UNDERSTANDING THE FACTORS THAT DISCOURAGE YOUNG PEOPLE FROM ACCESSING YOUTH FRIENDLY HEALTH SERVICES IN MBALE DISTRICT, UGANDA

by

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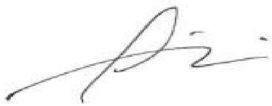
DECLARATION

I declare that *"Understanding the factors that discourage young people from accessing youth friendly health services in Mbale district, Uganda"* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Name: Chivuli Ukwimi Date: 16 November 2022



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DEDICATION

I am dedicating this work to my late mother, Astrida Bwalya.

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ACKNOWLEDGEMENTS

A special thank you to my supervisor, Dr Lungiswa Tsolekile, for your guidance, unwavering support, encouragement, and patience. This would not have been possible without you.

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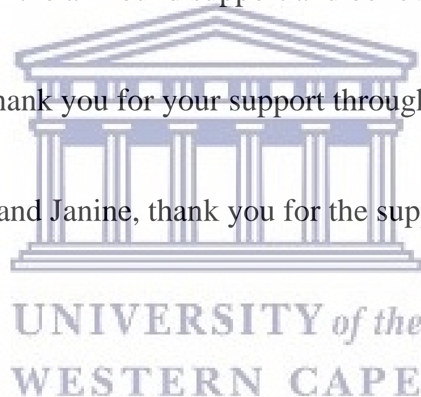

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KEYWORDS

Young people

Adolescents

Youth Friendly Health Services (YFHS)

Sexual and Reproductive Health & Rights (SRHR)

Sexual and Reproductive Health (SRH)

Mbale

Uganda

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LIST OF ACRONYMS AND ABBREVIATIONS

ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health & Rights
AFHS	Adolescent-Friendly Health Services
AIDS	Acquired Immunodeficiency Syndrome
CSE	Comprehensive Sexuality Education
HIV	Human Immunodeficiency Virus
FAWE	Forum for African Women Educationalists
ICPD	International Conference on Population and Development
LGBTI	Lesbian, Gay, Bisexual, Transgender, and Intersex
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UBOS	Uganda Bureau of Statistics
UNAIDS	United Nations Joint Programme on HIV/AIDs
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UYAHF	Uganda Youth and Adolescent Health Forum
WHO	World Health Organisation
YFCs	Youth-Friendly Corners
YFHS	Youth-Friendly Health Services

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DEFINITIONS OF OPERATIONAL TERMS

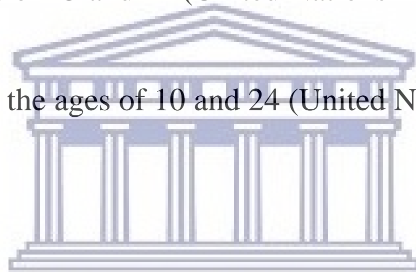
Adolescents: Individuals aged 10 to 19 (United Nations definition).

Adolescent-Friendly Health Services (also called youth-friendly services, YFS): Services designed to address the barriers faced by youth in accessing high-quality sexual and reproductive health (SRH) services.

SRH: The state of physical, emotional, mental, and social well-being in all aspects of sexuality and reproduction, and not merely the absence of disease, dysfunction, or infirmity (Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights).

Youth: Persons between the ages of 15 and 24 (United Nations Definition).

Young People: Persons between the ages of 10 and 24 (United Nations Definition).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ABSTRACT

Primary healthcare services in Uganda and sub-Saharan Africa are, for the most part, geared to the needs of adults. There are considerable gaps in delivering sexual and reproductive health (SRH) services for young people and adolescents. There are also ongoing structural barriers to the uptake of adolescent sexual and reproductive health (ASRH) services, particularly family planning, contraception, and human immunodeficiency virus (HIV) prevention, treatment, care and support. In many instances, lack of political will concerning sexual reproductive health and rights (SRHR) and human rights of girls, young women, and lesbian, gay, bisexual, and transgender (LGBT) youth means that there is a risk that the intended health and well-being outcomes for young people will not be achieved. This study aimed to explore the factors that prevent young people from accessing youth friendly health services (YFHS) in the Mbale district of Uganda.

This was a descriptive study that used a qualitative research approach. It utilised secondary data from the rapid assessment of young people's experiences, challenges, and best practices on demand, access, and utilisation of youth-friendly contraceptive services in the Mbale district of Uganda undertaken by the Uganda Youth and Adolescent Health Forum (UYAHF) in 2020.

The study found that personal (individual) and structural barriers discouraged young people and adolescents from accessing youth-friendly health services (YFHS) in the Mbale district. These barriers include a feeling of shame, a general lack of information on ASRH, negative provider attitudes and provider incompetency, and community-level stigma and discrimination embedded in deep cultural and religious beliefs.

Based on the findings, it was concluded that factors that prevent young people from accessing YFHS are multilayered and multidimensional, cutting across individual, structural, socio-cultural, and socio-economic factors. Future studies should assess whether young people prefer integrated or standalone YFHS and which approach will likely remove barriers to accessing YFHS.

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CHAPTER 1: INTRODUCTION

Globally and in sub-Saharan Africa, access to sexual and reproductive health (SRH) services remains a challenge for the majority of the population, especially adolescents and young people (Bearinger et al., 2007). The World Health Organisation (WHO) (2017) states that *"More than three thousand adolescents die every day from largely preventable causes which include SRH complications and HIV"*. The WHO defines adolescents as persons between the ages of 10 and 19. Further, young people are defined as persons between 10 and 24 years (Currie et al., 2004). Adolescence is a transition period from childhood to adulthood characterised by physical, psychological, social, and behavioural changes (Government of the Republic of Uganda, 2012).

Many countries have adopted the WHO definition for adolescents. However, the definition of young people or youth has many variations across diverse national legislations. For this report, the WHO definition was adopted. The 2018 Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights expanded and integrated the definition of SRH to include the state of physical, emotional, mental, and social well-being about all aspects of sexuality and reproduction, and not merely the absence of disease, dysfunction, or infirmity (Starrs et al., 2018). Key issues and challenges relating to adolescent sexual and reproductive health and rights (ASRHR) include teenage pregnancy, child marriage, access to contraceptives, and comprehensive sexuality education (CSE). However, in many countries, including Uganda, access to SRH services for young people remains a contested issue of 'cultural sensitivity' (United Nations Population Fund [UNFPA], 2017).

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1.1. Background

According to the Ugandan Bureau of Statistics (UBOS) (2016), Uganda has a predominantly young population, with 34.8% of Uganda's 34.6 million population being adolescents, with a similar sex distribution to the general population which is mainly female. Despite this large representation of the national demographic, there are substantial unmet SRH needs of adolescents in Uganda, including the low use of modern contraceptive methods, high rate of early and forced marriages, high rate of unintended pregnancies among school-going girls, and a high incidence sexual and gender-based violence (SGBV). Recent studies have shown high

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rates of the human immunodeficiency virus (HIV)/sexually transmitted infection (STI) co-infection among adolescents in Uganda, with 9.9% of youth reporting HIV/STI co-infection (Culbreth et al., 2020). In the sub-Saharan African context, teenage pregnancy rates in Uganda are among the highest, estimated at 25% (Nabugoomu, Seruwagi, and Hanning, 2020).

