with the utilisation of RH services with [AOR=2.48; 95%CI 1.25, 4.92], religious participation more than two times per month has no significant association with the utilisation of the RH services with [AOR=1.83; 95%CI 0.93, 3.58]. Moreover, the type of the respondent's religion, religious importance, the people with whom the young people live, night club participation, and whether the young people have information about RH services or not did not have significant association with the utilisation of the RH services.

Table 4.15 Bivariate and multiple logistic regression analyses for utilisation of SRH services according to selected respondents' character, East Gojjam Zone, Ethiopia 2023 (N=303)

Socio-demo-graphic variables	Utilisation of RH services No (%)		COR (95%CI)	AOR (95%CI)	P-value
	Yes	No			
Age in years					
15-17	7 (1.67)	26 (6.22)	3.00 (1.27, 7.08)	8.64 (2.79, 26.73)	**<.001**
18-24	172 41.15)	213 (50.96)	1.00		
Residence					
Rural	80	47	1.00	1.00	
Urban	99	192	3.30 (2.14, 5.10)	5.32 (2.87, 9.88)	**<.001**
Marital status					
Married	63 (15.07)	71 16.99)	1.00		
Unmarried	103 24.64)	92 (22.01)	0.79 (0.51, 1.23)	0.43 (0.24, 0.78)	**.005**
Widowed	13 (3.11)	76 (18.18)	5.18 (2.63, 10.23)	2.57 (1.16,5.71)	**.020**
Level of education					
Illiterate	39 (9.33)	98 (23.44)	1.00	1.00	
Primary	55 (13.16)	43 (10.29)	0.31 (0.18, 0.54)	0.29 (0.14, 0.58)	**<.001**
Secondary	42 (10.05)	23 (5.50)	0.22 (0.12, 0.41)	0.19 (0.09, 0.46)	**<.001**
College and above	43 (10.29)	75 (17.94)	0.69 (0.41, 1.18)	0.47 (0.23, 0.94)	**.033**
Religion					
Orthodox	144 (34.45)	220 (52.63)	1.00	1.00	
Muslim	31 (7.42)	12 (2.87)	0.25 (0.13,0.51)	0.74 (0.30, 1.82)	.517
Protestant	4 (0.96)	7 (1.67)	1.15 (0.33,3.98)	0.97 (0.23, 4.10)	.965
Religious					

Socio-demo-graphic variables	Utilisation of RH services No (%)		COR (95%CI)	AOR (95%CI)	P-value
	Yes	No			
participation					
More than two times per month	45 (10.77)	102 (24.40)	3.06 (1.90,4.91)	1.83 (0.93, 3.58)	.079
Up to two times per month	45 (10.77)	71 (16.99)	2.13 (1.30, 3.48)	2.48 (1.25, 4.92)	.**010**
No participation	89 (21.29)	66 (15.79)	1.00		
Religious importance					
Very much useful	93 (22.25)	161 (38.52)	1.00		
Useful	42 (10.05)	45 (10.77)	0.62 (0.38, 1.01)	0.87 (0.45,1.71)	.694
No use	44 (10.53)	33 (7.89)	0.43 (0.26, 0.73)	0.96 (0.46,1.99)	.910
Live with					
Both parents	82 (19.62)	72 (17.22)	1.00	1.00	
Mother	15 (3.59)	14 (3.35)	1.06 (0.48, 2.35)	0.99 (.39, 2.59)	.998
Father	9 (2.15)	16 (3.83)	2.03 (0.84, 4.86)	2.51 (0.91, 6.35)	.076
Relative	14 (3.35)	11 (2.63)	0.89 (0.38, 2.09)	0.69 (0.24, 1.98)	.488
Female friend	8 (1.91)	19 (4.55)	2.71 (1.11, 6.55)	1.47 (0.49, 4.42)	.491
Male friend	26 (6.22)	51 (12.20)	2.23 (1.27, 3.94)	1.52 (0.73, 3.16)	.259
Alone	25 (5.98)	5613.40)	2.55 (1.45, 4.50)	1.75 (0.86, 3.54)	.121
Night club participation					
Yes	113	121	0.59 (40, 0.89)	0.75 (0.45, 1.26)	.276.
No	66	118	1.00		
Getting money					
Yes	74 (17.70)	134 (32.06)	1.81 (1.22, 2.68)	1.83 (1.09, 3.06)	**.021**
No	105 (25.12)	105 (25.12)	1.00		
Having information about SRH service					
Yes	54 (12.92)	97 (23.21)	2.12 (1.06, 4.24)	1.13 (0.66, 1.91)	.660
No	125 (29.90)	142 (33.97)	1.00		

4.3 SUMMARY

Chapter 4 presented the main results from the quantitative stage. Data was presented in the form of tables, graphs, and pie charts. The main results of the quantitative stage are summarised in Chapter 4. Chapter 5 contains the qualitative information from the focus groups and the interviews.

CHAPTER 5

DESCRIPTION OF QUALITATIVE DATA RESULT

5.1 INTRODUCTON

In the preceding chapter, we reviewed quantitative data, such as the outcomes of a research survey and an observational checklist. This chapter delves into qualitative data. Data for this stage were collected from 4 focus groups and 11 in-depth interviews of the young people. Guides were used for both types of methods of data collection. The focus groups were from the young people who came to four different hospitals namely Debre Markos Comprehensive Referral Hospital, Mertulemaryam Primary District Hospital, Shegaw Motta Hospital and Lumame Primary District Hospital to seek services. All FGD conversations and in-depth interviews took place in the hospital settings.

5.2 DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Purpose sampling was based on the researcher's judgement and represented the characteristics of the population (De Vos et al 2012:232). There were 11 sample units for the in-depth interview 37 individuals in the four FGDs were used in the method. The average age was 19.7 years for the FGDs participants and 20.09 years for the in-depth interview participants.

Table 5.1 Demographic characteristics of the participants of the FGD in East Gojjam, Ethiopia, 2023

Group	Pseudo name (use code)	Sex	Age	Residence	Education level
Group 1	P1	F	18	Urban	Level-4
	P2	F	19	Rural	12 complete
	P3	M	23	Rural	Grade 10
	P4	M	18	Rural	Grade 9
	P5	M	24	Urban	Level-4
	P6	M	23	Urban	Grade 6
	P7	F	24	Rural	College
	P8	F	18	Rural	1st Degree
Group 2	P1	F	18	Urban	Level-4
	P2	M	19	Rural	12 complete

Group	Pseudo name (use code)	Sex	Age	Residence	Education level
	P3	M	20	Rural	Level-4
	P4	F	19	Rural	Grade 9
	P5	M	21	Urban	Level-4
	P6	F	22	Urban	Grade 5
	P7	F	16	Rural	College
	P8	M	19	Urban	Level-4
	P8	F	18	Urban	1st Degree
Group 3	P1	M	19	Rural	Level-4
	P2	F	18	Urban	12 complete
	P3	M	21	Urban	Degree
	P4	F	19	Rural	Grade 11
	P5	F	20	Urban	Level-4
	P6	F	21	Urban	Level-4
	P7	M	18	Urban	College
	P8	M	18	Urban	Level-4
	P9	M	20	Rural	12 complete
	P10	F	19	Urban	1st year BSc nursing
Group 4	P1	F	19	Urban	12 complete
	P2	F	20	Urban	12 complete
	P3	M	24	Urban	Degree
	P4	M	19	Urban	Grade 11
	P5	F	20	Urban	12 complete
	P6	M	19	Urban	Level-4
	P7	F	18	Urban	12 complete
	P8	M	20	Rural	Level-4
	P9	F	20	Urban	12 complete
	P10	M	18	Rural	Level-4

As shown in the above table, from 37 participants of the study, eighteen were male. Thirty-six of the participants were 18 to 24-years-old. Twenty-three participants were urban dwellers. Regarding their level of education, two participants were at primary, fourteen participants were at secondary, and 21 participants at were college and above.

Table 5.2 Socio-demographic characteristics of young people who participated in in-depth interviews

No.	Age	Sex	Rural	Level of education
1	23	F	Urban	Grade 10
2	22	F	Urban	2nd year midwifery
3	21	F	Rural	Degree
4	20	F	Urban	12 complete
5	18	F	Urban	Level-4
6	20	F	Urban	Grade 7
7	20	M	Urban	12 complete
8	20	F	Rural	Level-4
9	21	F	Urban	Level-4
10	18	F	Rural	12 complete
11	18	F	Urban	Grade 7

As shown in the above table, from eleven seven participants of the study, ten were female. All of the participants were 18 to 23-years-old. Eight participants were urban dwellers. Regarding their level of education, two participants were at primary, four participants were at secondary, and five participants at were college and above.

5.3 PHENOMENOLOGICAL METHOD OF DATA ANALYSIS

The qualitative data was analysed by the researcher using descriptive phenomenological method. The Stevick-Colaizzi-Keen (1978) method of phenomenological data analysis was used to analyse the interviews. This method was modified in 1994 by Moustakas and later by Creswell (2018:272). To carry out the data analysis, the following steps were employed: recounting personal experiences related to the phenomenon; constructing meaningful statements; categorising the statements into sub-themes; elaborating a narrative of the participants' experiences with this phenomenon, includes the following: Textual presentations and literal cases, structural description of the experience, and composite narrative of the phenomenon (Creswell 2018:272).

The researcher listened attentively to the information of the recorded audios and then transcribed it verbatim. He carefully read the transcribed data. The phenomenological data analysis steps used for qualitative data analysis and mentioned by Creswell (2018:272) were implemented. The steps are described as follows:

Data organisation: This involved creating and organising files to store data. The researcher uploaded the audio files from the recorders into the computer and stored them. Verbatim transcription was applied to transcribe. The transcribed data was stored in Microsoft Word file format.

Reading/memorising: The researcher conducted a textual analysis, making some notes and creating initial code. Subsequently, the recorded data was transcribed and saved in the computer to be analysed.

Division of data into themes and codes: Essentially, the phenomenon was described using themes and codes.

Categorising the data into themes and codes: The researcher broke down the data into sentences that made sense and divided it into categories like codes and themes.

Interpreting the data: The researcher developed a textual story of "what happened" and a structural story of the event; for example, how the health care providers interacted with the young people (15-24) and the challenges they faced.

Develop the "essence": This would give us a general idea of what the results/findings will be.

Representing/Visualising the data: The narrative of the outcomes was presented through the use of tables and discussions.

5.3.1 Analysis of qualitative data (data from 4 FGDs and 11 in-depth interviews)

5.3.1.1 Data saturation

Data saturation was reached after four FGDs and eleven in-depth interviews conducted in four hospitals. Information obtained after four FGDs and eleven in-depth interviews became repeated. There was no emergence of new idea. The data was generalised by three themes, seven sub-themes and 37 codes (refer to Table 5.1).

5.3.2 Themes, categories (sub-themes) and codes

The results were presented in the form of three main topics and seven minor sub-themes (Table 5.1).

Table 5.3 Themes, categories (sub-themes) and codes for data obtained from the young people of age 15-24 years, East Gojjam, Ethiopia

Theme	Category (sub-theme)
1 Health service utilisation for young people of age 15-24 years (young people)	1.1 SRH services for young people (6 codes)
	1.2 Mental and behavioural health services for the young people of age 15-24 years (young people) (1 code)
	1.3 Nutritional and chronic diseases in the young people of age 15-24 years (young people) (1 code)
2 Health service quality provided for the young people of 15-24 years (young people)	2.1 Quality health care for the young people of age 15-24 years (young people) (10 codes)
3 Challenges/factors related to providing services to 15-24-year-old (young people)	3.1 Demographic and socio-economic challenges/factors in the young people of age 15-24 years (young people) (8 codes)
	3.2 Socio-cognitive challenges/factors in the young people of age 15-24 years (young people) (3 codes)
	3.3 Institutional challenges/factors in the young people of age 15-24 years (young people) (8 codes)

Note: Theme 1 has 3 sub-themes with 8 codes and theme 2 has 1 sub-theme with 10 codes. There were 3 sub-themes in the third theme and 19 codes in the theme. The quotes from the focus groups were written with numbers representing the focus group and participant (group 1 participant 1) were referred to as G1/P1. For the in-depth interview, it was represented as I/Pi where I is for in-depth and Pi for the participant.

5.3.2.1 Theme 1: Health service utilisation for young people of age 15-24 years (young people)

In this theme, the type and level of health services provided at different institutions, the consequence of behavioral factors including exposure to harmful substances and the impact of culture and income level on nutrition are briefly stated. It addressed that youngsters of age 15-24 years described that SRH, mental and behavioural health and nutritional health were the health services for the young people provided at different levels.

5.3.2.1.1 Sub-theme 1.1: SRH services for young people

In this sub-theme, most participants described that the reproductive health services were provided at different levels in different health institutions. Some of the health services provided were family planning, health education and counselling, antenatal care, STI and HIV test and treatment and safe abortion services.

The discussion covered topics such as whether young people can abstain, when this is possible, and why they shouldn't, the age at which men and women can get married, the consequences of getting married earlier, what early marriage means, who young people should start having sex with, the impact of parental supervision, and the personal precautions that should be taken during menstruation. Additionally, they discussed their perceptions of STIs, particularly HIV transmission, and how they first learned about it.

Code 1: Family planning

Most participants responded that they went to health institutions to get family planning services. The participants also described some of the uses, types, preferences and disadvantages of contraceptive methods. Only some of them described the myths that are told in relation to the contraceptive use. Moreover, they described that some of the institutions provided most of the family planning services whereas some did not.

> *"Family planning services include the distribution of pills and implants which are provided to the adolescents. They are accustomed, being dependable and giving children space. Additionally, they postpone childbirth, although they can be stopped when a person wants another kid." (G1/P1).*

> *"Ummm … First, family planning … Moreover, it is used to delay early pregnancy. I use the twenty-eight days' tablets. It has some discomfort, vomiting and body reactions. Some increase menstrual bleeding. People also say that it may lead to sterility*." (G1/P2).

Sexual abstinence is one of the most important family planning methods identified as effective by the participants of the in-depth interview, as it is used to prevent early pregnancy and other reproductive health complications. Moreover, the participants

described their understanding about sexual abstinence and its advantage, and they put it as follows expressing it in relation to different age limits.

> *",,, it is possible to abstain sexually until marriage or one becomes 25-years-old, for it prevent early pregnancy and STIs. Moreover, youth should be physically and economically prepared before experiencing sex." (I/P1).*

> *"… Sexual abstinence is possible until the age of marriage or become 15-years-old. It is done for fear of unwanted pregnancy; it also prevents acquiring STIs. If sex is started before this age, especially girls may be exposed to fistula." (I/P4).*

> *"… it is possible to abstain up to time of marriage, i.e, 18-years-old. After this age young people can plan to marry and decide what to do."* (I/P3).

Code 2: Education and training (knowledge on SRH)

Some of the respondents did not know how to get the health services essential for them. Regarding the personal care taken by the young people of age 15 to 24 years during their menstrual period, most of the participants indicated that they do it.

> *"umm…still, I am not clear about the services specified for the youth including me. Therefore, we need further elaboration and basic trainings." (I/P2).*

> *"It is important to prevent infection." (I/P5)*

> *"… because they should be clean and free from bad smell*." (I/P8).

Code 3: Antenatal care

Antenatal care is one of the components of this sub-theme. Few participants described the availability of antenatal care service in the institutions they visited. An immunisation for tetanus was considered as one of the components of antenatal care by the respondents:

"In addition to follow up services, there are antenatal care service for pregnant women in the institution that include TT immunisation and physical examinations." (G1/P1).

Code 4: Delivery care

Few participants indicated that there was delivery service in the institution they visited. They perceived that giving birth in health institution prevents complications related to birth.

"… *there is delivery service in the hospital. I went there to give birth. It prevents complications like haemorrhage*." (G1/P3).

Code 5: STIs and HIV/AIDS

Regarding STIs including HIV/AIDS, the participants described the availability and management of the services in the institutions, the information they have about the services and their perception on the STIS and HIV/AIDS. They also mentioned their sources of information about the problems.

"*Eh … from the services which have been given to the young people HIV/AIDS counselling and testing are the major ones …" (G1/P1).*

"HIV/AIDS is a disease that can't be cured; It is a sexually transmitted disease that can be spread through unprotected sex and through sharp objects. I heard about it from Television and in school." (!/P2).

Code 6: Abortion

Most of the participants described that abortion is an illegal act which has no use; moreover, doing so is a sin. But some others described it as an act that may or may not be important depending on the situation it is conducted. There were some that considered it as a revenge measure against their partners with whom they got into disagreement because of the pregnancy. A few said, it can be considered as a family planning method to get rid of unwanted pregnancy.

"*I know about abortion. It is an act that is strictly forbidden in our culture and religion. It is even considered as a sin because it is taken as a criminal act. So, it is not necessary." (I/P1).*

"… I know about it. It may or may not be important. When unwanted pregnancy occurs for instance, it may be important. It helps to get rid of unwanted pregnancy. When there is parental conflict girls tend to abort to avenge their partner, which is very bad to do." (I/P6)

5.3.2.1.2 Sub-theme 1.2: Mental and behavioural health services for the young people of age 15-24 years (young people)

The participants indicated that most young people were behaviourally exposed to different harmful substances such as use of *chat*, alcohol, hashish and drugs. As a result, they were exposed to stress, academic failure, violence and assaults. They also described that in most of the hospitals there were units established to give mental and behavioural health support though they were not equipped with the necessary professionals and equipment. The respondents further indicated that there were cultural and religious ways of managing mental and behavioural problems of young people.

Code 1: Treatment and support on substance abuse and suicide attempts

The participants described that there was a problem in provision of the health services or treatments and supports on substance abuse and suicide attempts.

"*My friend frequently attempts a suicide. I took her to the hospital, but she couldn't get clinical support because the unit established to handle such a case in the hospital didn't have a professional that can treat her accordingly. They should provide a treatment and counselling service." (I/P1).*

"Umm … it is true that there are young people who are exposed to violence and assault. Some drink and get intoxicated, others take hashish, and some others are addicted to drugs. There are traditional and cultural ways of treating them by respected fathers in the village." (I/P3).

"… they lead to dangerous feelings and acts such as stress and suicide. Young people, either deliberately or not engage into dependence of substances that gradually leads them to stress, depression and academic failure. Consequently, they may commit suicide."

"uhh … as we know, youth age is a fire age. It is a period I which youth try and test everything that they are exposed to. Abnormal behaviours such as excessive alcohol drinking, chewing chat, smoking cigarette and other substance uses are mostly experienced at this age. I our surrounding, religious or spiritual management is mostly applied for these consequences." (I/P7)

5.3.2.1.3 Sub-theme 1.3: Nutritional and chronic diseases in the young people of age 15-24 years (young people)

Participants described that the economic or income issue basically influenced the nutritional lifestyle of the young people. Moreover, culture, religion, availability and their level of awareness were also considered to be fact.

Code 1: Nutrition and chronic disease

The diet preference of the young people enables them to have better physical and physiological preparation during their pregnancy. However, young people do not give time to their nutrition. The availability of food items also affects their preference.

"Young people are not concerned with their diet preference. They simply use what their parents provide. Because parental income matters it." (I/P7).

"Ok … availability of the food item has an impact on preference. Even though most part of the Zone is rich in teff, other varieties are not available in a desired manner. … there are also poor once who cannot afford to purchase and consume the available items." (I/P9).

"Young people are not worried about their nutritional health. I think our eating habit is mostly influenced by our religion, culture, and tradition. In our society, both Muslims and Christians fast many days of the year. Most females do not eat meat and poultry products even when they are lactating as an influence of our religion and culture." (I/P4).

"We need to have balanced diet, but no one can afford the cost?." (I/P11).

5.3.2.2 Theme 2: Health service quality provided for the young people of age 15-24 years (young people)

In this theme, the young people of age 15-24 years described that the safety of youth clients, effectiveness and appropriateness of the services provided, young people' participation, accessibility and efficiency, confidentiality and consent, competence, information management, evidence-based medicine, education and training and client participation.

5.3.2.2.1 Sub-theme 2.1: Quality health care for the young people of age 15-24 years (young people)

Care Code 1: Safety and privacy

The participants indicated that their safety and privacy were kept well. Most described that there were good conditions to keep their safety and privacy. The rooms were closed and screen was used in some of the hospitals. However, there were doubtful conditions in that the services were not provided in a separate room arranged for the young people. They were given in the MCH room shared with adult mothers.

"*umm … it was better. They tried to use a screen as well as to close the doors of the exam room during examination." (I/P2).*

"Even if their treatment was good, there was no separate room for the young people. They examine young people in the MCH room with other mothers." (I/P8).

"Oh ... there was no separate room for us. I think it was a room for all females. There was disturbing noise near to it. I suspected that others might hear what we were discussing" (I/P11).

"… because of poor documentation system, I encountered a problem of losing my ID number. They did not have computerised system." (G1/P7).

"… In contrast, the physician annoyed me that she did not keep my privacy during the counselling and examination phase. She did not give me the necessary attention while treating me because of that I was psychologically disturbed and I was not sure that she helped me properly." (G1/P3).

Safety was considered by both clients and caregivers as an important component of the health service. The participant indicated that caregivers wear personal protective equipment when they examine the client, for it safeguards the life of the client.

"*… the physicians tried to keep their safety wearing complete personal protective equipment." (G4/P6).*

There was also a problem in keeping the documents of the clients. The participant described the poor documentation system in the hospital.

"… because of poor documentation system I faced the problem of losing my previous ID number. When I asked them, they said they couldn't find it, as there was no computerised system in the hospital." (G1/P7).

Moreover, the participant indicated that clinical services should be provided in a procedure free of contamination using sterile or clean equipment.

"*I want the service to be done with clean equipment." (G1/P1).*

Code 2: Effectiveness

According to the participants' description, the final outcome of the service they received did not achieve their service need. Participants indicated that the services provided for them were not done in a right way. There were disparities between the prescribed medications and the diagnosis.

"Misdiagnosis was the critical problem I encountered. The examiner told me that I was positive for pregnancy test. However, I did not have any sexual contact before. I reacted annoyingly and he was not ready to accept my defense. I appealed to the medical director. After discussing on the issue they made me

have the second test. "The result was negative. After that time, I did not go to that hospital. I hate it." (G1/P6)

"I received wrong drugs that were not helpful for me. I have looked the name of the medicine written on the prescription paper was "Paracetamol", but the pharmacist gave me ciprofloxacin. I told her that she was mistaken, fortunately, she admitted her mistake and gave me the right medicine." (G1/P2).

Code 3: Appropriateness

Participants described that there were service providers or professionals that give appropriate information for the clients about the health care they provide. However, they indicated that the service should be provided in safe and ethical manner.

"*I know those who did not receive treatment service for their diseases for example, kidney infection, STI and HIV/IDS, and these might be because of lots of factors such as accessibility of the institutions, lack of appropriate professionals, materials and equipment's, cost of the service, and ethical discipline of the health staff." (G1/P8).*

"… service providers told me about disease prevention, how to take drugs prescribed to me, their side effects and follow ups." (G1/P3).

"It should be given with standardised procedures." (FG2/P7).

"It should be given safely, in ethical manner, with full awareness about the services." (G1/P6).

"… they did not ask me to give feedback." (G1/P7).

"There should be enough number of physicians." (G3/P10).

Code 4: Client participation

Regarding their participation during the service provision in the institutions, the participants described that most of them were not given chance to ask. The providers were not voluntary to listen clients' requests.

"… they were not voluntary to listen to clients' requests." (G2/P2).

Code 5: Accessibility

"E … 1st, the institution should be accessible round. It should be where there is high population." (G1/P8).

"I agree with her answer. Additionally, it should be in areas where there are more cases like lowlands." (G1/P7).

"It should be near to transport road. It should also not be in areas where public health emergency like volcano, earthquake and fire are common and anticipated and." (G1/P5).

Code 6: Efficiency

Regarding the efficiency of the services, participants responded that there is shortage of supplies, and service delivery time problem.

"I know they are not efficient because of different reasons such as, shortage of drug availability, inconsistent service delivery time, early office leave, and frequent meetings during the work time." (G1/P9).

"I faced the problem. The cost requested was over my capacity." (G2/P6).

"I want the service to be done …, instantly and timely following the desired quality procedures." (G1/P1).

"I did encounter a challenge. The physician appears in his office after we waited for her for 3 hours. Even after coming to office she entertained few cases only. Most of the clients were told to come the next day. I was from those appointed for the second day. I did not go by that day." (G2/P2).

"There was an appointment and programming problem. They did not keep their time." (G2/P1)

Code 7: Confidentiality and consent

The participants described the question whether there were any difficulties in this area which made the young people perceive the services were not secured and prevent them from going to the health service or not. Lacking trust on the confidentiality of the services hindered them from going to the institutions.

> *"… safely, in ethical manner with full awareness about the services." (G1/P6).*

> *"… some with ethical problem or confidentiality problem. It prevents me from going there" (I/P6).*

Code 8: Competence

The participants indicated that they know youth people who had a health problem for which they could not get appropriate treatment.

> *"I received wrong drugs that were not useful for my case. When I looked at the prescription paper it was "Paracetamol" written on it. However, the pharmacist gave me ciprofloxacin. I told her she was wrong, after admitting her mistake and extending her apology for that she gave me the right medicine." (G1/2).*

> *"My sister, who was 19-years-old, went to the hospital. She received incorrect prescription from the physician, but the dispenser informed her to go back to the physician for correction, as the prescribed medicine was not correct." (G1/P6).*

> *"The physicians are not confident enough that they have the desired knowledge." (G3/P3).*

Code 9: Information management

According to most participants' response, information management in most of the hospitals was not good. They indicated that because of poor documentation and information management system in the institutions, their previous files were lost Moreover, information gathering system to get client feedback was not strengthened.

"… my file was lost, and was obliged to have a new one." (G3/P7).

"… because of poor documentation system, I encountered a problem of loosing my ID number. They did not have computerised system." (G1/P7).

"Even though, I saw a feedback box around the corridor, I did not give any feedback." (G1/P3).

Code 10: Education and training

One of the answers given by the participants for the question, "What do you expect from health institutions and service providers regarding behavioural health and substance use?" was that they should give heath education on problems and services provided for the young people in the health institutions. Moreover, they indicated that young people did not utilise the health services well because of lack of awareness on their services.

"There should be health education on how to take drugs, substance abuse, and psychological assistance." G1/P7

"E … now, in our surrounding, sometimes health education is given for those who live along the street. However, there is lack of awareness regarding services provided for the young people." (G3/P10).

"… because of lack of awareness they do not utilise the services well. They do not have better awareness on the available services, their purposes and disadvantages." (I/P5).

5.3.2.3 Theme 3: Challenges/factors related to providing services to 15-24-year-olds (young people)

In this theme demographic and socioeconomic, socio-cognitive and institutional challenges and/or factors were described.

5.3.2.3.1 Sub-theme 3.1: Demographic and socio-economic challenges/factors in the young people of age 15-24 years

Code 1: Age

The participants described different age boundaries on defining sexual and/or marital age and age of early marriage and its advantages and disadvantages as requested as the component of reproductive health service issues.

> *"Early marriage is marriage held in less than 18 years or marriage with elders. It is not useful, as it may cause problems like uterine problem." (I/P2).*

> *"If it is in less than 15-years-old, is not acceptable, as it leads to early pregnancy, school drop-out, economical and physical complications. She may also develop fistula." (I/P9).*

Code 2: Violence

Participants described that violence against young people is a commonly experienced act in their areas. They indicated there were different forms of violence in their area that resulted in lifelong physical and social consequences and even death on some of their friends.

> *"Some forms include abduction and forced sexual act which results in unwanted pregnancy, reproductive organ malfunctions due to fistula and psychological problems likes tress and suicide." (I/P3).*

> *"Yaa ..., they are common experiences in our surrounding. forced and early marriage, which leads to school dropout for most of the young people, domestic abuse, commercial sexual exploitation; and in some areas crime are few of them." (I/P1).*

Code 3: Social influence

Social influences expressed in terms of familial cause, school related once, cultural norms, and unemployment were the most important social factors related to young people' life and health service seeking behaviour and utilisation.

"Ok … there are different types of causes such as academic failure, familial disputes, culture, lack of awareness about the impacts, hopelessness after some incidents like loss of family etc." (I/P2).

"Young people are exposed to different bad things. The most important one is exposure to substances. These days, the number of chat chewers is increasing. School drop-out can lead to alcohol dependence smoking and adultery." (I/P11).

Code 4: Religion

Of different difficulties or challenges in their area which prevent youth from going to the health service, the participants described religion as the most important one. The participants also indicated that most Orthodox Christian and Muslim religion followers did not accept family planning and safe abortion services since they are considered as a sin in their religion's dogma.

"Traditional thinking related to culture and religion especially about family planning and safe abortion services are most important challenges. Abortion and using family planning service are considered to be a sin in our area." (G3/P5).

Code 5: Residence

According to the participants, young people from the rural part of the region faced transportation challenge to come to service providers as compared to those from urban areas. They also indicated that the awareness level of the rural young people was not sufficient to initiate them to get the services.

"Lack of transportation; Young people from some rural areas are challenged by transportation access to reach the health institutions since they are not easily accessible. And they also do not have enough awareness regarding advantages and disadvantages of youth health services as compared to those who came from urban areas." (G1/P3).

"Two years ago, I was with irregular vaginal bleeding following my pregnancy. I did not get transport access timely and there was no ambulance service. Hence,

I was obliged to travel on foot for 3 hours to reach the health institution which was too tiresome." (G1/P3).

Code 6: Income

The participants described that there were young people who had a health problem for which they did not get help due to economic problem. They also said that the existence of health insurance made them happier because some of the young people' family got chance to be served in such a system.

"I heard that my friend could not accept treatment for STI due to lack of money." (G3/P3).

"My parents' economic inability that made me not to have better investigation like cervical cancer disappointed me much." (G3/P9).

"I was in economic problem to buy medications. I often borrow money to get treatment." (G4/P7).

"Lack of job or unemployment is, I think, a major cause. Graduates fed up if they do not get job. The crisis of war in the region is typical cause for instability and unemployment. Many young people become robbers and substance users." (I/P8).

Code 7: Familial/parental monitoring

Participants described the consequences of parental monitoring differently. Some said it has its own positive influence, but most explained its negative influences which makes the youth in not to get freely the health services they need.

"… for this question … ok, what I know is they don't go to health centres because of fear of their parents." (G3/P7)

"My friend hadunwanted pregnancy. She did not tell her family, she did not go to the health institution too because of her family." (G4/P3).

"It is good. For instance, it prevents unwanted and unplanned pregnancy." (I/P6).

Code 8: Peers' influence

Regarding the influence of peers on the life of the young people, participants described that most of the young people could be misled from their right way because of their peers. Peers led to bad areas like to house of drinks, hashish, *chat* chewing and other robbery acts.

> *"… peers' influence has bad outcome." (I/P2).*

> *"… peers' pressure is very difficult in that it leads to bad acts such as alcohol, hashish, chat, violence and thefts." (I/P3).*

5.3.2.3.2 Sub-theme 3.2: Socio-cognitive challenges/factors in the young people of age 15-24 years (young people)

The participants of the study described the effects of health seeking behaviour, perception on services, and perception on nature of illness on the services provided for the young people.

Code 1: Health seeking behaviour

Some of the participants described that they visited a health service institution for diagnostic, antenatal care follow-up, natal care, and to get treatment services for their illnesses.

> *"I visit it to seek treatment. I was sick." (I/P1).*

> *"I go there for follow-up of antenatal care." (I/P10).*

> *"I went to give birth." (I/P11).*

Code 2: Perception on service

The participants indicated that youth people did not utilise the SRH services well?

"… because of the shortage of services like drugs and medications and the flow of too many clients, most uses did not utilise the service well." (I/P1).

Code 3: Perception on nature of illness

The participants described what they heard of youth people who have had a health problem for which they could not get help. They described about that situation which the group felt. They also described about their perception about the nature of the problem or the illness including HIV/AIDS.

"I heard and I know a person who suspected that the professional might say his disease was HIV/IDS. For fear of this I did not go there." (G2/P1).

"A disease with no cure, it transmits by sex and sharp things." (I/P1).

The participants also described their perception about substance use and health (Chat/Kat, Hashish, cigarette or tobacco, alcohol, drugs, etc.).

"They are harmful, lead to death." (I/P1).

"I know they are dangerous. I was an alcoholic one. I drank varieties of drinks with my peers for more than two years. Mostly, I was out of my conscious level. So it is very dangerous." (I/P5).

Only few of the participants indicated their perception on whether there is any linkage between behavioural health and substance with SRH and what the linkage looked like. However, most of the participants did not know whether there is the linkage between them.

"… there will be effect on new-born e.g mental deficit." (I/P1).

"I don't think." (I/P4).

5.3.2.3.3 Sub-theme 3.3: Institutional challenges/factors in the young people of age 15-24 years (young people)

Participants described that cost of services, professional skill gap, leadership, environment and transport, service availability, resource supply, provider client relation and ethics, and providers' attitude determine the provision services for young people.

Code 1: Cost of service

Participants perceived that the cost of some of the services compared to their parental income level was expensive and they could not get the service as they want.

> ***"****My parents' poorness which made me not to have full health investigations dis-appointed me much. So, I think, the cost of some services is not in my capacity and no option to cope with it." (*G3/9).

