

# Youth-Friendly Service Quality and Associated Factors Among Adolescents and Youths at Public Health Facilities in South West Shoa Zone, Oromia, Ethiopia, 2022

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## ABSTRACT

**Background:** Adolescents and youth with special health care needs are essential for the future; however, many face poor outcomes due to inadequate sexual and reproductive health services and gaps in youth-friendly service quality.

**Objective:** This study aimed to assess the quality of youth-friendly services and the factors associated with them at public health facilities in the South West Shoa Zone, Oromia, Ethiopia, in 2022.

**Method:** A facility-based cross-sectional study design supported by qualitative data was employed in health centers of Southwest Shoa Zone, Ethiopia, involving 421 adolescents and youths, as well as 10 key informants, from July 28 to August 28, 2022. Systematic random sampling and purposive sampling were used to select the study participants. The quantitative data were coded, entered into Epi-data version 3.1, and exported to SPSS version 23.0 for analysis. Bivariable and multivariable logistic regression analyses were conducted to identify factors associated with the outcome variable. Independent variables with a p-value <0.25 in the bivariable analysis were included in the multivariable analysis. Adjusted odds ratios with 95% CI and p<0.05 were used to determine statistical significance. Finally, qualitative data were discussed by triangulating with quantitative data.

**Results:** A total of 414 study participants were enrolled, resulting in a 98.34% response rate. The overall magnitude of adolescent and youth-friendly health service quality was 32.1% (95% CI: 27.6-36.9), with 54.42%, 68.39%, and 71.32% for structural, process, and output quality parameters, respectively. Occupation (AOR: 1.71; 95% CI: 1.13, 2.68), privacy during the consultation (AOR: 6.47; 95% CI: 3.64, 11.52), and length of waiting time (AOR: 2.52; 95% CI: 1.56, 4.06) were significantly associated with the quality of adolescent and youth-friendly health services.

**Conclusion and Recommendation:** The study found that the overall quality of adolescent and youth-friendly health services was poor in structure, process, and outcome decisions. Occupation, waiting times, and privacy were significantly associated factors of service quality. The qualitative insights revealed that lack of educational materials, limited service hours, and insufficient trained staff, while privacy and affordability were key concerns for youths. To improve service quality, health facilities enhance infrastructure, reduce waiting times, ensure confidentiality, and actively involve adolescents and youths in service planning, all while adhering to national guidelines to provide accessible, youth-centered care.

**Keywords:** Structure, Process, Outcomes, Quality Health Care, Southwest Shoa

## Abbreviations

AOR : Adjusted odd ratio

AYFHS : Adolescent and Youth-Friendly Health Services

CI : confidence interval

ERB : Ethical Review Board

IEC : Information, education, and communication

WHO : World Health Organization

LMIC : Low and middle-income countries

YFS : Youth-Friendly Services

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## Introduction

Adolescent and youth service quality is defined as services that are accessible, acceptable, and appropriate. They should be available in the right place, at the right price, and delivered in the right way for adolescents and youth [1]. These services should be offered to young people in an effective, efficient, accessible, acceptable, equitable, and safe manner [2].

Based on recent estimates, young people between the ages of 15 and 24 represent 17.0 percent of the global population and 20.0 percent of Sub-Saharan Africa [3]. In Ethiopia, individuals aged 10 to 24 make up 33.8% of the total population. Unfortunately, many of them experience early mortality, illness, and inadequate healthcare, which hinders their ability to reach their full potential [4].

Despite the World Health Organization's (WHO) efforts to enhance the health of young people, a considerable number still suffer from injuries, illnesses, and premature deaths [5-12]. In 2019, around 1.5 million adolescents and young people aged 10 to 24 died, mainly due to preventable diseases. Notably, mortality rates in Africa and middle-income countries were over thirteen times higher than in high-income countries [13-15].

Evidence from low- and middle-income countries (LMICs) suggests that adolescent programs are frequently disorganized and of inconsistent quality [11,16,17]. Inadequate and untrained service providers, a lack of privacy and confidentiality, negative attitudes toward providers, a lack of necessary equipment to provide the essential service package such as health information materials, essential drugs, and supplies, and a lack of privacy and confidentiality are some of the contributing factors to poor service quality [10,18,19].

According to research findings, healthcare services for adolescents and youth are still inadequate and have not met the expected standards. Satisfaction with these services varies by country. In Switzerland, Uganda, Tanzania, and South Africa, 94%, 86%, 89%, and 87.1% of adolescents, respectively, expressed satisfaction with the services provided [20,23].