The concepts of adolescent-friendly health services (AFHS) and youth-friendly corners (YFCs) were applied by Uganda in its endeavour to address health issues affecting adolescents (Government of the Republic of Uganda, 2012). These ideas were deemed essential in ensuring that deliberate steps were taken at the facility level to respond to adolescent health issues. Furthermore, the government, through the Ministry of Health, identified the need to strengthen AFHS and, in doing so, developed the *Adolescent Health Policy Guidelines and Service Standards for Uganda* (Government of the Republic of Uganda, 2012). Contrary to previous efforts and policies, in 2016, the Government of the Republic of Uganda, through parliament, decreed a ban on CSE in schools which did not adhere to 'abstinence only'. However, in 2018 after much lobbying from civil society and other health groups, this ban was lifted (Boozalis et al., 2020).

In a rapid assessment of young people's experiences, challenges, and best practices on demand, access, and utilisation of youth-friendly contraceptive services in the Mbale district of Uganda undertaken by the Uganda Youth and Adolescent Health Forum (UYAHF) (2020), it was found that there is little focus on adolescent health at service-delivery points because they are treated like the general population without taking into account that adolescents have specific and unique health needs that require a tailored approach to their care at health facilities. It was further found that in some health facilities, efforts had been put in place to have adolescent-focused peer educators and counsellors. Still, these were not fully institutionalised and thus poorly facilitated (UYAHF, 2020).

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A recent study by Masanja et al. (2021) reported an STI prevalence rate of 26.0% among adolescents. Similarly, a survey conducted by the Ministry of Health of the Republic of Uganda showed that, in the period 2018-2020, teenage pregnancies increased from 10% to 20% among girls between 12 and 16 years, which led to a school dropout rate of over 45% among school-going girls in Mbale District in 2018 alone (UYAHF, 2020). These statistics showed high sexual activity among adolescents and young people, putting them at a higher risk of HIV STIs and unwanted pregnancies (UYAHF, 2020). This was previously noted by the Uganda

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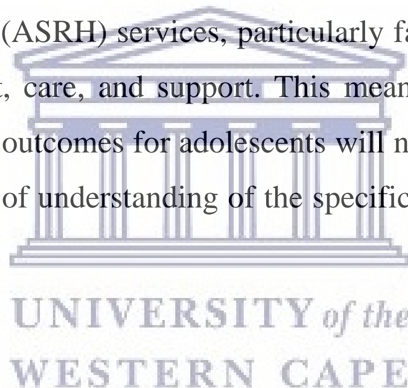
Population Secretariat (POPSEC) at the Ministry of Finance, Planning, and Economic Development of Uganda, which indicated that there was limited access and utilisation of antenatal, prenatal, and postnatal care among adolescents (Kwagala, 2013). There is, therefore, an urgent need to understand why adolescents are not accessing SRH services in districts spread across Uganda.

1.2. Problem Statement

Primary healthcare services in Uganda are, for the most part, geared to the needs of adults and therefore have significant gaps in the delivery of SRH services for adolescents and young people. At the same time, AFHS have yet to be adequately integrated into mainstream health services (Atuyambe et al., 2015). The gap in SRH services for adolescents in Uganda is very high; for example, according to the Uganda Bureau of Statistics (UBOS) (2016), the deficit for family planning among adolescents aged 15-19 stood at 30.4% in 2015, with the total demand standing at 52.3% (UBOS, 2016). There are also structural barriers to the uptake of adolescent sexual and reproductive health (ASRH) services, particularly family planning, contraception, and HIV prevention, treatment, care, and support. This means that there is a risk that the intended health and well-being outcomes for adolescents will not be achieved (Ivanova et al., 2019). There is an overall lack of understanding of the specific needs and concerns of young people in Uganda.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1.3. Rationale

The global adolescent population is estimated at 1.2 billion, representing approximately 16% of the global population (Assan, Kharisma, and Adaboh, 2018). It is, therefore, crucial to promote and protect the health of adolescents for the human development agenda and the sustainable development goals (SDGs) to be achieved. The Government of the Republic of Uganda, through its Ministry of Health, has made efforts to roll out services across the country tailored to fulfil the needs of adolescents by establishing AFHS in appointed public health facilities. However, adolescents still shy away from these services (Atuyambe et al., 2015), and the reasons are not fully understood.

The Government of the Republic of Uganda (2012), through the Adolescent Health Policy Guidelines and Service Standards for Uganda*,* is committed to ensuring that adolescents

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receive the required information and services that ensure sustained health throughout the health continuum of care. Furthermore, the original pledge made by the Ugandan Government in 2012 to decrease the health provision deficit among adolescents from 30.4% in 2016 to 25% in 2021 was revised downwards to 14% in 2017 (UYAHF, 2020). However, implementation challenges remain. It is, therefore, imperative that we try to understand the barriers that hinder adolescents from accessing SRH services in Uganda.

1.4. Outline of the Thesis

This thesis is divided into six chapters. Chapter two, a literature review, explores and provides insight into existing research on ASRH with a focus on awareness, availability, accessibility, and acceptability of youth-friendly services (YFS). Chapter three outlines and describes the research methodology and approach for this thesis, while chapter four presents the study findings. Chapter five discusses the study findings in detail, referring to the reviewed literature. Lastly, chapter six concludes the study findings and provides recommendations.

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CHAPTER 2: LITERATURE REVIEW

This chapter provides a literature review based on previous studies conducted on ASRH and ASRHR. In addition, this chapter defines YFS and ASRHR, giving insight into the various approaches and strategies implemented across sub-Saharan Africa and Uganda.

2.1. Sexual and Reproductive Health and Rights

The concept of sexual and reproductive health and rights (SRHR) was first explored at the International Conference on Population and Development (ICPD) in Cairo in 1994 (Ferguson and Desai, 2018). However, the period post-ICPD94 was marked by major arguments and contestation regarding the framing and language around SRHR (Eager, 2017). The United Nations (UN) agencies, in collaboration with the Women's Movement and other civil society organisations, kept pushing and advocating for a human rights approach to SRHR (Yamin and Cantor, 2014). The adoption of General Comment 22 on the right to SRH by the Committee on Economic, Social, and Cultural Rights (CESCR) in 2016 was a major turning point that saw the adoption of a human rights-based approach while extensively addressing states' legal obligations to realise the right to SRH (Berro Pizzarossa, 2018). The concept and definition of SRHR have evolved since ICPD94. According to the 2018 Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights, SRH and well-being is not merely the absence of disease but include the state of physical, emotional, mental, and social well-being in all aspects of sexuality and reproduction. This definition reinforces the human rights application to sexuality and reproduction (Starrs et al., 2018). The definition that emerged from the ICPD94 primarily focused on the traditional aspects of reproductive health, such as access to contraceptives and family planning services and HIV and acquired immunodeficiency syndrome (AIDS) services (Santhya and Jejeebhoy, 2015). However, the new and expanded definition of SRHR by the Guttmacher-Lancet Commission (2018) has incorporated the often controversial and excluded services such as CSE, safe abortion, STIs, infertility, reproductive cancers, psychosexual counselling, and treatment of sexual dysfunction and disorders (Ferguson and Desai, 2018).