Code 2: Professional skills gap

The participants described that whether heard of youth people who has had a health problem for which they could not get help and they discussed about that situation.

> *"My sister, 19-years-old, went to the hospital. She did receive incorrect prescription from the physician and the dispenser informed and made her turn back to the examiner and correction was done." (G2/P6).*

> *"I remembered. I was going for long term family planning methods to be in my upper arm. The counsellor made me worried that I will be sterile and there might be excess bleeding. So, I frustrated and did not have it." (G2/P3).*

> *"Ehh … the dispenser did not tell me how I took the drug at that time. I came back after more than 10 km travel to ask about. He asked great excuse, which made me trust him, and went with the corrections." (I/P6).*

> *"I don't know whether a skill problem. They did not communicate the lab results clearly."* (G4/P7).

Code 3: Leadership

The participants indicated the problems related to drug supply, service availability such as timely referral, time management, proper documentation, number of qualified staffs, materials and equipment were the result of poor leadership. A few indicated that they were happy with the communication with those young people having health insurance at that time.

> *"I know and it was because of shortage of availability of services and drugs, inconsistent service delivery time or they close the office earlier and due to frequent meetings during the work time." (G1/P9).*

> *"I faced the problem. My file was lost when I asked and gave my Identification card. I was obliged to have a new one. This was due to the institutional incompleteness in professionals, equipment and materials." (G1/P5).*

> *"I also have faced a challenge. One time, I have been ordered to buy drug outside institution and it was not there. The second time, the service was not there so that I have been referred to regional referral hospital for cervical cancer screening."* (G3/P4).

> *"… there should be timely referral system. Unless, patients may die with the dalliances."* (G3/P7).

Code 4: Environment and transport

The participants' response for the problems they faced or they heard from their friends includes transport access to reach the institution. They also indicated that health institutions should be set in areas where population is high in number.

> *"Emmm … it should be where there is high population." (G1/P1).*

> *"… one time, 2 years ago, I was with irregular vaginal bleeding following my pregnancy. I did not get transport access timely. No ambulance service. I travelled 3 hours to reach the health institution. I was too tiered."* (G3/P8).

Code 5: Availability of service

Participants described some of the available services in the institutions around. They also gave suggestions on those services to be available and fulfilled, and the available services should be known by the young people.

> *"… in addition, follow up services are given. Actually, there are also antenatal care services for pregnant women in the institution. These include TT immunisation and physical examinations." (G1/P1).*

> *"Services are given at health centres and hospitals. I expect good service. However, they are not known."* (I/P3).

Code 6: Material resource

The participants described the levels of young people' service utilisation is challenged by the inadequate supply of resources. Moreover, they indicated their own experience and the problem they faced and the reason for the occurrence.

> *"… services are not good. There is shortage of drugs, are costly, there is time wastage." (I/P2).*

> *"I know those who did not receive treatment service for their diseases for example, kidney infection, STI and HIV/IDS, and these might be because of lots of factors such as accessibility of the institutions, lack of appropriate professionals, shortages of drugs, materials and equipment's, …"* (G1/P8).

> *"When my friend was sick, there was no drug in the institution. She went to private pharmacy, but she couldn't buy the medicine because it was too costly to afford. Because of that she went to her home with no treatment. Instead, she started taking traditional medications." (G4/P2).*

> *"I faced shortage of medications in the hospital. They ordered me to buy from the private pharmacy which was costly."* (G3/P4).

The participants indicated some of the measures which should have been taken to combat those challenges.

"E … there should be enough drug and medication supply by the government. Clients should not be sent outside of the institutions to buy medications." (G2/P1).

Code 7: Provider client relation and ethics

Regarding the provider client relation and the ethical issues during the youth-care giver interaction, the participants described that the care givers approached differently. Some care givers approached in good manner, but others did not.

"I did get a service I disliked. There was voluntariness problem to briefly discuss the problem I faced. They were not ethical and did not to communicate with me politely. They were not happy to approach me brotherly and treat kindly." (G1/P5).

"… what I liked was their approach. They greet me well. Asked me why I went there. However, there was timing problem in the hospital. They did not come to their room for an hour." (G1/P1).

"… ethical problems of the professionals. They don't have respect for their clients. They insult, discourage and undermine them. They were not voluntary to be asked." (G1/P7).

However, some of the participants witnessed for those caregivers who admitted their mistakes politely.

"I received wrong drugs that were not useful for my case. The name of the medicine written on the prescription paper was "Paracetamol", whereas the pharmacist gave me ciprofloxacin. I told her she was wrong, and admitting her mistake and asking me an apology; she gave me the right one." (G1/P2).

"… the dispenser did not tell me how the drug was to be taken. I did not have his phone. After I went to my house, I travelled 10 kms back to ask for clarification. He asked great excuse, and made me trust him, and gave corrections." (G2/P6).

The participants also suggested what they expect in the service provision:

> *"E … 1st, standardised, professional, ethical service should be delivered. There should be equal treatment with no discrimination to language and religion." (G1/P8).*

> *"… the care giver should have provided the services politely, voluntarily, transparently, ethically and, in a standard procedure."* (G2/P1).

Code 8: Professionals' attitude

Participants reported that the providers' attitude affected the quality services provided.

> *"… they were not voluntary to be requested." (G2P/2).*

> *"Their attitude is partly good. It depends on professionals' attitude." (I/P7).*

> *"Not good. Their attitude poor, there is also a knowledge gap."* (I/P8).

5.4 SUMMARY

Chapter 5 presented the outcomes of the focus group and interview surveys. In Chapter 6, the results will be discussed and integrated into the overall interpretation of quantitative and qualitative outcomes to resolve research issues and determine whether quantitative and qualitative outcomes concur or contradict one another.

CHAPTER 6

INTEGRATION, INTERPRETATIONS AND DISCUSSIONS

6.1 INTRODUCTION

This chapter integrates, interprets and discusses the quantitative and qualitative conclusions of the data collected in the Phase 1 (quantitative) and Phase 2 (qualitative) studies. The associations of variables of the study were described in the analytical findings in Chapter 4. Whereas in Chapter 5, the themes and codes were described, substantiating them with extracts from the verbatim quotations of the participants. An overall picture of the findings is presented through interpretation. Integrated findings for qualitative and quantitative data presented on a theme (Creswell 2018:349).

The findings highlighted the challenges faced by health care services for young people aged 15-24 in terms of use and quality. The challenges for the young people' service delivery were demographic and socio-economic (age, violence, social influence, religion, residence, income, parental monitoring and peer influence), socio-cognitive (health seeking behaviour, perception on services and perception on nature of illness) and institutional (cost of service, professional skill gap, leadership, environment and transport, shortage and lack of supplies such as equipment, drugs, policy and guidelines, provider-client relation and ethics and professionals' attitude). Based on the results, strategies were developed to improve the quality and use of health services for young people. Recommendations were forwarded to relevant structures where permission was sought to evaluate the current health care services provision for young people and to determine the challenges for the utilisation of the services to improve the strategic approaches at all levels of health service delivery.

6.2 INTERPRETATION AND DISCUSSION OF INTEGRATED FINDINGS

6.2.1 Health service coverage

This study sought to evaluate the health care services by the young people of age 15-24 years (young people). This study looked at how health services for the young people

related to SRH, substance use, mental health, and nutrition are provided. As this was a mixed study, an in-depth investigation was made to understand how and to what extent the young people utilise the health services. This study provided a comprehensive overview of the use of health care services by young people. The results showed that people in the study were not getting the care they needed from the different levels of health care institutions they were attending.

6.2.1.1 Sexual and reproductive health service utilisation

As puberty approaches, many young people become increasingly concerned about their sexuality and gender identity. In some cases, these questions may arise before the onset of puberty (National Academics of Sciences, Engineering, and medicine 2019:49). The result of this research showed that SRH care services provided in the study set-up are family planning, health education and counselling, antenatal care including immunisation for tetanus, physical assessment for anaemia and its complications, STI and HIV testing, treatment and safe abortion. The result of the study also showed that age of the young people is significantly associated with SRH service which is supported by (Tilahun et.al 2021:1).

The finding of the study showed that SRH services were provided at different levels in the different health institutions. According to this study, the reasons young people went to the health institutions for SRH services are related to family planning, antenatal and natal care. Some of the participants indicated that they believe family planning methods lead to sterility and as result decided not to use it at all. This result is supported by the study done by Karijo et al (2020:25) that addressed very low reported levels of inability in young people to have access to health care services related to SRH. The result of the study also indicated that the contraceptive utilisation by the young people who had sex was low, at 32.67%, and it is supported by the study done by Abate, Ayisa and W/Mariam (2019:12), which showed contraception use among youth was 24.8% which was low, and as further indicated by the research. This low service utilisation might expose young students to a variety of reproductive health risks, which had a detrimental effect on their future wellbeing and hindered the achievement of the country's youth health policy objectives.

The study done by Latunji and Akinyemi (2018:52), confirmed the result of this study that level of education has significant positive association with health service utilisations and health seeking behaviour. In this study, marital status and income status were statistically positively associated with utilisation of health services, and the result is supported by (Workie et al 2021:5). Even though the legal age for getting married in many countries like Ethiopia, India, Vietnam, and Peru is 18 years, early marriage has still high prevalence in Amhara Region (Aychiluhm *et al* 2021:1). In this study, the result showed that the level of understanding of respondents about early marriage varied. Most of the participants answered that it is before 15 years and some others indicated it before 18-years-old.

According to the result of this study, female young people understood personal care during their menses time was to prevent contamination and bad odour. The result of the study showed that young females went to the health institutions to get ANC and delivery related services. The participants responded that giving birth in health institution prevents birth related complications. The result also showed that the participants got information regarding transmission and complications of SRH problems such as STIs and HIV/AIDS from television and school. The study in West Arsi Zone in Oromia Region, Ethiopia, done by Demelash, Yadessa, Abdisa and Assefa (2020:3) supported this finding. The result of the Qualitative strand of this study showed that most participants did not accept the legality of safe abortion and they said that it was considered to be a sin, and had no use, and not necessary at all. But some of the participants responded that abortion was taken to be a revenge measure against their partners when they quarrel with them. Only few participants said it could be considered as a family planning method to get rid of unwanted pregnancy. The quantitative result showed most 106 (70.2%) respondents did not have information about safe abortion care services. However, most participants 64 (61.54%), from those females who ever had been pregnant, ended with abortion, and this finding is supported by Demelash et al (2020:3). The study by Kerbo et al (2018:1) also revealed that only less than half of the youth were using youth friendly services.

6.2.1.2 Substance use and mental health service utilisation

Suicide and violence related to mental health issues are often overlooked when it comes to global health, but they are a major contributor to health issues that affect 10-20% of young people (Wonde et al 2018:1).

According to the result of this study, young people were behaviourally exposed to different harmful substances such as use of *chat,* alcohol, hashish and drugs, and as a result they were exposed to stress, academic failure, violence, assaults and suicidal act. The study done in Ethiopia by Oljira (2016:25) supported the finding that addictive substances such as *Chat*, tobacco and alcohol are widely used by the young people and they were taken to be the major factors of suicidal act and other maladaptive behaviours. The result also revealed that most institutions in the study set-ups did not have assigned professionals in their units established to give mental and behavioural health support. Moreover, cultural and religious (for example, going to priests to tell their sin and baptising) ways of management were considered to be crucial. Youth clients did not trust the institutions and their caregivers for fear of disclosure of their private issues. A study done by Goicolea et.al (2018:1) supported the result, and it suggested that to improve access to mental health services, health institutions need to be trusted by young people and should have a multi-disciplinary team to deliver the services.

6.2.1.3 Nutritional Health service utilisation

Young people are one of the population segments of 18.1 million people who suffered from food insecurity in Ethiopia and required food assistance (Sisay 2019:5). Despite food insecurity and other related factors, healthy eating is perceived by 18 and 25-years young people with depression, as both time-consuming (82%) and expensive (70%) (Bayes et al 2020:1). According to the participants of the study, the socio-economic issues including income, culture or eating habit, religion, availability of food items and their level of awareness basically influenced the nutritional lifestyle and food preference of the young people. As a result, young people are not worried about their nutritional health; youth females do not eat meat and poultry products even when they are lactating as an influence of their religion and culture during fast time. Moreover, they do not take iron rich diets during their menses.

The study done in Ethiopia by USAID (2018:4) supports the finding revealing the fact that despite Ethiopia's great progress and improvement in health and nutrition over the past 30 years, poor nutrition remains a persistent challenge and the prevalence among women of reproductive age were expressed 24% for anaemia. Providing young girls with the right information to make healthy choices would be a great way to help them make lasting

changes throughout their lives when it comes to making dietary changes (Baxter et al 2018:103).

6.2.2 Health service quality

The primary focus of high-quality health services is to address complex issues through the implementation of prevention, detection, and response strategies, as well as the preservation of peace and the safeguarding of the economy, which in turn, results in improved health outcomes, reduced health inequalities, and improved economic growth (Perehudoff et al 2020:54). The researcher included the following quality indicators to evaluate health services to young people (young people of age 15-24 years) in East Gojjam, Ethiopia.

6.2.2.1 Accessibility, appropriateness, efficiency, effectiveness and client participation

Quality improvement refers to improvement in outcomes or effectiveness, decrease cost and waiting time, improve accessibility and improve the appropriateness of care experience for providers and staff (Kilkenny & Bravata 2021:419). The participants of this study described that the health institutions were not accessible and they recommended that they should be in areas where there is high population and transport access. They should not be in areas where public health emergency like volcano, earthquake and fire are anticipated and frequent.

The result also showed that the services in most of the institutions were not efficient because of shortage of drug availability, inconsistent service delivery time because they close the office earlier and due to frequent meetings during the work time. The cost of the services requested in most of the institutions was also not affordable; young people did not participate in the process, and these challenges collectively reduced the efficiency and effectiveness of the services. A study by Nkole et al (2021:353) strengthen the result. Efficiency and effectiveness of service delivery factors, such as information dissemination, proper time utilisation, proper material and drug supply and community engagement through community participation are also important to ensure health service quality.

6.2.2.2 Leadership, competence, education and training

This study revealed that the participants concluded that the problems in most institutions that are related to drug supply, service availability such as timely referral, time management and proper documentation, recruitment of qualified staffs, materials and equipment were the outcome of poor leadership. The result also showed that most health institutions did not give heath education on problems and services provided for the young people. Moreover, the result indicated that young people did not utilise the health services in a desired manner because of lack of awareness on their purposes. Gebrie et al (2021:16) concurred with these findings, finding that the poor quality of adolescent and youth health outcomes was due to a number of structural factors, including a lack of trained and experienced providers, weak facility governance structure, inadequate guidelines, protocols and procedures, and poor compliance with national standards, as well as poor output.

6.2.2.3 Safety and privacy, confidentiality and information management

Privacy and confidentiality are barriers to access quality services (Thongmixay et al 2019:10). The result of this study showed that the safety and privacy of most young people who went to get the services did not keep well. The services in most institutions were not provided in a separate room arranged for the young people alone. They were given in the MCH room that was used for other maternal services. Only few participants of the study described that there were good conditions to keep their safety and privacy in which the rooms were closed and screen was used. The result also showed that there was poor documentation and information management system in most institutions. This result is supported by the study which indicated that young people's services are poorly documented so efforts should be intensified to improve the quality and completeness of health registers (Doyle et al 2019:1).

6.2.3 Challenges (factors) influencing health services to the young people

The results of this study showed that there were three classes of challenges/factors including demographic and socio-economic (age, violence, social influence, religion, residence, income, familial/parental monitoring and peers' influence); socio-cognitive (health seeking behaviour, perception on service and perception on nature of illness);

and institutional (cost of service, professional skill gap, leadership, environment and transport, availability of service, resource supply, provider client relation and ethics and professionals' attitude).

6.2.3.1 Demographic and socio-economic factors

The result showed that the age of young people was considered to be a factor that led them to different problems such as early marriage and its consequences. Participants described the age limit for early marriage differently. However, most of them agreed, it is before the age of 15 years. Nkole et al (2021:359) supported the finding. Most respondents of age 18-24 (93.36%) in this study strongly agreed with the importance of RH services in general. However, the result specific to the utilisation of family planning methods showed only 99 (32.67%) of the respondents used contraceptive methods. Participants of this study also described that there were different forms of violence including abduction, forced sexual act, domestic abuse, commercial sex exploitation, forced and early marriage that often resulted in lifelong physical and social consequences including school dropout, unwanted pregnancy, reproductive organ malfunctions due to fistula, psychological problems like stress and suicide and even death in some of the young people. Rice et al (2018:S9) supported the finding.

Moreover, social influences including parental monitoring, school related issues, cultural norms and unemployment were the most important social factors related to young people' life and health service seeking behaviour and utilisation. Regarding religious influence, the participants of the study described that most Orthodox Christian and Muslim religion followers did not accept family planning and safe abortion services since such services are considered as a sin in their religion.

Regarding the impact of residence on the health service utilisation, the result of the study, showed young people who were from the rural part of the region were more affected than those from urban areas. The participants also indicated that the awareness level of the rural young people to get the services was lower as compared to the urban once.

6.2.3.2 Socio-cognitive influences on health services for young people

The result of the study addressed the health seeking behaviour, perception of the young people on services and nature of illness. The study by Ngwenya et al (2020:2) supported this finding, and it indicated socio-ecological and behavioural factors like perceived negative attitudes of health providers and perceived poor staff competencies, normative beliefs, fear of stigmatisation and gossip are additional challenges.

The result showed that young people visited a health service because they had concerns about their health and the communal reasons were to seek treatment and follow up cares. Whereas the study by Mboweni and Sumbane (2019:67) showed family planning and antenatal care were the common reasons for seeking health care. This study also showed that in health institutions, the services provided had lots of challenges, and they made young people to doubt and question the outcomes of these services. Moreover, the result indicated the participants heard of youth people who had a health problem but did not get help. According to the result, the nature of illness such as HIV/AIDS made a sense of fear of societal discrimination among the young people, and they did not seek the health service for it. The participants also perceived that there is linkage between behavioural health and substance use with SRH and what the linkage might result in bad foetal effect.

6.2.3.3 Organisational barriers/factors on health services for young people

The result showed that high cost of services was one of the challenges to get the service by the young people. This is supported by Kalseth and Halvorsen (2020:435), which concludes that the cost of the health service (pharmaceuticals and medical tests) as well as the out-of-pocket costs (travel to health care facilities) are the primary determinants for the youth. Professional skill gap in diagnosing and prescribing correct drugs, administering medications at proper sites, communicating the lab results on the service provided for the young people are additional factors. The EDHS (2016:17) confirmed that professionals' skill should be developed through continuous professional trainings to effectively respond to the needs of the young people through breaching inappropriate approaches such as information disclosure, like non-disclosure, judgemental and intolerant views on sex, drugs, and discrimination.

The result of this study also pointed out poor leadership resulted in the supply related problems such as drug, equipment and material, service availability such as timely referral, time management, documentation and number of qualified staffs. A scoping review by Garney et al (2021:1), supported the finding in that organisational or structural barriers in health care systems that hinder young people from receiving services are leadership related.

The accessibility or transport access was another challenge indicated in the result of the study; institutions were not built in highly populated areas. The study by Thongmixay et al (2019:8) strengthens the finding in that geographical inaccessibility and insufficient availability of youth-friendly health services were the two most important institutional barriers. Regarding the provider client relation and the ethics or disciplinary issues during the youth-care giver interaction, the participants of the study indicated there were unethical disciplinary issues reflected by the service providers which led to disagreements with young people that consequently made the young people not to accept the services provided.

6.3 SUMMARY

The finding of the study showed that health service provision for the young people of age 15-24 years (for the young people), in East Gojjam Zone, Ethiopia was not in an expected level, and it was challenged by different factors. The broadest categories of the demographic, socio-economic, socio-cognitive and institutional factors indicated that there should be an integrated effort towards the improvement of the expected outcomes. The concerned bodies including Ethiopian Ministry of Health (EMOH), the Regional Health Bureau, the Zonal Health Department, the District Health offices, the institutions, the stake holders and the youth clients are expected to cooperatively act for the changes. Hence, based on the results of the study, the recommendations and expectations are forwarded (Chapter 8).

CHAPTER 7

DEVELOPMENT AND VALIDATION OF STRATEGIES TO IMPROVE HEALTH CARE SERVICES FOR YOUNG PEOPLE

7.1 INTRODUCTION

In this chapter, the researcher discusses the development of strategies to enhance the utilisation, coverage, and quality of the health services for the young people aged 15-24 years in East Gojjam Zone, Ethiopia. Based on the literature review, the researcher used the findings to develop and validate strategies. These strategies were validated by public health experts to achieve the third objective in a Qualitative strand, namely:

- To develop strategies to enhance the utilisation, coverage, and quality of the health services for the young people in East Gojjam Zone, Ethiopia.

7.2 DEFINITION OF STRATEGIES

Strategy is shaping the future, how people use available resources to achieve desired objectives (Max Mackeowun 2016:12). It is a series of plans, decisions, or actions designed to help an organisation achieve its goals (Millerand Dess 1996:34). In this study, strategies are the actions that family, community, political, religious and health care institutions should take regarding health service utilisation for young people aged 15-24 years.

7.3 PURPOSE OF STRATEGIES

The purpose of developing the strategies was to provide evidence-based recommendations to help improve the capacity of the institutions to achieve their goals of providing quality health care services to young people aged 15-24 years in East Gojjam Zone, Ethiopia.

7.4 SCOPE OF THE STRATEGIES

The developed strategies work for all health professionals working in the health institutions in East Gojjam Zone. They may also be applicable at the national level, where the development of health education programmes faces challenges regarding the utilisation of health services by young people.

7.5 DEVELOPMENT OF THE STRATEGIES

The strategy development process includes the analysis of process and findings and the identification of national objectives, the development of service quality definitions, and the application of systematic efforts to improve performance through elements of situational analysis, which are integrated into a comprehensive stakeholder engagement process. This process focuses on capacity building and advocacy to improve care and build a culture of excellence across the health system (WHO 2018:15). According to the CMOE (2020:2), strategy development steps include collecting objective data, reviewing current strategy, considering necessary changes, identifying creative strategy tools, creating a customised strategy development process, establishing a foundation for the strategy development process, driving experts to achieve desired results, through the validation, establishing an accountability team and measuring effectiveness (Figure 7.1).

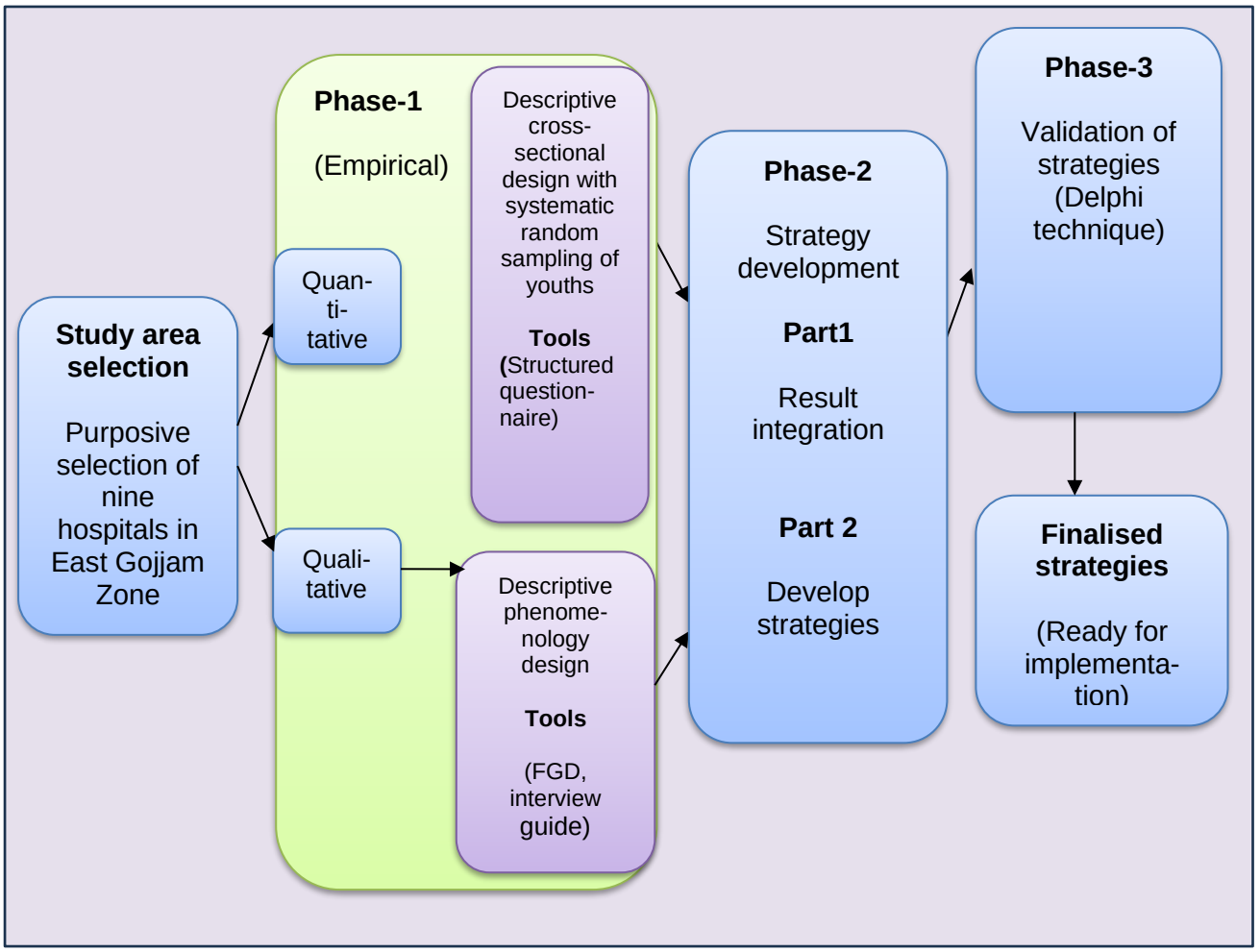

Figure 7.1 Strategy development and validation

(Nunu, Makhado, Mabunda & Lebese 2020)

The researcher examined current national health strategy presented in the health institutions to provide health services to young people. The researcher also considered necessary changes and identified strategic tools for the development process. A team of public health experts was established to achieve the desired outcome, and the outcome was ultimately measured against health service key performance indicators (KPIs).

7.6 VALIDATION OF THE STRATEGIES-THE DELPHI TECHNIQUE

7.6.1 Preliminary stage

In this study, Delphi technique was conducted to elicit expert opinion on the design of the system and the agreed schedule of activities. In the Delphi method, a panel of experts were asked to answer multiple rounds of questionnaires, focusing judgments on topics

of interest through multiple rounds of dialogue (Polit & Beck 2018:319). The researcher used purposive sampling methods to select participants and test the utility of the strategy. Of the 20 recruited experts in the first round of the Delphi process, 18 experts completed the Delphi questionnaire (see Table 7.1).

Table 7.1 Demographic data of the Delphi experts

No	Sex	Age	Position	Experience in years	Academic qualification	Level of education
1	M	42	Head of district health office	16	Public health	MPH
2	M	56	Hospital manager	23	Hospital administration	MSc
3	F	38	Zonal public health coordinator	16	Nurse	BSc
4	M	36	District officer	10	Public health	MPH in Health Service Management
5	M	48	Maternal and youth-friendly health service reproductive health officer	17	Midwifery	MPH in Health Education/Health Promotion and RH
6	M	34	Head of the health centre	12	Health officer	BSc
7	M	45	Head of district health officer	21	Public health	MPH, RH
8	M	34	Researcher at regional public health institute	12	Public health	Master of Public Health (MPH)
9	F	48	Regional maternal and neonatal health technical advisor	25	Nurse	MPH
10	M	35	Public health institute director	15	Public health	MPH
11	M	40	Hospital physician	9	Medical doctor	General practitioner (GP or BSc)
12	M	39	Hospital physician	10	Medical doctor	General Practitioner (GP or BSc)
13	M	38	Surgeon	12	Public health	HO, Emergency Surgeon
14	M	32	Senior bedside ward nurse and severe acute malnutrition focus	8	Nurse	MPH, Epidemiology

No	Sex	Age	Position	Experience in years	Academic qualification	Level of education
15	M	40	National health system quality improvement and innovation officer	13	Nurse	BSc, MPH
16	M	44	District officer	14	Public health	MPH
17	M	50	Ward coordinator	22	Nurse	MSc
18	M	48	Department coordinator	20	Nurse	Bsc, MPH

As shown in the table above, participants had a mean age of 41.5 years (n=18) and held various positions in various departments related to their field of study. They had an average of 15.6 years of experience and are familiar enough with young people's lives to be able to assess or validate the strategies. The academic level for most of them was master's degree or above.

The strategy validation form included the following criteria used in evaluating strategies: clarity, completeness, applicability, adaptability, reliability and effectiveness. Table 7.2 shows the strategy validation results and comments for each criterion.

7.6.2 Round 1

The researcher notified the experts via email and telegrams to send and receive information about Delphi's explorations. The researcher sent a consent form, a strategy validation form and an outlined strategy based on the study results. The evaluation guide includes a three-level scale of approval or agreement based on the AGREE II guideline criteria, with space for comments and suggestions (Annexure BB). The longest evaluation period was two weeks though, didn't take that long practically.

Quantitative analysis of round 1 feedback

The first-round response rate was 90% (n=16). For the analysis, the researcher applied both quantitative and qualitative approaches. In the Quantitative strand, intraclass correlations of response frequencies to the criteria and agreement with SPSS Version 28 were calculated. The Qualitative strand was handled by grouping the strategies and the comments given into themes.

Table 7.2 Health expert evaluation of the strategies: Frequencies of expert responses for each criterion in round-1 Delphi

Validating criteria for strategies	Number of experts responded for each criteria in round-1 (n=18)			
	1	**2**	**3**	**Full acceptance of the strategies (%)**
Clarity	0	0	18	100.0
Specificity	0	1	17	94.44
Reliability	1	1	16	88.89
Flexibility/adaptability	0	1	17	94.44
Effectiveness	0	4	14	77.78
Validity	1	1	16	88.89
Relevance	0	1	17	94.44
Applicability	0	7	11	61.11
Acceptability	1	6	11	61.11
Achievability	0	10	8	44.44

As shown in the table above, all 18 participants (100%) fully accepted the clarity of the strategies described. Regarding strategies' specificity, applicability, and relevance, 17 (94.4%) of the experts for each criterion fully agreed that the strategy was accepted as described. There were 16 (89.9%) experts who accepted the reliability and validity of the presented strategies as described. These strategies were considered prudent, but applicability issues were considered difficult, with seven (38.9%) of the experts who provided comments recommending changes to the strategies, specifically targeting communities and religious institutions. Regarding acceptance of the strategy, 11 (61.11%) of the experts agreed that the strategies could be implemented as described. Only 8 of the experts (44.44%) fully agreed that the strategies were viable as described, while the remaining 10 (55.56%) agreed that the strategies were viable with the recommended changes.

Overall results from the first round showed that the experts agreed on the strategies' clarity, specificity, flexibility, relevance, reliability, and effectiveness with a level of agreement greater than 70% (Slade, Dionne, Underwood & Buchbinder 2014:2). However, no agreement was reached on the applicability, acceptability or achievability of this round of strategies (<70%).

Intra-class correlation coefficients of inter-rater reliability for round 1 outcome

Intra-class correlation coefficients of inter-rater reliability for Round 1 outcomes In this study, intra-class correlation coefficient (ICC) scores were used to determine inter-reviewer reliability. A two-way mixed-effects model was used to measure ICC. The ICC is higher when there is little difference in expert responses (Govender 2018:795). Although there was a lower level of agreement (<70%) for some of the above criteria, the overall quantitative score for this round showed strong agreement (0.807) with 95% confidence intervals in expert assessment.

Table 7.3 Intraclass correlation coefficient for inter-rate reliability (round 1)

Intraclass correlation coefficient							
	Intraclass correlation[b]	95% Confidence interval		F Test for True value 0			
		Lower bound	Upper bound	Value	df1	df2	Sig
Single measures	.295[a]	.151	.522	5.180	17	153	<.001
Average measures	.807[c]	.640	.916	5.180	17	153	<.001
Two-way mixed effects model where people effects are random and measures effects are fixed.							
a. The estimator is the same, whether the interaction effect is present or not.							
b. Type C intra-class correlation coefficients using a consistency definition. The between-measure variance is excluded from the denominator variance.							
c. This estimate is computed assuming the interaction effect is absent, because it is not estimable otherwise.							

7.6.3 Round 2

While broad agreement was reached in round 1 on strategies criteria, no agreement was reached in round 1 on strategies' applicability, acceptability and achievability (<70%). Therefore, the researcher revised the strategies based on the comments received in the first round and sent the document to experts for evaluation against the consensus validation criteria (Appendix CC). Only those who participated in round 1 were invited to this round. After the first round, a summary of general comments was sent to the experts.

Quantitative analysis of round 2 feedback

Of 18 experts who participated in round 1 and were allowed to participate in round 2, 17 (94.4%) responded to the strategies criteria. The frequency and mean values of the within-class correlation coefficients were compared with SPSS Version 28. It was calculated based on the AGREE II guideline criteria for ranking the strategies (Tables 7.4 and 7.5).