Poor quality healthcare services for adolescents and young people can lead to various health issues, including nutrition, mental health, substance abuse, injuries, and sexual and reproductive health concerns [2].

In previous studies in Ethiopia, the focus was on factors that affect the consumption and quality of Youth-Friendly Services (YFS) using only structural dimensions. There is a lack of information on the quality of Adolescent and Youth-Friendly Health Services (AYFHS) when considering all three dimensions. Therefore, this study aims to assess the quality of Youth-Friendly Services and associated factors at public health facilities in the South West Shoa Zone of Ethiopia in 2022.

## Methods

### Study design, period, and area

A facility-based cross-sectional study design supported by qualitative data was employed in health centers of Southwest Shoa Zone, Ethiopia, from July 28 to August 28, 2022. Southwest

Shoa zone is one of the zones in the Oromia regional state located 114 km from Addis Ababa the capital city of Ethiopia. The 2022 southwest Shoa zone population project figure was 1283646. Out of the total population, there are 628987 males and 654659 females, with youth making up one-third (449276) of the total population. There are fifty-four health centers, five public, and 1 private (Lukas) hospital, but only around [15] fifteen health centers provide youth-friendly services in southwest Shoa Zone.

## Sopulation

### Source population

For quantitative all adolescents and youth people between 10 to 24 years who attend youth-friendly services in southwest Shoa zone public health facilities. For qualitative all health center managers and YFS providers in the public health facilities in the southwest Shoa zone.

### Study Population

For quantitative all adolescents and youth between 10 and 24 years who attend youth-friendly services in the five selected southwest Shoa zone public health facilities during the study period. All purposively selected health center managers and YFS providers in the five selected public health facilities in the southwest Shoa zone were included for qualitative data.

### Study Unit

For quantitative data individuals who fulfilled the inclusion criteria during the time of data collection. For qualitative data each health facility manager and YFS service provider in five selected health facilities.

### Inclusion and Exclusion Criteria

For quantitative all youth [10-24] years of age who come to the health institution during the data collection period were included in the study. For qualitative all purposively selected Health center managers, and service providers were included.

### Sample Size Determination and Sampling Technique

For quantitative data; the sample size for the study was calculated using a single population proportion formula by considering the following assumptions, 95% confidence level, and 5% degree of precision, and using the proportion from the previous study, the output of youth health service was 47.2% [10].

$$\frac{(Z_{\alpha/2})^2 P(1-P)}{d^2} = \frac{(1.96)^2 \cdot 472(0.528)}{.05^2} = 383$$

The minimum required sample size will be 383, after considering a 10% non-response rate, the total sample size is 421. For qualitative data the sample size was determined based on the point of saturation during data collection in the study area.

For quantitative data, a systematic random sampling technique was used to select the required sample size from study populations. The study was conducted at the five public health centers in the zone, Tullu Bollo, Terre, Harbu Culule, Dawo, and Teji Health Center, a youth-friendly service in the southwest Shoa zone. All five health facilities selected by using the lottery method and which deliver AYFHS were included in the study. The sample was allocated proportionally to each public health facility based on the average number of young clients flowing in the last year

of 1 month report from (June 21, 2021- July 20, 2021, E.C) in the selected health centers was obtained from the service provider. Based on the total number of youth in each randomly selected health center, the sample was proportionally allocated to each health center (Sample fraction =sample size/total number of youth in selected health centers =421/4082=0.10, then multiply the number of youth in each selected health centers by 0.10 to get allocated sample size). Then the first individuals was selected by lottery method from 1-10 intervals and continued every ten youth-friendly service users. For qualitative data five health center heads were selected purposively to get rich information on the availability of resources and health facility management issues related to AYFHS. Also, five AYFHS providers were included to obtain information on resources, client-provider interactions, and other AYFHS quality issues.

### Study Variables

The dependent variable was the quality of youth-friendly services. Socio-demographic characteristics (Sex, Marital status, Age, Occupation), Structural quality factors (Equipment, Personnel, Facilities, Financial, Information), Process quality factors (Diagnosis, Rehabilitation, Therapeutic care, Preventive care), Outcome quality factors (Resources, Patient well-being, Health status, and Satisfaction) were independent variables.

### Operational Definition

**Good /poor quality AYFHS care:** Youth Friendly Services quality under the study was assessed using the three (structure, process, and outcome) parameters if a health center achieves a score of 75 percent or higher by combining the three quality assessment items for structure, process, and output, it is classified as “good quality” or “good standard of care,” while a score of less than 75 percent is classified as “poor quality of care” or “below the standard of care”[24].