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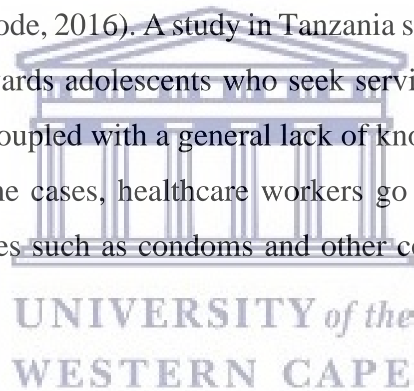
2.2. Sexual and Reproductive Health Services for Youth and Adolescents Globally

Access to SRH services for young people across the globe remains a challenge (Braeken and Rondinelli, 2012). The New Zealand Parliamentarians' Group on Population and Development (2013) observed that young people often avoid services offered at health clinics because of the fear of being judged and the embarrassment that comes with it. Hopkins and Collins (2017) argued that countries in the Southern African Development Community (SADC) region, through the Sexual and Reproductive Health Strategy for the SADC Region 2006-2015, recognise that adolescent reproductive health merits special consideration for several reasons. The strategy further indicates that most of the region's population is young and vulnerable due to the many challenges faced, including a lack of access to health services (Hopkins and Collins, 2017). However, many healthcare providers are still reluctant to offer SRH services to young people. A study conducted in South Africa's KwaZulu Natal region showed that many social workers are unwilling to provide services to young people due to their conservative views (Essack, Toohey, and Strode, 2016). A study in Tanzania showed that healthcare workers have paternalistic attitudes towards adolescents who seek services in public health facilities. This paternalistic approach is coupled with a general lack of knowledge about ASRH services (Mchome et al., 2015). In some cases, healthcare workers go as far as discouraging young people from using SRH services such as condoms and other contraceptives (Mchome et al., 2015).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Similarly, a study in the Juba district of South Sudan showed that social and cultural norms prevent young people from accessing SRH services, such as contraceptives, resulting in a high rate of teenage pregnancies (Vincent and Alemu, 2016). A study in Rwanda showed that, away from the health facility, adolescents face additional cultural and social barriers in their family and social settings, with religious and family members hindering their ability to seek SRH services by promoting abstinence and discouraging the use of contraceptives (Ndayishimiye et al., 2020). A similar study in Zambia showed that most parents perceive providing SRH education and services as immoral due to cultural and religious beliefs (Nkole, Munalula, and Zulu, 2019). Some community members also strongly objected to the distribution of contraception and condoms to adolescents (Nkole, Munalula, and Zulu, 2019).

Studies have also shown that the environment and service delivery set up at a health centre can

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be barriers to adolescents seeking SRH services from that facility (Abuosi and Anaba, 2019). A study in Ethiopia showed that, although most facilities have YFCs, there is a general lack of confidentiality and privacy, which leaves adolescents feeling shy and ashamed when accessing SRH services (Tilahun et al., 2012). Another study conducted in Bolivia, Ecuador, and Nicaragua showed that very little is done at the implementation level to improve the 'youth friendliness' of health facilities as the policies promoting ASRH services are put into practice (Jaruseviciene et al., 2013). According to Braeken and Rondinelli (2012), when promoting the uptake of YFS by young people, it is crucial to consider young people's pathways in seeking services and the barriers they face when accessing the services and when they leave the service site.

2.3. Sexual and Reproductive Health Services for Youth and Adolescents in Uganda

Although access to health services for most people in developing countries, Uganda included, generally remains poor (Kwesiga, Zikusooka, and Ataguba, 2015), Crossland et al. (2015) argued that this rings truer for young people and adolescents. Access to SRH and HIV services is further restricted for young people in developing countries like Uganda due to structural and legal barriers such as laws and policies (UNICEF, 2012). According to Warenius et al. (2006), most nurses and midwives do not offer comprehensive SRH services to young people and adolescents in Uganda and Zambia because they disapprove of activities like masturbation, the use of contraceptives, and abortion among young people. This challenge is embedded in personal and social beliefs that further enhance stigma and discrimination and prevent adolescents from accessing services. A recent study in Uganda showed that adolescents know how and where to access other forms of contraception, including condoms. However, teenage pregnancies and dropout rates of young girls from school remain considerably high, indicating that ASRH is still a challenge in Uganda, with significant barriers such as inaccessible and unaffordable services (Renzaho et al., 2017). Though some studies have shown that young people are eager to get information about SRH and HIV, healthcare service providers do not adequately meet the information needs of young people (Crossland et al., 2015). Therefore, providing ASRH for young people in Uganda remains a considerable challenge. The onset of coronavirus disease (COVID-19) across the globe and in Uganda has resulted in various state-instituted lockdowns and other public health restrictions, such as physical distancing, which has added a new dimension of barriers to access services for adolescents (Mambo et al., 2020).

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2.4. Limitations of Previous Studies

The studies above appear to focus mainly on the ‘delivery side,’ i.e., healthcare workers and healthcare facilities, with less focus directed at the ‘demand side’ of ASRH. This, in turn, means that the adolescents’ voices are not amplified enough for us to understand why they shun ASRH services.

It also appears that the ‘rights’ component of SRHR is overlooked, with most studies focusing on the service package of commodities and information. Similarly, most of the studies have looked at adolescents as a homogenous group without taking into account issues of diversity and marginalisation, such as lesbian, gay, bisexual, transgender, and intersex (LGBTI) adolescents, as well as the unique needs of adolescents living with disabilities. These intersectional challenges may play a critical role in determining whether a particular group of adolescents can access services or not.

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CHAPTER 3: METHODOLOGY

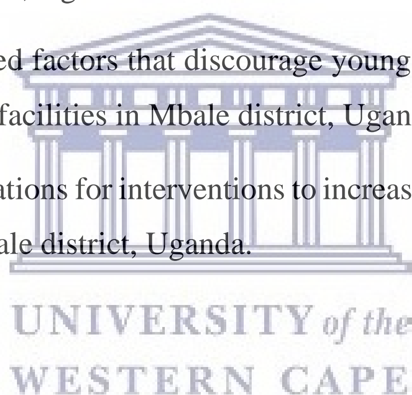
This chapter outlines the study aims and objectives and describes the study design, study setting, population, and inclusion criteria used. Moreover, this chapter explains the data collection and analysis method, sample size, study limitations, and ethical considerations.

