


**COLLEGE OF EDUCATION AND LANGUAGE STUDIES**

**SCHOOL OF PSYCHOLOGY**

# ASSESSMENT OF THE BARRIERS AND FACILITATORS OF TELE-COUNSELING SERVICE DELIVERY IN ADDIS ABABA, ETHIOPIA

**BY: ABYSSINIA BESHADA**

**A THESIS SUBMITTED TO SCHOOL OF PSYCHOLOGY**

**IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE**

**OF MASTER OF ARTS IN COUNSELING PSYCHOLOGY**

**JUNE, 2026**

**ADDIS ABABA, ETHIOPIA**

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ADDIS ABABA, ETHIOPIA

**Addis Ababa University**

**College of Education and Language**

**Studies School of Psychology**

**Assessment of The Barriers and Facilitators of Tele-Counseling Service Delivery in Addis Ababa, Ethiopia.**

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**Declaration**

Abyssinia Beshada, hereby declares that the thesis on the title Assessment of The Barriers and Facilitators of Tele-Counseling Service Delivery in Addis Ababa, Ethiopia. is my original work and it has not been presented for any academic purpose in any other university prior to this time and that all source of materials used for thesis have been properly acknowledged.

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The thesis has been submitted for examination with my approval as a university advisor.

Name of advisor: Abera Getachew(Assistant Professor)

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Date: _____

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# ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AAU | Addis Ababa University |
| COVID-19 | Coronavirus Disease 2019 |
| WHO | World Health Organization |
| LMICs | Low- and Middle-Income Countries |
| eHealth | Electronic Health |

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## *ABSTRACT*

*The adoption of remote mental health services in Ethiopia is hindered by prevailing cultural norms, inadequate technological infrastructure, and economic constraints. This study explored the barriers and facilitators of tele-counseling service delivery in Addis Ababa, Ethiopia, from the perspectives of clients and mental health professionals. A qualitative descriptive phenomenological design was employed, involving twenty participants (n = 20), including ten tele-counseling clients and ten mental health counselors selected through purposive sampling from private psychological centers and the Ministry of Health Helpline. Data were collected through semi-structured interviews and analyzed using Colaizzi's seven-step phenomenological method. The findings revealed four major themes: (1) Stigma, (2) Infrastructure, (3) Privacy, and (4) Facilitators. Tele-counseling effectively helped clients avoid social stigma by ensuring absolute privacy and anonymity, thereby lowering barriers to entry for individuals fearing judgment or social consequences. Key facilitators included enhanced scheduling flexibility, reduced travel time amid Addis Ababa's traffic, audio-only anonymity that supported emotional disclosure, and counselors' adaptation through culturally appropriate communication (plain Amharic), vocal tone, and leveraging family collectivism for treatment adherence. Conversely, the identified barriers centered on Infrastructure challenges (unstable internet connectivity, frequent power interruptions, and high data costs that disrupted sessions and created financial strain) and Privacy deficits (lack of private spaces in crowded multi-generational households, forcing clients into creative and sometimes unsafe workarounds such as parked cars or outdoor locations). These barriers compromised therapeutic continuity and safety, particularly during emotional or crisis moments. Based on these findings, the study offers the following recommendations: the Ministry of Health should establish stronger collaborations with Ethio Telecom to provide institutional toll-free mental health hotlines; academic institutions should set up dedicated, private counseling spaces on university campuses for students; and mental health organizations should develop low-bandwidth, flexible tele-counseling platforms capable of functioning during poor internet connectivity. Additionally, targeted public awareness campaigns should be launched to maximize digital e-health opportunities and further dismantle mental health stigma.*



***Keywords:*** *Tele-counseling, Mental Health, Descriptive Phenomenology, Mental Health Stigma.*

# 1. CHAPTER ONE

# 1.1 INTRODUCTION

## 1.2. Background of the Study

Mental health disorders, including depression, anxiety, substance abuse, and trauma-related conditions, represent a profound and accelerating burden on global public health, significantly undermining human productivity, quality of life, and macroeconomic development (WHO, 2022). For decades, the delivery of psychiatric and psychosocial care relied almost exclusively on brick-and-mortar, face-to-face clinical paradigms. However, this traditional model has historically failed to achieve equitable reach due to systemic challenges such as geographical maldistribution of specialists, high structural costs, and pervasive social alienation. The onset of the COVID-19 pandemic severely exacerbated this ongoing crisis, precipitating a dramatic surge in psychological distress while simultaneously forcing the total or partial closure of physical mental health facilities worldwide.