Table 7.4 Expert evaluation of the strategies: Frequencies of expert responses for each criterion in round-2 Delphi

Validating criteria for strategies	Number of experts responded for each criteria (n=17)			
	1	2	3	Full acceptance of the strategies (%)
Clarity	0	0	17	100.0
Specificity	0	0	17	100.0
Reliability	0	1	16	94.12
Flexibility/ adaptability	0	1	16	94.12
Effectiveness	0	1	16	94.12
Validity	0	1	16	94.12
Relevance	0	1	16	94.12
Applicability	0	1	16	94.12
Acceptability	0	2	15	88.23
Achievability	0	3	14	82.35

As shown in the table above, all participating experts fully accepted the strategies according to the established criteria. Even though there was no consensus (<70%) on the applicability, acceptability and achievability of the strategies among the experts participating in the first round, in the second round they agreed on all criteria (Table 7.4).

Intra-class correlation coefficient for inter-rater reliability of round 2 outcomes. In a second round, inter-rater reliability was calculated using intra-class correlation coefficient (ICC) scores. As in round 1, a two-way mixed-effects model was applied to measure ICC. In this round, a strong consensus was reached using the ICC mean score (0.891) and 95% confidence interval (Table 7.5).

Table 7.5 Intraclass correlation coefficient for inter-rater reliability (round 2)

Intraclass correlation coefficient							
	Intraclass correlation[b]	95% Confidence interval		F Test for True value 0			
		Lower bound	Upper bound	Value	df1	df2	Sig
Single measures	.450[a]	.277	.675	9.173	16	144	<.001
Average measures	.891[c]	.793	.954	9.173	16	144	<.001
Two-way mixed effects model where people effects are random and measures effects are fixed.							
a. The estimator is the same, whether the interaction effect is present or not.							
b. Type C intra-class correlation coefficients using a consistency definition. The between-measure variance is excluded from the denominator variance.							
c. This estimate is computed assuming the interaction effect is absent, because it is not estimable otherwise.							

7.7 PRESENTATION OF VALIDATED STRATEGIES (QUALITATIVE STRAND BASED ON THE TWO ROUNDS)

Strategy development and validation includes collecting objective data, examining the current strategy, reviewing necessary changes, identifying creative strategy tools, creating a customised strategy development process, establishing a foundation for the strategy development process, driving experts to achieve desired outcomes, establishing accountability teams and measuring effectiveness (CMOE 2020:2). In the quantitative analysis part, the researcher briefly analysed the degree of agreement as shown earlier. The researcher reviewed expert comments on strategies' criteria and put suggestions (Table 7.6).

Table 7.6 Health experts' evaluation of the strategies

Validating criteria for strategies	Comments
Clarity: The specific proposed strategies are simple and easily understandable.	• Strategies are clearly written and they convey precise recommendations.
Specificity: The strategies are targeting or focusing on health service for the young people.	• Most are good but it is better to say youth than young people of age 15-24 years. And most strategies are compressive and addressed to all people. Economic empowerment of the family is also of the strategies to be considered.
Reliability: Other health institutions consistently used the strategies.	• It is difficult to assure reliability consistently used in other health care facilities since the health seeking behaviour is different among people who get services at rural and urban residences. • Might be difficult to address it in other health facilities, for example, at private level.
Flexibility/adaptability: The strategies can be applied flexibly or could be applied in different circumstances.	• Strategies can be applied to different circumstances. However, flexibility may be challenging at religious institutions.
Effectiveness: Strategies are capable to attain the objectives, which is to enhance the utilisation, coverage and quality of the health services for young people.	• Really most strategies are achievable and targeted to the objective. But huge budget and human resource is needed for the specific youth services.
Validity: Strategies are reasonable or evidence-based.	• Strategies are well justifiable. However, a question "What was your evidence to put the strategies?" was addressed by one expert.
Relevance: Strategies are appropriate to enhance the utilisation of health services by the young people.	• Most of the strategies are appropriate to enhance service utilisation.
Applicability: The strategies have the potential to be applied in the formulation of utilisation of health services among young people.	• The strategies are smart, but, applicability issue is challenging specifically to community based and religious institution targeted strategies.
Acceptability: The strategies are realistic and acceptable by the targeted institutions (health, academic and religious).	• Some strategies such as using family planning methods may not be acceptable by Muslim and Orthodox religious institutions.
Achievability: The strategies can be executed by the targeted institutions (health, academic and religious).	• Ensure health extension reform implementation as a strategy. • Sustainable and supportive supervision and coaching is needed. • It is difficult to ensure religious programme in academic curriculum.

The general comments on the strategies which were given in the first round were stated as follows where V stands for Validators and R stands for Researcher. The researcher conducted a qualitative analysis for the experts' responses including those comments.

- V: Most strategies are good, but it is better to say youth than young people of age 15-24 years and most of them are compressive and addressed to all people.
- R: the comment was appreciated that most strategies were good, but it was better to say youth than young people of age 15-24 years and most of them were compressive and addressed to all people. However, young people were segments of the general population and the strategies were also targeted to them.
- V: Economical empowerment of the family is also of the strategies to be considered.
- R: The researcher had made it to be one of family targeted strategies. Because the income level of the family is important for young people to get the health services (refer to demographic and socio-economic challenges in the sub-item in chapter 5).
- V: It is difficult to assure reliability consistently used in others health care facilities since the health seeking behaviour is different among people who get services at rural and urban residences.
- R: The health seeking behaviour for young people can be varied based on the residence. However, the researcher put strategies which can be applied at both rural and urban setups based on the service types targeted to them.
- V: Huge budget and human resource are needed for the specific youth services.
- R: It is expected that the strategies addressed will need budget. Therefore, the recommended bodies and the institutions mentioned for the strategies have to arrange the budget.
- V: Strategies are well justifiable. However, what was your evidence to put the strategies?
- R: Nice, the evidence for the outlined strategies was the findings of the study and taking the previous studies into consideration.
- V: The strategies are smart, but applicability issue is challenging specifically to community based and religious institution targeted strategies.
- R: Every activity is not simple. There will be a challenge at every attempt. Since both the religious and the community organisations are the people themselves, activities of the strategies designed shall better show the how to manage better the challenges

through the development of their awareness.

- V: Ensure health extension reform implementation as a strategy.
- R: The recommendation was recognised and strategies were developed targeted at the health institutions in “strengthening health systems and services”.
- V: Sustainable and supportive supervision and coaching is needed.
- R: Definitely. However, it was addressed in conducting monitoring and evaluation to improve the delivery and effectiveness of health service programmes for the young people. It was stated at “strengthening health systems and services”.
- V: The research topic is on: Evaluation of health education programme regarding the utilisation of health (RH, mental health, nutritional) services for young people in East Gojjam Zone.) However, the listed strategy mentioned can’t address RH, mental and nutritional status.
- R: Yes, the issues about RH, mental health and nutritional status were addressed in the theoretical framework. They were also mentioned in the strategies at numbers 2.1, 2.6, 2.7, 4.2, 4.4. Moreover, most of the issues stated in the strategies targeted on the issues addressing the approaches to increase awareness and manage reproductive, mental and nutrition related challenges.
- V: The overall purpose of the study was to determine utilisation and challenges of health education but the strategy as well as the specific objective includes “assessing health education quality”, so either you have to change the title or remove the objective that try to assess the quality part of the research.
- R: Health service quality was one of the components of utilisation as shown at the theoretical framework. Therefore, the mentioned specific objective was better explained in the strategies under each targeted component to achieve the utilisation. The purpose of the study was to evaluate the utilisation, coverage, quality, and challenges of health service provision for young people in East Gojjam Zone, Ethiopia. Where the study findings were to be used to develop strategies to enhance utilisation of the health services for young people in East Gojjam Zone, Ethiopia.

Based on the remarks and recommendations of the two rounds, the validated strategies had been merged as six themes by the researcher (Table 7.7). A rational and recommendations for each strategy are also presented (Table 7.8).

Table 7.7 Themes and categories for validated strategies

Themes		Categories	
1	Family targeted strategies	1.1	Family and young people free discussions
		1.2	Avoiding gender based maltreatment
		1.3	Economic empowerment
2	School targeted strategies	2.1	Incorporating health service issues in the curricula
		2.2	Evidence-based health education
		2.3	Re-design different teaching modalities
		2.4	Awareness creation programmes
		2.5	Teachers' training
		2.6	Need assessment
		2.7	Media programmes
		2.8	Better leadership
3	Political, security and legal targeted strategies	3.1	Inter-sectorial governance
		3.2	Safer environment and transportation
		3.3	Application of mandatory laws
		3.4	Creating awareness
4	Community targeted strategies	4.1	Community awareness
		4.2	Social development programmes
		4.3	Gender-based violence
		4.4	Community participation
		4.5	Psycho-social forms of managements
		4.6	Environmental modifications
5	Religious institution targeted strategies	5.1	Religious programmes which create awareness in the young people's self-control from malpractices.
		5.2	Comprehensive religious education curricula (religious dogmatic versus scientific issues like fasting versus nutrition)
		5.3	Application of religious programmes in academic setups
		5.4	Preaching love and tolerance
6	Health institution targeted strategies	6.1	Strengthening health promotion
		6.2	Strengthening health systems and services
		6.2	Building partnership
		6.4	Conducting research regarding the young people's health and the challenges faced

7.7.1 Theme 1: Family targeted strategies

Based on the qualitative findings analysed from the collected data, the strategies targeted to the family were developed in this theme. It considered free discussions on reproductive health issues, violence and maltreatments.

Rational for the implementation of the family targeted strategies

The rational for the strategies include scaling the free discussions regarding reproductive health issues like initiation of sexual practices, age of marriage and uses of family planning methods. Free discussions should be taken as means of self-adjustments with perceptions, customs, traditions and beliefs to ensure gender equity and equality and to equip young people with better awareness to prevent themselves from different forms of abuses and violence.

Recommendations for the implementation of the family targeted strategies

A trend of free discussions among family members should be practiced to enhance the capability of young people to control and lead themselves. Familial monitoring becomes effective with the acceptance of the young people. Economic empowerment of the family should also be considered as a strategy.

7.7.2 Theme 2: School targeted strategies

This theme presents issues about evidence-based health services to be incorporated in the need based academic curriculum which addresses different teaching modalities to be implemented with better leadership.

Rational for the implementation of the school targeted strategies

The rationale for the strategies include taking deeper insight to the needs of the young people and addressing those needs in the educational curricula so as to create awareness regarding health services for the young people through different media and enable them to practically apply in their lives.

Recommendations for the implementation of the school targeted strategies

Since young people spend most of their young lives in school, the behaviour change strategies discussed are of paramount importance. Health education methods such as physical activity and dietary changes lead to improved health outcomes. Therefore, it is important to consider these in curriculum development.

7.7.3 Theme 3: Political, security and legal targeted strategies

This theme explored strategies for making young people feel safe in their surroundings. Here, the role of political leaders in improving the lives of young people is well illustrated.

Rationale for the implementation of the political, security and legal targeted strategies

To promote youth healthcare, we need to create a safe, crime-free environment for young people. Health education programmes also need a stable environment to address young people's health issues that are of concern to policy makers.

Recommendations for the implementation of the political, security and legal targeted strategies

A key strategy is the provision of health education to raise awareness of youth health among political leaders. Leaders should seek to promote gender equality in employment opportunities and wages, and to mitigate the impact of war-induced migration, such as in Ethiopia, which endangers the lives of young people. Leaders should also make efforts to improve transportation infrastructure such as roads. Appropriate systems to punish violence and abuse should be put in place, for all crimes committed.

7.7.4 Theme 4: Community targeted strategies

The findings for the quantitative and qualitative data of the research; and the literatures, were the sources of information stated in this theme. Participants mentioned that community related challenges including low economic level; gender-based violence, and low-level participation were some of the factors which affect the health care services provided for the young people.

Rationale for the implementation of the community targeted strategies

Young people should participate in the community to identify community needs, environmental modifications, discussions on social and economic development and elimination of gender-based violence.

Recommendations for the implementation of community targeted strategies

The community representatives should involve young people during their discussions on issues targeted to the health of young people. Young people should participate in discussions and activities related to social development programmes, psycho-social forms of managements, environmental modifications and community participation.

7.7.5 Theme 5: Religious institution targeted strategies

Based on the quantitative findings, religious participation was very much useful for young people. Thus, this theme addressed the rational and recommendations related to the strategies to be implemented at religious institution level.

Rationale for the implementation of the religious institution targeted strategies

Young people might experience self-control of malpractices through different religious programmes which modify their behaviours. Religious institutions are trusted by the young people to stabilise their lives during stresses and suicidal attempts.

Recommendations for the implementation of the religious institution targeted strategies

Religious leaders should reach young people through Sunday school programmes, Gibi-gubaes and communicate them in a way they adhere to religious ethical principles to promote their healthy life. There should be young people centred curricula to address their needs. Additionally, the young people should also attend religious programmes *which play a role in developing tolerance and affection.*

7.7.6 Theme 6: Health institution targeted strategies

According to the qualitative findings, service delivery time, cost of the services, shortage of materials and drugs, prophetical skill gap and leadership problems were the major institutional challenges faced for health care services for young people. This theme addressed the rational and recommendations for the implementation of health institution targeted strategies.

Rational for the implementation of health institution targeted strategies

Health institutions play major role in providing health services for the young people. The fulfilment of facilities, appropriate service delivery and better leadership along with competency of the professionals bring undeniable change in the service provision for the young people.

Recommendations for the implementation of health institution targeted strategies

Young people should improve their health seeking behaviour so that they should develop a trend to go to health institutions and get services they prefer. The health institution managers and leaders should arrange the institutions in a way that they can serve young clients better. Health care givers should improve their professional skill through readings and demonstrations.

7.8 SUMMARY

This chapter discussed the development and validation of the strategies which were obtained from the results of quantitative and qualitative data supported by the literatures. Those strategies were suggested for implementation by the health professionals throughout the hierarchy in the health institutions with the assistance of regional bureau, zonal health department and district offices.

Knowledgeable and skilful stakeholders, including leaders from community, religious institutions, schools and political institutions, regarding the health services for young people can be called to strengthen the service provision.

Conclusions, limitations, and recommendations for further improvements are discussed in the Chapter 8.

CHAPTER 8

CONCLUSION, LIMITATION, AND RECOMMMENDATION OF THE FINDINGS

8.1 INTRODUCTION

Chapter 7 discussed the development and validation of guidelines. In this chapter, pertinent findings from all sources of the data, conclusions regarding the research, limitations of the research and recommendations for further research on the evaluation of health care services for 15-24-years-old young people are briefly addressed.

This chapter also addressed the development of strategies for the explored challenges based on the pertinent findings of the evaluation done in the study.

8.2 PURPOSE OF THE STUDY

The purpose of this research was to evaluate the utilisation, coverage, quality and challenges of health service provision for young people in the East Gojjam Zone, Ethiopia, and to develop strategies to improve the utilisation of health services.

8.3 RESEARCH DESIGN AND METHODS

This study used a mixed method research of the parallel convergent design, which employed equal quantitative and qualitative research methods to evaluate the utilisation, coverage, quality, and challenges of health service provision for young people in the East Gojjam Zone, Ethiopia. Survey and observation were for the Quantitative strand, while descriptive phenomenology was for the Qualitative strand.

The pragmatism paradigm was used both inductively and deductively to explore the multiple perspectives on the provision of health services to the young people in East Gojjam and to answer the research questions (Cohen et al 2018:34). This paradigm was also used in this study to clarify the challenges and provide ways to understand and evaluate their effects on health services for young people.

8.3.1 Quantitative strand

Quantitative data was collected from nine hospitals using survey questionnaire and a service quality observation tool.

8.3.1.1 Survey

The researcher applied probabilistic random sampling to select 441 young people for this survey. The survey was used to quantitatively and qualitatively describe the utilisation, coverage, quality, and challenges of health service provision for young people in the East Gojjam Zone, Ethiopia. Questionnaire was provided to the respondents. The 418 young people who responded to the survey were from nine hospitals in the East Gojjam Zone, Ethiopia. Data entry was performed using epi-data Version 3.1 templates and quantitative responses were analysed using SPSS Version 28.

8.3.1.2 Observation checklist

Nine health service quality observation checklists were applied for the data collection on the utilisation and quality of health service in the nine health institutions or hospitals (Annexure V).

8.3.2 Qualitative strand

Eleven in-depth interviews and four FGDs were conducted in the Qualitative strand. The data were analysed in three themes, seven sub-themes, and 37 codes (Table 5.3). Atlas-ti software with manual assistance was used for the analysis. The seven steps in Colaizi's data analysis method for descriptive phenomenological study were briefly described as stated by Morrow et al (2015:643), and complete data was collected and conducted to respond to the research question: How do the specific health care institutions in East Gojjam Zone, Ethiopia uphold the quality of the services they provide to young people?

8.3.3 Development and validation of strategies

The findings of the research to formulate final reports that were to develop the strategies were integrated in chapter 6. The recommended strategies were sent for validation to public health experts, who were managers of health institutions. The strategies were validated using the Delphi technique and the feedback obtained from the experts was analysed, and the recommended changes were used to summarise the strategies (Chapter 7 and Annexure BB). Table 8.1 summarises rationales for the validated strategies.

The last two objectives addressed in this section are to develop strategies to enhance the utilisation, coverage, and quality of health services for young people, and to validate the strategies of public health experts.

8.3.4 Summary of the research findings and the rational for the implementation of the proposed strategies

The findings of the study showed that health service provision for young people aged 15-24 years (the youth) in East Gojjam Zone, Ethiopia, was not at an expected level and was challenged by different factors. The broadest categories of demographic, socio-economic, socio-cognitive, and institutional factors indicated that there should be an integrated effort towards the improvement of the expected outcomes. The concerned bodies, including the Ethiopian Ministry of Health (EMOH), the Regional Health Bureau, the Zonal Health Department, the District offices, the institutions, the stakeholders, and the youth clients, are expected to act cooperatively for the changes. The following strategies were developed based on the findings of this study and validated using public health experts:

Table 8.1 Strategies and rationales for implementation to enhance provision of health services for young people in the East Gojjam Zone, Ethiopia

Strategies	Rationale for the implementation of the Strategies
1 Family targeted strategies	The strategy equips young people to develop self-confidence and eliminate frustrations and shyness while discussing reproductive health issues. It also enables them to decide on peer selection to avoid different malpractices.
2 School targeted strategies	The strategy advocates for curricula to incorporate reproductive, behavioural, mental, and nutritional issues related to the lives of young people. It also enables instructors of young people to practically apply different health education techniques to easily address issues related to health services for young people, the challenges faced, and coping mechanisms.
3 Political, security and legal target strategies	Firstly, the strategy ensures gender equity and equality, and equips and empowers young people with the freedom to decide on their choice. Secondly, it ensures the application of legal acts of ethical principles on maltreatment and behavioural misconduct regarding health services for young people. Thirdly, it enables infrastructure access, which makes young people to easily access and utilise health services at their nearby health institutions in shorter time duration, in a secure and confidential manner.
4 Community targeted strategies	The strategy equips community members with better awareness regarding health services for young people, the challenges faced, and how they can combat them. It also enables the design of social development programmes, such as community participation, to increase the level of young people's health-seeking behaviour and decrease different socioeconomic challenges. In addition, it enables environmental modifications that provide a chance to reduce and control substance abuse and malpractice in community settings.
5 Religious institution targeted strategies	The strategy enables religious institutions to design their education curricula, and ways of preaching to incorporate the health issues of the youth, regarding the challenges and coping mechanisms in line with the biblical contexts. It also helps increase young people's attachment to religious programmes for their behavioural modification.
6 Health institution targeted strategies	Firstly, the strategy enables health care givers to focus more on the primordial and primary levels of prevention than on clinical and curative services. Secondly, it equips health care givers with acquiring professional skills through skill gap training to provide

Strategies	Rationale for the implementation of the Strategies
	qualified health services to young people and cope with challenges. Thirdly, it enables a safer and risk-free environment for young people to obtain timely, informed, and fair health services. Fourthly, it equips young people with decision-making skills for leadership and managerial issues related to health service delivery. Fifthly, it strengthens linkages and collaborations with internal staff members through multidisciplinary engagement for quality and integrated service delivery and with external stakeholders, such as NGOs, through financial capability development.

8.4 CONCLUSION

The purpose of the study was to evaluate the utilisation, coverage, quality, and challenges of health service provision for young people in East Gojjam Zone, Ethiopia. Where the study findings were to be used to develop strategies to enhance utilisation of the health services for young people in East Gojjam Zone, Ethiopia. Improving health service delivery by health care providers and increasing the utilisation of services by young people are essential components in the success of health service organisations. Health service utilisation in the quality and coverage dimensions was evaluated, and there were different challenges (factors) that affected the utilisation of health services for young people.

8.4.1 Conclusions on quantitative strand

Questionnaires completed by 418 participants were used in the research. According to the findings of the survey on the evaluation of health services for young people: age, level of education, religion, frequency of religious participation, living with family, and participation in nightclubs were challenges for the utilisation of reproductive health services. These challenges include demographic, socio-economic, socio-cognitive, and institutional factors. The respondents, who were widowed, participated more than two times per month in their religion, participated in the night club, and lived with their mother,

father, relatives, female friends, or male friends or alone, were also highly challenged to get reproductive health services.

8.4.2 Conclusions on qualitative strand

Qualitative data from young people were collected from four FGDs and 11 in-depth interviews. Data saturation was reached after four FGDs and 11 in-depth interviews were conducted. Reproductive, behavioural, mental, and nutritional health services were addressed in this research. The quality of the services was evaluated in terms of safety and privacy, effectiveness, client participation, efficiency, confidentiality and consent, professional competence, information management, education, and training.

Most participants reported that there were undeniable challenges related to these services. Not being abstained, poor perception on STIS, HIV/AIDS, and safe abortion, behavioural exposure to different harmful substances such as chat, alcohol, hashish, and drugs lead to consequences such as failure from school and colleges, which further exposes young people to violence and assaults. Institutional challenges are related to the costs of services and drugs, professional skill gaps, leadership, accessibility or distance, resource availability, and professional ethics. According to findings from the participants' reports, most of the challenges faced were related to family, peers, society or community, culture, religion, and institution (school and health). There had been no effective attempts by respective bodies to alleviate these challenges.

8.5 RECOMMENDATIONS

8.5.1 Recommendation for the health institutions

The institutional challenges facing the provision of health service to young people faced in this study had been linked to a higher organisational hierarchy. Setting appropriate guidelines, policy procedures, and strategies are an important focus area for top-level officials. Therefore, the Ethiopian Ministry of Health should review and align policies and strategic guidelines regarding health services for the young people aged 15-24 years (i.e., young people). The setting up of health institutions, including the location, human resource management in the selection and placement of well-trained and skilled professionals or care givers, and delivering on-job training are some of the important

areas recommended to be evaluated to undertake corrective measures taken by the EMOH. The Ethiopian government should also focus more on female empowerment strategies related to reducing and altering gender-based violence to reduce the negative impact of the peer influences. Constructing infrastructure such as roads and allocating as many ambulances as districts and kebeles required to access health organisations should also be done by the government.

8.5.2 Recommendation for the Amhara Regional Bureau and East Gojjam Zonal Health Department

Once proper guidelines and policies are set by the higher bodies, a series of close supervision and monitoring is the responsibility of the inferior bodies of the organisational hierarchy. The Amhara Regional Health Bureau should appropriately address the strategic guidelines and closely monitor implementation at the zonal management level. The zonal health department is also responsible for evaluating and monitoring the implementation of strategic guidelines and policies by inferior or executive bodies. Youth-centred services should be evaluated and checked for their targeted achievements. Equity or proper allocation of resources, including staff, equipment, drugs, and other supplies should be consciously evaluated. Taking immediate corrective measures for the challenges faced and those that did not get solutions at the lower levels should receive immediate answers by the top level.

8.5.3 Recommendation for the District Health offices

District offices should work hard to build relationships with youth-serving agencies like churches, Sunday Schools, community and social organisations like Edir and Ekub, as well as schools, to create strategies that foster strong connections between parents and their kids.

8.5.4 Recommendation for the stake holders and parents of the young people

Different stakeholders, including religious institutions, education sectors, political and legal institutions, and parents of young people should perform their responsibilities regarding the health of young people. These include:

- Initiating young people to adhere to religious disciplines, which have shown positive results in the self-protection of ill-behaviours.
- Clear and open communication, which might be included in the curriculum of education sectors, to increase the awareness of young people to protect themselves from exposure to behavioural risk factors should be made. Schools should also strengthen their media communication in accessing young people, addressing sexual, reproductive, mental, behavioural, and nutritional health services, and reducing exposure.
- Ensuring gender equity and equality with the freedom to decide on their choice of health services, and application of legal acts of ethical principles on maltreatment and behavioural misconducts against health services for young people.
- It is also better to strengthen a close parental control to bring behavioural modification through the reduction and control of the exposing factors like drinking alcohol, chewing *chat*, using hashish and engaging in un-protective sexual act. Having a really mature family discussion about sex should be a priority. Raising the educational standards of the parents is a key to having open discussions about reproductive and sexual health, with a focus on the effects of all the risk behaviours mentioned above, including the negative effects of peer pressure.

8.5.5 Recommendation for the young people

Despite the other concerned parties, the youth should take their own responsibility for the advancement of the health of young people, the young people themselves should look into different areas of concern for the improvement of their lives. They should prepare themselves to receive youth-based health services. They should also avoid exposure to different misbehaving acts. They should exercise self-control from going to areas of higher exposure, such as chewing / smoking, hashish houses, and where gender violence is rife. They should increase their level of awareness of health services through education and training.

8.5.6 Recommendation for the next researchers

It is essential for future researchers to consider the barriers that prevent young people from accessing health services, particularly those related to religious adherence, communication between parents and their children, education of parents, and monitoring

of parents as a means of intervention to reduce the sexual risk behaviours of young people. Furthermore, further research should be conducted to establish a temporal relationship through the use of longitudinal study designs.

8.6 CONTRIBUTION OF THE RESEARCH

The research contributes to the existing body of knowledge on the enhancement of health services for young people through improvements in coverage and quality of health services. The findings of the study regarding the identification of those challenges for health services for young people have created better awareness and outlined strategies to be implemented by the targeted bodies (family, community, schools, religious organisations, legal institutions, and health institutions). This topic is too comprehensive and uses vigorous methodology with both qualitative and quantitative approaches to evaluate health services for young people in the study area.

Based on the results of the research, targeted strategies have been proposed for the enhancement of health services for young people through advancements in utilisation and better service quality. If these strategies are accepted and applied in practice, the challenges may be combated, and young people may better utilise health services both in coverage and quality.

8.7 LIMITATIONS OF THE STUDY

For the Quantitative strand of the study, the survey-based data was collected only from the respondents, and health care providers were not provided with the survey tool. If this had been done by the caregivers, the researcher would have been enabled to triangulate the results more in addition to the data collected through the observation tool. Additionally, the area for the study was restricted to a single Zone of the Regional State, which had a total of 11 Zones. Thus, the results can be generalised only to Zones with similar features.

For the qualitative strand, especially for the use of the Delphi technique, this study may have a number of limitations: Firstly, it focused on the health care system that existed in the health institutions in East Gojjam Zone, and there may be a further tool requirement for other contexts or for areas with different characteristics. Secondly, there is a

continuous change to population and contexts, but the tool revealed facts and practices only at the duration of the research (Wallendorf & Belk 1989:69). Due to changes of new facts and experiences, strategies become outdated or require modification. Thirdly, because a single objective reality does not exist, the use of peers during the analysis and development of the strategies could have been important (Lincoln & Guba 1985).

Although there were limitations to this research, all the objectives of the research were met, and strategies for targeted institutions and bodies were developed and validated. Strategies had been developed to enhance the utilisation of health services for young people in East Gojjam Zone, Amhara, Ethiopia.

8.8 CONCLUDING REMARKS

In this study, the question of how the specific health care institutions in East Gojjam Zone, Ethiopia, uphold the quality of the services they provide to young people was addressed with evidence. This study showed that different challenges made young people not to adequately utilise health services in terms of coverage and quality. The lower the utilisation of services because of lower quality and coverage, the higher the level of failure in terms of client morale and satisfaction, resource utilisation, trust, and respect for the services. Better service utilisation by young people can be achieved by paying more attention to the reduction of challenges through participatory and multidisciplinary approaches. Comprehensive strategies regarding health services for young people should have been built for health education programmes at the family, community, legal bodies, religious, academic, and health institution levels, as suggested in this study.

The research achieved all of its objectives. In addition to the existing body of knowledge in the health service provision through the development and validation of the strategies, basic improvements are needed regarding health service strategies for young people in the East Gojjam Zone.

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ANNEXURES

ANNEXURE A: Ethical Clearance Certificate from the University of South Africa

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

07 June 2022

Dear Mr Gizew Damtie Demeke

Decision:
Ethics Approval from 07 June 2022 to 07 June 2027

NHREC Registration # :
Rec-240816-052
CREC Reference # :
46340262_CREC_CHS_2022

Researcher(s): **Name: Mr GD Demeke**
Contact details: 46340262@mylife.unisa.ac.za
Supervisor(s): **Name: Dr. MG Makua**
Contact details: makuamg@unisa.ac.za

Title: Evaluation for health care services for young people in East Gojjam Zone, Ethiopia

Degree Purpose: PHD

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for five years.

The ***medium risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

Open Rubric

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confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(07 June 2027).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **46340262_CREC_CHS_2022** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature:

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Signature: PP

Prof K. Masemola
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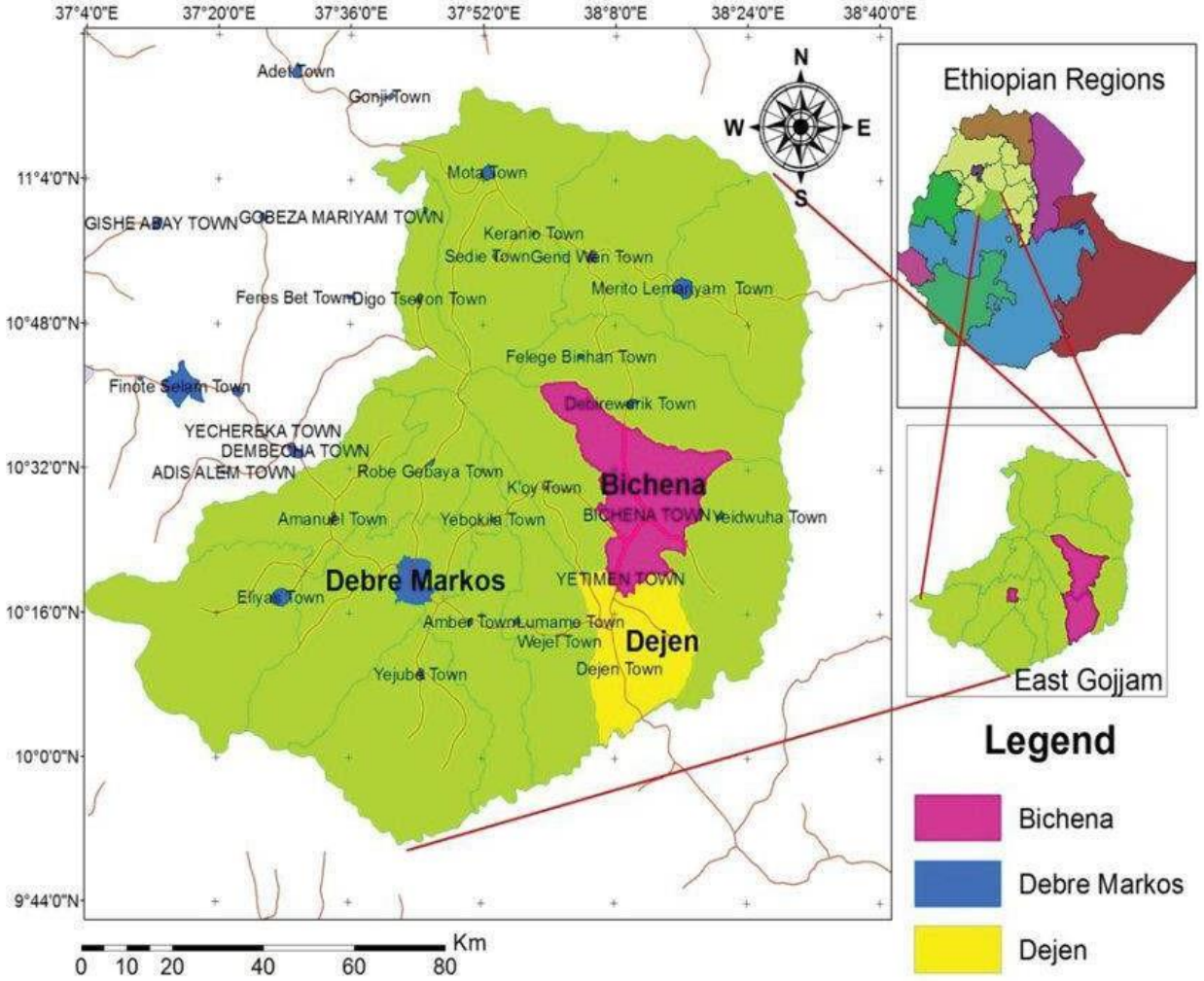
ANNEXURE B: Map of Ethiopia, East Gojjam Zone and the Districts



ANNEXURE C: Permission requested to conduct the study

Title: Evaluation for health care services for young people in East Gojjam Zone, Ethiopia

To Mr. Taye Zeru Tadege
Amhara Regional Health Research & Technology Directorate Director;
Room no: 03; Mobile number: +251948012892; Email address: zerutaye@gmail.com

Dear Mr Taye ZeruTadege

I, Gizew Damtie Demeke, am doing research supervised by Prof MG Makua, to a PhD in Public Health at the University of South Africa. The study is entitled: Evaluation for health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia.