3.1. Study Aim and Objectives

The study aimed to explore the factors that prevent young people from accessing SRH services in Mbale district, Uganda.

The **objectives** of the study were:

- To explore the perceptions of young people about the YFHS offered at public health facilities in Mbale district, Uganda.
- To describe the perceived factors that discourage young people from accessing YFHS offered at public health facilities in Mbale district, Uganda.
- To propose recommendations for interventions to increase the uptake of ASRH services for young people in Mbale district, Uganda.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3.2. Study Design

The study was a descriptive study that used a qualitative research approach. The study utilised secondary data from the rapid assessment of young people's experiences, challenges, and best practices on demand, access, and utilisation of youth-friendly contraceptive services in the Mbale district of Uganda undertaken by the UYAHF between January and February 2020. Having already established that young people and adolescents are a complex group, it was vital to employ a study approach that delved deep into adolescents' perspectives to understand what their ideal world would entail concerning ASRH services. A qualitative approach made it possible to understand why young people and adolescents who are subjected to the same 'objective reality' potentially act in different ways. The qualitative approach further made it possible to analyse the feelings, attitudes, and behaviours of young people and adolescents as respondents while also allowing respondents to expand on their responses, giving the

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researcher insight into unforeseen issues (Rich and Ginsburg, 1999).

3.3. Study Setting

The primary study was conducted in the Mbale district of Uganda, the Ugandan Government's administrative centre for the eastern region. According to the 2014 census, Mbale has a population of 488,960, of which 57.63% is made up of the 0-19 age group (UBOS, 2014). However, Mbale's population is projected to increase to about 621,800 in 2022 (UBOS, 2022). Mbale has one of the highest rates of STIs, teenage pregnancy, and school dropout rates for school-going girls (UYAHF, 2020). The primary study targeted health service providers and adolescents in the surrounding communities of Mbale. A total of nine health facilities were included in the study, which consisted of the regional referral hospital and level IV, Level III, and Level II public health centres.

3.4. Study Population

The primary study population was made up of adolescents aged between 10 and 19 years of age and healthcare personnel from the Mbale district in Uganda.

3.5. Sampling Procedure and Sample Size

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This study utilised data from a secondary data set that was collected in a rapid assessment of young people's experiences, challenges, and best practices on demand, access, and utilisation of youth-friendly contraceptive services in the Mbale district of Uganda, undertaken by the UYAHF between January and February 2020.

The primary study conducted a theoretical and purposive sampling method to select participants from the nine selected health facilities in the Mbale district by narrowing it down to respondents who were knowledgeable on adolescent reproductive health issues.

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The primary study sample size had 86 participants, of which 50 were adolescents, and 36 were healthcare personnel. The participants were sampled as follows:

- 50 male and female adolescents aged between 10 and 19 years of age within the catchment areas of the nine health facilities
- 36 healthcare personnel from nine health facilities which included facility in-charges, senior midwives and records officers.

3.6. Data Collection

Electronic copies of data sources were obtained from the UYAHF, which included an Excel spreadsheet sheet consolidating all interview responses, transcripts from focus group discussions, and the final research report. The primary data was collected through:

- 27 key informant interviews with key health facility staff, including facility in-charges, senior midwives, records officers, and district biostatistician
- Two focus group discussions FGDs) with 25 adolescents in each (50 adolescents in total) between the ages of 10 and 19 in the catchment areas of the sample health facilities. Staff from UYAHF constituted the data collection team and facilitated the FGDs. The main methods of data collection during the FGDs were audio recording, note-taking and participant observation. Discussions were held in English, and research assistants observed nonverbal interactions to capture and record non-verbal communication. The FGDs were held at a local community center within Mbale.
- Nine structured interviews (administered through questionnaires) with health facility in-charges at their respective health facilities.

Data saturation was reached when there was enough information to replicate the study, and further coding was no longer feasible.

3.7. Data Analysis

Since the study sought to draw emerging issues and themes from individual interviews and focus group discussions, the best-suited approach for data analysis was thematic analysis. The study adopted and applied the Braun and Clarke (2006) six-phase approach for conducting thematic analysis:

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- Data familiarisation - all data sources, including the actual interview transcripts of the interviews, were reviewed multiple times to gain a good understanding and appreciation of the data that had been collected in the primary research.
- Generation of initial codes - initial codes were generated by ensuring that all the collected data was meaningfully and systematically organised by grouping the data into batches of categories. Electronic coding was done using Atlas.ti.
- Identification of initial themes – initial themes were identified under which the identified codes were categorised.
- Review of potential themes - the identified potential themes were then reviewed and tested for 'fit for purpose', i.e. checked whether the identified themes made logical sense and whether the available data supported the themes that had been identified.
- Definition and naming of themes - the identified themes were defined, clearly stating what each theme was, the data that it represented, and the particular interesting finding or message that it sought to communicate from the data.
- Report production – a report was drafted to demonstrate the common thread and message emanating within and across themes.

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3.8. Rigour

Trustworthiness in this study was ensured by employing techniques that guaranteed credibility, dependability, and transferability. These included both open review and single-blind peer reviews with neutral colleagues and professionals in the field of ASRH who provided written feedback. Trustworthiness was also ensured through the triangulation of data methods, which included in-depth interviews and focus group discussions. In addition, triangulation was used on multiple data sources, including adolescent and key informant interviews. Trustworthiness was further ensured by providing a 'thick description' through a detailed description of the research methodology that will enable other researchers to replicate the study in a different context with different respondents.

Confirmability was ensured by keeping an audit trail and conducting peer reviews of the data collection and analysis and the outcomes of the research. There was systematic documentation of how all the data was collected, recorded and analysed. The research process and findings

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were cross-checked and discussed with neutral colleagues.

3.9. Ethical Statement

This study was approved by the Biomedical Research Ethics Committee (BMREC) at the University of the Western Cape (ethical approval number - BM21/6/17). Official permission to use the secondary data for this study was sought from the UYAHF. The UYAHF obtained consent from primary study participants to use their data for other studies. The UYAHF freely provided the data without any coercion. Principles of anonymity and confidentiality were strictly adhered to, ensuring that participants were not personally identifiable. Primary data were shared by the UYAHF through an encrypted shared cloud drive with an expiry period of 60 days.

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CHAPTER 4: FINDINGS

This chapter presents findings on factors that discourage adolescents from accessing YFS at local public health facilities in the Mable district of Uganda. Thematic analysis was used to assess these factors and findings are presented based on the main themes that emerged.

4.1. Socio-Demographic Information and Description of Health Facilities

4.1.1. Socio-demographic information

The primary study targeted health service providers and adolescents in the surrounding communities of Mbale. The total number of respondents was 86, comprising 50 adolescents and 36 healthcare providers. Of the 50 adolescents, 29 were females, and 21 were males between the ages of 10 and 19. However, the majority of the adolescent respondents were above 15 years of age and school-going. The 29 female adolescents included 10 teenage girls with hearing disabilities. The 36 healthcare providers included facility in-charges and nursing officers.