In response to these unprecedented disruptions, global health systems rapidly shifted toward digital health ecosystems, elevating tele-mental health and tele-counseling from peripheral innovations to essential pillars of continuous clinical care (WHO, 2024; Appleton et al., 2025). Tele-counseling encompasses the provision of professional psychological therapy, assessment, and psychosocial intervention mediated through remote telecommunication technologies, including synchronous voice calls, encrypted video conferencing, interactive mobile applications, and web-based portals. Empirically, synchronous digital interventions have demonstrated therapeutic equivalence to face-to-face modalities in reducing clinical symptoms of affective disorders, offering a highly scalable vehicle to bypass structural friction points such as

transit times, financial barriers, and the localized visibility that often fuels institutionalized stigma (Karyotaki et al., 2023).

Despite its transformative potential, the global operationalization of tele-counseling is highly uneven. In low- and middle-income countries (LMICs), the deployment of digital health infrastructure encounters a complex matrix of systemic friction points. These include acute technological deficits, variable digital literacy among both providers and service users, ambiguous ethical boundaries regarding remote data storage, and a systemic lack of formalized clinical guidelines specifically tailored for virtual spaces (Dar & Sobhana, 2025; Heng et al., 2023).

Within Sub-Saharan Africa, these macro-level systemic constraints are further intensified by historical underfunding of mental health infrastructure, which coexists alongside a rising demand for care driven by compounding geopolitical, economic, and environmental stressors. While the rapid penetration of mobile telephony and mobile internet across the continent has laid a foundational technical layer for e-health applications, the operational reality of digital counseling remains severely compromised. Services routinely battle unstable national grids, high tariffs for data transmission, linguistic fragmentation, and an overwhelming shortage of trained mental health professionals who are formally certified in remote triage and digital therapeutic alliances.

In Ethiopia, the intersection of these structural and cultural challenges creates a critical bottleneck for mental health accessibility. In urban hubs like Addis Ababa, rapid urbanization, socio-economic pressures, and shifting community structures have led to a measurable escalation in psychological distress and a corresponding demand for psychosocial support systems. Simultaneously, the proliferation of smartphone usage and localized digital applications (such as

Telegram and dedicated helplines) has prompted private psychological centers and non-governmental entities to launch fragmented, remote telephone and online counseling initiatives. However, these emerging digital services operate within an empirical vacuum. Extant local literature remains disproportionately focused on generalized telemedicine or basic electronic medical records (EMR) systems, leaving the specific clinical, ethical, economic, and infrastructural dynamics of tele-counseling completely unexamined. Consequently, this study aims to systematically assess the specific barriers and facilitators influencing tele-counseling service delivery in Addis Ababa, Ethiopia, providing an empirical foundation to inform sustainable, accessible, and culturally contextualized digital mental health frameworks.

## 1.3. Statement of the problem

The implementation of tele-counseling in low-resource settings holds substantial promise for narrowing the mental health treatment gap. However, transitioning clinical counseling from controlled, in-person environments to digital platforms introduces acute operational friction points that remain poorly understood in the Ethiopian context.

The core problem is that while remote counseling services have spontaneously emerged in Addis Ababa across various private networks, non-governmental helplines, and digital channels such as Zoom, Telegram, and telephone hotlines, they are currently operating in a fragmented, unstandardized, and empirically unmonitored environment. This lack of structural integration creates significant vulnerabilities for both clients and practitioners. Globally, evidence suggests that digital health interventions require rigorous contextualization regarding platform security, bandwidth adaptability, and culturally specific communication cues to achieve clinical efficacy (Equatora et al., 2021; Ghazanfarpour et al., 2021). Yet, in Ethiopia, there is an absolute dearth

of empirical data documenting how local structural realities interact with remote therapeutic practices.

The ongoing implementation of tele-counseling in Addis Ababa faces critical and unaddressed challenges across several dimensions. One major challenge involves infrastructural and economic barriers. Digital service delivery depends heavily on external utilities, and the persistent reality of unstable electrical grids, frequent power interruptions, and fluctuating internet connectivity can disrupt active therapeutic sessions, potentially compromising clinical safety. In addition, high data costs place an unexamined financial burden on low-income clients, sometimes forcing them to conduct counseling sessions in public, outdoor, or otherwise unsuitable environments that may compromise their privacy and confidentiality.