The purpose of this research is to evaluate health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilisation of the health services among young people in East Gojjam, Ethiopia.

Data will be collected from the participants through interviews and focus groups. A template will be used to collect data from the health care institutions. The researcher will be helped by trained research assistants during data collection.

The study will involve direct human participants, minor discomfort or inconvenience may occur during data collection, and this may not bring a risk above the everyday anxiety in people when they are asked questions.

Trained data collectors will help to offer support or counselling to participants if distressed during the data collection process, which is unlikely.

I request permission to collect data from specific health care institutions within East Gojjam Zone Health Department, Ethiopia. The following documents are included to for more information:

Ethical clearance certificate from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study.

The approved research proposal and data collection tools.

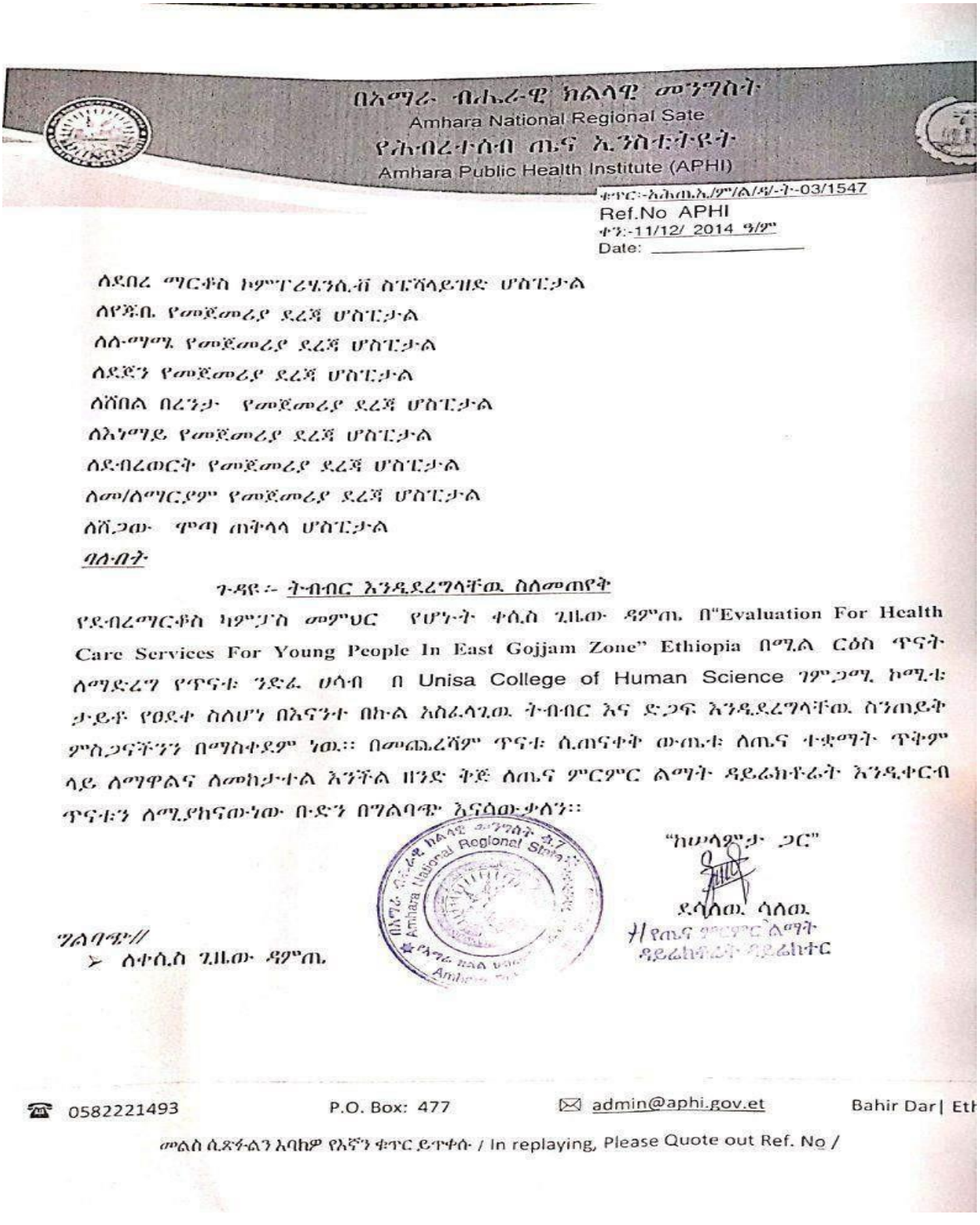
Proof of registration as a student with the UNISA.

Feedback will entail presenting the finding of the study in a workshop to the representatives of relevant organisations that participated in the study and submitting a copy of the full thesis to the organisations.

Yours sincerely

Gizew Damtie Demeke
PhD candidate at University of South Africa

ANNEXURE D: Regional research and technology institute approval



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Amhara National Regional Sate
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Amhara Public Health Institute (APHI)

ቁጥር፡-አሕጤኢ/ም/ል/ዳ/ት--03/1547
Ref.No APHI
ቀን:-11/12/ 2014 ዓ/ም
Date: _____

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ግልባጭ//
- ለቀሲስ ጊዜው ዳምጤ

☎ 0582221493 P.O. Box: 477 ✉ admin@aphi.gov.et Bahir Dar| Eth

መልስ ሲጽፉልን እባክዎ የእኛን ቁጥር ይጥቀሱ / In replaying, Please Quote out Ref. No /

ANNEXURE E: Permission requested for hospitals to conduct the study

Title: **Evaluation of health care services for young people in East Gojjam Zone, Ethiopia**

To Mr _____
The Head of the hospital
Room no: _____;

Mobile number: _____

Dear Mr _____

I, Gizew Damtie Demeke, am doing research supervised by Prof MG Makua, towarda Doctor of Philisophy (PhD) in Public Health at the University of South Africa. The study is entitled: Evaluation for health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia.

The purpose of this research is to evaluate health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia and challenges to develop strategies to increase the utilisation of the health services among young people in East Gojjam, Ethiopia.

Data will be collected from the participants through FGDs and interviews. A template will be used to collect data from the health care institutions. The researcher will be helped by trained research assistants during data collection.

The study will involve direct human participants, minor discomfort or inconvenience may occur during data collection, and this may not cause a risk above the everyday anxiety in people when they are asked questions.

Trained data collectors will help to offer support or counselling to participants if distressed during the data collection process, which is unlikely.

I request permission to collect data from specific health care institutions within East Gojjam Zone Health Department, Ethiopia. The following documents are included to for more information:

- Ethical clearance certificate from UNISA, College of Human Sciences (CHS), higher degrees committee, indicating the approval to do the research.
- The approved research proposal & data collection tools.
- Proof of registration as a student of UNISA.

Feedback will entail presenting the finding of the study in a workshop to the representatives of relevant organisations that participated in the study and submitting a copy of the full thesis to the organisations.

Yours sincerely

Gizew DamtieDemeke
PhD candidate at University of South Africa

ANNEXURE F: Permission granted from Mertule Maryam Primary Hospital

Ref no: መምህ/61/ህ-4

Date: 05/12/2014 ዓ.ም

To: Gizew Damtie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

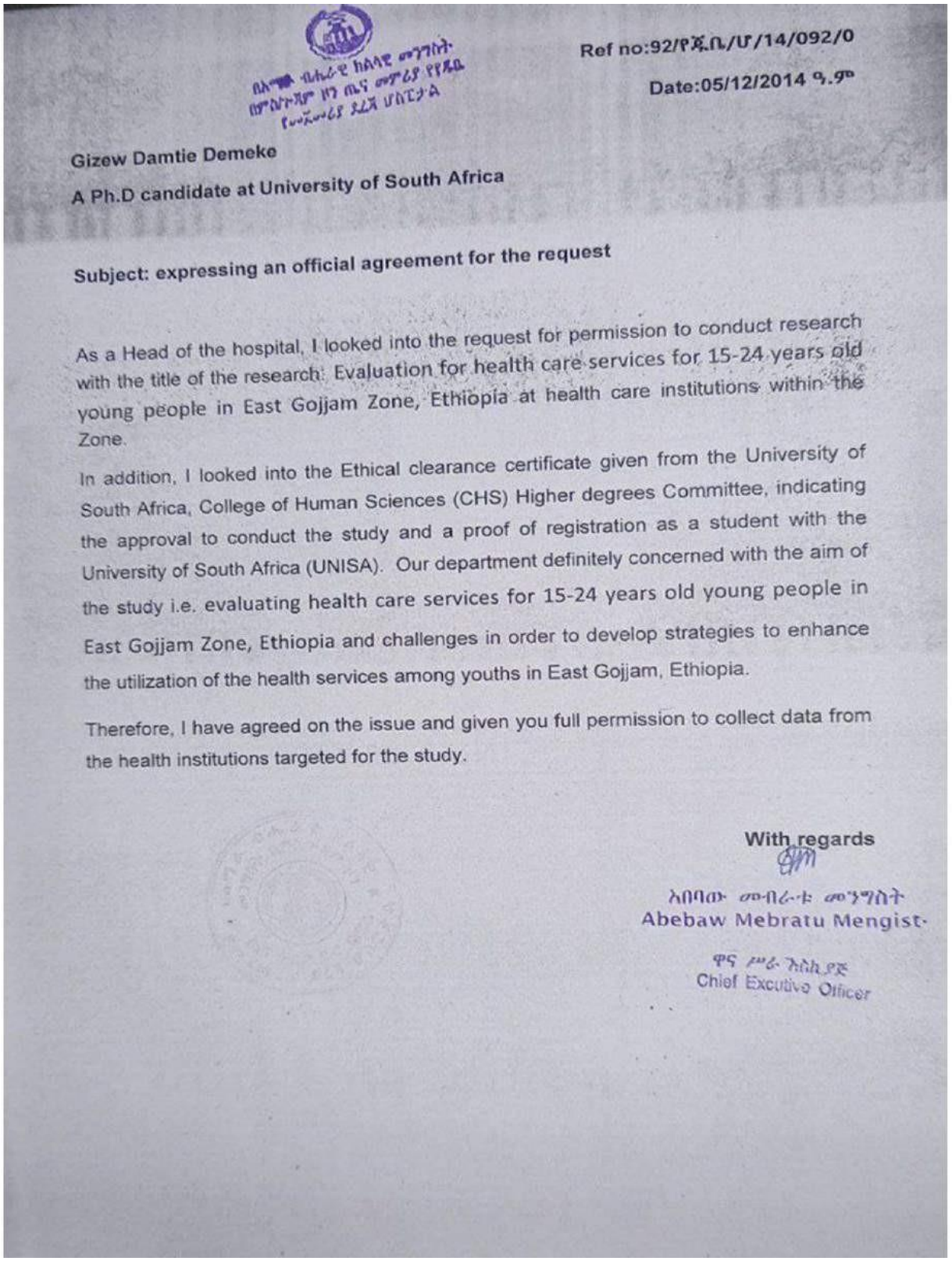
ዳኘው አስናቀ ወንዲ

Degnachew Asnake Wondie

ሜ/ኤክስ

G/Manager

ANNEXURE G: Permission granted from Yejube Primary Hospital



Ref no:92/የጀ.ቤ/ሆ/14/092/0

Date:05/12/2014 ዓ.ም

Gizew Damtie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

አበባው መብራቱ መንግስት

Abebaw Mebratu Mengist

ዋና ሥራ አስኪያጅ

Chief Excutive Officer

ANNEXURE H: Permission granted from Dejen Primary Hospital

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Ref no:- [illegible]

Date:- [illegible]

To: Gizew Damtie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

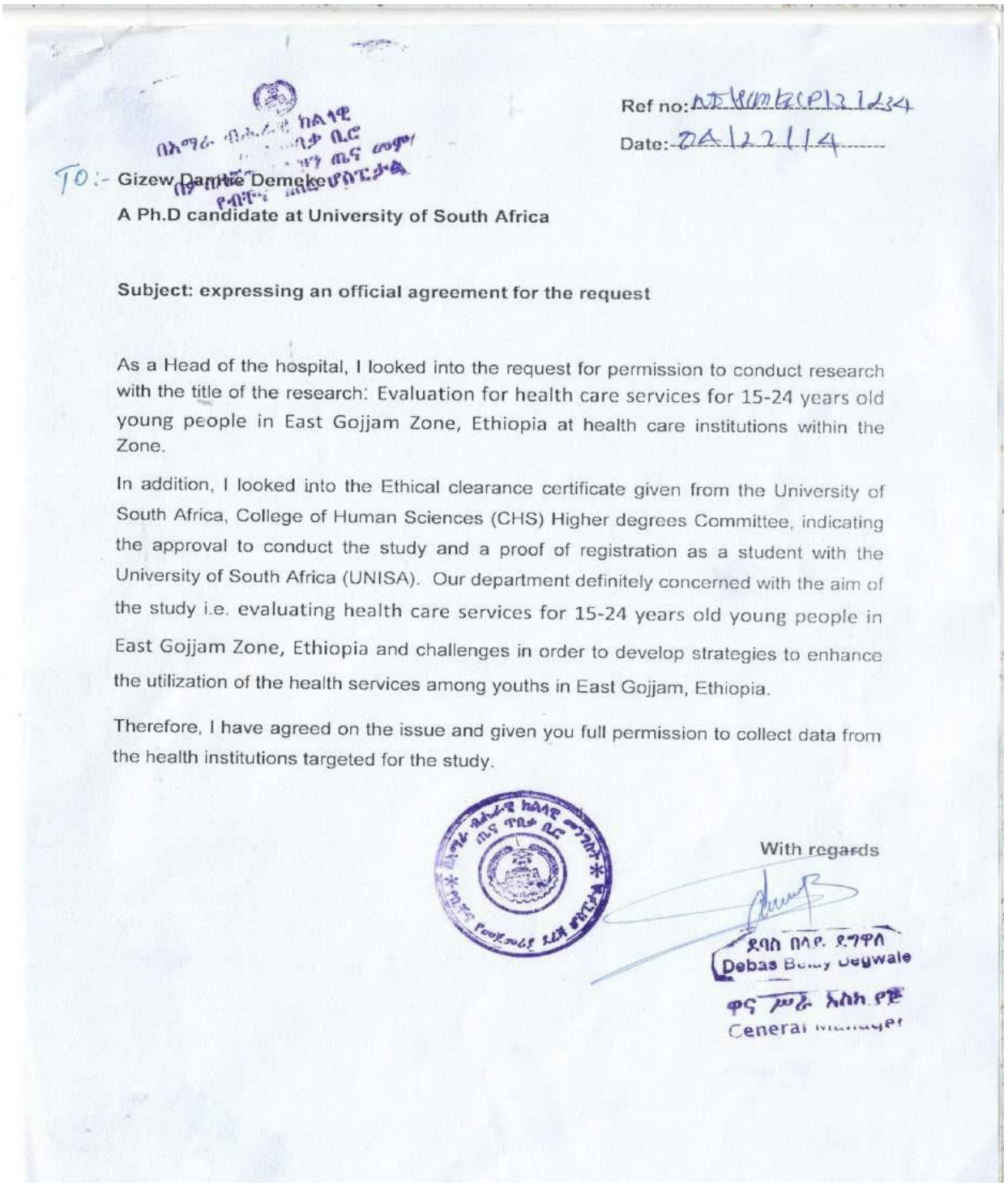
With regards

Adugnaw Moseye Asse[illegible]

ዋና ስራ አስኪያጅ

General Manager

ANNEXURE I: Permission granted from Bichena Primary Hospital



Ref no: [illegible]

Date: 24/12/14

TO:- Gizew Dannie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

ደባስ በላዩ ደግዋለ

Debas Belay Degwale

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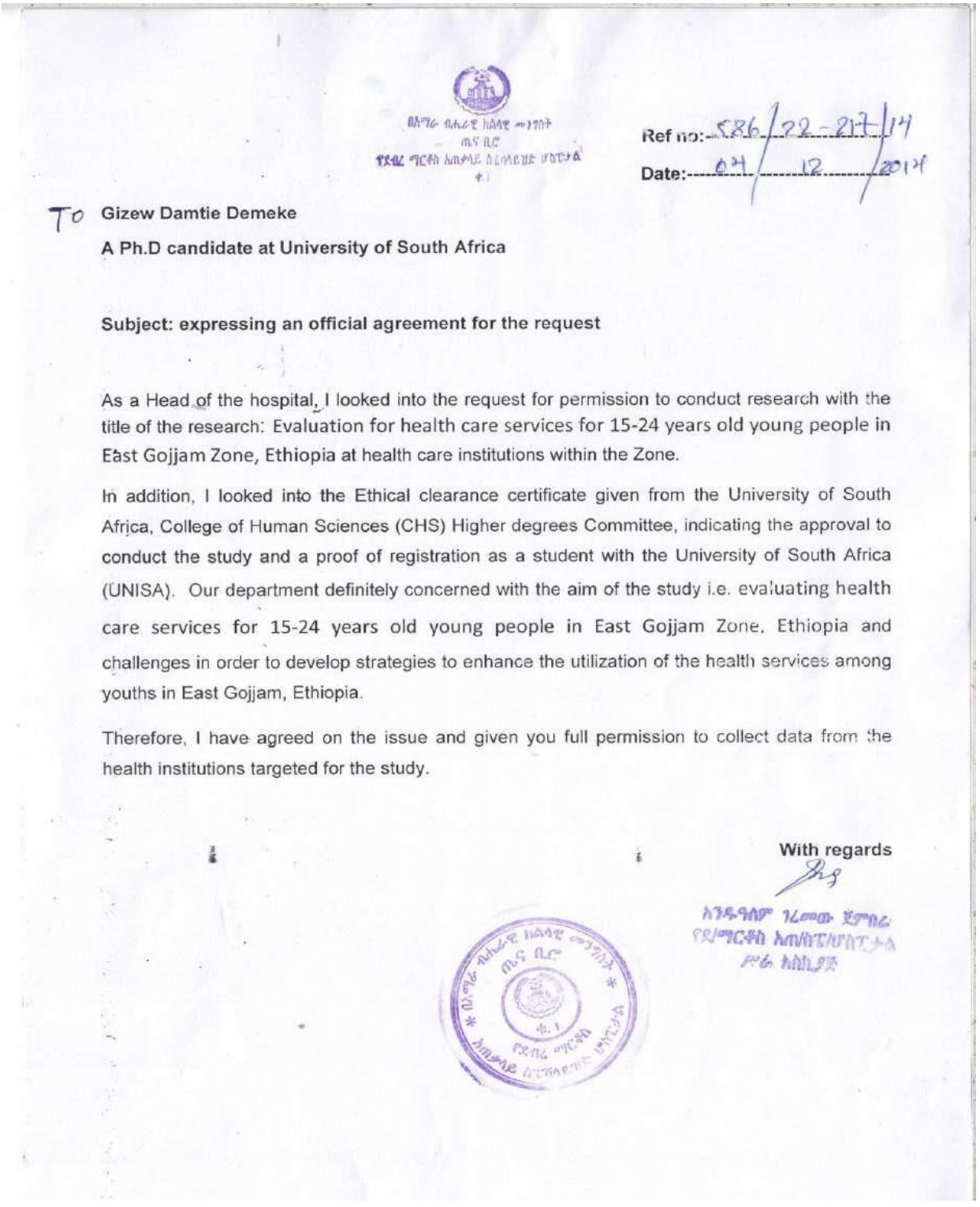
General Manager

ANNEXURE J: Permission granted from Debre Markos Comprehensive Hospital



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Ref no: 586/22-217/14

Date: 04/12/2014

To Gizew Damtie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

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ANNEXURE K: Permission granted from Motta Primary Hospital

Ref no: 56/2/10

Date: 5/12/2021

Gizew Damtie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

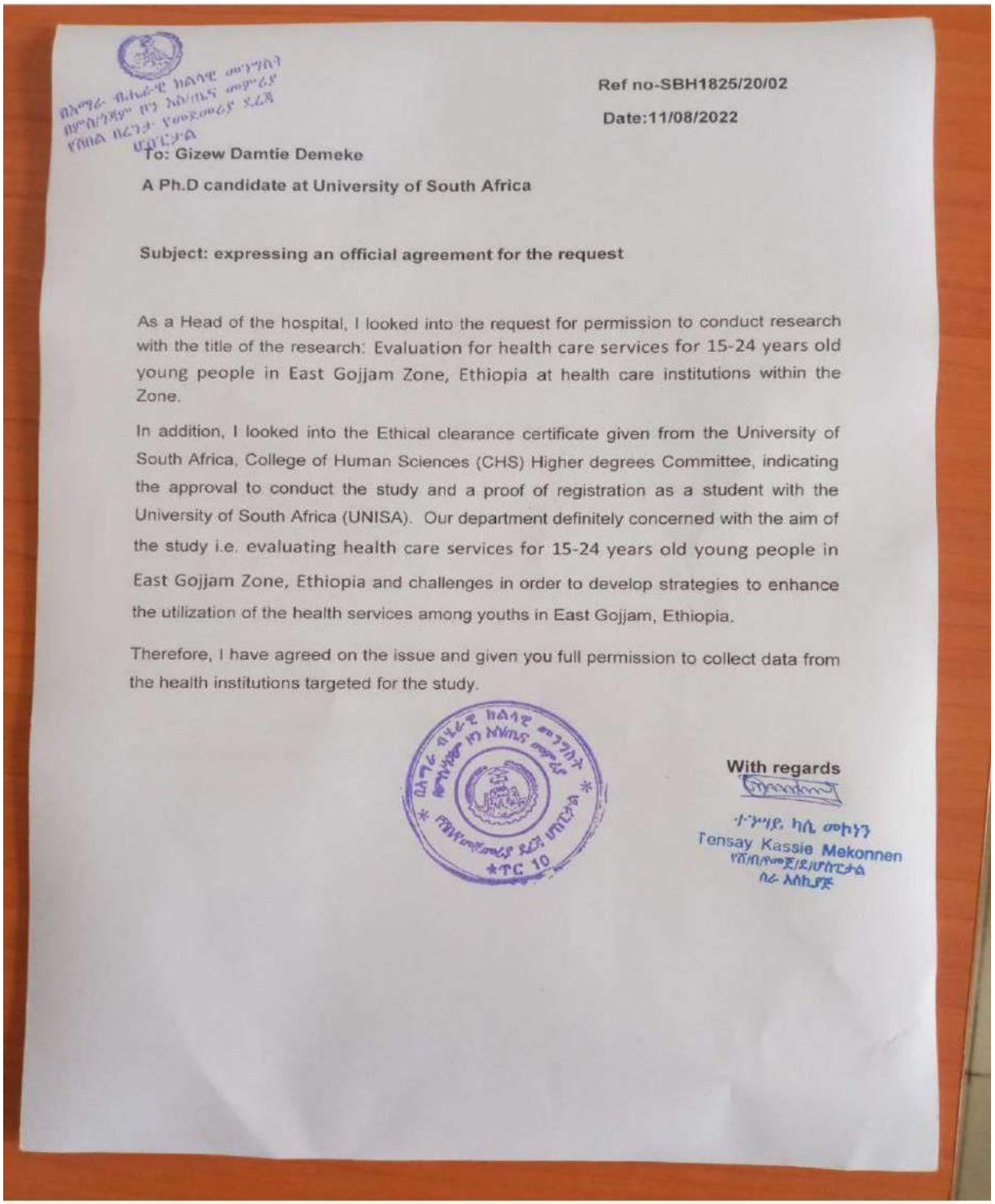
With regards

Adugnaw Wale Zeleke

Executive Officer

(CEO)

ANNEXURE L: Permission granted from Shebel Berenta Primary Hospital



Ref no-SBH1825/20/02

Date:11/08/2022

To: Gizew Damtie Demeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

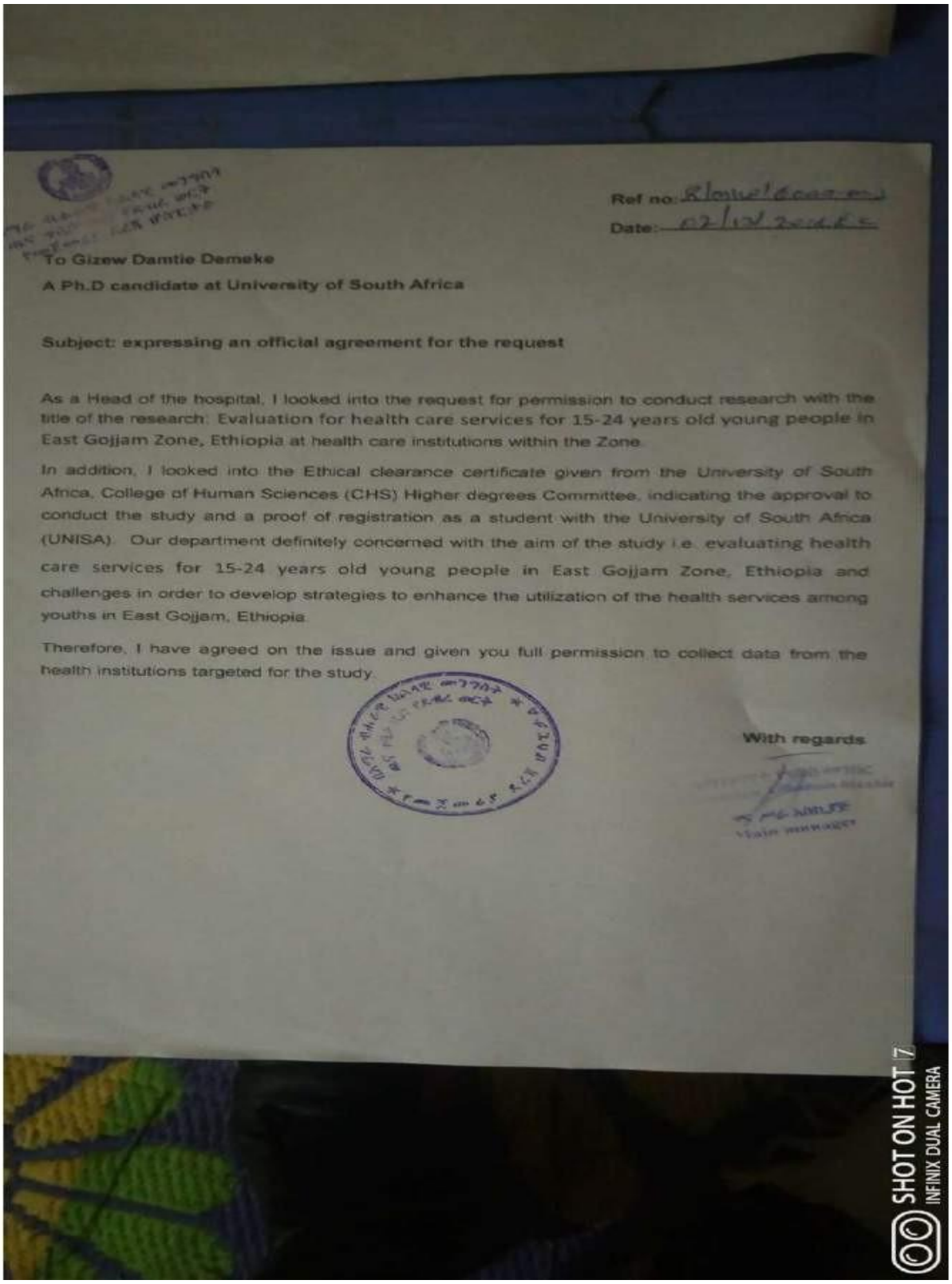
In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

Tensay Kassie Mekonnen

ANNEXURE M: Permission granted from Debre-Work Primary Hospital



Ref no: [illegible]
Date: 02/12/2016 E.C

To Gizew Damtie Demeke
A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

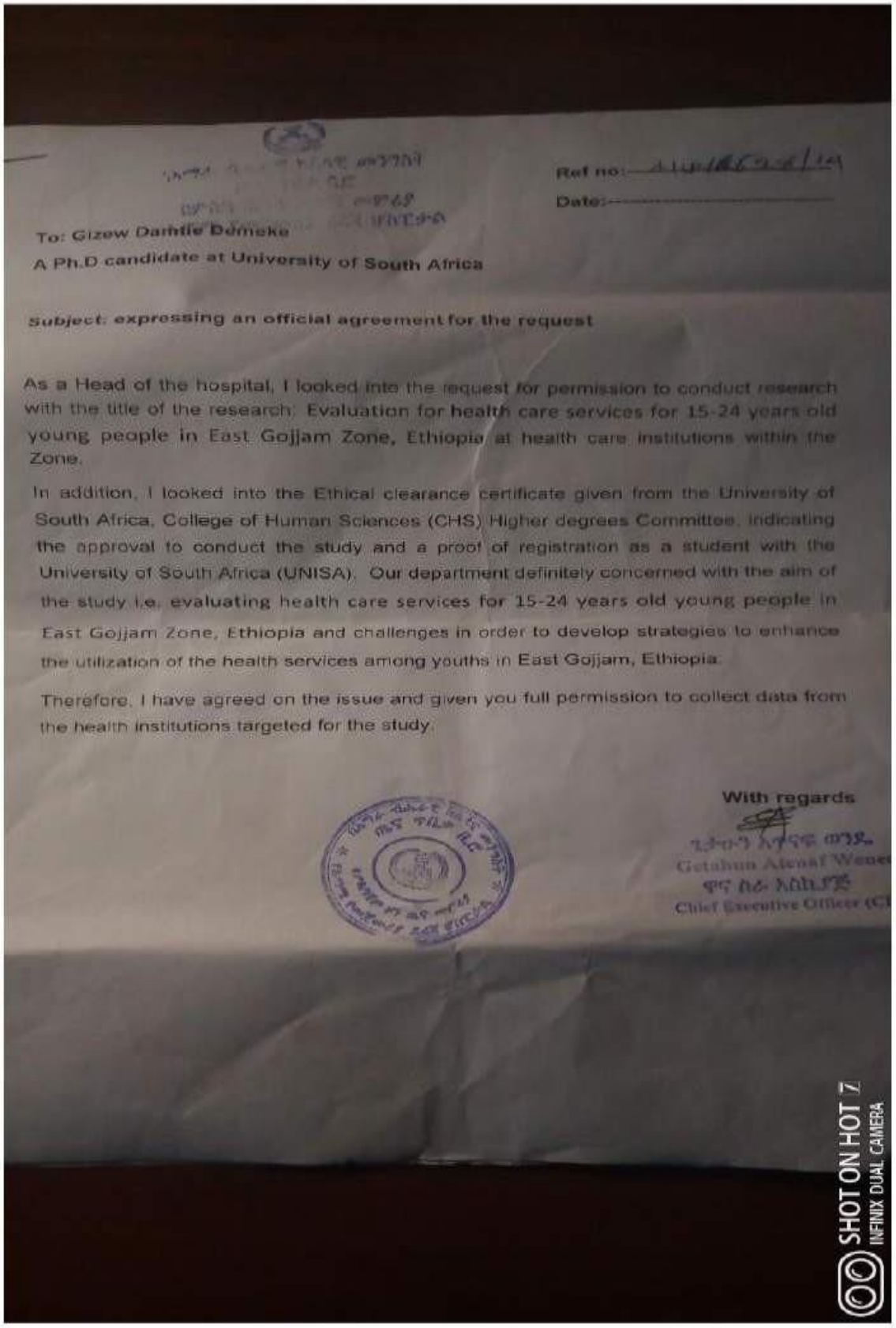
As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

ANNEXURE N: Permission granted from Lumame Primary Hospital



Ref no:

Date:

To: Gizew Dahtie Domeke

A Ph.D candidate at University of South Africa

Subject: expressing an official agreement for the request

As a Head of the hospital, I looked into the request for permission to conduct research with the title of the research: Evaluation for health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia at health care institutions within the Zone.

In addition, I looked into the Ethical clearance certificate given from the University of South Africa, College of Human Sciences (CHS) Higher degrees Committee, indicating the approval to conduct the study and a proof of registration as a student with the University of South Africa (UNISA). Our department definitely concerned with the aim of the study i.e. evaluating health care services for 15-24 years old young people in East Gojjam Zone, Ethiopia and challenges in order to develop strategies to enhance the utilization of the health services among youths in East Gojjam, Ethiopia.

Therefore, I have agreed on the issue and given you full permission to collect data from the health institutions targeted for the study.