**The Structure:** was assessed using 7 dichotomized “Yes” and “No” questions which were recoded as 1 and 0 respectively. The structure was assessed using 7 dichotomized “Yes” and “No” questions which yes were recoded as 1 and 0 respectively. Then after, all the responses were added and divided by the sample size.

**The Process:** was assessed using 8 dichotomized with “Yes” and “No” questions which yes were recoded as 1 and 0 respectively. Then after, all the responses were added and divided by the sample size.

**The outcome:** was assessed using 11 dichotomized “Yes” and “No” questions which were recoded as 1 and 0 respectively. Then after, all the responses were added and divided by the sample size.

**The overall quality of YFS:** was assessed by firstly, estimating the value for each using adding up all the responses and calculating the overall estimate value for structure, process, and outcome and each was categorized as below mean as zero (0) and above mean as (1) by taking mean score of 0.5 for each three (structure, process, and outcome) parameters, then after estimating the overall value for each parameter, categorize as below mean of 0.75 and above 0.75 [24].

### Data Collection Tools and Techniques

Both quantitative and qualitative data collection methods were employed to generate findings from health facility managers, service providers, and service users. The quantitative data were collected through structured client exit interview questionnaires. Qualitative data were collected through in-depth interviews using an interview checklist and client-provider interaction score sheets. Data collection tools were adapted from the WHO standard tools [10,25] and national guidelines. The data from the youth client exit interview, Health facility manager interview, and client-provider interaction were conducted by five nurses and supervised by one senior BSC nurse. All data collectors and supervisors were intentionally selected and used from other facilities/that do not belong to the study health facility.

### Data Quality Control and Management

For quantitative the data collection tool was prepared in English tool preparation version and translated into Afan Oromo and, then back to English by language teachers to ensure its coherence with the original version. One day of training will be given to data collectors and supervisors on data collection tools and procedures. The questionnaire was pretested on 5% of the sample size (17 youths) at the Leman Health Center of Kersa Malima Woreda to check for consistency, errors, and necessary modifications were made on some items of the questionnaire before the actual data collection. Supervisors monitored the data collection process daily. The collected data were reviewed and checked for consistency, clarity, and completeness throughout the data collection process by supervisors and investigators.

For qualitative data, the trustworthiness of the findings was ensured through credibility, dependability, transferability, and conformability. Credibility was assured through multiple measures, including triangulating data from each source, spending extended time with the study participant, clarifying the researcher’s position, and the principal investigator discussed the findings and colleagues who have previous experience in qualitative research. To ensure dependability, a consistent approach was used for data collection and analysis. Record-keeping was also implemented to maintain an audit trail of all documents. Additionally, the transcripts were repeatedly checked for errors to ensure accuracy. Conformability was achieved by congruence with colleagues who have previous experience in qualitative research on the data accuracy, relevance, or meaning during data coding and analysis. To ensure transferability, a thick description of the research context was provided. Additionally, the study participants were selected using the maximum variation principle.

### Data Processing and Analysis

For quantitative the data were entered into the computer using Epi data version 3.1, exported to SPSS version 25, cleaned, and checked before analysis. Descriptive statistics were carried out to describe the study participants under study in terms of frequency and percentage. Bivariable logistic regression was used to select candidate variables for multivariable logistic regression. Those variables with a p-value of less than 0.25 in bivariate analysis were included in a multivariable logistic regression model. Before the multivariable model fitting the Hosmer and Lemeshow’s goodness-of-fit test was assessed to check for important assumptions of logistic regression and the value

was 0.914, indicating that the model best fitted the variables. A p-value < 0.05 was used to test statistical significance and adjusted odds ratio (AOR) with a 95% confidence interval (CI) as a measure of the strength of association between variables. Finally, the data were presented using texts, tables, and charts.

For qualitative the recorded data was transcribed verbatim and reviewed with audiotapes, as well as notes were taken. Then, the data was translated from Afan Oromo to English and saved into Word. Then, the final result was discussed by triangulating with quantitative findings.

### **Ethical and Legal Consideration**

Ethical clearance for this study was obtained from the Ethical Review Board (ERB) of Ambo University College of Health Sciences and Referral Hospital. The official letter was submitted to the district health office and health centers, and a permission letter was obtained. Informed verbal consent was obtained from all subjects who are [18-24] and written assent for those [10-17] was taken from their parents for their participation after the nature of the study was fully explained to them in their local using language and those who give consent participated in the study. Throughout the study, participants were informed that data was kept private and confidential and used only for research purposes. The participants were also assured that they had the right to refuse or withdraw if they were not comfortable with the question at any time as their participation is voluntary. Personal privacy and cultural norms were respected.