Another significant challenge relates to institutional and regulatory deficits. Ethiopia currently lacks dedicated national e-health legal frameworks, localized digital ethical protocols, and standardized clinical guidelines for remote psychological care. This regulatory gap leaves practitioners without clear guidance regarding informed consent procedures, remote crisis intervention strategies, including the management of acute suicidality, and the maintenance of client confidentiality across different digital platforms.

Cultural and behavioral factors also present substantial barriers to effective tele-counseling. Deeply rooted socio-cultural misconceptions and stigma surrounding mental health continue to influence help-seeking behaviors in Ethiopia. Although tele-counseling provides a level of anonymity that may help individuals avoid public scrutiny, it also faces challenges arising from concerns about digital privacy, a preference for traditional face-to-face and community-based interactions, and varying levels of digital literacy among potential service users.

Compounding these operational challenges is a significant empirical gap in the existing literature. Previous digital health research in Ethiopia has focused primarily on macro-level telemedicine systems, mobile health (mHealth) interventions such as maternal care text-message reminders, and electronic hospital administration systems. To date, no qualitative phenomenological study has explored the lived experiences of the primary stakeholders involved in tele-counseling, namely the clients receiving remote therapy and the counselors responsible for managing digital clinical practices.

Without targeted empirical evidence that distinguishes systemic barriers from effective facilitators, efforts to scale, regulate, or invest in remote mental health services are likely to remain ineffective. Therefore, this study seeks to address this gap by conducting a rigorous qualitative assessment of the barriers and facilitators influencing tele-counseling service delivery in Addis Ababa. The findings will provide critical evidence to support policymakers, the Ministry of Health, psychiatric institutions, and digital health developers in designing secure, equitable, culturally sensitive, and structurally resilient tele-counseling frameworks.

### 1.3. Research Questions

1. What are the firsthand lived experiences of clients accessing and utilizing tele-counseling services in Addis Ababa?
2. What are the firsthand lived experiences of mental health counselors delivering services through tele-counseling platforms in Addis Ababa?
3. What do clients and counselors perceive as the primary technological, socioeconomic, and cultural barriers to effective tele-counseling delivery?
4. What factors do clients and counselors perceive as facilitators that support and enhance the delivery of tele-counseling services?

## 1.4. Significance of the Study

This study will have practical, academic, institutional, and policy contributions to mental health and digital healthcare services in Ethiopia. By examining the barriers and facilitators of tele-counseling service delivery in Addis Ababa, the study will provide evidence that can help improve access to mental health services through digital platforms.

First, the study will support policymakers and government institutions, particularly the Ethiopian Ministry of Health, by providing information on the technological, institutional, socioeconomic, and cultural factors affecting tele-counseling services. The findings may help in developing policies, guidelines, and strategies for strengthening tele-mental health services in Ethiopia.

Second, the study will benefit mental health professionals, counselors, psychologists, and counseling centers by identifying the major challenges and facilitators related to tele-counseling service delivery. This can help improve the quality, accessibility, confidentiality, and effectiveness of digital counseling services, as well as support training in digital counseling skills and ethical practices.

Third, the study may help improve community access to mental health services, especially for individuals who face barriers to face-to-face counseling because of stigma, financial limitations, transportation problems, or time constraints. The findings may contribute to expanding affordable and flexible mental health support services for urban populations, youth, students, and other vulnerable groups.

Fourth, the study will contribute to academic knowledge on tele-counseling and digital mental health services in Ethiopia and other low- and middle-income countries. Since research on tele-

counseling in Ethiopia is limited, this study will help fill an important knowledge gap and serve as a reference for future researchers.

Finally, the study may increase awareness about the importance of mental health and the role of digital technologies in improving mental healthcare access. It may also encourage collaboration among healthcare institutions, universities, counseling centers, technology providers, and development organizations to strengthen sustainable tele-counseling services in Ethiopia.

### 1.5. Study Scope, Setting, and Instrument Alignment

**Geographical Setting:** The scope of this study is strictly delimited to **Addis Ababa, Ethiopia**. This urban setting was purposely selected due to its relatively higher internet penetration, smartphone accessibility, and the concentrated emergence of both private psychological centers and public helplines offering remote services.

**Instrument Alignment:** To accurately capture the nuanced difference between a participant's *lived experiences* and their *perceptions*, this study utilizes **semi-structured qualitative interviews**. Questionnaires and quantitative instruments were deemed invalid for this specific scope, as they force participants into predefined categories. Semi-structured interviews provide the necessary exploratory flexibility, allowing participants to narrate their firsthand practical experiences with technology while also elaborating on their personal beliefs regarding digital mental health care.