With regards

Getahun Alenaf Wene

Chief Executive Officer (C

SHOT ON HOT 7
INFINIX DUAL CAMERA

ANNEXURE O: Participant information sheet

REQUEST TO PARTICIPATE/RECRUITMENT IN THE STUDY

Ethics clearance reference number:	46340262_CREC_CHS_2022
NHREC Registration #:	Rec-240816-052
Date (clearance issued on):	07 June 2022

Study Title: Evaluation for health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia

Dear Prospective Participant

My name is Gizew Damtie Demeke and I am doing research under the supervision of Dr MG Makua, at the Department of Health Studies, College of Human Sciences, towards a Doctor of Philosophy (Ph.D) in Public Health at the University of South Africa. We are inviting you to participate in a study entitled evaluation of utilisation of health care services for 15-24-year- old young people in East Gojjam zone, Ethiopia.

WHAT IS THE PURPOSE OF THE STUDY?

I am conducting this research to evaluate the utilisation of Reproductive Health Services and challenges among young people in East Gojjam Zone, Ethiopia in order to develop strategies to enhance the quality of the health services to young people in East Gojjam, Ethiopia.

WHY AM I BEING INVITED TO PARTICIPATE?

I am asking you to help me learn more about health services for young people in your community. I am inviting you to take part in this research project. If you accept, you will be asked to take part in a discussion with 8-10 other people of your age group. discussion will be guided by a group discussion leader. The session will start with an invitation to discuss the issue at hand and information regarding the utilisation and challenges of health services to young people. Each group then starts conversation, writing down and making notes of significant opinions, feelings and ideas.

I will not ask you to share personal beliefs, practices or stories and you do not have to share any knowledge that you are not comfortable to share. No one else but the people who take part in the discussion and guide or myself will be present during this discussion.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

The study involves audio recording of the focus groups or in-depth interviews. You will be asked questions regarding the utilisation of the health services provided to you as young people in East Gojjam Zone, Ethiopia. The process will end on one scheduled day, with no follow up visits. It may take up to two hours for the focus group discussion, and one hour for in-depth interviews. You will not necessarily take part in both, but only one of them.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

Participants may benefit from taking part in the research study by learning more about utilisation and challenges of health services to young people. The finding of the study will provide latest information about the utilisation and challenges for health services provision for young people in East Gojjam Zone, Ethiopia. The findings of this study will have implications for both practice, strategy and policy development. They will enable health care workers and other responsible bodies to identify challenges to utilisation of health services to young people and subsequently to develop strategies to enhance the health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia.

ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the discussion if you feel the question (s) are too personal or if talking about them makes you uncomfortable.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPTCONFIDENTIAL?

You have the right to insist that your name will not be recorder anywhere and that no one, apart from the researcher and identified members of the research team, will know about your involvement in this research [this measure refers to confidentiality] OR your name will not be recorded anywhere and no one will be able to connect you to the answers you give [this measure refers to anonymity]. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings [this measure refers to confidentiality.

Only the researcher will know what your number is and we will lock that information up in a secure location. It will not be shared with or given to anyone except to research supervisor and transcribers/external coder who signed a confidentiality agreement. Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcribers, external coder, and the study supervisor. Otherwise, records that identify you will be available only to people working on the study.

The data may be used for other purposes, such as a research report, journal articles and/or conference proceedings. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report or article. In the focus group there are a group of 8-10 participants who will be guided by a facilitator. While every effort will be made by the researcher to ensure that you will not be connected to the information that you share during the focus group, I cannot guarantee that other participants in the focus group will treat information confidentially. I shall, however,

encourage all participants to do so. For this reason, I advise you not to disclose personally sensitive information in the focus group.

HOW WILL THE RESEARCHER (S) PROTECT THE SECURITY OF DATA?

Hard copies of your answers will be stored by the researcher for a minimum period of five years in a locked cupboard/filing cabinet in the researcher's home for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. The information recorded is confidential, and no one else except the researcher will have access to the tapes. The tapes will be destroyed after five years. Hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?

There will be no incentive for taking part in the research.

HAS THE STUDY RECEIVED ETHICS APPROVAL

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his study has received written approval from the Research Ethics Review Committee of the College of Human Sciences Research Ethics Committee (CREC) at UNISA. A copy of the approval letter can be obtained from the researcher if you so wish.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

If you would like to be informed of the final research findings, please contact Gizew Damtie Demeke on +251913557200 or email to 46340262@mylife.unisa.ac.za.

The findings are accessible from 2022 may onwards.

Should you require any further information or want to contact the researcher about any aspect of this study, please do so using the researcher's contact details as provided before.

Should you have concerns about the way in which the research has been conducted, you may contact the research study supervisor, prof. MG Makua makuamg@unisa.ac.za. OR contact the research ethics chairperson of the College Research Ethics Committee (CREC), Dr KJ Malesa, +27 12 429 4780, E-mail: maleskj@unisa.ac.za if you have any ethical concerns.

Thank you for taking time to read this information sheet. If you are willing to participate in this study, kindly complete the consent form below.

Kind regards

Gizew Damtie Demeke
Researcher

PARTICIPANT INFORMATION SHEET (AMHARIC VERSION)

በጥናቱ ለመሳተፍ የተደረገ ስምምነት

ስለጥናቱ ለተሳታፊዎች የቀረበ የመረጃ ቅጽ የአማርኛ ትርጉም

በጥናት እና ምርምሩ ለመሳተፍ ከተሳታፊዎች ጋር የተደረገ ስምምነ

የትናት እና ምርምር ፈቃድ መለያ ቁጥር: 46340262_CREC_CHS_2022

ጥናቱን ለማካሄድ የተሰጠፈቃድ መለያቁጥር (ካስፈለገ): ----------

የትናት እና ምርምር ፈቃድ የተሰጠበት ቀን:-07 June 2022

የጥናቱርዕስ: በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ ጥራት እና ችግሮች/ተጽዕኖዎች ማጥናት

ዉድ ተሳታፊዎች፡ ስሜ ጊዜዉ ዳምጤ ይባላል። በደቡብ አፍሪካ ጤና ኮሌጅ የጤና ድፓረትመንት ዉስጥ የሁለተኛ ዲግሪዬን አየተማርኩ ጥናት እያካሄድኩ ነዉ። ጥናቱን የምትከታተለኝ እና የምትቆጣጠረኝ ዶክትር ማኩዋ ሜሜ ትባላለች።በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ጥራት እና ችግሮች/ተጽዕኖዎች ላይ በሚጠና ጥናት አንችን/ተን ተሳታፊ እንድትሆኚ/ን እንፈልጋለን።

የጥናቱ ዓላማ፡ የጥናቱ ዓላማ በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ ጥራት እና ችግሮች/ተጽዕኖዎችን ለመየት እና የአገልግሎት አጠቃቀሙን፤ እና ጥራቱን ከፍ ለማድረግ ነዉ።

በጥናቱ ተሳታፊ መሆን ያስፈለገበት፡ በአካባቢዉ ስላለዉ የወጣቶች ጤና አገልግሎት መረጃ እንዲትሰጪኝ/ጠኝ በአክብሮት እጠየቃለሁ። በዚህም ጥናት ተሳታፊ እንድትሆኝ/ን ጋብዣለሁ። የምትስማሚ/ማ ከ 8-10 ከሚሆኑ ሌሎች የቡድኑ ተሳታፊዎች ጋር እንድትሳተፊ/ፍ እጠየቃለሁ።ሂደቱ የሚጀምረዉ በአሁኑ ሰዓት ያለዉን በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ጥራት እና ችግሮች/ ተጽዕኖዎች በተመለከተ እንዲያብራሩ በመጋበዝ ነው፡ ፡ስለሆነም እያንዳንዱ ቡድን በመወያየት ወሳኝ ነጥብ፤ ስሜትን እና ሀሳብ እንዲጽፉ ተጋብዘዋል።የግል እምነታችሁን ታሪካችሁን እና በተግባር ያከናወናችሁትን አልጠይቅም።ሳይስማማችሁ እና ቅር እየተሰኛችሁ

ሀሳብ እንድትሰጡ አናሰገድድም።ዉይይቱን ከሚመሩ አና ከእኔ በቀር ሌሎች ሰዎች በዉይይቱ ወቅት አይሳተፉም።.

የተሳትፎዉ ሂደት ምን ይመስላል ይህ ጥናት የቡድን ዉይይት እና ቃለ መጠይቅ የድምጽ ቀረጻ ይከናወንበታል።በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ጥራት እና ችግሮች/ተጽዕኖዎች ጥያቄዎችን ትጠየቃላችሁ።ሒደቱ ያለ ቀጣይግንኙነት በአንድ ቀን ቢበዛሁለት ሰዓት ለቡድን ዉይይት እና አንድ ሰዓት ለቃለ መጠይቁ በመዉሰድ ይጠናቀቃል።በቡድን ተሳትፎ ወይም በቃለ መጠይቅ ሂደቱ እንጂ በሁለቱም መሳተፍ አሣስፈልግም።

ስምምነት ከተዋዋልኩ በኋላ ማቋረጥ እችላለሁን? በዚህ ጥናት የሚደረገዉ ተሳትፎ ያለ ማስገደድ በፈቃደኝነት ብቻ ነዉ። ከተስማማሽ/ህ እና ለመሳተፍ ከወሰንሽ/ክ የስምምነት ቅጽ በማቅረብ እንድትፈርሚ/ም ይሆናል።ያለምንም ምክንያት በማንኛዉም ሰዓት ማቋረጥ ይቻላል።

ተሳታፊዎች የምያገኙት ጥቅም ምንድን ነዉ?

ተሳታፊዎች በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ ጥራት እና ችግሮች /ተጽዕኖዎች በለመለከተ በሚጠናዉ ጥናት ተሳታፊ በመሆን የዉጤቱ የጋራ ተጠቃሚ ይሆናሉ።የጥናቱ ዉጤት የትግበራ ስልት ለመዘርጋት ወሳኝ ይሆናል።የጤና ባለሙያዎች እና ሌሎች ሀላፊነት ያለባቸዉ አካላት በወጣቶች ጤና አጋልግሎት አጠቃቀም፤ ሽፋን እና ጥራት አኳያ የሚያጋጥሙ ችግሮችን ለይቶ ማወቅ እና አጠቃቀምን፤ ሽፋንን እና ጥራትን ከፍ ለማድረግ የሚያስችል ስልት መዘርጋት ዋነኛዉ ጥቅም ነዉ።

በመሳተፌ መጥፎ ዉጤቶች ይገጥሙኛልን? በዉይይቱ ወቅት ምስጢራዊ የሆኑ ጥቂት መረጃዎችን ልትናገሪ/ር ወይም በተወሰኑ ነጥቦች ላይ ደስተኛ ያለመሆን ሁኔታ ሊከሰትይችላል። ግላዊ የሆኑ እና የማይመቹ ሀሳቦችን መመለስ አይጠበቅብሽም/ህም።

የምሰጠዉ መረጃ ምስጢራዊነቱ ይጠበቃልን? በሂደቱ የተሳታፊዋ/ዉ ስም አየጻፍም፤አይቀረጽም። ከጥናቱ ባለቤት እና ከረዳቶቹ እንድሁም ከተሳታፊ አባላት በቀር የአንተን/ቺን ተሳትፎ ማንም አዉቅም። የሚሰጡት ምላሾች ኮድ ተደርገዉ እስከ ሪፖርት የሚደርሱበት ሁኔታ ይጠበቃል። የጥናቱ ባለቤት ብቻ ስለ ሚሰጠዉ ኮድ ዕዉቅና ይኖረዋል። መረጃዉም በጥብቅ ቦታ ይቀመጣል። የተቀመጠዉ መረጃ ከተቆጣጣሪዋ እና ከመረጃ ተርጓሚ በቀር ለሌላ ሰዉ ተላለፎ አይሰጥም። የተሳታፊዎች ማንነት ሳይገለጽ

መረጃዉ ለጥናታዊ ሪፖርት፤ ጆርናል ዝግጅት እና ህትመት ሊያገለግል ይችላል። ይህ በእድህ እያለ ስለተሳታፊዎች ምሥጢር ጠባቂነት ኃላፊነት ልወስድ ግን አልችልም። ይሁን እንጂ ሁሉንም ተሳታፊዎች ምስጢር እንዲጠብቁ እያበረታታሁ መነገር የሌለባቸዉን ግላዊ የሆኑ መረጃዎች እንዳትሰጡ እመክራለሁ።

የጥናቱ ባለቤት የመረጃዉን ደህንነት እንዴት ይጠብቃል? በጽሑፍ የሚቀርቡ መረጃዎች ቢያንስ ለ አምስት ዓመታት በሼልፍ ዉስጥ በጥንቃቄ የቀመጣሉ። በሶፍት የሚቀመጡ መረጃዎች የደህንነት ቁልፍ ተሰጥቷቸዉ በኮምፒዉተር ዉስጥ ይቀመጣሉ። የጥናት ህግን መሰረት በማድረግ ወደፊት መረጃዉን መጠቀም ይቻላል። የሚቀመጠዉ መረጃም ስዉራዊነቱ የተጠበቀ ይሆናል። የቀረጻ መሳሪያዎች እና ዶክመንቶች ከ5 ዓመታት በኋላ ይወገዳሉ።

በመሳተፌ የሚሰጠኝ ክፍያ ይኖራልን? ለምትሳተፈበት ምንም ዓይነት ክፍያ የለዉም።

የጥናቱ ሕጋዊነት ከሚመለከተዉ አካል ተረጋግጧልን? ይህ ጥናት ከደቡብ አፍሪካ ዩኒቨርሲቲ የጥናት እና ምርምር ሕግ እና ተገቢነት ክፍል ጸድቆ ተሰጥቷል። አስፈላጊ ከሆነ የጥናቱን ባለቤት ማግኘት ይቻላል።

የጥናቱን ዉጤት እንዴት ላዉቅ እችላለሁ? የጥናቱን ዉጤት ማወቅ ከተፈለገ የጥናቱን ባለቤት ጊዜዉ ዳምጤ ደመቀን በስልክ ቁጥር +251913557200 ወይም በኢሜይል 46340262@mylife.unisa.ac.za ማግኘት ይቻላል። በተረፈ ለማንኛዉም መረጃ የጥናቱን ባለቤት እና የጥናቱን ተቆጣጣሪ በኢሜይል makuamg@unisa.ac.za. ወይም የዩኒቨርሲቲዉን የጥናት እና ምርምር ሕግ ክፍል ኮሚቴ ሐላፊ ፕሮፌሰር ማኩዋን +27 12 429 4780 ኢሜይል maleskj@unisa.ac.za ማግኘት ይቻላል።
ጊዜ በመስጠት መረጃዉን ስላነበባቸሁ አመሰግናለሁ። ለመሳተፍ ፈቃደኛ ከሆንሽ/ክ የሚከተለዉን የስምምነት ቅጽ እንዲትሞይ/ላ በአክብሮት እጠይቃለሁ።

ከታላቅ አክብሮት ጋር
ጊዜዉ ዳምጤ ደመቀ
የጥናቱ ባለቤት

በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ጥራት እና ችግሮች/ተጽዕኖዎች በተመለከተ በሚደረገዉ ጥናት ተሳታፊ ለመሆን የተደረገ ስምምነት

እኔ---------- (የተሳታፊስም) የጥናቱ ባለቤት የጥናቱን አጠቃላይ ሁኔታ እና ሂደት የሚኖረዉን ጥቅም እና ጉዳት በዝርዝር ያስረዳኝ መሆኑን አረጋግጣለሁ። በቀረበዉ ቅጽ ላይ ያለዉ መረጃ በአግባቡ አንብቤ ተረድቻለሁ። ግልጽ ባልሆኑ ጉዳዮች ላይ ጥያቄ ለመጠየቅ እና ለመሳተፍ እንድወስን ዕድል ተሰጥቶኛል።

በጥናቱ የሚኖረኝ ተሳታፊነት ሙሉበሙሉ በፈቃደኝነት ላይ የተመሰረተ እንደሚሆን ተገንዝቤአለሁ። ካልተስማማሁ በማንኛዉም ጊዜ ያለምንም ቅጣት ማቋረጥ እንደምችል ተገንዝቤአለሁ። የዚህ ጥናት ዉጤት ለወደፊት ጥናታዊ ሪፖርት፤ ጆርናሎች፤ህትመቶች፤ ኮንፈረንሶች ጥቅም ላይ እንደሚዉል ተረድቻለሁ። በተጨማሪም እኔ እስካልተስማማሁ ድረስ በሂደቱ የምሰጠዉ መረጃ ምስጥራዊነቱ የተጠበቀ እንደሚሆን ተገንዝቤአለሁ። በቃለ መጠይቁ/በቡድን ውይይቱ በሚደረገዉም ቀረጻ ተስማምቻለሁ። ይህንንም በፊርማዬ አረጋግጣለሁ።

የተሳታፊዉ ሙሉ ስም _____

የተሳታፊዉ ፊርማ _____ ቀን _____

የጥናቱ ባለቤት ስም- _____

የጥናቱ ባለቤት ፊርማ _____ ቀን _____

ANNEXURE P: Consent to participate in the study

Title of the study: Evaluation for health care services for young people in East Gojjam Zone, Ethiopia

I,_____ (participant name), ensure that the individual requesting my participation in this study has provided me with information regarding the subject matter, methodology, expected advantages and expected challenges of participation.

I have read the study (or had it read to me) as described on the information sheet. I have read the study.

I have read the information sheet and have had a chance to ask questions. I am ready to take part in the study (or have been made aware of it) and have a good understanding of the study.

I acknowledge that my attendance is non-mandatory and that I have the right to resign at any time without consequence (if applicable).

I understand that the results of this study will feed into a research paper, journal articles and/or conference discussions, but that my involvement will remain confidential unless otherwise stated.

I accept to record the in-depth interview/group discussion. I received a signed informed consent agreement.

Name and Surname of the Participant (please print)

Participant signature _____ Date _____

Researcher's name and surname _____

Researcher's signature _____ Date _____

CONSENT TO PARTICIPATE IN THE STUDY (AMHARIC VERSION)

በጥናቱለመሳተፍየተደረገስምምነት

በኢትዮጵያበምሥራቅጎጃምዞንለወጣቶችእየቀረቡያሉየጤናአገልግሎቶች፡አጠቃቀም፤ ሽፋን፤
ጥራትእናችግሮች/ተጽዕኖዎችበተመለከተበሚደረገዉጥናትተሳታፊለመሆንየተደረገስምምነት

እኔ---------- (የተሳታፊስም)

የጥናቱባለቤትየጥናቱንአጠቃላይሁኔታእናሂደትየሚኖረዉንጥቅምእናጉዳትበዝርዝርያስረዳኝመሆኑን አረጋግጣለሁ፡፡በቀረበዉቅጽላይያለዉመረጃበአግባቡአንብቤተረድቻለሁ፡፡

ግልጽባልሆኑጉዳዮችላይጥያቄለመጠየቅእናለመሳተፍእንድወስንዕድልተሰጥቶኛል፡፡

በጥናቱየሚኖረኝተሳታፊነትሙሉበሙሉበፈቃደኝነትላይየተመሰረተእንደሚሆንተገንዝቤአለሁ፡፡

ካልተስማማሁበማንኛዉምጊዜያለምንምቅጣትማቋረጥእንደምችልተገንዝቤአለሁ፡፡

የዚህጥናትዉጤትለወደፊትጥናታዊሪፖርት፤ጆርናሎች፤ህትመቶች፤

ኮንፈረንሶችጥቅምላይእንደሚዉልተረድቻለሁ፡፡

በተጨማሪምእኔእስካልተስማማሁድረስበሂደቱየምሰጠዉመረጃምስጥራዊነቱየተጠበቀእንደሚሆንተ ገንዝቤአለሁ፡፡

በቃለመጠይቁ/በቡድንዉይይቱበሚደረገዉምቀረጻተስማምቻለሁ፡፡ይህንንምበፊርማዬአረጋግጣለሁ፡ ፡

የተሳታፊዉሙሉስም _____

የተሳታፊዉፊርማ _____ ቀን _____

የጥናቱባለቤትስም _____

የጥናቱባለቤትፊርማ _____ ቀን _____

ANNEXURE Q: Consent to participate in an interview of the study

I ----------the undersigned, declare that I am an adult who is above 18 years. I have read the information leaflet accompanying this consent form for the study titled: Evaluation for health care services for young people in East Gojjam Zone, Ethiopia. The researcher informed me that the duration of the focus interview would be thirty minutes. I have been informed that the conversation will be recorded on a tape. I understand that I am not obligated to participate in the study and that I am free to withdraw from it at any point without any repercussions on my part. The researcher said that all the information would be kept private and that I would stay anonymous. It was further clarified that the data would be utilised to develop guidance, compose a thesis paper to be stored in the UNISA library, and compose articles for publication and presentations at conferences. It's my right to get the results when I want them!. I understand that there is no monetary reward attached to the completion of this study. I know what the study is about and what's in the consent form. All my inquiries regarding the study have been answered. Whether or not I agree to participate in the focus group has been determined (remove any questions that are not relevant to you).

Signature of the participant _____ Date _____

Witness (name in block letters) _____ Signature _____

ANNEXURE R: Parental/guardians' permission for children

PARTICIPATION IN RESEARCH

Title: Evaluation for health care services for 15-24-years-old young people in East Gojjam Zone, Ethiopia

Introduction

The purpose of this form is to provide you (as the guardian of a prospective research study participant) information that may affect your decision as to whether to let the child participate in this research study. The person performing the research will describe the study to you and answer all your questions. Read the information below and ask any questions you might have before deciding whether to give your permission for the child to take part. If you decide to let the child be involved in this study, this form will be used to record your permission.

Purpose of the study

If you agree, the child under your care will be asked to participate in a research study with the purpose of evaluating the quality, coverage, utilisation and challenges of health service provision for young people in East Gojjam Zone, Ethiopia.

What is the child going to be asked to do?

If you allow the child to participate in this study, he/she will be asked to participate in a focus group of not more than 10 children per focus group. He/she will be asked to answer questions related to their participation in the SARC's support group. This study will take place during the weekly support group sessions that the child is already attending under the SARCS programme.

NOTE:
This is a research study and, therefore, not intended to provide a medical or therapeutic diagnosis or treatment.

What are the risks involved in this study?

This research study may involve risks that are currently unforeseeable. Possible risks associated with this study are psychological; the SARCS programme has support staff that will be debriefing and counselling participants when necessary to ensure their psychological wellbeing while participating in the research.

What are the possible benefits of this study?

The participant will receive no direct benefit from participating in this study; but through their participation, they will not only be equipped in identifying factors that affect their psychosocial wellbeing, but in doing so, will be able to cultivate better support systems when addressing health services delivered to young people.

Does the child under your care have to participate?

No, the child's participation in this study is voluntary. The child may decline to participate or can withdraw from participation at any time. Withdrawal or refusing to participate will not affect their relationship with SARCS in anyway. You can agree to allow the child to be in the study now and change your mind later without any penalty.

What if the child under my care does not want to participate?

In addition to your permission, the child must agree to participate in the study. If the child does not want to participate, he/she will not be included in the study and there will be no penalty. If the child initially agrees to be in the study, he/she can change their mind later without any penalty.

Will there be any compensation?

Neither you nor the child under your care will receive any type of payment for participating in this study.

How will the child's privacy and confidentiality be protected if s/he participates in this research study?

The child's privacy and the confidentiality of his/her data will be protected as the study will collect anonymous data where no names will be utilised.

If it becomes necessary for the Institutional Review Board to review the study records, information that can be linked to the child under your care will be protected to the extent permitted by law. The child's research records will not be released without your consent unless required by law or a court order. The data resulting from the child's participation may be made available to other researchers in the future for research purposes not detailed within this consent form. In these cases, the data will contain no identifying information that could associate it with the child under your guardianship, or with the child's participation in any study.

Audio recordings will be made during focus group discussion.

If you choose to participate in this study, the child will be audio recorded. Any audio recordings will be stored securely and only the research team will have access to the recordings. Recordings will be kept for the duration of the study, then they will be transcribed word by word (verbatim). The verbatim transcripts will be kept safe for the minimum period prescribed by the UNISA Research policy, then erased.

Whom to contact with questions about the study?

Prior, during or after your permission for the child to participate, you can contact the researchers Gizew Damtie Demeke at +251913557200 or send an email to gizew2009@yahoo.com or Prof MG Makua makuamg@unisa.ac.za, for any questions or more information. This study has been approved by UNISA, College of Human Sciences Research Ethics Committee (CREC) crec@unisa.ac.za
The chairperson is Dr KJ Malesa, E-mail**:** maleskj@unisa.ac.za

Informed consent

In the decision to allow the child under your guardianship to participate in this study, your signature below indicates that you have read the information provided above and have decided to allow them to participate in the study. If you later decide that you wish to withdraw your permission for the child to participate in the study, you may discontinue his or her participation at any time. You will be given a copy of this document.

The child may be audio recorded _____

The child may not be audio recorded _____

Printed name of the child _____

Signature of legal guardian _____ Date _____

Signature of researcher _____ Date _____

Name of a witness (signature) _____ Date _____

PARENTAL/GUARDIAN'S PERMISSION FOR CHILDREN'S PARTICIPATION IN RESEARCH (AMHARIC VERSION)

የወላጅስምምነት

በኢትዮጵያበምሥራቅጎጃምዞንለወጣቶችእየቀረቡያሉየጤናአገልግሎቶች፡አጠቃቀም፤ሽፋን፤ ጥራትእናችግሮች/ተጽዕኖዎችበተመለከተበሚካሄድጥናትልጆቻቸዉተሳታፊእንዲሆኑከወላጅወ ይምከአሳዳጊዎችጋርየተደረገስምምነት፡፡

መግቢያ

የዚህቅጽዋናዓላማልጅዎትንበዚህጥናትተሳታፊሃሳብላይዉሳኔዎንለማወቅያስችላል፡፡

የጥናቱባለቤትስለጥናቱ ገለጻያደርጋል ፡፡ እርስዎለሚያቀርቡትጥያቄምመልስይሰጣል፡፡

ከዚህበታችየቀረበዉንመረጃበመገንዘብልጅዎበጥናቱእሳታፊእንዲሆንከመወሰንዎበፊትማንኛዉንምጥያቄ መጠየቅይችላሉ፡፡ ልጅዎበጥናቱእንዲሳተፍከተስማሙፈቃደኝነትዎንበዚህቅጽአናረጋግጣለን፡፡

የጥናቱዓላማ

ስምምነትላይከደረሱበርስዎዕዉቅናእናክትትልልጅዎበኢትዮጵያበምሥራቅጎጃምዞንለወጣቶችእየቀረቡያሉ የጤናአገልግሎቶች፡አጠቃቀም፤ሽፋን፤

ጥራትእናችግሮች/ተጽዕኖዎችላይበሚደረገዉጥናትላይእንዲሳተፍጥያቄይቀርብለታል፡፡

ልጅዎየሚቀርብለትጥያቄ

ልጅዎበጥናቱእንዲሳተፍከፈቀዱልጅዎቁጥራቸዉከ 10 ባልበለጡየቡድንአባልሆኖእንዲሳተፍይጠየቃል፡፡

የሚሮረዉንተሳትፎበተመለከተጥያቄዎች ይቀርቡለታል፡፡

ይህዉይይትየልጅዎንየትምህርትፕሮግራምበማያዛባሁኔታይከናወናል፡፡

ማስታወሻ:ይህጥናትእናምርምርእንጂህክምናለማቅረብወይምየምርመራአገልግሎትለመስጠትየሚደረግ ዓይደለም

በዚህጥናትዉስጥሊያጋጥሙየሚችሉችግሮች

ከዚህጥናትጋር በተያያዘ ሊያጋጥሙየሚችሉችግሮችንበዚህሠዓትመረዳትአይቻልም።
ሊከሰቱይችላሉተብሎየሚታሰቡትየመንፈስአለመረጋገትሲሆንበጥናቱየተዋቀረዉየእገዛቡድንችግሩንለመከ
ላከልአስፈላጊበሆነጊዜየምክርአገልግሎትይሰጣል።

ከዚህ ጥናትየሚገኝዉጥቅም

ልጅዎከዚህጥናትቀጥተኛየሆነምንምጥቅምአያገኝም።
ነገርግንበመሳተፉበወጣቶችጤናአገልግሎትአቅርቦትዙርያያሉችግሮችንከመለየትለይቶከማወቅበተጨማሪለ
ሌሎችየተሻለአገልግሎት እንዴት ሊያገኙእንደሚችሉሲስተምለመዘርጋትያስችላል።

የልጆችተሰትፎሁኔታ

የልጅዎተሳታፊነትሙሉበሙሉበፈቃደኝነትላይየተመሰረተይሆናል። በጥናቱሂደት
በማናቸዉምሠዓትአቋርጦመሄድይችላል።
ለጅዎበጥናቱእንዲሳተፍአሁንፈቃደኛቢሆኑምእስካልተመቸዎትድረስያለምንምቅጣትበማንኛዉምሠዓትሀ
ሳብዎንመቀየርይችላሉ።

ልጅዎፈቃደኛባይሆን

በጥናቱላይለመሳተፍልጅዎፈቃደኛባይሆንያለመስማማትመብቱነዉ። ከተስማማእናወደ ዉይይት ዉስጥ
ከገባበኋላምያለምንምቅጣትማቋረጥይችላል።

የጥናቱንማካካሻበተመለከተ

እርስዎምሆኑልጅዎከጥናቱጋርበተያያዘየሚያገኙትአንዳችክፍያአይኖርም።

ምስጢራዊነት

እርስዎምሆኑልጅዎበጥናቱለመሳተፍከወሰኑየልጅዎንስምእናማንነትበመጠይቁላይባለማካተትእናየሚሰጠ
ዉንመረጃበጥንቃቄበመያዝምስጢራዊነቱይጠበቃል።
የተቋሙየጥናትማረጋገጫቦርድቀረጻዉንለማየትአስፈላጊሆኖካገኘዉህግንመሰረትባደረገመልኩሊጠቀመ
ዉይችላል። ህጋዊካልሆነእናካልተፈቀደበቀርየተቀረጸዉማስረጃበምንምመንገድተላልፎአይሠጥም።
ከጥናቱየሚገኝዉመረጃየርስዎንምሆነ
የልጅዎንማንነትበማያሳዉቅመልኩወደፊትለሚደረጉጥናቶችሊያገለገልይችላል።

ቀረጻንበተመለከተ

ፈቃደኛከሆኑልጅዎበጥናቱወቅትይቀረጻል። ማናቸዉምቀረጻዎችበጥንቃቄምስጢራዊነቱተጠብቆይኖራል።
በጥናቱተሳታፊከሆነዉቡድንበቀርማንምየማግኘትእድልአይኖረዉም።
የተቀረጸዉመረጃጥናቱእስከሚጠናቀቅይቆያልቃልበቃልምወደጽሁፋዊመረጃነት ይቀየራል።
የተቀየረዉምመረጃየደቡብአፍሪካዩኒቨርሲቲንየጥናትፖሊሲታሳቢባደረገመልኩደህንነቱተጠብቆይቆያል።

ስለጥናቱ ጥያቄካለዎት

የልጅዎንተሳተፎከመወሰንዎበፊትበዉሳኔጊዜምሆነበኋላመረጃከፈለጉየጥናቱንባለቤትጊዜዉዳምጤደመቀ
ን በስልክቁጥር +251913557200 ወይምፕሮፌሰርሜሜማኩዋን በmakuamg@unisa.ac.za
በማግኘትማናቸዉንምጥያቄመጠየቅይቻላል። ይህጥናትበደቡብአፍሪካዩኒቨርሲቲየጤና ሳይንስ
ጥናትእናምርምርየህግኮሚቴየጸደቀነዉ።ለዚህምበ crec@unisa.ac.zaማረጋገጥይቻላል።
የኮሚቴዉኃላፊ ዶ/ር ማሌሳይባላሉኢሜይል:maleskj@unisa.ac.za

የስምምነትዉል

ለጅዎንበጥናቱእንዲሳተፍበፈቀዱበትበዚህዉሳኔከታችየሚቀመጠዉፊርማዎየቀረበዉንሀሳብበደንብአንብ
በዉእንደተረዱእናልጅዎበዚህጥናትእንዲሳተፍየፈቀዱመሆኑንያረጋግጣል።
ከዉሳኔዎበኋላሀሳብለመቀየርከፈለጉበማናቸዉምሰዓትአቋርጦመዉጣትይቻላል።
የዚህስምምነትዶክመንትኮፒይሰጥዎታል።

ልጅዎድምጹሊቀረጽይችላል _____

ልጅዎድምጹላይቀረጽይችላል _____

የተሳታፊዉልጅስም_____

የወላጅ/ያሳዳጊፊርማ _____ቀን _____

የጥናቱባለቤትፊርማ _____ ቀን _____

የእማኝሙሉስም _____ ፊርማ _____ ቀን _____

ANNEXURE S: Survey instrument

Self-administered questionnaire on Evaluation of health care services for 15-24-years old-young people in East Gojjam Zone, Ethiopia

Instruction: For the questions below, circle the answer you prefer

Part I: Background information

SN	Descriptions/questions	Answers/choices
101.	Sex	1. Male 2. Female
102.	Residence	1. Urban 2. Rural
103.	Age in year	
104.	Marital status	1. Single 2. Married 3. Unmarried 4. Divorce 5. Separated
105.	Level of education	1. Illiterate 2. Primary 3. Secondary 4. Tertiary
106.	Your religion _ _ .	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Other
107.	Frequency of religious participation	1. Everyday 2. At least 1 time per week 3. At least 1 time per month 4. Rarely 5. Never
108.	Religious level of importance	1. Very important 2. Important 3. Not important
109.	Type of ethnicity do you have	1. Oromo 2. Amara 3. Tigre 4. Guragie
110.	With whom do you live?	1. With parents 2. Only With mother 3. Only With father 4. Only With relatives