Gender considerations were made during data collection to ensure gender equality and a representative view of both genders. Gender equality was understood as working with adolescent girls and boys and young women and men to explore their attitudes, behaviours, and roles and responsibilities at home, in the community, and broader institutional structures. This study also recognised and appreciated the differences between women, men, girls, and boys in terms of their relative access to resources and power.

4.1.2. Description of health facilities

A total of nine public health facilities, including the regional referral hospital, level IV, level III and level II public health centres, were included in this study, as illustrated in Table 1 below.

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Table 1: Health facilities assessed

Health Facility	Level of Care
1. Mbale Regional Hospital	RR Hospital
2. Nakaloke Health Centre	III
3. Namatala Health Centre	IV
4. Mbale Epicenter Health Centre	II
5. Bufumbo Health Centre	II
6. Lwangoli Health Centre	III
7. Busiu Health Centre	IV
8. Maluku Health centre	III
9. Jewa Health Centre	II

Source: UYAHF (2020)

4.2. Findings

Factors that discourage young people from accessing YFS in the Mbale district of Uganda were assessed from the points of view of adolescents and service providers. Five themes explaining the factors that discourage adolescents from accessing YFS at local public health facilities were identified as policy-, facility-, provider-, community-, and personal (adolescent)-level factors (Table 2). Themes were identified as a result of coding and categorising participants' responses to questions addressing factors that discourage adolescents from using the services.

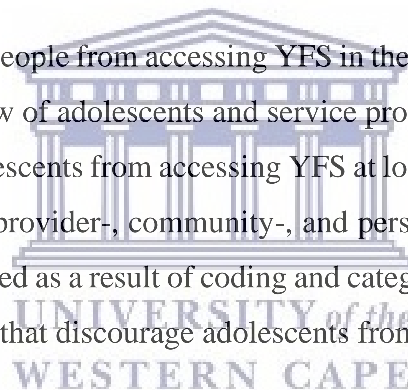
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Table 2: Main themes and sub-themes demonstrating perceived factors that discourage adolescents from using and accessing adolescent health services

Main Themes	**Sub-theme**
Policy-level factors	Gaps in policy implementation Lack of dedicated resources
Facility-level factors	Resource allocation Infrastructural factors
Provider-level factors	Disrespect and confidentiality breach Judgemental attitude Provider incompetency
Community-level factors	Stigma and discrimination Lack of parental support
Personal (adolescent)-level factors	Shame Lack of information Financial constraints

Source: Researcher's own compilation

4.2.1. Theme 1: Policy-level factors

Based on this theme, healthcare providers shared their personal and organisational experiences concerning their access, understanding, and implementation of adolescent health policies and guidelines. Under this theme, two subthemes emerged, namely poor implementation and lack of dedicated resources.

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4.2.1.1. Sub-theme 1.1: Poor Implementation

Healthcare providers interviewed from eight out of the nine public health facilities reported that they do not have access to the national guidelines on adolescent health. They added that, even when district health officials undertake support visits at the health facilities, they never leave behind any hardcopies of the guidelines.

> *"I heard about the adolescent guidelines during my training at the nursing college, but I have never seen these guidelines."* (Health care provider)

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Healthcare providers interviewed at the remaining public health facility reported having the adolescent guidelines at the health facility but admitted they rarely use them.

> *"There is a lack of implementation of the guidelines, and documents are not sufficiently disseminated and implemented at district and health facility levels, and we don't even have case management guidelines."* (Health care provider)

4.2.1.2. Sub-theme 1.2: Lack of dedicated resources

Healthcare providers and facility in-charges indicated that appropriate resources have not been made available to support the effective implementation of national adolescent health service standards and guidelines. Furthermore, funds disbursed to health facilities do not have specific budget allocations or targets for adolescent health.

> *"There is no specific or dedicated budget at the facility level to implement adolescent health services. The only budgets that we sometimes have are from partner [non-governmental organisation (NGO)] supported funding allocations."* (Health care provider)

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4.2.2. Theme 2: Facility-level factors

Facility-level factors were identified from the reported work experience of healthcare providers and client experiences of adolescents at the local public health facilities. Facility-level factors that emerged include the insufficient number of trained staff, stockout of SRH commodities, lack of privacy and appropriate space, and long waiting time.

4.2.2.1. Sub-theme 2.1: Resource allocation

Facility in-charges reported having insufficient numbers of trained staff to provide adolescent and youth-friendly services (AYFS) at their health facilities, underscoring the problem of a lack of skilled human resources to provide adolescent health services.

> *"We do not have enough staff to handle adolescent cases. We are short-staffed."* (Health care provider)

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Adolescents reported stockouts of key SRH commodities in health facilities. Participants reported being given referrals to private or non-governmental organisation (NGO) facilities to access essential SRH commodities such as contraceptives.

> *"Sometimes when we go to the clinics, we are told that they don't have condoms."* (Adolescent Male, 17)

> *"I don't bother to go to the youth-friendly corner at the clinic anymore because there is nothing there, so I usually buy from the pharmacy or get from friends."* (Adolescent Female, 19)

> *"Most of the clinics I go to refer me to pharmacies to buy things like contraceptives, so I just go straight to the pharmacy."* (Adolescent Female, 18)

4.2.2.2. Sub-theme 2.3: Infrastructural factors

The participants in this study reported that, although they receive some semblance of AFHS at some health centres, most health facilities do not have structures to guarantee privacy. Moreover, they do not feel a sense of privacy when walking into an adolescent-friendly health facility.

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> *"The clinics are too crowded during the day, and there is no privacy, so I prefer to go in the evening when there are fewer people."* (Adolescent Male, 15)

> *"We have no space at the clinic, so we have had to improvise and use a storeroom with poor ventilation as a counselling space for adolescents."* (Health care provider)

> *"I don't feel comfortable going to the clinic because all the adults there look at you in a funny way."* (Adolescent Female, 16)

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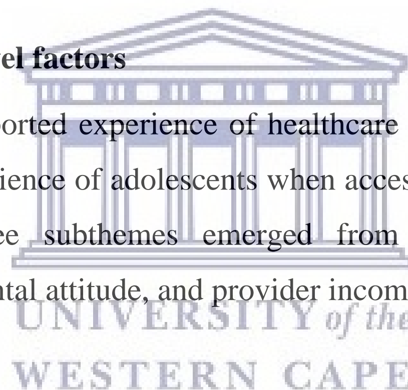
Long waiting times at the health facilities were reported by adolescents, adding that they are not comfortable with mixing with adults in crowded waiting areas.

> *"It's always crowded at the clinic with long waiting times, and during the long waiting periods some adults start asking you funny questions."* (Adolescent Male, 15)

Healthcare providers perceived that adolescents wait long hours in queues for services. Generally, adolescents lack the patience to wait for long hours, especially for a service that is not related to any serious illness, such as family planning services or HIV and STI screening.