### **Results**

#### **Socio-Demographic Characteristics of the study participants**

There was a total of 414 study participants involved in the study with a response rate of 98.34%. Among these study participants, 229 (55.31%) were female respondents. Two hundred fifty (60.53%) of respondents were between 20 and 24 years old. Regarding respondents' educational status, 368 (87.68 %) of them had below the secondary level of education. Slightly more than 222 (53.62%) of study participants were urban residents and more proportion 211 (50.97) of study participants were not employed (Table 1).

#### **Structural Quality of Youth-Friendly Health Service.**

Above half of the study participants, among those who visited health facilities before, 206 (49.76%) have served in the past 12 months. During their visit, more than half (50.48%) of adolescents and young people viewed educational materials (Table 2).

#### **Process Quality**

About 284 (68.6%) of the respondents got comfortable seating areas when waiting for the service in the health facility. The majority 387 (93.48) of study participants recommended other adolescents to come to this facility for the services. Out of them, 239 (57.73%) thought that the wait time for the service was satisfactory (Table 3).

#### **Outcome Quality**

Participants in the survey said that 79.9% of health professionals asked about smoking and alcohol drinking, 63.5% of waiting times to see HCPs were comfortable, and 76.33% had friends

who were healthcare professionals. Approximately 79% of healthcare professionals inquired about the smoking and alcohol consumption habits of adolescents and young people who were attending the health facilities (Table 4).

#### **Overall Quality of Youth-Friendly Health Services.**

The overall score and level of YFS was 32.1% which for (structural, process, and output quality) dimensions were 54.42%, 68.39%, and 71.32%, respectively. As observed in the table below, all the YFS sites scored lower than the set cut-off point (75%) in three quality dimensions. Hence, the overall quality of YFS is categorized as "not good quality" or "below standard" (Fig).

### **Discussion**

In this study, the overall prevalence of adolescent and youth-friendly health services quality was 32.2% (95% CI: 27.6-36.9) and 54.42%, 68.39%, and 71.32%, for structural, process, and output quality parameters respectively.

In this study, the prevalence of adolescent and youth-friendly health services quality for structural quality is 54.42%. Based on this finding was shows that the structure quality of youth-friendly service was poor according to the referred WHO cutoff value. This reason for the poor quality of YFS for the structure may be due to the reasons assed by the qualitative findings which showed that: Information, education, and communication (IEC) materials to educate youth clients are not available. Service information delivering materials like signposts are erected at both YFS sites, but a list of service hours and service provided to young clients is not posted at all health centers except Tullu Bollo [26]. This finding is consistent with the China quality assessment report [15] and the study from Southern Ethiopia [24]. The level of structural quality is poor, and it is comparable with YFS assessments made in South Africa [18]. This may result from resource scarcity, including a lack of trained personnel and adequate facilities, which hinders the provision of youth-friendly health services [27]. Qualitative insight: "The problem on the youth side is very broad and requires a lot of attention. In the past, the NGO worked on youth aid, so there are a lot of educational materials available. But now the problem we are facing is that things don't even have health education" (Seden Soddo Health Center Primary health care unit worker).

In this study, the magnitude of adolescent and youth-friendly health services quality for outcome quality was 71.32%. This finding shows that the outcome quality of youth-friendly service was poor according to the referred WHO cutoff value. This reason for the poor quality of YFS outcome may be due to the reasons assed by the qualitative findings which showed that: Service opening hour for all of YFS facilities is from Monday to Friday (from 2:30 to 11:30 local time) and YFS corners are closed at night time and weekends which affect the service of YFS. Regarding youth involvement, none of the facilities included youths in their governance Structure (planning, monitoring, and evaluation of health service delivery). In addition, none of the health facilities had clear AYFHS operation budgets [10]. The result is higher than a study conducted in the Ethiopian town of Arba Minch, which was 49.1%. In contrast to surveys done in South Africa (81.7%), Dejen district, West Gojam, Ethiopia



(60.7%), and Dessie town (58.9%), the level of service quality is lower here. This discrepancy may be explained by the difference in the quality of service delivery across the health facilities [13].