SN	Descriptions/questions	Answers/choices
		5. With a girlfriend 6. With boy friend 7. Alone
111.	Residence in past six months	1. With family 2. In rental house 3. In dormitory 4. Other
112.	Did you participate in day/night party?	1. Yes 2. No
113.	If yes for the above Q 12, how often?	1. Weekly 2. Every two weeks 3. Once a month 4. Twice a month 5. Once in three months
114.	Dou you get money from parents?	1. Yes 2. No
115.	If the answer for Q14 is yes, how often?	1. Every week 2. Two times per month 3. One time per 3 months 4. Two times per year 5. Annually 6. Other
116.	Marital status for father	1. Together with wife 2. Separated 3. Divorced 4. Widowed
117.	Marital status for mother	1. Together with husband 2. Separated 3. Divorced 4. Widowed
118.	Age of father in years	
119.	Education level for father	1. Not literate at all 2. Only read and write 3. Primary school 4. Secondary school 5. Above secondary school/college & above
120.	Father's occupation	1. Lady/housewife 2. Employed at private institution 3. Governmental employee 4. Small business owner 5. Medium business owner 6. Large business owner 7. Other
121.	Mother's age in years	--------
122.	Education level for mother	1. Not literate at all 2. Only read and write

SN	Descriptions/questions	Answers/choices
		3. Primary school 4. Secondary school 5. Above secondary school/college and above
123.	Mother's	1. Lady/housewife 2. Employed at private institution 3. Governmental employee 4. Small business owner 5. Medium business owner 6. Large business owner 7. Other
124.	Estimated monthly income of the parents' (ETB)	1. <1000 2. 1001-2000 3. 2001-3000 4. 3001-4000 5. 4001-5000 6. <5001
125.	Number of family in number	
126.	Head of family	1. Father 2. Mother 3. Other (specify)

Part II: Knowledge about RH and contact with health workers

No	Questions	Alternative choices
201.	Information about RH service	1. Yes 2. No
202.	If yes for Q2 01, what service do you know? (can choose multiple answers)	
	Contraceptive	1. Yes 2. No
	STI treatment	1. Yes 2. No
	VCT for HIV/AIDS	1. Yes 2. No
	Abortion	1. Yes 2. No
	Post abortion care	1. Yes 2. No
	Antenatal	1. Yes 2. No
	Post natal	1. Yes 2. No
	Other	Specify
203.	If yes for Q 202, where do you get the information? (can choose multiple answers)	
	Parents	1. Yes 2. No
	Teacher	1. Yes 2. No
	Health worker	1. Yes 2. No
	Friends	1. Yes 2. No
	Newspaper	1. Yes 2. No
	Poster	1. Yes 2. No
	Mass media	1. Yes 2. No
	Social media	1. Yes 2. No
204.	If you used any service from 202, circle them	1,2,3,4,5,6,7,8
205.	Do you know about reproductive health?	1. Yes 2. No
206.	Do you know about health extension workers?	1. Yes 2. No
207.	Did you have any contact with HEW?	1. Yes 2. No
208.	If yes for Q 207, how often per year?	1. Once 2. Twice 3. 3 times 4. $\geq$ 4 times 5. Others
209.	If your answer is (NO for Q 207) what is/are your possible reason?	1. I don't wish to be contacted 2. They are not working in our campus 3. They are not friendly 4. I do not know them at all 5. Other

No	Questions	Alternative choices
210.	Whom do you wish to be RH service provider?	1. Young caregiver with same sex 2. Young caregiver (opposite sex) 3. Young caregiver 4. Any sex 5. Young adult caregiver (same sex) 6. Young adult caregiver (opposite sex) 7. Young adult caregiver (any sex) 8. Other
211.	How often do you participate in day/night clubs? (Risky to life)	1. Often 2. Rarely 3. Never
212.	The consumption of alcohol, chewing tobacco, or the taking of any medication can have an impact on the refusal to utilise RH service (condom, pills, etc.) at time of sex	1. Often/frequently 2. Rarely/sometimes 3. Never
213.	How often do movies or television programmes prompt me to use contraception during sexual intercourse?	1. Often/frequently 2. Rarely/sometimes 3. Never

Part III: Young people' attitudes towards RH services

Choose and encircle your choice for your agreement

Please determine to what degree you agree or disagree with the following assertions:

301.	It's really important for young people like me to have access to health and wellness services.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
302.	Every young person should know how important RH service is.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
303.	It is even more difficult for young people to obtain RH service compared to adults.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
304.	If the health provider is judgmental, it is unlikely that RH service will be used.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
305.	It is unlikely that you will avail of RH service if there is a long wait at the service centre.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
306.	It is highly unlikely that you will avail of RH service if the providers of RH service are not friendly.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
307.	If the RH service isn't confidential, then it's highly unlikely that you'll be using the RH service.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
308.	If the RH service price is high, it is unlikely that you will be able to avail of RH service.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree
309.	If there are fewer providers of RH service in the health facility of my resident, it is unlikely that they will provide RH service.	1. Strongly agree 2. Agree 3. Neutral 4. Disagree 5. Strongly disagree

Part (IV) Reproductive health behaviours

A. This text discusses the topic of sexual activity and the use of contraception.		
401	How many boyfriends and girlfriends did you have?	1. One 2. Two 3. Three 4. Four and above 5. Others
402	How many of them did sex with you?	1. 1 2. 2 3. 3 4. > 5. No sex (**skip to 414**)
403	How old were you when you had your first sexual encounter?	_____
404	How old was the first sexual partner of yours?	_____
405	During your first sexual copulation, did you use any form of contraception?	1. Yes 2. No (**skip to 407)**
406	If your answer is (**Yes)** for **405;** Which method of birth control do you use during the first time?	1. Pills 2. EC (Emergency contraception) 3. Injection 4. Male-condom 5. Safe period 6. Other
407	When was the last time you had sex?	1. Last week 2. Last month 3. Last six months 4. Last year 5. Before one year ago 6. Others _____-
408	How many sexual partners have you had in the last 3 months?	1. One 2. Two 3. Three 4. Four 5. More than 4 6. Other (specify)_____
409	How many sexual partners have you had up until this point?	1. One 2. Two 3. Three 4. Four 5. More than 4 6. Other (specify)
410	Do you usually use a method of birth control?	1. Yes 2. No **(skip to 413)**
411	If your answer is (**Yes**) for **Q 410**; Who makes the decision to use a contraceptive?	1. Myself 2. My parent 3. Joint decision

412	If your answer is (**Yes**) for **Q410**; What kind of birth control do you use?	1. Pills 2. EC (Emergency contraception) 3. Injection 4. Male 5. Safe period 6. Withdrawal 7. Other
413	If you haven't used any form of contraception, why not? (more than one choice permitted)	1. I don't know where I can get contraceptives. 2. I'm Afraid to Buy 3. I don't know what method of contraception. 4. I don't have the money to buy those contraceptives. 5. My girlfriend/boyfriend makes me have sex for free. 6. I never forget 7. Other
414	Have you ever experienced unsafe sexual practice following a day/night celebration?	1. Yes 2. No
415	Do you plan on using birth control in the future?	1. Yes 2. No
416	If your answer is (**YES**) for Q (**415**); What is your probable reason?	1. To protect unwanted pregnancy 2. To protect from different STIs including HIV/AIDS 3. For spacing purpose 4. Other reason-------
417	If your answer is (**NO**) for **Q (415)**; what can be your possible reason?	1. It is forbidden in my culture 2. It is forbidder 3. I don't worry about my future 4. It is against rule of God 5. Others------
B. For females only		
418	If your answer is (NO) for Q402; why you didn't have sexual intercourse still?	1. It is not the right time 2. Doesn't have boy/girl friend 3. I fear having sex 4. Others (specify)----------
419	Have you ever been pregnant?	1. Yes 2. No skip to 426
420	If your answer is (YES for 419); what happened to the pregnancy?	1. Currently pregnant 2. Abortion 3. Miscarriage 4. Live birth
421	If the pregnancy is ended by abortion from where you get the service?	1. Gov't. health centres/hospitals 2. Pharmacy/drug store 3. Traditional attendant 4. Any private

		5. Health centre/HOSPITAL 6. Others (specify)
422	If you aborted; did you server **post abortion care** service from any health institution?	1. Yes 2. No
423	If your answer is (**NO for Q4 22)**; what is the possible reason for not using the **post abortion care** service?	1. Does not have money 2. Don't know where to go 3. Cultural against 4. Fear of parents 5. Inconvenient location 6. Inconvenient time of services 7. Feeling healthy 8. Distance to facility 9. Others (specify)
424	How many times have you been pregnant?	1. Once 2. Two times 3. Three and above time
425	How many times you made abortion?	1. Never 2. Once 3. Two times 4. Three and above times
426	Did you ever use EC (Emergency contraceptive) after unsafe sexual intercourse?	1. Never 2. Once 3. Two times 4. Three and above times
427	If your answer is (**Yes** for **Q 426**); how many times you use EC after your sexual intercourse?	1. Yes 2. No
A. **Voluntary Counselling and Testing (VCT) for STI and HIV/AIDS**		
428	Have you ever had a voluntary counselling and testing service (VCT) for HIV/ADIS? If your answer is **Yes** from where you tested?	1. Govt. health centre/hospital 2. Pharmacy (drug store) 3. Any private health centre/hospital 4. Others (specify)----------
429	Did you have voluntary counselling and test in service (VCT) before your first sexual intercourse? if your answer is **No** why?	1. Too young to go the service 2. Don't have money 3. Don't know the purpose 4. Don't know where to have the test 5. Fear of parent 6. Inconvenient location 7. Inconvenient time of services 8. Feel health 9. Long distance to facility 10. Others (specify)----------
430	How often did you go for voluntary counselling and testing service (VCT)?	1. When exposed to risk 2. Every three month 3. Every six month 4. Every year

		5. Others (specify)----------
431	Have you ever had symptoms of STIs such as, genital ulcer, genital discharge or genital swelling?	1. Yes 2. No **(skip to 434)**
432	How many times you affect by STDs?	1. Once 2. Twice 3. More than two times
433	What did you do first when you had STLs?	1. I did nothing treatment 2. Self 3. Went to campuses' clinic pharmacy 4. Went to public health centre 5. Went to public health institution 6. Went to private clinic/hospital 7. Went to traditional healer
B. **Availability of RH services and utilisation**		
434	Is there any RH service in your Campus compound?	1. Yes 2. No **(skip to Q 438)**
435	If your answer is (**Yes for Q4 34)**; did you ever use the RH service?	1. Yes 2. No
436	If your answer is (**Yes** for **Q 435)**; which service, you use in the campus?	1. Pills 2. EC (emergency contraceptive) 3. Injection 4. Condom 5. For VTC service 6. Post-abortion care service 7. Others _____
437	If your answer is (**No for Q435)** what is/are your possible reasons?	1. I fear the service provider 2. Didn't find all the RH service want 3. The RH service providers are not friendly 4. I use the service centre only for other ill cases 5. Other (specify) ----------.
438	Where do you likely to receive RH services? (m**ultiple response permitted)**	1. Any govt. health centres/ hospital 2. Pharmacy/Drug store 3. Traditional method 4. Any health institution nearby 5. Others (specify)----------
439	Do you believe there are enough RH service centres in your resident to have the service easily when you want?	1. Yes 2. No
440	Where do you prefer the RH service centre to be located?	1. Anywhere out of my resident area 2. Anywhere nearby the main road 3. Somewhere out of the main road 4. Other (specify)
441	Is waiting hour to have reproductive health service is too long?	1. Yes 2. No

442	Which time do you think convenient for youth to have RH service?	1. In the usual time with other users 2. When other users are not around health centre 3. Other (specify) _____
443	If you use any RH services, did you face any shortage to take the service (condom, pills, etc) in the health institution?	1. Yes 2. No
444	Did you ever face shortage of money for the RH service?	1. Yes 2. No
445	If your answer is **Yes** for **Q 444**; how you solve the problem?	1. Borrowing and get 2. Leave the service 3. Work
446	What do you prefer on service fees for youth?	1. As usual rate 2. With discount for youth 3. Free of charge 4. Other (specify)
447	Do you believe your religiosity has effect on using or not using RH services?	1. Yes 2. No
448	Do you discuss about reproductive health (sexual related issues) with your parents (guardians)?	1. Yes 2. No
449	If your answer is (**Yes** for **Q 447**). How often you discuss with your parents (guardians)?	1. Often 2. Occasionally 3. Others_____

SURVEY INSTRUMENT (AMHARIC VERSION)

መመሪያ

- ለሚከተሉት ጥያቄዎች ከተሰጡት አማራጮች ውስጥ ላንተ/ቺ መልስ ተስማሚ የሆነውን ምርጫ ብቻ አክብብ/ቢ
- መጠይቁንም ሞልቶ መጨረስ ከ40 -60 ደቂቃ ወስዶ ለሚችል በትግስት መልሱን ይስጡ
- በመጠይቁ ላይ ስሙን መጻፍ አስፈላጊ አይደለም
- መረጃው የሚፈለገው በዋናነት ሁለተኛ ዲግሪ ማሟያ ሆኖ የተማሪዎች ሥነ- ተዋልዶ ጤና አገልግሎት አጠቃቀማቸው ጋር ተያይዞ ለጉዳዮችን አጥንቶ ለሚመለከታቸው አካላት ማመልከት ነው።

ክፍል፩፡- አጠቃላይ መረጃ

ተ.ቁ	**ጥያቄዎች**	**ምርጫ**
101	ጾታ	**1.** ወንድ 2. ሴት
102	የትውልድ ቦታህ/ሽ	**1.** አዲስ አበባ **2.** ከአዲስ አበባ ውጪ ሆኖ ገጠራማ አካባቢ **3.** ከአዲስ አበባ ውጪሆኖ ከተማ ውስጥ
103	ዕድሜ	_____ዓመት
104	ያንተ/ቺ የጋብቻ ሁኔታ	1. ፍቅረኛ ያላው/ላት 2. ያገባ/ች 3. አንድ የፍቅር ጓደኛያሆው/ያላት 4. የተፋታ/ች 5. ተወያይቶ የሚኖር 6. ሌላከሆነ ጥቀስ/ሽ----------
105	የስንተኛ ዓመት ተማሪ ነህ/ሽ	**1. 1ኛ** 2. 2ኛ 3. 3ኛ **4.**4ኛ **5. 5ኛ** እና ከዚያ በላይ
106	ዲፓርትመንት	_____
107	ሃይማኖትህ/ሽየትኛው ነው?	**1.**ኦርቶዶክስ ክርስቲያን **2.** ሙስሊም **3.**ፕሮቴስታንት **4.** ካቶሊክ **5.** ያንተን/ቺን ጻፍ/ፊ ----------
108	ሐይመኖታዊሥርዓቶች (ጸሎት፣ ሶሊት)ለምን ያህል ተሳትፋለህ/ሽ ስርዓቶች (ጸልት፣ሶሊት) ለምን ያህል ትሳተፋለህ/ሽ?	**1.** በየቀኑ 2.በሳምንት ቢያንስ ለአንድ ጊዜ **3.** በወር ለአንድ ጊዜ **4.** አልፎ አልፎ **5.**አልሳተፍም

109	ሃይማኖታዊ ሥርዓቶች ለይመሰተፍ በህይወትህ/ሽ ምን ያህል ጥቅም አለው?	**1 1** በጣም ጥቅም አለው **2.** ጥቅም አለው **3.**አይጠቅምም
110	የየትኛ ብሔረሰብ ተወላጅ ነህ/ሽ?	**1 1** ኦሮሞ **2.** አማራ **3.** ትግሬ**4.**ጉራጌ **5.**ሌላ ከሆነ ጻፍ _____
111	አንተ/ቺ ከማን ጋር ነው የምትኖረው/ኖሪው?	**1 1** ከአባትና እናቴ **2.**ከእናቴ ጋር**3.** ከአባቴ ጋር 4.ከዘመዳ ጋር5. ከሴት ጓደኛዬ ጋር 6. ከወንድ ጓዳኛዬ ጋር.7.ለብቻዬ 8. ሌላ ካለጥቀስ/ሽ----------
112	ላለፉት ስድስት ወራት ይበልጥ የኖርከው/ሽው የት ነው?	**1.**ከቤተሰቤ ጋር **2.** በክራይ ቤት **3.**ድርም **4. ሌላ ከሆነ**ጥቀሽ/ሽ _____
113	በቀን ወይም በምሽት ክለብ ትሳተፋለህ/ፊያለሽ?	**1.** አዎን **2.** አልሳተፍም (**ወደ 115)**
114	ለጥያቄ 113መልስህ/ሽ አዎን ከሆነ ምንያህሌ?	**1.** በየሳምንቱ **2 1** በወር 2 ጊዜ ብቻ **3.** በየወሩ **4**.በየ3 ወሩ 5. በየ6 ወሩ**6.**በየ6 ዓመቱ **7.** ሌላ መልስ ካለጥቀስ/ሽ_____
115	ከቤተሰብህ/ሽ የኪስ ገንዘብ ይሰጥሃል/ሻል?	**1.** አዎ **2.** አይሰጠኝም (**ወደ117)**
116	ለጥያቄ 115 መልስህ/ሽአዎንከሆነየስንትጊዜታገኛለህ/ሽ ?	**1.**በየሳምንቱ **2 1** በወር 2 ጊዜ **3.**በየወሩ **4.**በየ3 ወሩ **5.** በየ6 ወሩ **6.** በየዓመቱ **7.** ሌላ መልስ ካለው ጥቀስ/ሽ
117	የአባትህ/ሽ የጋብቻ ሁኔታ	**1.** አብረው የሚኖሩ **2.ተ**ለያይተውየሚኖሩ **3.** የተፋቱ **4.** በሕይወት ያለው አባት ብቻ ነው **5.**በሕይወት ያላችው እናት ብቻ ናት
118	የእናትህ/ሽ የጋብቻ ሁኔታ	**1.** አብረው የሚኖሩ **2.** ተለያይተው የሚኖሩ **3.** የተፋቱ **4.** በህይወት ያለው አባት ብቻ ነው **5.**በህይወት ያለችው እናት ብቻ ናት
119	የአባትህ/ሽ (ወንድ አሳዳጊ ህ/ሽ) ዕድሜ ስንት ነው?	
120	የአባትህ/ሽ (ወንድ አሳዳጊ ህ/ሽ) የትምህርት ደረጃ ምን ያህል ነው ?	**1.** ማንበብና መጻፍ አይችልም **2.** ማንበብና መጻፍ ብቻ ይችላል **3 1** ከ1ኛ አስከ 8ኛ**4.** ከ9ኛ እስከ 10ኛ 5.የመሰናዶ ትምህርት 6. በሰርቲፊኬት ወይም የዲፕሎማ ተመራቂ **7.** ዲግሪና ከዚያ በላይ
121	የአባህ/ሽ (ወንድ አሳዳጊህ/ሽ) ሥራ ምንድን ነው?	**1.** ሥራ የለውም **2.** የግል መሰሪያቤት ሠራተኛ **3.** የመንግስት ሠራተኛ **4.** አነስተኛ ነጋዴ **5.** መካከለኛ ነጋዴ **6.** ከፍተኛ ነጋዳ **7.** ግብርና **8.** ሌላ ካለ ጥቀስ/ሽ

122	የእናትህ/ሽ (ሴት አሳዳጊህ/ሽ) እድሜ ስንት ነው?	------
123	የእናትህ/ሽ (ሴት አሳዳጊህ/ሽ) የትምህርት ደረጃ ምን ያህል ነው?	**1.** ማንበብና መጻፍ አትችልም **2.** ማንበብና መጻፍ ብቻ ትችላለች **3.** ከ1ኛ እስከ 8ኛ **4.** ከ9ኛ እስከ 10ኛ **5 1** በሰርቴፊኬት ወይም የዲፕሎማ ተመራቂ **6.** ዲግሪና ከዚያ በላይ
124	የእናትህ/ሽ (ሴት ሥራ ምንድን ነው? አሳዳጊህ/ሽ)	**1.** የቤት እመቤት **2.** የግል መሰሪያቤት ሠራተኛ **3.** የመንግስት መስሪያ ቤት ሠራተኛ **4.** አነስተኛ ነጋዴ **5.**መካከለኛ ነጋዴ **6.**ከፍተኛ ነጋዴ **7.**ሌላ ከሆነ ጥቀስ/ሽ____
125	የቤተሰብህ/ሽ አማካይ የወር ገቢ በግምት ስንት ነው?	**1.** ከ1000 ብር በታ **2.** ከ1001-2000 ብር 3. ከ2001 - 3000 ብር **4.** ከ3001 - 4000 ብር **5 1** ከ 4001 – 5000 ብር 6. ከ5001 ብር በላይ
126	የቤተሰብህ/ሽ ብዛት ስንት ነው?	
127	የቤተሰብህ/ሽ አስተዳዳሪ ማን ነው?	**1.**አባት **2.**እናት **3** ሌላ ካለ ጥቀስ/ሽ
128	መሰናዶ ትምህርት የት/ቤት ተማርክ/ሽ?	**1.**የመንግስት **2.**የግል **3.**ሌላ_
129	መሰናዶ ትምህርት የትሃገር ተማርህ/ሽ	**1.**አዲስ አበባ **2.** ከአዲስ አበባ ውጭ

ክፍል፪

ከህምና ባለሙያዎች ጋር ያላቸው ቅርርብ እና ስነ ተዋልዶ ጤና ያላቸው እውቀት

201	ስለማንኛውም ሥነ-ተዋልዶ ጤና አገልግሎት እውቀት ወይም ግንዛቤ አለህ/አለሽ?	**1.**አዎን **2.** የለኝም **(ወደ ጥያቄ 205)**
202	ለጥያቄ 201 መልስህ/ሽ አዎን ከሆነ የትኞቹን የስነ-ተዋልዶ አገልግሎቶችን ታውቃለህ/ሽ? **(ከአንድ በላይ መመ ለስ ይቻላል)**	**1 1** የእርግዝና መከላከያ ዘዴዎች **2.** ከአባላዘር በሽታ ህክምና**3.** የኤች አይ ቪ ኤድስ ምርመራ እና ምክር አገልግሎት **4.**የውርጃ አገልግሎት **5.** ከውርጃ በኋላ የህምና አገልግሎት **6.**ቅድመ ወሊድ ክትትል **7.** ክሊድ በኋላ ክትትል **8.** ሌላ መልስ ካለ____
203	የጥያቄ 201 መልስህ/ሽ አዎን ከሆነ መረጃውን ከየት አገኘ ህ/ሽ? (**ከአንዴበሊይመመሠ ስይቻሊሌ)**	**1.** ከቤተሰብ **2.** ከመምህራን ከት/ቤት **3.** ከጤና ባለሙያዎች **4.**ከጓደኞቼ **5.**ከጋዜጣ **6.** ከበራሪ ጽሑፍ **7.** ከራዲዮና ከቴሌቪዥን **8.**ከኢንተረኔት

		9. ከሌላ ካለ ጥቀስ/ሽ__
204	ጥያቄ 202 ላይ ከተዘረዘሩት አገልግሎቶች የተጠቀምካቸዉን ጻፍ/ፊ	
205	ሥነ-ዋልዶ ጤና እውቀት ወይም ግንዛቤ እንዲኖርህ/ሽ ትፈልጊያለሽ/ህ?	**1.**አዎን **2.** አልፈልግም
206	ጤና ኤክሰተንሽን ባለሙያዎችን ታውቃለህ ታውቂያለሽ?	**1.**አዎን **2.** አላውቅም (**ወዯጥያቄ210**)
207	ከጤና ኤክስቴንሽ ባለሙያዎች ጋር የምትገናኝበት አጋጣሚ አለ ?	**1.**አዎን **2.** የሇም (**ወዯጥያቄ209**)
208	ለጥያቄ 207 መልስህ/ሽ አዎን ከሆነ በምን ያህል ጊዜ ትገኛላችሁ?	**1 1** በዓመት አንድ ጊዜ **2.** በዓመት ሁለት ጊዜ **3 1** በዓመት ሶስት ጊዜ **4.** በዓመት አራት ጊዜና ከዚያ በላይ **5.** ሌላ መልስ ካለው _
209	የጥያቂ 207 መልስህ/ሽ የለም ከሆነ ምክንያት ህ/ሽ ምን ሊሆን ይችላል?	**1.** መገናኘት ስለማልፈልግ **2.** ባሙያዎቹ እኛ ግቢ ውስጥ ስላሉ **3.** አገልግሎት አሰጣጣቸው ስለማያስደስት **4.**ስለማላውቃቸው **5**.ሌላ ምክንያት ካለ---------
210	ለወጣቶች ስነተዋልዶ ጤና ማን ሀኪም ቢሆን ትመርጣለህ/ሽ ?	**1 1** ወጣት ሆኖ ተመሳሳይ ጾታ **2.** ወጣት ሆኖ ተቃራኒ ጾታ **3.** መጣት ሆኖ ማንኛውም ጾታ**4.** አዋቂ ሆኖ ተመሳሳይ ጾታ **5 1** አዋቂ ሆኖ ተቃራኒ ጾታ **6.** አዋቂ ሆኖ ማነኛውም ጾታ **7.** ሌላ መልስ ካለ_____
2011	በቀን ወይም በምሽት የመዘናኛ ፕሮግራም ለመሳተፍ ጥንቃቄ ለጐደለው ወሲብ ጥቃት ያጋልጣል?	**1ሁል ጊዜ** **3.** አልፎ አልፎ
212	አልኮል መጠጣት ፣ጫት መቃም፣ ወይም ሌሎች ዕጾችን፣ መጠቀም በወሲብ ሰዓት የስነ-ተዋልዶ ጤና አገልግሎት (ኮንዶም ፣ፔልስ ወዘተ) እንዳልጠቀም ያደርገኛል?	**1.**ሁልጊዜ **2.** አልፎ አልፎ **3.** ምንም ችግር የለውም

213	ፊልም መመልከት የእርግዝናመከሊከያ እንዴጠቀምይረዲኛሌ?	**1.** ሁልጊዜ **2.** አልፎ አልፎ 3.አይጠቅምም

ክፈልፍ፡- ወጣቶች ለስነ-ተዋልዶ ጤና አገልግሎት ያላቸው ዝንባሌ

ለሚከተሉት ጥያቄዎች የተስማማህበትን/ሽበትን እና ያልተስማማህበትን/ሽበትን በመወሰን ምረጥ/ጭ፤

301	የስነ ተዋልዶ ጤና አግልግሎት እንድ እኔ ላለው ወጣት ጠቃሚ ነው ?	**1.** በጣም እስማማለሁ **2.** እስማማለሁ **3.** መካከለኛ **4.** አልስማማም **5.** በጣም አልስማማም
302	እያንዳነዱ ወጣት ስለስነተዋልዶ ጤና አገልግሎት ጥቅም መረዳት አሉት ?	**1.** በጣም እስማማለሁ **2.** እስማማለሁ **3.** መካከለኛ **4.**አልስማማም **5.** በጣም አልስማማም
303	የሥነ - ተዋልዶ ጤና አገልግሎት ለማግኘት ከአዋቂዎች ይልቅ ወጣቶች ይቸገራሉ?	**1.** በጣም እስማማለሁ **2.** እስማማለሁ **3.** መካከለኛ **4.**አልስማማም **5.** በጣም አልስማማም
304	ጤና ባለሙያው/ዋ ስለእኔ ህክምና በእኔ ቦታ ሆኖ/ና የሚወስን/ምትወስን ከሆነ የስነ-ተዋልዶ ጤና ህክምናውን ምቹ አያደርገውም?	**1.** በጣም እስማማለሁ **2.** እስማማለሁ 3.መካከለኛ 4. አልስማማም 5. በጣም አልስማማም
305	በስነ-ተዋልዶ ጤና ህክምና መስጫ ቦታ ላይ ለረጅም ሰዓት የምቆይ ከሆነ ህክምናውን ምቹ አያደርገውም?	**1.** በጣም እስማማለሁ **2.** እስማማለሁ **3.** መካከለኛ 4. አልስማማም 5.በጣም አልስማማም
306	የስነ ተዋዶ ጤና ህከምና በባለሙያዎች ተግባቢ ካልሆኑ ህክምናውን ምቹ አያደርገውም?	**1.** በጣም እስማማለሁ **2.** እስማማለሁ 3. መካከለኛ 4. አልስማማም 5.በጣም አልስማማም
307	የሥነ-ተዋልዶ ጤና ህክምና ባለሙያዎች ሚስጥር ጠባቂዎች	**1.** በጣም አስማማለሁ **2.**እስማማለሁ 3.መካከለኛ 4 1 አልስማማም 5. በጣም አልስማማም

	ካልሆኑ ህክምናውን ምቹ አያደርገውም ?	
308	ለስነ-ተዋልዶ ጤና ህክምና የሚከፈለው ክፍያ ወደ ከሆነ ህክምናውን ምቹ አያደርገውም ?	**1.** በጣም እስማማለሁ **2.**እስማማለሁ 3.መካከለኛ 4. አልስማማም 5.በጣም አልስማማም
309	እኔ በምኖርበት አካባቢ በቂ የስነ ተዋልዶ ጤና አገልግሎት መስጫ ባለመኖሩ ህክምናውን ምቹ አላደረገውም?	**1**.በጣም እስማማለሁ**2.** እስማማለሁ 3. መካከለኛ 4.አልስማም 5. በጣም አልስማም

ክፍል ፬ ከሥነ ተዋለወዶ ጤና ጋር ተያያዥነት ያላቸው መጠይቆች

1. ግብረ ስጋ ግንኙነት እና የእርግዝና መከላከያ ዘዴ አጠቃቀም		
401	ከዚህ በፊት የወንድ ወይም የሴት ጓደኛ ነበረህ/ሽ?	1.1ዴ 2.2ት 3.3ስት4. 4ትና ከዚያ በላይ 5.ሌላ መልስ ካለ _____
402	ከስንቶቹ ጋር የግብረስጋ ግንኙነት ፈጽመሃል/ሻል?	1.1ዴ 2. 2ት 3.3ስት 4.4ትና ከዚያ በላይ 5. አልጀምርኩም (ወደ 414) 4ትናከዚያበሊይ5.
403	በመጀመሪያ ግብረስጋ ግንኙነትህ/ሽ ወቅት እድሜህ/ሽ ስንት ነበር ?	_____
404	በመጀመሪያ ግንኙነትህ/ሽ ወቅት የሴት/የወንድ ጓዳኛህ/ሽ እድሜ በግምት ስንት ነበር ?	_____
405	በመጀመሪያ ግብረ- ስጋ ግንኙነትህ/ሽ የእርግዝና መከላከያ ተጠቅመሃል/ሻል?	**1.** አዎን **2.** አልተጠቀምሁም (ወደ**407**)
406	ለጥያቄ 405 መልስህ አዎን ከሆነ የተጠቀምከው/ሽው የወሊድ መከላከያ የትኛው ነው ?	**1 1 በየቀኑ የሚዋጥ ክኒን (ፒልስ) 2.** በ72 ሰዓት ውስጥ ሚዋጥ የእርግዝና መከላከያ 3. በየ3 ወሩ የሚወጋ መርፌ 4. የወንድ ኮንዶም 5. የወር አበባ **4.** የወንዴኮንድም **5 1** የወርአበባ ኡ ጭት በመከተሌ **6.**ላሊመሌስካሇ_____

407	ለመጨረሻጊዜግብረስጋግንኙነትያደረከዉ/ሽዉመቼነዉ?	1. ባለፈዉሳምንት 2. ባለፈዉአንድወር 3. ባለፈዉስድስትወር 4. ባለፈዉአንድአመት 5. ከአንድአመትበፊት
408	ባልፉትሶስትወራትዉስጥከምንያህ ልሴቶች/ወንዶችጋርወሲባዊግንኙነት ነበረህ/ሽ?	1. አንዴ 2. ሁለቴ 3. ሶስቴ 4. አራቴ 5. ከአራተበላይ 6. ሌላመልስካለ_____
409	እስካሁንእድሜህ/ሽድረስከስንትሴቶች/ወንዶችጋርግበረስጋግንኙነትአድርገሃል/ሻል?	1. ከአንድ 2. ከሁለት 3. ከሶስት 4. ከአራት 5. ከአራትበላይ 6. ሌላመልስካለ----------
410	የግብረስጋግንኙነትሰትፈጽምሁልጊዜየእርግዝናመከላከያትጠቀማለህ/ሽ?	1. አዎን 2. አልጠቀምም (ወዩ413)
411	ለጥያቄ 410 መልስህአዎንከሆነዉሳኔዉየማንነው?	1. የሴትጓደኛዬ 2. የወንድጓደኛዬ 3. የሁለታችንዉሳኔ
412	ለጥያቄ 410 መልስህአዎንከሆነየትኛዉየመከላከያዘዴይበልጥትጠቀማለህ?	1. በየቀኑሚዋጥክኒን (ፒልስ) 2. የ72 ሰአትየእርግዝናመከላከያ 3. የወርመርፌመከላከያ 4. የወርአበባኡደትበመከተሌ 5. ዘርንከማህንወደዉጪማፍሰስ 6. ሌላመለስካለ_____
413	በግብረስጋግንኙነትወቅትማንኛዉምአይነትእርግዝናመከላከያየማትጠቀም/ሚከሆነምክንያትህ/ሽምንሊሆንይችላል?	1. የእርግዝናመከላከያዉንመግዛቦታስለማላዉቅ 2. መግዣቦታዉንባዉቅምመግዛትስለምፈራ 3. አጠቃቅሙንስለማላዉቅ 4. መግዣብርስለይኖረኝ 5. የፍቅርጓደኛዬስለማትወድ/ማይወድ 6. በግብረስጋግንኙነትጊዜስለምረሳዉ 7. ሌላምክንያትካለጥቀስ/ሽ_____
414	የቀንወይምየለሊትጭፈራስትሳተፍጥንቃቄለጎደለዉየግብረስጋግንኙነትተጋልጠህ/ሽታዉቃለህ/ሽ	1. አዎ 2. አላዉቅም