> *"Young people don't have the patience to wait for a long time, especially when the clinic is crowded. They end up leaving without being attended to."* (Health care provider)

4.2.3. Theme 3: Provider-level factors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This theme focused on the reported experience of healthcare providers in providing ASRH services and the reported experience of adolescents when accessing SRH services at the local public health facilities. Three subthemes emerged from this theme: disrespect and confidentiality breach, judgmental attitude, and provider incompetency.

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4.2.3.1. Sub-theme 3.1: Disrespect and confidentiality breach

Feeling disrespected and a breach of client confidentiality emerged as factors discouraging adolescents from seeking SRH services at public health facilities. Adolescents in this study reported instances where they were shouted at or rudely spoken to by healthcare providers. Adolescents further indicated that healthcare providers' tendencies to shout out the services the adolescents come to seek are a breach of confidentiality.

> *"The nurses are rude and often shout at us as if we were little kids."* (Adolescent Male, 17)

> *"The nurses usually speak loudly for everyone to hear, and it is embarrassing."* (Adolescent Female, 16)

Adolescents in this study indicated that it is difficult to talk about their SRH issues and needs with healthcare providers that are their parents' age. This results in a discomfort in seeking services and a lack of trust in the adolescents.

> *"Some of the healthcare providers know our parents, and they might disclose everything that we tell them to our parents.* (Adolescent Male, 14)

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4.2.3.2. Sub-theme 3.2: Judgmental attitude

The judgmental attitude of healthcare providers emerged as another critical factor that discourages adolescents from seeking SRH services. Adolescents in this study perceived that healthcare providers judged them for seeking SRH services due to societal expectations of young people not to have sex before marriage.

> *"A nurse told me I was too young to be asking for condoms and I should wait for marriage to start having sex."* (Adolescent Male, 15)

> *"I am only comfortable with providing contraceptives to young people above the age of 18 years."* (Health care provider)

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4.2.3.3. *Sub-theme 3.3: Provider incompetency*

Adolescents in this study perceived that most healthcare providers assigned to YFCs were not competent enough to handle adolescent health issues. The adolescents further added that they do not feel like the nurses understand adolescent health issues and the specific SRH needs of adolescents.

> *"The nurses don't understand our issues; when I asked for specific information and available contraceptive options, the nurse couldn't give me proper information."* (Adolescent Female, 19)

Healthcare providers in this study indicated that allocation to YFCs was often not based on competence or skills but on a rotational or availability basis due to a shortage of staff at the facilities.

> *"Whenever there are trainings for healthcare providers on adolescent health friendly services, it is usually the health facility in-charge that attends, denying other staff the opportunity."* (Health care provider)

4.2.4. Theme 4: Community-level factors

This theme was based on the reported reactions and attitudes from members of the community when healthcare providers or adolescents raised the issue of access to SRH services by adolescents and young people. Two subthemes emerged from this theme: stigma and discrimination and lack of parental support.

4.2.4.1. *Sub-theme 4.1: Stigma and discrimination*

Stigma and discrimination reinforced by social norms, customs, cultural practices, and religious beliefs, especially on access to contraceptives and abortion services for adolescents, were perceived to be one of the major factors that discourage adolescents from seeking and accessing SRH services.

> *"Ugandan society is predominantly Christian, and Christian teachings strongly object to family planning services such as access to condoms and abortion services, especially for young people."* (Health care provider)

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"When people see you at the clinic, they think you are pregnant, and having sex before marriage is not allowed in my religion and church." (Adolescent Female, 17)

4.2.4.2. Sub-theme 4.2: Lack of parental and social support

The absence of parental support was reported as a factor that discourages adolescents from seeking SRH services. Adolescents in this study indicated that their parents are not in favour of them seeking SRH services at the health facilities, adding that they usually seek SRH services without the knowledge of their parents for fear of being castigated.

"My mother doesn't allow me to go to the clinic for condoms; she says I should wait until I am old enough for sex." (Adolescent Male, 16)

4.2.5. Theme 5: Personal (adolescent)-level factors

This subtheme was based on the reported experiences by adolescents when they sought or accessed SRH services at the local public health facilities. Four subthemes emerged under this theme: shame, discomfort, lack of information, and financial constraints.

4.2.5.1. Sub-theme 5.1: Shame

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Feelings of shame when seeking or accessing SRH services emerged as a critical factor discouraging adolescents from seeking assistance. Adolescents in this study indicated that because they come from backgrounds where it is taboo for young people to talk about sex, it is embarrassing to ask for SRH services and commodities such as contraceptives.

"I feel shy and afraid to ask for condoms at the clinic because the adults there will judge me for having sex." (Adolescent Female, 16)

"At church, we are taught that sex before marriage is sinful, so I feel ashamed to talk about sex or seek services." (Adolescent Female, 15)

"It is a taboo in my culture to talk about sex with your parents." (Adolescent Male, 17)

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4.2.5.2. Sub-theme 5.3: Lack of information

It emerged that there are information gaps among adolescents regarding SHR services. These gaps include knowing where to go to seek appropriate services and having a low-risk perception regarding STIs and other SHR issues. Adolescents indicated that they do not have access to credible information on SRH, and the little they know comes from their peer circles.

> *"I am not sure about what happens at the clinic, and I hear that most young people go there for condoms and abortions."* (Adolescent Female, 13)

> *"I think family planning clinics are for married and pregnant women and not young people like since I am not married."* (Adolescent Female, 16)

4.2.5.3. Sub-theme 5.4: Financial constraints

Healthcare providers perceived that a lack of financial resources discourages adolescents from seeking SRH services, especially in fee-paying facilities. They further added that most adolescents depend on their families for financial income and do not, therefore, have the financial freedom to spend money on SRH services, among other competing needs and priorities. Adolescent participants in this study also indicated that lack of income and financial resources discourage them from seeking services, citing issues like a lack of transport money to go to the clinic.

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> *"Adolescents depend on their families for financial assistance … sometimes they don't have transport money to go to health facilities."* (Health care provider)

> *"The clinic does not have condoms sometimes, and you need to buy from the pharmacy, but I can't ask my parents for money to buy condoms."* (Adolescent Male, 16)

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CHAPTER 5: DISCUSSION

This chapter discusses the study findings in detail. It provides insights into the factors that prevent the youth in the Mbale district from accessing YFHS. It further sheds light on the structural barriers to the provision of ASRH services for the youth in Mbale.

5.1. Barriers to Accessing Youth-Friendly Health Services for Young People in the Mbale District

According to the study findings, structural barriers (policy-level, facility-level, provider-level, and community-level barriers) and personal (individual) were found to be prominent factors that discourage young people and adolescents from seeking and accessing YFS at public health facilities in the Mbale district of Uganda.