In this study, the magnitude of adolescent and youth-friendly health services quality for process quality is 68.39%. This finding shows that the process quality of youth-friendly service was poor according to the referred WHO cutoff value. This finding shows that the process quality of youth-friendly service was poor according to the referred WHO cutoff value. This reason for the poor quality of YFS for the process may be due to the reasons ascribed by the qualitative findings which showed that all service providers are found to be males with the age ranging from 25 to 40 years and due to waiting time of more than one hour. Youth-friendly services are provided by trained (YFS) health workers except Terre HCs. However, there are inadequate health workers in all health centers and there's only one health professional assigned to youth friendly service ward. All facilities have separate YFS rooms and adequate medical instruments, which enable them to provide minimum packages. Terre and Teji Health Center have no separate waiting areas [28]. Qualitative insight: "Few people who can afford [paid services], such as government employees, use them frequently." (Male healthcare provider)."

In this study, employment is significantly associated with the quality of youth-friendly service. This finding was consistent with the study conducted in Southern Ethiopia [24]. This may be because unemployed patients tend to estimate their health condition as worse and are preoccupied with the perception that the service quality provided to them will be poor, which will create a communication barrier with health workers [29]. However, a study conducted in America revealed that employed clients tend to have poor quality services than their counterparts. This difference may be due to differences in client attitudes, provider practice, and low expectations of service quality [30]. This is supported by qualitative findings. "When individuals between the ages of 10 and 24 visit the facility, we offer the youth services that we have access to. Although the majority of the services are paid for, few people who can afford them such as government employees use them frequently." (26 years old male health care provider).

This study found that waiting time is significantly associated with YFS quality. This finding is supported by a study conducted in Ethiopia, the Amhara region, and Southern Ethiopia [24] which indicates that clients who waited longer are significantly associated as compared to their counterparts [31].

This study also shows that privacy during the consultation was 4.62 times more likely than those study participants provided by qualified healthcare professionals in a separate room in all health facilities are satisfied with quality services than their counterparts. These findings supported a study conducted in Southern Ethiopia [24]. This could be the fact that every client needs privacy when in a service physical environment that permits privacy during therapy is a crucial component of high-quality AYFHS [13]. Therefore, keeping the clients while providing service is very important. This is supported by qualitative findings. "Young individuals prefer that no one see them while they receive services" (29-year-old Health facility head).

### Limitation of the Study

The study was geographically restricted to the southwest region and concentrated only on patients who went to public health facilities; it is, therefore, inapplicable to patients who do not attend medical facilities and patients who go to private settings. Using a cross-sectional design makes it difficult to determine the cause-effect relationship of associated factors.

### Conclusion

The study revealed that the overall quality of adolescent and youth-friendly health services was poor across structural, process, and outcome dimensions based on WHO standards. Factors associated with the quality of youth-friendly services included having a job, short waiting times, and privacy. The qualitative findings indicated that the lack of educational materials, limited service hours, and insufficiently trained staff contributed to poor service quality. One health worker noted the absence of health education materials, while providers highlighted that most government employees could afford paid services. Privacy was crucial, with youths preferring confidential consultations. Therefore, to improve service quality, health facilities should enhance infrastructure, reduce waiting times, ensure privacy, and engage adolescents and youths in service planning while adhering to national guidelines to provide accessible, youth-centered care.

**Lesson learned:** Quality youth services need adequate resources, privacy, and youth involvement. Considering the socio-economic factors and reducing waiting times are also key to improving access and satisfaction.

### Declarations

#### Conflict of interest

The authors declared that they have no competing interests.

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### Ethical consideration

Ethical clearance for this study was obtained from the Ethical Review Board (ERB) of Ambo University College of Health Sciences and Referral Hospital. The official letter was submitted to the district health office and health centres, and a permission letter was obtained. Informed verbal consent was obtained from all subjects aged [18-24], and written assent was taken from parents of those aged [10-17], after the nature of the study was fully explained to them in their local language. Participants who gave consent took part in the study. Throughout the study, participants were informed that data was kept private and confidential, and used only for research purposes. The participants were also assured that they had the right to refuse or withdraw at any time, as their participation was voluntary. Personal privacy and cultural norms were respected.

### Author Contributions

All authors made substantial contributions to the article. Kebede Jifara; writing the original draft, data analysis and interpretation of findings; Elias Teferi: interpreting the finding and revising it critically for important intellectual content; and final approval of the version to be published; Bedesa Tesema: interpreting the finding and revising it critically for important intellectual content

and final approval of the version to be published; Diriba Etana Tola: data analysis and interpretation of findings and revising it critically for important intellectual content; Birhanu Wogane Ilala: preparing manuscript and interpretation of findings and revising it critically for important intellectual content.

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