415	በወደፊቱህይወትህ/ሽየወሊድመከላከያ እጠቀማለሁብለህ/ሽታስባለህ/ሽ?	1. አዎን 2. አላስብም (ወዩ417)
416	ለጥያቄ 415 መልስህ/ሽአዎንከሆነምክንያትህ/ሽምን ሊሆንይቺላል?	1. ያልተፈለገእርግዝናንለመከላከል 2. ከአባላዘርበሽታለመከላከል 3. አራርከለመዉለድ 4. ሌላምከክንያትካለጥቀስ/ሽ_____
417	ለጥያቄ 415 መልስህ/ሽአላስብምከሆነምክንያትህም ንሊሆንይችላል?	1. በባህላችንክልክልስለሆነ 2. በሐይማኖቴስለማይፈቀድ 3. ስለወደፊትህይወቴአሁንማሰብስለማልፈልግ 4. ሌላምክንያትካለጥቀስ/ሽ_____
418	ለጥያቄ 402 መልስህ/ሽ **(የግብረስጋግንኙነትአልጀመርኩም)** ከሆነምክንያትህ/ ምንሊሆንይቺላል	1. በዚህእድሜዬመጀመርስለማለፈልግ 2. የወንድወይምየሴትጓደኛስለሌለኝ 3. የግብረስጋግንኙነትማድረግስለምፈራ 4. ሌላምክንያትካለጥቀስ/ሽ_____
ለሴቶችብቻየሚጠቅም (ከ419 427) **2. እርግዝናእናዉርጃ**		
419	ከዚህበፊትበፍቅረኛሽ/በባለበትሽወይም ከሌላወንድአርግዘሽታዉቂያለሽወይ?	1. አዎን 2. አላዉቅም (ወዩ426)
420	ለጥያቄ 419 መልስሽአዎንከሆነየእርግዝናዉመጨረሻ እንዴትነበር?	1. አሁንእርጉዝነኝ 2. አስወረድኩት 3. በህመምምክንያትጽንሱተቋረጠ 4. ተወለደ
421	እርግዝናዉየተቋረጠዉበማስወረድከሆነ የማስወረድህክምናዉንየትተጠቀምሽ?	1. በመንግስትህክምናተቋም 2. ከመድሃኒትቤትመድሃኒትበመግዛት 3. በባህላዊመድሃኒት 4. ሌላመንገድተጠቅመሽከሆነግለጭ
422	እርግዝናዉየተቋረጠዉበማስወረድከሆነ ካስወረድሽዉበኋላየህክምናአገልግሎት ተጠቅመሻል?	1. አዎ 2. አልተጠቀምኩም
423	የህክምናአገልግሎቱንካልተጠቀምሽምን ያትሽምንሊሆንይችላል?	1. የአገልግሎቱክፍያዉድስለሆነ 2. አገልግሎትማግኛቦታዉንስለማላዉቀዉ 3. በባህላችንክልክልስለሆነ 4. ቤተሰቦቼን/ሚያዉቁኝንሰዎችስለምፈራ

		5. አገልግሎትመስጫቦታዉአማካይቦታላይስላልሆ ነ 6. አገልግሎትመስጫጊዜዉምቹስላልሆነ 7. የህመምስሜትስላልተሰማኝ 8. አገልግሎትመስጫቦታዉሩቅስለሆነ 9. ሌላምክንያትካለጥቀሽ?
424	ከዚህበፊትለምንያክልጊዜእርግዝናተከስ ቶብሽያዉቃል?	1. ለአንድጊዜ 2. ለሁለትጊዜብቻ 3. ለሶስትእናከእዚያበላይጊዜ
425	ከዚህበፊትለምንያህልጊዜአስወርደሽታ ዉቂያለሽ?	1. አስወርጇአላዉቅም 2. ለአንድጊዜብቻ 3. ለሁለትጊዜብቻ 4. ለሶስትእናከዚያበላይ
426	ከግብረስጋግንኙነትበኋላበ72 ሰዓትዉስጥየሚዋጥየእርግዝናመከላከ ያተጥቅመሽታዉቂያለሽ?	1. አዎን 2. ተጠቅሜአላዉቅም
427	ለጥያቄ 426 መልስሽአዎንከሆነለምንያህልጊዜተጠቀ ምሽ?	1. ለአንድጊዜብቻ 2. ለሁለትጊዜብቻ 3. ለሶስትጊዜ 4. አራትእናከዚያበላይጊዜ
3. ለአባላዘርበሽታእናለኤችአይቪኤዲስየተደረገየምክርአገልግሎት		
428	የኤችአይቪኤዲስምርመራወይምየምክ ርአገልግሎትአግኝተህ/ሽታዉቃለህ/ሽ? መልስህ/ሽአዎንከሆነከየትኛዉተቋምአገ ልግሎቱንአገኘህ?	1. የመንግስትጤናተቋም/ሆስፒታል 2. ፋርማሲዉስጥ 3. የግልጤናተቋም/ሆስፒታል 4. ሌላካለጥቀስ/ሽ_____
429	ለመጀመሪያጊዜየግብረስጋግንኙነትከማ ድረግህ/ሽበፊትየምክርአገልግሎትአግኝ ተህ/ሽታዉቃለህ/ሽ? መልስህአላዉቅምከሆነምክንያትህ/ሽም ንሊሆንይችላል?	1. እድሜዉትንሽስለሆነ 2. በቂገንዘብስለሌለኝ 3. ጥቅሙስለማይገባኝ 4. ቦታዉንስለማላዉቀዉ 5. ቤተሰቦቸንስለምፈራ 6. ቦታዉስለማይመች 7. ህመምስላልተሰማኝ 8. መመርመሪያዉርቀትስላለዉ 9. ሌላምክንያትካለ_____
430	የምርመራእናየምክርአገልግሎትመቼመ ቼትጠቀማለህ/ለሽ?	1. ጥንቃቀየጎደለዉየግብረስጋግንኙነትስፈጽም 2. በየ 3 ወሩ 3. በየ 6 ወሩ 4. በየአመቱ 5. ሌላካለ_____

431	ከዚህበፊትበአባላዘርበሽታተይዘህ/ሽታ ዉኪያለህ/ሽ?	1. አዎን 2. አላዉቅም (ወደ 434)
432	መልስህ/ሽአዎንከሆነምንያህልጊዜ?	1. አንድጊዜ 2. ሁለትጊዜ 3. ከሁለትበላይ
433	የአባላዘርህመምይዘህ/ሽከነበረምንመፍ ትሄወሰድክ/ሽ?	1. ምንምአላደረኩም 2. በግልአከምኩትእናዳንኩ 3. በዩንቨርስቲዉሃኪምቤትታከምኩ 4. መድሃኒትበትሄድኩ 5. በለላየመንግስትሃኪምቤትታከምኩ 6. የግልህክምናተቋምታከምኩ 7. በባህላዊህክምናታከምኩ
4. **የስነተዋልዶጤናአገልግሎትእናአጠቃቀም**		
434	በምትማርበትዩኒቨርስቲግቢዉስጥየስነ ተዋልዶጤናአገልግሎትይሰጣል?	1. አዎን 2. የለም (ወደ438)
435	ለጥያቄ 434 መልስህ/ሽ (አዎን) ከሆነአገልግሎቱንተጠቅመህ/ሽታዉቃለ ህ/ሽ?	1. አዎን 2. አላዉቅም
436	ለጥያቄ 435 መልስህ/ሽ (አዎን) ከሆነየትኛዉንአገልግሎትተጠቀምክ/ሽ?	1. በየቀኑሚዋጥክኒን (ፒልስ) 2. የ 72 ሰዓት 3. የ 3 ወርመርፌ 4. ኮንዶምለመዉሰድ 5. የምክርአገልግሎት 6. ከዉርጃበኋላየምክርአገልግሎት 7. ሌላከሆነ_____
437	ለጥያቄ 435 መልስህ/ሽአላዉቅምከሆነመክንያትህ/ሽ ምንሊሆንይችላል?	1. ሃኪሞቹንስለምፈራ 2. የምፈልገዉንህክምናስለማላገኝ 3. ሃኪሞቹህመምተኛንስለማይንከባከቡ 4. የህክምናቦታዉለመታከምስለማይመች 5. የስነተዋልዶጤናህክምናከዩኒቨርስቲዉጪስለምታ ከም 6. ሌላምክንያትካለህ/ሽ_____
438	የስነተዋልዶጤናአገልግሎትንየትመጠቀ ምታዘወትራለህ/ሽ? **(ከአንድበላይመልስመመልስይቻላል ?)**	1. የመንግስትጤናተቋም/ሆስፒታል 2. የግልጤናተቋም/ሆስፒታል 3. ፋርማሲዉስጥ 4. ባህላዊህክምና 5. በቅርብያለሆኖማንኛዉንምህክምናተቋምእጠቀማለ ሁ 6. ሌላካለጥቀስ/ሽ_____

439	አንተ/ቺበምትኖርበት/ሪበትአካባቢያለየ ስነተውልዶጤናአገልግሎትመስጫማእ ከልበቂናቸዉትላለህ/ሽ?	1. አዎን 2. በቂአይደለም
440	የስነተዋልዶጤናአገልግሎትመስጫማእ ከልየትአካባቢቢሆንትወዳለህ/ሽ?	1. የትምአካባቢይመቸኛል 2. ከመኖሪያሰፈርዉጪሆኖመንገድዳር 3. ከመኖሪያሰፈርዉጪሆኖሰዋራአካባቢ 4. ሌላመልስካለ_____
441	የስነተዋልዶጤናአገልግሎትለማግኘትፈ ልገህ/ሽረጅምሰአትጠብቀህ/ሽታዉካለህ /ሽ?	1. አዎን 2. አላዉቅም
442	የስነተዋልዶጤናአገልግሎትለወጣቶችም ቹሰአትየትኛዉይመስልሃል/ሽ?	1. በመደበኛዉሰአትሆኖከሌሎችታካሚዎችጋር 2. ሌሎችታካሚዎችበሌሉበትመታከም 3. ሌላመልስካለ_____
443	በየትኛዉጤናተቋምከዚህበፊትየስነተዋ ልዶእናጤናአገልግሎትተጠክመህ/ሽከሆ ነየእርግዝናመከላከያ (ኮንዶም፣ፒልስ፣ የመሳሰሉት)አልቋልተብለህ/ሽታዉቃለህ /ሽ?	1. አዎ 2. አላዉቅም
444	የስነተዋልዶጤናአገልግሎት (ኮንዶምወይምሌሎችየወሊድመከላከያ) ለመጠቀምገንዘብበማጣትየተቸገርክበ ትጊዜአለ?	1. አዎ 2. የለም
445	ለጥያቄ 444 መልስህአዎንከሆነችግሩንእንዴትተወጣ ሀዉ/ሽዉ?	_____
446	የስነተዋልዶጤናአገልግሎትክፍያዉእን ዴትቢሆንትመክራለህ/ሽ?	1. ባለዉይቀጥል 2. የወጣቶችበቅናሽቢሆን 3. በነጻቢሆን 4. ሌላሃሳብካለህ/ሽ_____

447	ያንተ/ቺሃይማኖተኛመሆንእናአለመሆን በስነተዋልዶጤናአገልግሎትአጠቃቀምላ ይተጽእኖአለዉትላለህ/ሽ?	1. አዎን 2. የለዉም
448	ከወላጆችህ/ሽ (አሳዳጊዎችህ/ሽ) ጋርስለስነተዋልዶጤና (ጾታዊጉዳዮች)ላይትወያያለህ/ሽ?	1. አዎን 2. አልወያይም
449	የምትወያዩከሆነበምንያህልጊዜ?	1. ሁልጊዜ 2. አልፎአልፎ 3. ሌላመልስ_____

ANNEXURE T: Semi-structured interview tool

Title: Evaluation of reproductive health services utilisation and challenges among young people in East Gojjam Zone, Ethiopia

PART 1: INSTITUTIONAL YOUTH-FRIENDLYSERVICES INDICATORS

No	**Indicators**	**Choices**	
	Sexual and reproductive health service	**Code**	**Descriptions**
01.	**Accessibility**		
	1.1. Is there convenient opening hour?	01	Yes
		02	No; Why?
	1.2. Is there easier transport to facility?	01	Yes
		02	No; Why?
	1.3. Is the service affordable?	01	Yes
		02	No; Why?
	1.4. Is there an outreach RH service in the community?	01	Yes
		02	No; Why?
	1.5. Do young people have awareness of location, hours and services?	01	Yes
		02	No; Why?
	1.6. Is there an appointment system available?	01	Yes
		02	No; Why?
	1.7. Is there a youth-only hour arrangement?	01	Yes
		02	No; Why?
	1.8. Is there social media for education and services?	01	Yes
		02	No; Why?
	1.9. Do facilities open during entire posted time?	01	Yes
		02	No; Why?
02.	**Acceptability**		
	2.1. Do you think that a client satisfies with the service?	01	Yes
		02	No; Why?
	2.2. Does a provider demographics reflect clients (*young, similar gender*)?	01	Yes
		02	No; Why?

	1.3. Was there a client come with friend's recommendation?	01	Yes
		02	No; Why?
	1.4. Does an organisation have good reputation?	01	Yes
		02	No; Why?
03.	**Appropriateness**		
	3.1. Does a package of care fulfills needs either at point of delivery or through referral linkages?	01	Yes
		02	No; Why?
	3.2. Does a client has choice of treatment options?	01	Yes
		02	No; Why?
	3.3. Does the data collected to determine young people's health needs in community?	01	Yes
		02	No; Why?
	3.4. Does a stakeholder participate in RH service provisions?	01	Yes
		02	No; Why?
04.	**Equitability**	02	No; Why?
	4.1. Is the service open to all regardless of age?	01	Yes
		02	No; Why?
	4.2. Is the service irrespective of the service open to both sexes?	01	Yes
		02	No; Why?
	4.3. Is the service open all ethnic groups?	01	Yes
		02	No; Why?
	4.5. Is the service open to all religious followers?	01	Yes
		02	No; Why?
	4.6. Is a service welcoming regardless of marital status?	01	Yes
	4.7. Is a service welcoming regardless of relationship status?	02	No; Why?
05.	**Effectiveness**		
	5.1. Supplies available onsite?	01	Yes
		02	No; Why?
	5.2. Are providers competent?	01	Yes
		02	No; Why?
	5.3. Does a provider take client history properly?	01	Yes
		02	No; Why?
	5.4. Does a client follow caregivers advice, adherence to treatment?	01	Yes
		02	No; Why?
	5.6. Is there an equipment to provide services available?	01	Yes
		02	No; Why?
	5.7. Are an Infection control procedures are followed?	01	Yes
		02	No; Why?
	5.8. Does a provider takes appropriate physical examination according to guidelines	01	Yes
		02	No; Why?
06.	**Administrative procedure**		
	6.1. Is there indicator for Waiting times?	01	Yes

		02	No; Why?
	6.2. Is there a plan for follow up care scheduled?	01	Yes
		02	No; Why?
	6.3. Is there referral care available, and scheduled?	01	Yes
		02	No; Why?
	6.4. Is there a system which allows stakeholders (patients, physicians, employers, insurance companies, pharmaceutical firms and government) participate in the service delivery & service quality improvement?	01	Yes
		02	No; Why?
	6.5. Is there a system to get feedback (information for client satisfaction)?	01	Yes
		02	No; Why?
07.	**Staff characteristics and competency**		
	7.1 Are providers non-judgmental?	01	Yes
		02	No; Why?
	7.2 Has a provider have positive attitude to young people?	01	Yes
		02	No; Why?
	7.3 Does a client receive adequate information from provider?	01	Yes
		02	No; Why?
	7.4 Are providers friendly?	01	Yes
		02	No; Why?
	7.5 Are providers respectful?	01	Yes
		02	No; Why?
	7.6 Do providers give opportunity to clients to ask questions?	01	Yes
		02	No; Why?
	7.7 Do providers listen to client problems	01	Yes
		02	No; Why?
	7.8 Are there providers trained in reproductive health service provision?	01	Yes
		02	No; Why?
	7.9 Have providers positive attitude to young people?	01	Yes
		02	No; Why?
	7.10 Does a provider use language that is understandable to clients?	01	Yes
		02	No; Why?
	7.11 Does support and supervision for staff available?	01	Yes
		02	No; Why?
	7.12 Is a client given time for test results to be absorbed and understood?	01	Yes
		02	No; Why?
	7.13 Is there a training plan in place that meets needs of staff?	01	Yes
		02	No; Why?
	7.14 Does a client have opportunity to ask all questions?	01	Yes
		02	No; Why?
		01	Yes

	7.15 Does RH service provider professional wear identification badges?	02	No; Why?
		02	No; Why?
08.	**Confidentiality and privacy**		
	8.1. Does a client consultation cannot be heard or seen by other clients or staff?	01	Yes
		02	No; Why?
	8.2 Is privacy respected?	01	Yes
		02	No; Why?
	8.3. Is parental consent not required?	01	Yes
		02	No; Why?
	8.4. Is consultation not interrupted?	01	Yes
		02	No; Why?
	8.5. Are tests handled confidentially?	01	Yes
		02	No; Why?
09.	**Education and communication**		
	9.1. Are there understandable and accurate SRH materials available?	01	Yes
		02	No; Why?
	9.2 Is there text message for follow-up or education?	01	Yes
		02	No; Why?
	9.3 Is there peer education system?	01	Yes
		02	No; Why?
10.	**Environment**		
	10.1 Is it comfortable (not crowded)?	01	Yes
		02	No; Why?
	10.2 Reading and/or entertainment materials available around?	01	Yes
		02	No; Why?
	10.3 Is it clean?	01	Yes
		02	No; Why?
	10.4 Is it a youth-only space?	01	Yes
		02	No; Why?
	10.5 Toilet facility quality?	01	Yes
		02	No; Why?
	10.6 Is there clean piped water?	01	Yes
		02	No; Why?
	10.7 Is there adequate lighting and ventilation?	01	Yes
		02	No; Why?
	10.8. Is principles of distancing for prevention of communicability of diseases especially COVID-19 on action?	01	Yes
		02	No; Why?
	10.9. Is there a system/programme/to give health education for young people regarding prevention of COVID-19?	01	Yes
		02	No; Why?

11.	**Services provided**		
	11.1 Is there STIs screening, counseling and treatment service unit in the organisation?	01	Yes
		02	No; Why?
	11.2 Is there family planning methods provision service?	01	Yes
		02	No; Why?
	11.3 Is there cervical cancer screening service and appropriately implemented for the youth?	01	Yes
		02	No; Why?
	11.4 Is there safe abortion service?	01	Yes
		02	No; Why?
	11.5 Are there appropriate and sufficient drug supplies in the institution?	01	Yes
		02	No; Why?
	11.6 Is there mental health service?	01	Yes
		02	No; Why?
	11.7 Is there behavioural Health service?	01	Yes
		02	No; Why?
	• Is there behavioural health counseling and treatment unit in the organisation?	01	Yes
		02	No; Why?
	• Is the unit privatised/secured? (is there vision and audio privacy)?	01	Yes
		02	No; Why?
	• Is there an up-to-date guideline/procedural policy for behavioural health services?	01	Yes
		02	No; Why?
	• Is there properly registered book/list in each unit?	01	Yes
		02	No; Why?
	• Is there trained professional assigned in the unit?	01	Yes
		02	No; Why?
	• Is there screening and counseling service for risky behaviour like smoking, alcohol use, khat use, violence?)	01	Yes
		02	No; Why?
	• Is the information secured/does anyone except the respected professional, not access it?	01	Yes
		02	No; Why?
	• Are there appropriate and sufficient drug supplies in the institution?	01	Yes
		02	No; Why?

ANNEXURE U: Data collection tool for a focus group

What questions are asked in the focus groups?

Questions asked in the focus groups can be changed to suit the specific conditions in which the research takes place.

Title: Evaluation for health care services for young people in East Gojjam Zone, Ethiopia

Question 1

Facilitator asks: "What youth health services are available to young people here? Can you list all of them?"
ምን ምን ዓይነትየወጣቶችጤናአገልግሎትአየተሰጠይገኛል? ዘርዝሩ

Question 2
Facilitator asks: "Have you ever heard of youth peoplewho has had a health problem for which they could not get help? Can you tell the group more about that situation?"
የጤናችግርገጥሟቸዉየጤና እገዛያላገኙወጣቶችን ያዉቃሉ? ስለሁኔታዉለቡድኑይንገሩ/ያስረዱ

Question 3
Facilitator asks: "Coming to your own experiences, have you ever had a problem that you found you could not get help for?" why?
ካለዎትልምድበመነሳትየጤናችግርገጥሞዎትርዳታሳያገኙቀርተዉያዉቃሉ?ለምን?

Question 4
Facilitator asks: "Can you think back to the last time you used the health service and can you tell the group what you liked and what you did not like about the service you received?"
ከዚህበፊትያገኙትየጤናአገልግሎትአስበዉስለአገልግሎቱበጎእናየወደዱትነገርእናበጎ-ያልሆነዉንወይምያልወደዱትንለቡድኑአባላትያስረዱ።

Question 5
Facilitator asks: "If you could not receive whatever you wanted at the health institution what you would like to have on offer?"
በጤናተቋማትእንዲያገኙየሚፈልጉትየጤናአገልግሎትምንቢሆንይፈላጋሉ?

Question 6
Facilitator asks: "How would you like these services to be offered?
አነዚህአገልግሎቶችበምንመልኩቢሰጡይወዳሉ?

- What opening times would you prefer?
- አገልግሎቱምንሠዓትቢሰጥይመርጣሉ?
- How would a perfect service be organised, one service per day or everything on the same day?
- ጥሩየጤናአገልገሎትአሰጣጥእንዴትቢደራጅይመረጣል?
  በቀንአንድአገልግሎትወይስበየቀኑብዙአገልግሎቶች?

- Where should the health institution be?
- የጤናተቋማትየትአካባቢቢሆኑይመረጣል?
- How would you like to be treated?"
- በጤናተቋማትበምንመልኩአገልግሎት እንዲያገኙይወድዳሉ?

Question 7: This is a ranking exercise on health services for youth.
The facilitator runs a priority ranking exercise with the groups. She or he explains that, while everything is not always possible in reality, this exercise is to help health service managers decide which services must be provided urgently, and which services can be introduced slowly or are not important for youth people' health. The exercise consists of presenting to the group a series of statements or cards that give the names of different kinds of services which are provided at that time or which could be provided in future.

Ask group members if they think there are any youth people' health services which are very important but which are not listed on the cards. If they mention any, write them down on extra blank cards in the language of their choice.

The group is asked collectively to sort the cards into different piles, depending on the importance they agree to assign to particular services. Such an exercise encourages participants to attend to one another rather than to the group facilitator and compels them to explain their different perspectives.

After the most important service has been chosen, remove that card and then ask which service is the next most important. This process is repeated until a list of priorities, ranging from the most to the least important has been generated. Ideally, the discussion that takes place should be tape recorded and transcribed. It is also vital to have careful notes taken either by a note-taker or by the facilitator involving the participants in recording key issues on a flip chart.

Fill in the rankings that the group came up with after following the instructions for this exercise, using the table in the questionnaire. Remember you will need a clean, new questionnaire for each group.

Question 8
Facilitator asks: "Are there any difficulties in this area which prevent youth from going to the health service? If so, explain what these are."
ወጣቶችየጤናአገልግሎትለማግኘትወደጤናተቋማትእንዳይመጡየሚያደርጉሁኔታዎች/ችግሮችአሉ?ካሉይዘርዝሩ

Question 9
Facilitator asks: "At the health service, if you have a question can you asks the health worker at the health institution?"
በጤናተቋማትየጤናአገልግሎትበማግኘትላይእያሉጥያቄለመጠየቅ/ያልገባዎትንእንዲጠይቁይፈቀድልዎትነበር?

Question 10
Facilitator asks: "Are you involved at all in the running of the health service (such as on a health institution committee, stakeholder)?"
የወጣቶችጤናአገልግሎትንበተመለከተበጤናተቋማትበሚከናወኑተግባራትይሳተፉነበር? (ለምሳሌበኮሚቴ፤ በባለድረሻአካልነትወ.ዘ.ተ)

Question 11

Facilitator asks: "where and how can you lodge a complaint if you have one?"

የወጣቶችንጤናአገልግሎትበተመለከተቅሬታወይምአሰተያየትሲኖርዎየትእናእንዴት/በምንመልኩያቀርቡነበር?

ANNEXURE V: An in-depth interview guide for young people

Title: Evaluation of reproductive health services utilisation and challenges among young people in East Gojjam Zone, Ethiopia

INTRODUCTION

I am interested in learning about some of the health needs of young people living in your community. I would like to ask your permission to ask you questions about:

General issues on

1. Perception on health service provision for young people.
2. Knowledge on health services for young people.
3. Attitude on health services and service providers for youth.
4. Knowledge about the challenges of health service provision for youth.

Specific issues on: Reproductive health service utilisation and the challenges

- Your answers will be confidential.
- The information will help us to identify the gaps with regard to the above issues and how to best assist you as your youth age.
- I expect our conversation to last about **one hour.** If you feel that there are related issues that are relevant and important, you are most welcome to raise these issues. The interview will be taped and transcribed at a later stage for analysis. Only members of the evaluation team will have access to this material.

General questions

1. Age_____
2. Gender_____
3. Have you ever visited a health service because you had concerns about your health? [behaviour]
4. What was the reason for you to go there? (If you do not want to tell, please do not!) [attitude]
5. How were you treated by the health service provider? [social influence]

A. Sexual and Reproductive Health (SRH) service utilisation

6. Do you think it is possible for youth people to abstain? Why (not)?
7. Up to when should youth people abstain from sexual intercourse? Why?
8. What do you know about an age limit for marriage for male and female? Why not be before or later?
9. Can you describe personal cares to be taken during menstrual period? What is the reason for doing so?
5. Would you explain about early marriage? What advantages and disadvantages does it have?
6. What do you perceive about sexual behaviour? (age of initiation, where, when, with whom)
7. I'm not sure I understand what you're saying on peer influence. Is there anything else to say?
8. What do you know about and how do you perceive on HIV and other STI transmissions? How did you hear about?
9. Would you say something about parental monitoring on SRH issues? (How would they respond if they knew that you visit the SRH services?
10. Can you describe uses, types when they are preferred and disadvantages of contraceptive methods? What myths are there related to them?
11. Do you know about safe abortion? Do you believe it is essential? If no, why not? If yes, When?
12. Can you describe any gender-based violence related to SRH services?
13. Do you know places where you can obtain SRH service? Do you expect good services from them? Why (not)?

14. To what extent are you able to make your own decision to go to a health service provider or not?
15. Can you describe what you do when your friends or parents discourage you to go there?
16. Can you say how discussion with partner on SRH issues is important?
17. Can you say youth people utilise SRH services well?
18. What do you think of the quality of health services in health institutions? Are the care providers friendly to you?

Probe – Do they ensure confidentiality for you? Do you feel judged? Is it affordable? Is it accessible? Etc.

B. Behavioural health and substance use

19. What do you think about substance use and health (Khat, Hashish, cigarette or tobacco, Alcohol, Drug etc.)
20. Why youth engage to the use of substances?
21. What do you perceive health institutions & service providers do regarding behavioural health and substance use?
22. Can you say peers influence behavioural health and substance use? How?
23. Do you think any linkage between behavioural health and substance with SRH? If yes, How?

Thank you for your patient participation!!!

ለወጣቶችመጠይቅየሚዉልመመሪያ

የጥናቱርዕስ: በኢትዮጵያ በምሥራቅ ጎጃም ዞን ለወጣቶች እየቀረቡ ያሉ የጤና አገልግሎቶች፡ አጠቃቀም፤ ሽፋን፤ ጥራት እና ችግሮች/ተጽዕኖዎች ማጥናት

ለጠያቂዉየተሰጡአቅጣጫዎች

ይህመመሪያእያንዳንዱንወጣትተሳታፊለመጠየቅየሚያገለግልነዉ። መመሪያዎች ትኩረትየሚያደርገበት፡

- ለመጠይቁ ተስማሚየሆኑትንጥያቄዎችንብቻመጠቀምይገባል።
- ጥያቄዎቹ ከጥናቱ ዓላማጋርየተዛመደመሆን ይጠበቅበታል
- የተጠያቂዎቹንዕድሜማዕከልማድረግይኖርበታል

መግቢያ

በጤናተቋማትለወጣቶችእየተሰጠስላለዉየጤናአገልገሎት፣ ለማወቅአፈልጋለሁ።

ስለሆነምየሚከተሉትንጥያቄዎችለመጠየቅየአንተን/ቺንፈቃድእጠይቀለሁ።

አጠቃላይጉዳዮች፡-ለወጣቶች እየተሰጠ ስለሚገኘዉ የስነ ተዋልዶ የጤና አገልግሎት እና ችግሮች ያለዉ አስተሳሰብ

1. ለወጣቶች እየተሰጠስለሚገኘዉየጤናአገልግሎትያለዕዉቀት
2. ለወጣቶች እየተሰጠስለሚገኘዉየጤናአገልግሎትያለአመለካከት
3. ለወጣቶች እየተሰጠለሚገኘዉየጤናአገልግሎትእንቅፋትየሆኑጉዳዮች

ተናጠልጉዳዮች

- የሥነ-ተዋልዶጤናንበተመለከተ
- የሥነ-አዕምሮጤና፤ የባጎርያትንእናለሱሰኝነትየሚያጋልጡነገሮችንተጠቃሚነትበተመለከተ

አጠቃላይመረጃ

- የሚሰጠዉምላሽምስጠራዊነቱየተጠበቀይሆናል
- የምናገኘዉመረጃከላይለተዘረዘሩትአጠቃላይእናተናጠልጉዳዮችዙሪያያሉክፍተቶችንለመለየትእና እንደዕድሜደረጃችሁእገዛለመስጠትያስችላል።

- ቃለ-መጠይቁበአንድሠዓትዉስጥእንደሚጠናቀቅእጠብቃለሁ።

  ተዛማጅየሆኑእናመጠየቅያለባቸዉጉዳዮችካሉመጠየቅይቻላል።

- ቃለ-

  መጠይቁበመቅረጸድምጽይቀረጻልበመጨረሻምለትንታኔእንዲዉልሙሉሀሳቡሳይዛባወደጽሑፋዊ መረጃነትይቀየራል።.

- ከሥልጠናዉጋርግንኙነትያላቸዉአካላትብቻመጠይቁንሊገለገሉበትይችላሉ።

አጠቃላይመጠይቆች

1. ዕድሜ----------
2. ጸታ----------
3. የጤናአገልግሎችለማግኘትሞክረዉያዉቃሉ**?** (ባህሪያዊ)
4. ወደጤናተቋሙለመሄድ ያስፈለገበትምክንየቱምንነበር**?**

   (መናገርካልፈለጉመተዉይቻላል)/አመለካከት/
5. የጤናባለሙያዉበምንመልኩአስተናገደዎት**?** (ማህበራዊጫና)

የሥነተዋልዶጤናንበተመለከተ

1. ወጣቶችመታቀብይችላሉብለዉያስባሉ? ለምን?
2. ወጣቶችእስከመቼሊታቀቡይችላሉ?ለምን?
3. ወጣቶችጋብቻየሚፈጽሙበትዕድሜመቼነዉ? ከዚያበፊትወይምበኋላለምንዓይሆንም?
4. ያለ-ዕድሜጋብቻማለትምንማለትእነደሆነቢገልጹ። ምንጠቀሜታእናጉዳቶችአሉት**?**
5. ስለ-ሥነተዋልዶባህርያት ምንያስባሉ? (ዕድሜ፤ቦታ፤ጊዜ፤ከማንጋር)
6. በሥነ-ተዋልዶጤናጉዳይየጓደኛተጽኖንበተመለከተ ምን ይላሉ**?**
7. ስለኤችአይ ቪ ኤድስ ምን ያዉቃሉ**?**/መተላለፊያ/የሰሙበትመንገድ/
8. በስነ-ተዋልዶጤናጉዳይስለቤተሰብቁጥጥርምንይላሉ**?**
9. ለአገልግሎትበተመረጡጊዜያለንየወሊድመቆጣጠሪያዎችንዓይነት፤

   ጥቅምእናጉዳትመግለጽቢሞክሩ።/ተያያዥ የሆኑአባባሎች/
10. ደኅንነቱስለተጠበቀየዉርጃአገልግሎትያዉቃሉ? አስፈላጊነዉብለዉያምናሉ? ለምን? መቼ?
11. ከስነ-ተዋልዶጋርየተያያዙጥቃቶችንቢገልጹልን?
12. የስነ-ተዋልዶጤናአገልግሎት የሚያገኙትን የትነዉ?