5.1.1. Policy-level barriers

Lastly, findings in this study showed that policy-level factors such as the gaps in the implementation of ASRH policies and guidelines and a lack of dedicated financial resources to implement them greatly impact the provision of ASRH services. This further results in the poor implementation of YFS and discourages adolescents from seeking and accessing YFS. This finding was consistent with a similar study in the Democratic Republic of Congo by Odimba et al. (2021), which reported that poor implementation and under-resourcing of ASRH programmes and YFS have poor health outcomes for adolescents. Budget allocations towards health are generally low in Uganda, and this, in turn, impacts health services, such as SRH, which are not usually prioritised. It is, therefore, crucial that policymakers and public health managers invest resources in the implementation of policies and guidelines at the facility level. Interventions could include ensuring that adolescent health guidelines are available in hardcopy for easy access to adolescent healthcare providers.

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5.1.2. Facility-level barriers

Another prominent structural barrier to young people accessing YFS in the Mbale district is facility-level factors, such as a lack of privacy or appropriate space for providing ASRH services. A similar study in the Wasiko district of Uganda by Atuyambe et al. (2015) found

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that privacy and safety are of great importance to adolescents who want to have a sense of security when seeking and accessing SRH services at public health facilities. In addition, the study reported that adolescents are less likely to seek SRH services if they perceive that their privacy and safety are not guaranteed. This study also found that adolescents are less likely to seek ASRH services if the waiting periods are too long. Adolescents end up leaving the facility without accessing the services. This finding was similar to a study in Nepal by Pandey, Seale, and Razee (2019), which reported that improving privacy, space appropriateness, and waiting periods significantly improves adolescents accessing SRH services.

5.1.3. Provider-level barriers

Provider-level factors such as negative provider attitudes and incompetency emerged as significant barriers to young people accessing SRH services in Mbale. This finding was consistent with a similar study by Onokerhoraye and Dudu (2017) in the Delta state of Nigeria, which reported that adolescents are less likely to seek ASRH services if they perceive providers as hostile or unfriendly. Another similar study in South Africa by Müller et al. (2016) reported that adolescents are likely to open up about their SRH needs and disclose sensitive information to providers they perceive as non-judgmental. Previous studies have shown that training can improve attitudes among healthcare providers. A study in Bangladesh by Geibel et al. (2017) reported that targeted stigma-reduction training rapidly improves provider attitudes and increases service satisfaction among young people. It is, therefore, imperative that healthcare managers and facility in-charges emphasise and promote adolescent-friendly and affirming attitudes among adolescent healthcare providers.

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5.1.4. Community-level barriers

In this study, community-level factors such as stigma and discrimination were found to be critical barriers in discouraging adolescents from seeking and accessing ASRH services. This was in line with a similar study by Mazur, Brindis, and Decker (2018), which found that stigma and discrimination that are reinforced by social norms, customs, cultural practices, and religious beliefs are barriers to adolescents seeking and accessing SRH services. Closely related to this is the lack of or low parental support. Adolescents generally require consent and approval from their parents and guardians before accessing SRH services. However, negative community and social attitudes towards ASRH in many African societies stem from deep-

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rooted cultural and religious beliefs and influence. A similar study by Odhiambo (2022) in the Kisumu and Kakamega districts of Kenya reported that openly talking about sex is generally considered to be a taboo in most African cultures, making it difficult for young people to talk about their SRH needs and seek SRH services. Therefore, a lack of parental consent or strong sentiments of disapproval from the community results in adolescents not seeking or accessing SRH services.

5.1.5. Personal-level barriers

These barriers include the feeling of shame, discomfort, a general lack of information on ASRH, and financial constraints in accessing SRH services. This finding was in line with a similar study in rural South Africa by Geary et al. (2014), where it was found that shame, discomfort, and lack of information were major barriers to accessing YFS by adolescents. This study also found that stigma, discrimination, and negative community perceptions about ASRH instil these feelings of shame and discomfort in adolescents. It is, therefore, essential that the provision of ASRH services addresses and allays these feelings of shame and discomfort through community outreach activities in schools and other social spaces frequented by adolescents.

Furthermore, study findings showed that a lack of financial resources discourages adolescents from seeking and accessing ASRH services. Young people and adolescents are not independent income earners and, as such, depend on their parents and guardians for financial support. This means that young people and adolescents do not have the financial freedom to make independent choices regarding their SRH.

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5.2. Summary

In this chapter, the study findings were presented and discussed. The discussion also related the study's findings to similar studies in Uganda and across sub–Saharan Africa. This discussion focused on the personal-level and structural-level barriers that discourage young people from accessing YFHS in the Mbale district. This chapter also included a discussion on some possible root causes and ways of addressing these barriers.

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CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

This study explored various factors that present barriers to young people accessing YFHS in the Mbale district of Uganda. Based on the findings, it was concluded that factors preventing young people from accessing YFHS are multilayered and multidimensional, cutting across individual, structural, socio-cultural, and socio-economic factors. However, the study showed that structural factors such as provider attitudes and skills, facility setup, services offered, and policies for ASRH have the most impact young people's ability to access YFHS. In addition, the study also showed that community and social attitudes play a significant role in preventing young people from accessing YFHS. The community and social attitudes are rooted in deep cultural and religious beliefs that generally frown upon ASRH.

This study showed a general lack of knowledge and awareness among young people in the Mbale district regarding their SRH and the services available to them. Informed decision-making is important for young people to make choices about their SRH needs; therefore, a lack of awareness and information presents a massive barrier to YFHS for young people. Finally, there is an overall lack of understanding of the specific needs, issues, and concerns of adolescents. Therefore, this study and its findings provide an opportunity for all ASRHR stakeholders in the Mbale district and Uganda at large to better understand the factors that prevent young people from accessing YFHS and how to approach and address these factors.

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6.2. Recommendations

All relevant stakeholders can utilise the findings of this study within the SRHR sector in the Mbale district, specifically those focused on providing YFS to young people and addressing the SRH needs of young people and adolescents. Based on these findings, the study recommends the following:

1. Meaningful involvement and engagement of young people in the design and implementation of YFHS should be adopted at the district and national levels to ensure that the needs of young people inform the designed interventions.
2. Sexual and reproductive health and rights (SRHR) interventions targeting young people should prioritise education and awareness outreach programmes for school-going and out-of-school young people and adolescents.
3. Adolescent sexual and reproductive health and rights (ASRHR) programmes should systematically address negative social attitudes towards ASRH through targeted and collaborative community sensitisation interventions. Such interventions should meaningfully involve the community, religious and cultural leaders, and parents in conceptualising and implementing YFHS.
4. Budgets at the health facility level should have dedicated budget lines to provide YFHS.
5. Health facilities should increase the number of appropriately trained and dedicated staff for the provision of YFHS.
6. Health facilities should have dedicated and appropriate YFCs that young people can easily access in a safe environment.
7. National adolescent and youth-friendly health policies should be localised at the district and facility level through continued training of healthcare providers and facility managers. Hard copies of these policies and guidelines should be available for easy reference.
8. Sexual and reproductive health and rights (SRHR) stakeholders in the Mbale district should establish an ASRHR task force or working group to ensure a well-coordinated and collaborative approach without duplication of efforts.

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APPENDICES

Appendix 1: *Permission letter to Uganda Youth and Adolescent Health Forum (UYAHF)*

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Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

21st May 2021

The Executive Director,

Uganda Youth and Adolescent Health Forum,

1 Bukoto Street

Kampala.

Dear Sir/Madam

RE: Permission to utilise primary data

UNIVERSITY of the WESTERN CAPE

I am writing to request permission to utilise the primary data that was collected by yourselves between January and February 2020 in the *rapid assessment on young people's experiences, challenges and best practices on demand, access and utilisation of youth friendly contraceptive services in mbale district.* I am currently enrolled as a Masters student at the University of Western Cape's School of Public Health. The title of my Masters research is: *Understanding the factors that discourage young people from accessing youth-friendly health services in Mbale district, Uganda.*

The purpose of this research is to develop an understanding of why young people do not access sexual and reproductive health services at public health facilities in Mbale district, Uganda. The study will explore young people's perceptions on the awareness, acceptability, accessibility and affordability of these services and these factors impact on young people's decision to access or not access sexual and reproductive health services at public health centers and how these factors can be addressed.

I am trying to gather the insights of those with relevant experience in the area of Adolescent Sexual and Reproductive health (ASRH). I hope to develop a set of strong recommendations that will contribute to greater accessibility of youth-friendly Sexual and Reproductive Health (SRH) services for young people in Uganda. I hope that your office will allow me to review and analyse the primary data that you collected in your rapid assessment.

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If approval is granted I hope to explore the factors that prevent young people from accessing sexual and reproductive health services in Mbale district, Uganda.

The results will help in the design of important recommendations and will identify areas for further research in this area. I am willing to send you a draft copy of my final report for suggestions or comments.

Your approval to utilise your primary data for this study will be greatly appreciated. I am happy to answer any questions or concerns that you may have. You may contact me at my email address: chivuli@gmail.com or mobile phone: +26.096.309.99015.

If you agree, kindly sign below and return a scanned copy to me. Alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging your consent and permission for me to utilise your primary data.

I see this project as an important contribution to the field of adolescent health research.

Sincerely,

Chivuli Ukwimi

Approval: ……………………..

Name: ……………………..

Designation: ……………………..

Date: ……………………..

Signature: ……………………..

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Appendix 2: *UYAHF Participant Consent Forms*

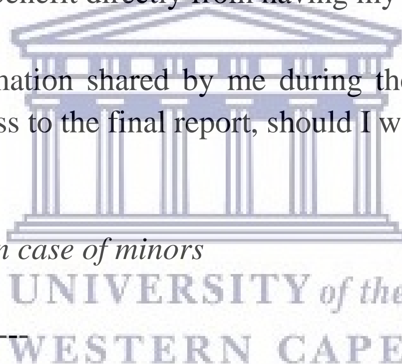
CONSENT TO TAKE PART IN RESEARCH STUDY

- I……………………………………… voluntarily agree to participate in this activity.

- I understand that my participation is voluntary, and I am free to withdraw at any point in the process by informing the interviewer.

- I have had the purpose and nature of the activity explained to me in writing and I have had the opportunity to ask questions.
- I understand that participation might involve personal information to which I have a right to either agree to share or respectfully decline to share.
- I understand that my anonymity will be respected should I choose not to be identified in the research. This preference will be made clear to the interviewer before the interview.
- I understand that my an audio recording, a written record, photo and or video will be taken to be used in the reporting of this activity. I have consented in a separate form to this regard and made it clear where I am not willing to be recorded.
- I understand that I will not benefit directly from having my photo taken.

- I understand that all information shared by me during the interview will be used with respect and I will have access to the final report, should I want to read it.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Name of participant/guardian in case of minors

Signature of participant: ………………………… Date: …………………….

Signature of interviewer: ………………………… Date: …………………….

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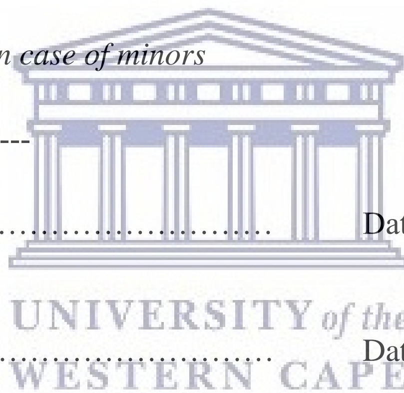
CONSENT TO HAVE MY PHOTO TAKEN

- I……………………………………… voluntarily agree to participate in this activity.
- I have had the purpose and nature of the activity explained to me in writing and I have had the opportunity to ask questions.
- I understand that participation involves taking photos and that my photo may be taken to be used in the reporting of this activity.
- I understand that I will not benefit directly from having my photo taken.
- I agree to my photo being taken.
- I understand that my photo will be used with respect.

Name of participant/guardian in case of minors

Signature of participant: ….…………………………. Date: …………………….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Signature of photographer: …………………………… Date: …………………….

I believe the participant is giving informed consent to have their photo taken

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Appendix 3: *Approval Letter from UYAHF*

UGANDA YOUTH AND ADOLOSCENTS HEALTH FORUM
Plot 1238, Bukoto 1 - UCB Zone, P.O Box 25914 - Kampala, Uganda
Email: info@uyahf.com - Tel: +256 776385819/+256 200902407 - www.uyahf.com

25th May 2021

The Chair
Biomedical Research Ethics Committee
University of the Western Cape
Private Bag X17
Bellville
7535

Dear sir/madam

RE: Letter of Cooperation and Permission

Chivuli Ukwimi has requested permission to receive already existing data for research purposes from the Uganda Youth and Adolescent Health Forum (UYAHF).

This is the primary data that was collected by UYAHF between January and February 2020 in the *rapid assessment on young people's experiences, challenges and best practices on demand, access and utilisation of youth friendly contraceptive services in Mbale district* of Uganda.

I have been informed of the purposes of the study and the nature of the research procedures. I have also been given an opportunity to ask questions of the researcher.

As the Team Leader of UYAHF I am authorized to grant permission to have the researcher receive archival data for secondary analysis. The researcher is hereby granted permission to access and use this data for their study titled **'Understanding the factors that discourage young people from accessing youth-friendly health services in Mbale district, Uganda'**.

If you have any questions, please contact me at patsewa@uyahf.com / patsewa@gmail.com and +256 700385818

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Kind Regards

Patrick Mwesigye
Team Leader – UYAHF

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Appendix 4: *Ethics Approval from the Biomedical Research Ethics Committee*

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17 August 2021

Ms C Ukwimi
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM21/6/17

Project Title: Understanding the factors that discourage young people from accessing youth-friendly health services in Mbale District, Uganda.

Approval Period: 17 August 2021 – 17 August 2024

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

NHREC Registration Number: BMREC-130416-050

Director: Research Development
University of the Western Cape
Private Bag X 17
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Tel: +27 21 959 4111
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FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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