    ከእነዚህተቋማትጥሩአገልግሎትይጠብቃሉ?ለምን?

13. ወደጤናአገልጎሎትሰጪባለሙያበራስዎለመሄድወይምላለመሄድያለዎትዉሳኔምንያክልነዉ?ለምን ?
14. ወደጤናተቋምመሄድዎን ጓደኞችወይምወላጆችባይደግፉምንእንደሚያደርጉበነግሩን
15. ገጾታዊአጋርጋርስለሚደረግዉይይትእናጥቅምቢነግሩን
16. ወጣቶችየስነ-ተዋልዶጤናአገልግሎትንበተገቢሁኔታተጠቃሚናቸዉ**?** ካልሆኑለምን?
17. በጤናተቋማትስሚሰጡየጤናአገልግሎቶችጥራትምንይላሉ? ስለባለሙያዎቹቤተሰባዊየሆነአቀራረብሁኔታምንይላሉ?ማዉጣጣት**–** (ምስጢራዊነቱ፤ የወሳኝነትሚና፤የአቅምጉዳይ፤ተደራሽነትወዘተ)

የሥነ-ባኅርይሁኔታእናለሱሰኝነትየሚያጋልጡየነገሮችንተጠቃሚነትበተመለከተ

18. ለሱሰኝነትስለሚያጋልጡነገሮችአጠቃቀምምንያስባሉ (ጫት፤ሃሽሽ፤ትምባሆ፤አልኮሆል፤ መድሀኒትወዘተ...)
19. ወጣቶችለሱሰኝነትወደሚያጋልጡነገሮችንእንዴትለገቡይችላሉ?
20. የሥነ-ባኅርይሁኔታእናለሱሰኝነትየሚያጋልጡነገሮችንበተመለከተየጤናተቋማትእናጤናባለሙያዎችሚና ምንመሆንአለበትይላሉ?
21. የጓደኛተጽዕኖ የሥነ ባኅርይሁኔታእናለሱሰኝነትየሚያጋልጡየነገሮችንተጠቃሚነትላይተጽዕኖአለዉ? እንዴት?
22. የሥነ-ባኅርይሁኔታእናለሱሰኝነትየሚያጋልጡየነገሮችንተጠቃሚነትከስነ-ተዋልዶጤናጋርግንኙነትአለዉብለህታስባለህ?እንዴት?

ስለተሳትፎዎበጣምአመሰግናለሁ!!!

ANNEXURE W: Institutional observation checklist

Title: Evaluation of reproductive health services for young people in East Gojjam Zone, Ethiopia

A TABLE FOR SHOWING GLOBAL STANDARDS FOR QUALITY HEALTH CARE SERVICES FOR YOUNG PEOPLE

No	Input Input criteria Output criteria	Yes	No
Young people' health literacy	Standard 1. The health facility implements systems to ensure that young people are knowledgeable about their own health, and they know where and when to obtain health services.		
Community support	Standard 2. The health facility implements systems to ensure that parents, guardians and other community members and community organisations recognize the value of providing health services to young people and support such provision and the utilisation of services by young people.		
Appropriate package of services	Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all young people. Services are provided in the facility and through referral linkages and outreach.		
Providers' competencies	Standard 4. Health care providers demonstrate the technical competence required to provide effective health services to young people. Both health care providers and support staff respect, protect and fulfil young people' rights to information, privacy, confidentiality, non- discrimination, non-judgmental attitude and respect.		
Facility characteristics	Standard 5. The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to young people.		
Equity and non-discrimination	Standard 6. The health facility provides quality services to all young people irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.		
Data and quality improvement	Standard 7. The health facility collects, analyses and uses data on service utilisation and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.		
Young people' participation	Standard 8. Young people are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.		

Measurable criteria of Standard 1

No	Input Input criteria Output criteria	Yes	No
1.	Operating hours are indicated on the health facility's signboard.		
2.	In the waiting area, the health facility has the latest information, training and communication materials specially designed for young people.		
3.	Providers of health-related services have the skills to deliver health education to young people and to communicate he information. (including health, and other services).		
4.	Outreach workers got training to educate young people.		
5.	There is outreach plan in the facility to promote young people		
	Process criteria		
6.	Health care professionals offer age and developmental health education and guidance to young people and make sure they know where health, social and other services are available.		
7.	Health facilities carry-out outreach activities to improve youth health and increase service utilisation by young people		
	Output criteria		
8.	Youth are conscious about services		
9.	Young people know what health services are available, where they are available, when they are available and how to access them.		

Measurable criteria of Standard 2

No	Input Input criteria Output criteria	Yes	No
10.	Health care providers have the skills and resources to talk to parents, guardians, other community members and organisations about the importance of providing health care services to young people.		
11.	Health facility has an active list of agencies with which it collaborates to boost community support for young people.		
12.	Outreach activities and/or outreach worker involvement are planned to boost gatekeeper support for young people's use of services,		
	Process criteria		
13.	Process criteria are met. Health facility partners with young people, gatekeepers and community organisations to create health education and communication strategies and materials that focus on behaviour and plan service delivery.		
14.	Parents/guardians who visit the health facilty are informed about the importance of youth health service.		
15.	Health care providers share information about youth health services with parents and teachers during school meetings.		
16.	Health care professionals and/or outreach staff disseminate information to young people and other community members regarding the importance of health services to young people.		
	Output criteria		
17.	Gatekeepers and community groups promote the delivery and use of health services by young people.		

Measurable criteria of Standard 3

No	Input Input criteria Output criteria	Yes	No
18.	There are policies in place that set out what kind of health information, advice, tests, treatments, and care services are needed and can be provided.		
	Health facilities have policies and procedures that determine which health services are offered in the facility and which are offered in community settings like schools.		
19.	There are policies and processes in place that the referral system for both in-house and out-of-house services, including transitional care for young with the chronic conditions.		
20.	**Process criteria**		
	In accordance with policies and practices, health care providers deliver the necessary suite of the information, counselling, diagnostics, treatments and care in facilities and community settings.		
21.	Service providers ensure that young people are referred to the appropriate services and level of care in accordance with local regulations and practices, and adhere to transition care policies.		
22.	**Output**		
	The health facility offers a comprehensive range of health services to meet the requirements of all young people, both with the facility itself and/or through referrals and outreach.		
23.	There are policies in place that set out what kind of health information, advice, tests, treatments, and care services are needed and can be provided.		

Measurable criteria of Standard 4

No	Input Input criteria Output criteria	Yes	No
24.	Providers and personnel with the profile requirements are already in place.		
25.	Providers of health-related services possess the necessary technical capabilities to deliver the desired set of services.		
26.	Providers of health care services have been sensitised to the importance of safeguarding the rights of the young persons' access to data, privacy, and confidentiality, as well as the health care they receive in a courteous, nonjudgmental, and non-racist manner.		
27.	The health facility clearly outlines the responsibilities of providers and the rights of young people.		
28.	As part of the service package, decision support tools (guidelines, protocols, algorithms) address clinical care topics.		
29.	A supportive oversight framework is implemented to enhance the performance of health care providers.		
30.	In order to guarantee lifelong learning, a continuum of professional training programme is implemented, which includes a component for adolescent health care.		
	Process criteria		
31.	A continuum of professional training programme with young people's health-related component is implemented to guarantee lifelong learning.		
32.	Providers and support staff interact with young people in a positive manner and respect their privacy, confidentiality, rights, non-discriminatory treatment, and care.		
	Output criteria		
33.	Health care providers and support staff communicate with youth in a positive manner and respect their privacy, confidentiality, data protection, non-discrimination, and treatment rights.		
34.	The services provided to young people are provided in an open, welcoming, and respectful manner that is non-discriminatory and non-judgmental, and they are aware of their health care rights.		
35.	Young people are given accurate, age-appropriate and clear information so they can make an informed decision.		

Measurable criteria of Standard 5

No	Input Input criteria Output criteria	Yes	No
36.	A policy is in place, including a shared responsibility between providers and support staff, to foster a hospitable and clean atmosphere, shorten waiting times, and offer flexible operating hours and scheduling of appointments.		
37.	The facility is equipped with essential services such as electricity, water, hygiene and waste disposal.		
38.	Privacy policies and procedures are in place to protect the personal and confidential data of young people. Health care workers and support staff are aware of these policies and procedures, and they know their roles and responsibilities.		
39.	A procurement and inventory management system are in place for the drugs and supplies needed to provide the package of services.		
40.	There's a system in place for getting the equipment, keeping track of it, keeping it clean and making sure it's used safely to provide the services you need.		
	Process criteria		
41.	With or without an appointment, Health care providers offer consultations at a time that is convenient for young people in your locality.		
42.	Providers of health care and support personnel shall adhere to policies and procedures designed to safeguard the privacy and confidential information of Young people.		
43.	Medications and supplies are available in sufficient amounts without shortages (stocks) and are used in a proportionate manner.		
44.	The tools needed to deliver the right package to young people are in place, functional and used in the right way.		
	Output criteria		
45.	The health facility has easy-to-use hours, scheduling and waiting times that are kept to a minimum.		
46.	The overall atmosphere of the health facility is warm and inviting.		
47.	At every step of the consultation process, young people get private and confidential health care.		
	The facility is equipped with the necessary tools, pharmaceuticals, equipment and technology to provide the necessary services to young people.		
48.	A policy is in place, including a shared responsibility between providers and support staff, to foster a hospitable and clean atmosphere, shorten waiting times, and offer flexible operating hours and scheduling of appointments.		

Measurable criteria of Standard 6

No	Input Input criteria Output criteria	Yes	No
49.	Facility policies and procedures specify that facility personnel must provide services to all young people regardless of their financial capacity, age, gender, marital status, educational background, racial/ethnic origin, sexual orientation or any other characteristic.		
50.	For services that are offered for free or at an affordable price, there are policies and procedures in place.		
51.	Providers and support staff are familiar with the policies and procedures mentioned above and know how to apply them.		
52.	The health facility's political promise to treat all young people equally and to take corrective measures when needed is reflected in the facility.		
53.	Health care professionals are familiar with the groups of young people at risk in their local community (ies).		
	Process criteria		
54.	Health care professionals and support staff show the same welcoming, nonjudgmental, and respectful attitude towards all young people, no matter their age, gender, marital status, sexuality, culture, ethnicity, disability or any other.		
55.	Providers of health care services do not discriminate against any group of young people, in accordance with relevant laws and regulations.		
56.	The health facility engages vulnerable groups of young people in the planning, monitoring and assessment of health services, and in certain aspects of the provision of health services.		
	Output criteria		
57.	Regardless of income, age, gender, marital status, educational background, ethnic background, sexual orientation or any other characteristic, all young people experience similar levels of care.		
58.	Young people who are in vulnerable situations are involved in helping to plan, track and assess health care, as well as some other parts of health services.		

Measurable criteria of Standard 7

No	**Input** **Input criteria Output criteria**	**Yes**	**No**
59.	A system is implemented to facilitate the collection of data on service utilisation that is broken down by age, gender and other relevant socio-demographic profiles.		
60.	Health care providers receive training on data collection and analysis to support quality improvement efforts. .		
61.	There are tools and systems in place to self-monitor the quality of youth health services		
62.	There are also follow-up mechanisms to link support supervision with areas of improvement identified during standardisation.		
63.	There are also systems in place to reward and recognise exceptional health care professionals and support staff.		
	Process criteria		
64.	The health facility also collects age and gender-based data on service use and performs periodic self-assessment of quality.		
65.	Health care providers and staff use data on how often services are used and how well care is done to plan and put into action quality improvement plans.		
66.	Providers and support staff receive on-the-job training in areas identified by self-assessment.		
67.	Individuals who demonstrate excellence are acknowledged and rewarded accordingly.		
	Output criteria		
68.	In its reports to districts, the facility provides data on the cause-specific use of services by young people, aggregated by age and gender.		
69.	The focus of the facility's quality of care reports to districts is on youth.		
70.	Health facility personnel experience a sense of empowerment from their supervisors and a drive to meet the requirements of the standards.		

Measurable criteria of Standard 8

No	Input Input criteria Output criteria	Yes	No
71.	The governance of the facility involves the involvement of young people.		
72.	A policy is in place to involve young people in the planning, supervision and evaluation of services.		
73.	Youth are well-versed in the laws and regulations that help them make wise choices, and they understand the process of giving consent is made clear in the policies and procedures of the facility, which are in line with the law.		
	Process criteria		
74.	Youth are familiar with the laws and regulations that assist them in making informed choices, and the consent process is clearly outlined in the facility's policies and procedures, in accordance with the relevant laws and regulations.		
75.	Health care professionals give clear and specific details about what the illness is and what treatment options there are, and they take into account the teen's decision on what to do next.		
76.	The health facility undertakes activities to develop the skills of young people in certain areas of health-related services.		
	Output criteria		
77.	Health services are planned, monitored and evaluated by young people.		
78.	Young people are actively involved in making choices about their own care.		
79.	There are several ways in which youth are involved in the service delivery.		

Source

Nair, M, Baltag, V, Bose, K, Boschi-Pinto, C, Lambrechts, T & Mathai, M. 2015. Improving the quality of healthcare services for Young people globally: a standards-driven approach. *J Adol Health,* 57:288–98.

WHO. 2015. *UNAIDS. Global standards for quality healthcare services for young people. A guide to implement a standards-driven approach to improve the quality of healthcare services for Youth*. Volume 1: Standards and criteria.

ANNEXURE X: Moderator's agreement

Research Title: Evaluation of health services for young people in East Gojjam Zone, Ethiopia

Principal Investigator: Gizew Damtie Demeke Supervisor: Prof MG Makua
(hereafter referred to as the researchers)

and

Tesfa Birlew Tsegaye (MSc in Epidemiology)

(hereafter referred to as the counsellour)

hereby agreed and declared by and between the parties as follows:

The moderator should:

- Sets up equipment, arranges refreshments and organises the interview room.
- Welcomes the participants as they arrive and hands out honorariums.
- During the interview monitors equipment, welcomes late-comers and resolves interruptions.
- Oversees data gathering by being non-judgmental.
- Facilitates the discussion **/**encourages interaction among group members, ensures all people participate.
- Regulates any overly dominant group members.
- Thanks participants.

Takes notes throughout the discussion for the purpose of debriefing (as negotiated with the moderator).

Debriefs the session after the interview**/**summarises points made by group members.
Transcribes and analyses interview data.

The researcher should:

Provide equipment required and pay the agreed payment (500ETB per group) timely

Tesfa Birlew Tsegaye	Gizew Damtie Demeke
Moderator's print name	Research's printed name
	
Signature	Signature
Date:	
6/22/2022	6/22/2022

ANNEXURE Y: Transcription and translation agreement

Research Title: Evaluation of reproductive health services utilisation and challenges among young people in East Gojjam Zone, Ethiopia

Transcription and translation agreement between

Principal Investigator: Gizew Damtie Demeke Supervisor: Prof MG Makua
(hereafter referred to as the researchers)

and

Dr Mekonnen Esubalew Tariku

(hereafter referred to as the transcriber and translator)

hereby agreed and declared by and between the parties as follows:

The principal investigator agrees to pay 500 birr per page timely for translation and transcription of the research data for research title specified above.

The transcriber and translator agree to:

- keep all research data that is shared with him (e.g. audio or video recordings, DVDs/CDs, transcripts, data, etc.) confidential by not discussing or sharing this information verbally or in any format with anyone other than the principal investigator of this study;
- ensure these curity of research data (e.g. audio or video recordings, DVDs/CDs, transcripts, data etc.) while it is in the researchers' possession.

This includes:

- using closed headphones when transcribing audio taped interviews
- keeping all transcript documents and digitised interviews on a password protected computer with password-protected files

- closing any transcription programmes and documents when temporarily away from the computer
- keeping any printed transcripts in a secure location such as a locked file cabinet
- permanently deleting any digital communication containing the data
- not make copies of research data (e.g. audio or video recordings, DVDs/CDs, transcripts, data, etc.) unless specifically instructed to do so by the principal investigator; give all research data (e.g. audio or video recordings, DVDs/CDs, transcripts, data, etc.) and research participant information, back to the principal investigator upon completion of the duties as a transcriber and translator
- after discussing it with the principal investigator, erase or destroy all research data (e.g. audio or video recordings, DVDs/CDs, transcripts, data, etc.) that cannot be returned to the principal investigator upon completion of the duties as a transcriber and translator

Dr Mekonnen Esubalew Tariku mekesu655@yahoo.com +251911932655

Transcriber and translator's print name Email Phone

Signature

Date: 11/05/2020

Gizew Damitie Demeke gizew2009@yahoo.com +251913557200

Principal investigator's print name Email Phone

Signature

Date: 11/05/2020

ANNEXURE Z: Data collector's agreement

Appendix 7f

Data Collector Confidentiality Agreement

Research Title: Evaluation of reproductive health services utilization and challenges among youths in East Gojjam Zone, Ethiopia

This agreement is committed to the collection of high-quality, independent, and unbiased data. This Code of Conduct and Assurance of Confidentiality defines the principles that are at thefoundation of our data collection. By following these principles, the agreement assures clients, researchers, health educators and health policy makers that they can have confidencein the data that have been collected.

The basic principles guiding data collection are:

I. Ethics

- All respondents that participate in our studies are to be provided with the information about the basic elements of a study asset forth in survey materials.
- Respondents are to be treated with respect and their concerns are to be addressed promptly, openly, and courteously.
- Data Collectors are to maintain high standards of personal conduct and perform their job in a manner which will not harm, humiliate, or mislead respondents.
- Data Collectors have an obligation to submit time information that accurately reflects the work performed.

II. Work Style

- Data Collectors are to follow the study protocol and procedures as specified in the study manual, at training, and in post-training memos.
- Data Collectors are to perform work that conforms to the quality requirements for thestudy.
- Data Collectors are to perform their work as effectively as possible and in such a way that meets the goals set for the study.
- Data Collectors are to accept responsibility for the quality of the data they collect andthe work they complete.
- Data Collectors are to demonstrate commitment, initiative, consistency, and organization in their approach to the work.
- Data Collectors are to display a professional attitude during the conduct of their work.
- Data Collectors are to communicate professionally and effectively with clients, respondents, and other employees.
- Data Collectors are to work effectively with the project team.
- If at any time Data Collectors have questions or concerns, they should immediately contact their supervisor.

III. Confidentiality

A. Policy on Confidentiality of Survey Data

The agreement is firmly committed to the principle that the privacy of respondents and the confidentiality of individual data obtained through the completion of the study surveys must be protected. This principle holds whether or not any specific guarantee of confidentiality was given at the time of data collection, and whether or not there are specific contractual obligations to the client. When guarantees have been given or contractual obligations regarding confidentiality have been entered into, they may impose additional requirements, which are to be adhered to strictly.

B. Protecting the Privacy and Rights of Survey Participants

Successful survey research depends upon the cooperation of respondents. Data Collectors are expected to gain cooperation using the methods described at training sessions or by their supervisor. Data Collectors are also expected to respect the privacy of respondents and must not engage in any selling or promotion of products or services or in any other activity unrelated to the survey.

C. Procedures for Maintaining Confidentiality

1. The researcher and Data Collectors shall sign this Confidentiality Agreement.
2. Data Collectors shall keep completely confidential the names and addresses of respondents, all information or opinions collected in the course of the interviews, and any information learned incidentally about individual respondents, responding organizations, or the places and organization where respondents work and live. Data Collectors shall exercise care to prevent access by others to survey data.
3. Unless specifically instructed otherwise for a particular study, the Data Collector, upon encountering a respondent or information pertaining to a respondent that s/he knows personally, shall immediately terminate the activity and contact his/her supervisor for instructions.

Alemtsehay Getahun Hunegnaw — *Data collector's Print Name*

Signature

6/20/2022 — *Date*

Girma Damtie Demeke — *Research's Printed Name*

Researcher's Signature

6/20/2022 — *Date*

III. Confidentiality

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Ermyas Andargie Limenih	Gizew Damtie Dameke
Data collector's Print Name	*Research's Printed Name*
Signature	*Researcher's Signature*
06/10/2022	01/10/2022
Date	*Date*

III. Confidentiality

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The agreement is firmly committed to the principle that the privacy of respondents and the confidentiality of individual data obtained through the completion of the study surveys must be protected. This principle holds whether or not any specific guarantee of confidentiality was given at the time of data collection, and whether or not there are specific contractual obligations to the client. When guarantees have been given or contractual obligationsregarding confidentiality have been entered into, they may impose additional requirements, which are to be adhered to strictly.

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3. Unless specifically instructed otherwise for a particular study, the Data Collector, upon encountering a respondent or information pertaining to a respondent that s/he knows personally, shall immediately terminate the activity and contact his/her supervisor for instructions.

Fasil Kefale Minale
Data collector's Print Name

Signature

05/10/2022
Date

(MSc in Nursing)

Gizew Damtie Demeke
Research's Printed Name

Researcher's Signature

05/20/2022
Date

III. Confidentiality

A. Policy on Confidentiality of Survey Data

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B. Protecting the Privacy and Rights of Survey Participants

Successful survey research depends upon the cooperation of respondents. Data Collectors are expected to gain cooperation using the methods described at training sessions or by their supervisor. Data Collectors are also expected to respect the privacy of respondents and must notengage in any selling or promotion of products or services or in any other activity unrelated to the survey.

C. Procedures for Maintaining Confidentiality

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2. Data Collectors shall keep completely confidential the names and addresses of respondents, all information or opinions collected in the course of the interviews, and any information learned incidentally about individual respondents, responding organizations, or the places and organization where respondents work and live. Data Collectors shall exercise care to prevent access by others to survey data.
3. Unless specifically instructed otherwise for a particular study, the Data Collector, upon encountering a respondent or information pertaining to a respondent that s/he knows personally, shall immediately terminate the activity and contact his/her supervisor for instructions.

Habtamu Iyasu
Data collector's Print Name

Gizew Damtie
Research's Printed Name

Signature

Researcher's Signature

06/20/2022
Date

6/20/2022
Date

(Bsc in Nursing)

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Sefanit Sileshi Mekete
Data collector's Print Name

Signature

05/20/2022
Date

Gizew Damtie Demeke
Research's Printed Name

Researcher's Signature

05/20/2022
Date

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Sileshi Bekihun
Data collector's Print Name

SB
Signature

05/20/2022
Date

Gizew Damtie Demeke
Research's Printed Name

Researcher's Signature

05/20/2022
Date

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Tinwork Yinesu
Data collector's Print Name

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6/20/2022
Date

(Bsc. in Nursing)

Gizew Damtie Demeke
Research's Printed Name

Researcher's Signature

6/20/2022
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Yigardie Getahun
Data collector's Print Name

Signature

05/10/2022
Date

(Bsc in Pharmacy)

Gizew Damtie Dawoke
Research's Printed Name

Researcher's Signature

05/10/2022
Date

ANNEXURE AA: CRONBACH'S TEST (CONSISTENCY TEST FOR QUESTIONS MEASURING AGREEMENT LEVEL)

Reliability

Scale: ALL VARIABLES IN Section 301-308

Case Processing Summary

		N	%
Cases	Valid	418	100.0
	Excluded[a]	0	.0
	Total	418	100.0
a. Listwise deletion based on all variables in the procedure.			

Reliability Statistics

Cronbach's Alpha	Cronbach's Alpha Based on Standardised Items	N of Items
.823	.816	8

ANNEXURE BB: Part of FGD transcript

Question 1

Facilitator asks: "What youth health services are available to young people here? Can you list all of them?"

P2: Thanks for the chance given to me. Eh…..from the services which have been to the young people include: first HIV/AIDS counselling and testing, second, family planning service.

Facilitator: Thanks. What about others?

P1: in addition, follow up services are given.
P4: Thank you for the chance given to me. Ummm… First family planning, u… HIV/IDS prevention; how to prevent and treat, the other, treatment services irrespective of the ages, antennal follow-up care for pregnant.
P6: STI prevention and treatment services have been given.

Question 2

Facilitator asks: "Have you ever heard of youth people who has had a health problem for which they could not get help? Can you tell the group more about that situation?"

P8: Ok, I know those who did not receive treatment service for their diseases for example, kidney infection, STI and HIV/IDS, and these might be because of lots of factors such as accessibility of the institutions, lack of appropriate professionals, materials and equipment's, cost of the service, ethical discipline of the health staff.
P3 Yes, I know some young people. This was because of transport access to their villages.
P9: Yes, I know and it was because of shortage of drug availability, incontinent service delivery time or they close the office earlier and due to frequent meetings during the work time.

Question 3

Facilitator asks: "Coming to your own experiences, have you ever had a problem that you found you could not get help for?" why?

P5: Yes, I faced the problem. This was due to the institutional incompleteness in professionals, equipment and materials.

Facilitator: What do you add on what your friend said? Or if you have any additional response?

P7: Yes, I have also faced the problem and it was because of poor documentation system that they said me that they could not find my previous ID number. They did not have computerised system. Actually, I also lost as well as forgot it and I did not have it when I went there.

Facilitator: Do you have any other response?

P4: I also have faced a challenge. One time, I have been ordered to buy drug outside institution and it was not there. The second time, the service was not there so that I have been referee to regional referral hospital for cervical cancer screening.

Question 4

Facilitator asks: "Can you think back to the last time you used the health service and can you tell the group what you liked and what you did not like about the service you received?"

P5 ok…,I did get a service I disliked. There was voluntariness problem to briefly discuss the problem I faced. They were not ethical to politely communicate me. They were not happier to approach me brotherly and treat kindly.

Facilitator: ok…what others else?

P7: I have got the drug ordered to me. This made me happier. Otherwise, there was politeness problem, undermining me and their face was not inviting me to discuss more.
P1: what I liked was their approach. They greet me well. Asked me why I went there. However, there was timing problem in the hospital. They did not come to their room for 1 working hour past.
P3: I have seen good actions they took like arranging us in the order of coming. The admin staff were cooperative in locating the different rooms where I did pay for card and buy drugs. In contrast, the physician annoyed me that she did not keep my privacy during the counselling and examination phase. She did not concern with what she did. It made me psychologically disturbed and I was in doubt that she supported me and I had been cured.
P6: Misdiagnosis was the critical problem I have encountered and what I disliked more. The examiner told me that I was positive for pregnancy test. However, I did not have any sexual contact before. I reacted annoyingly and he was not ready to accept my defence. I appealed to the medical director and he came soon to him. They discussed on it. Finally, the second test was done. It was negative. After that time, I did not go to that hospital. I hate it.
P2: I received wrong drugs which was not useful for my case. I have looked the name was “Paracetamol” written on the prescription paper. The pharmacist gave me ciprofloxacin. I told her as the drug was paracetamol and the one she gave me was not correct. She saw the prescription. She admitted her mistake and asked an excuse.

Question 5

Facilitator asks:" If you could not receive whatever you wanted at the health institution what you would like to have on offer?"

P8: ok. E….1st, the institution should be accessible round. Then, complete material and equipment’s should be in it. Standardised, professional, ethical service should be delivered.
P1: Ok. I want the service to be done with clean equipment, fast and timely; quality procedures. There should be equal treatment with no discrimination with language and religion.

P7: There should be health education on how to take drugs, substance abuses, psychological assistance.
P2: The institution should have referral system. There should be its own ambulance or transport system. There should be enough drug supply in type and quantity.

Question 6

Facilitator asks: "How would you like these services to be offered?

- What opening times would you prefer?

P9: 24 hours. With staff shifts in order not make the staff overburdened.
P3: The whole day. We do not know when we feel sick.

- How would a perfect service be organised, one service per day or everything on the same day?

P4: well, it depends on the type of cases and available services. If rare, it might be once a day. But frequent cases should not be limited.
P5: no, we should not limit it. Because we cannot plan on problems and demands for health seeking behaviour.

- Where should the health institution be?

P1: Emmm… it should be where there is high population.
P8: I agree on her answer. Additionally, it should be in areas where there is more cases like desert areas.
P5: it should be near the transport road. It should not be in areas where public health emergency like volcano, earthquake and fire is anticipated and frequent.

- How would you like to be treated?"

P6: Ok…safely, in ethical manner with full awareness about the services.
P9: With simple communication without frustration. There should be honest.
P1: With appropriate time without delay.

Question 7: This is a ranking exercise on health services for youth.

The facilitator runs a priority ranking exercise with the groups. She or he explains that, while everything is not always possible in reality, this exercise is to help health service managers decide which services must be provided urgently, and which services can be introduced slowly or are not important for youth people' health. The exercise consists of presenting to the group a series of statements or cards that give the names of different kinds of services which are provided at that time or which could be provided in future.

Ask group members if they think there are any youth people' health services which are very important but which are not listed on the cards. If they mention any, write them down on extra blank cards in the language of their choice.

The group is asked collectively to sort the cards into different piles, depending on the importance they agree to assign to particular services. Such an exercise encourages participants to attend to one another rather than to the group facilitator and compels them to explain their different perspectives.

After the most important service has been chosen, remove that card and then ask which service is the next most important. This process is repeated until a list of priorities, ranging from the most to the least important has been generated. Ideally, the discussion that takes place should be tape recorded and transcribed. It is also vital to have careful notes taken either by a note-taker or by the facilitator involving the participants in recording key issues on a flip chart.

Fill in the rankings that the group came up with after following the instructions for this exercise, using the table in the questionnaire. Remember you will need a clean, new questionnaire for each group.

Group's consensus (prioritised answer)

1. Harmful substance prevention (khat chewing, smoking, using Hashish, being alcoholic, drug dependency)
2. Family planning
3. Nutrition

4. Safe abortion
5. Mental health
6. Sexually transmittable disease
7. Antenatal care
8. Natal care
9. Postnatal care

Question 8

Facilitator asks: "Are there any difficulties in this area which prevent youth from going to the health service? If so, explain what these are."

P1: Lack of awareness, frightening
P3: Lack of transport. Traditional thinking related to culture and religion especially about family planning and safe abortion services.
P6: Economical problem
P7: Ethical problems of the professionals. They insult, discourage and undermine clients with no respect.
P9: Shortage of drugs and medications

Question 9

Facilitator asks: "At the health service, if you have a question can you ask the health worker at the health institution?"

P3: Yes, they told me about disease prevention, how to take drugs given to me, their side effects and follow ups.
P9: No, they were not volunteer to be requested,
P4: I asked questions. But she did not answer properly. I did not understand what she said.

Question 10

Facilitator asks: "Are you involved at all in the running of the health service (such as on a health institution committee, stakeholder)?"

P5: no, I did not

P3: no, I did not

P9: no, I did not

P2: no, I did not

P6: Never

Question 11

Facilitator asks: "where and how can you lodge a complaint if you have one?"

P1: I did not give yet

P3: I did not give any feedback. However, I have seen a feedback box near at the corridor

P9: I gave orally to the physician's feedback request

P4: I did not give yet

P7: they did not ask me to give feedback

Facilitator: Thank you very much.

ANNEXURE CC: Strategies' validation form

Proposed strategies: Evaluation of health education programme regarding the utilisation of health (RH, Mental Health, nutritional) services for young people in East Gojjam Zone.

Evaluation criteria:

1=Strategies not acceptable, need major changes

2=Strategies recommended changes

3=Strategies acceptable and ascribed

Kindly use the provided criteria to rate the proposed strategies and use the last column for comments shown in the table below:

Validating criteria for strategies	1	2	3	Comments
Clarity: the specific proposed strategies are simple and easily understandable.				
Specificity: The strategies are targeting or focusing on health service for the young people.				
Reliability: The strategies can be used consistently by other health care facilities.				
Flexibility/ adaptability: The strategies can flexibly be applied or could be applied in different circumstances.				
Effectiveness: Strategies are able to achieve the objective, which is to enhance the utilisation, coverage and quality of the health services for young people.				
Validity: Strategies are justifiable or evidence based.				
Relevance: Strategies are appropriate to enhance the utilisation of health services by the young people.				
Applicability: The strategies have the potential to be applied in the formulation of utilisation of health services among young people.				
Acceptability: The strategies are realistic and acceptable by the targeted institutions (health, academic and religious).				
Achievability: The strategies can be executed by the targeted institutions (health, academic and religious).				

Mister Abebe Sinishaw (PHO, MSC)

Thank you for valuable contribution.

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ANNEXURE DD: Receipt for originality Turnitin report

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Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

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Submission title:	All chapters
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Page count:	312
Word count:	58,911
Character count:	349,185
Submission date:	07-Sep-2023 02:59PM (UTC+0200)
Submission ID:	2159818060

ANNEXURE EE: Agreement and correspondence with WHO regarding the standardization of quantitative data collection instruments

RESOLVED: 362570 Permission request for WHO copyrighted material

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WHO published information is freely accessible on the WHO's website, and therefore we would ask external web sites to link to the web page from where the documents are accessible. The document that you are interested in is available at :
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