## 1.6. Operational Definition of Key Terms

To ensure conceptual clarity and tailor terminology to the specific context of this study, the following operational definitions are established:

- **Tele-counseling:** In the context of this study, this refers specifically to remote mental health support and psychological interventions provided to individuals in Addis Ababa through synchronous digital communication platforms, specifically regular voice calls, Zoom, Telegram, and WhatsApp.
- **Lived Experience:** Refers to the direct, firsthand, subjective, and practical encounters of individuals actively participating in tele-counseling. It focuses strictly on *what actually happened* during remote sessions (e.g., navigating the technology, experiencing a session interruption, or securing a private space).
- **Perception:** Refers to the cognitive interpretations, attitudes, and beliefs held by clients and counselors regarding the overall tele-counseling ecosystem. It focuses on *what participants think or feel* about the service's effectiveness, challenges, and future potential.
- **Perceived Barriers:** The specific technological (e.g., internet instability), socioeconomic (e.g., high mobile data costs), cultural (e.g., mental health stigma), and institutional challenges that participants *believe* hinder the effective delivery and utilization of tele-counseling in Addis Ababa.
- **Perceived Facilitators:** The conditions, tools, and strategies (e.g., service anonymity, flexible scheduling, and family support) that participants *believe* enable or enhance the success of remote psychological care.

- **Counselors:** Licensed psychologists, psychiatrists, and professional therapists who provide remote mental health services via digital platforms from private or public institutions located within Addis Ababa.
- **Clients:** Individuals residing in Addis Ababa who have directly utilized digital or telephone-based platforms to receive professional psychological support.

## 1.7. Organization of the Study

This thesis is organized into five interconnected chapters. Chapter One introduces the study by presenting the background, statement of the problem, research questions, objectives, significance, scope, and operational definitions of key terms. Chapter Two reviews relevant literature on tele-counseling, examining global and local perspectives, barriers and facilitators, research gaps, and the theoretical frameworks guiding the study. Chapter Three describes the research methodology, including the research design, study setting, target population, sampling procedures, data collection methods, data analysis process, trustworthiness measures, and ethical considerations. Chapter Four presents and discusses the findings, including participant demographics and the major themes related to barriers and facilitators of tele-counseling service delivery. Finally, Chapter Five summarizes the key findings, draws conclusions, provides recommendations for policymakers and practitioners, and suggests directions for future research.

# 2. CHAPTER TWO

## 2.1 Review of Literature

### 2.1.1 Conceptual Overview of Tele-Counseling

Tele-counseling is providing of counseling and psychological support services through digital communication technologies such as telephone calls, video conferencing, mobile applications, emails, messaging platforms, and online systems. It is an central part of tele-mental health services that aim to improve access, continuity, flexibility, and efficiency of mental heal thcare provision (WHO, 2024). Tele-counseling allows counselors and clients to communicate remotely without meeting face-to-face. The growth of internet access, smartphone use, and digital technologies has contributed to the increasing use of tele-counseling worldwide. The COVID-19 pandemic accelerated the adoption of tele-counseling because movement restrictions and social distancing disrupted traditional face-to-face counseling services.

Tele-counseling is an important method for maintaining continuity of mental healthcare while reducing physical contact (Appleton et al., 2021). Studies show that tele-counseling can help ma nage depression, anxiety, stress-related disorders, trauma, and other psychosocial problems, especially for people living in remote or underserved areas (King et al., 2023). Tele-counseling is also important for reducing barriers related to geographical distance, transportation costs, shortages of mental health professionals, disability, stigma, and time limitations. However, despit e its benefits, tele-counseling implementation still faces challenges such as poor internet access, limited technological infrastructure, financial constraints, ethical concerns, and sociocultural barriers (Nazemi et al., 2023).

### 2.1.2 Global Perspectives on Tele-Counseling Service Delivery

Mental health disorders are a major global public health concern affecting people of all ages and social backgrounds. According to the World Health Organization (WHO, 2024), depression and anxiety are among the leading causes of disability worldwide. The growing number of people experiencing mental health problems has increased the demand for innovative and accessible mental health services, including tele-counseling and other digital mental health interventions. In many high-income countries, tele-counseling has become an important part of healthcare systems because of improved digital technology, reliable internet access, and support ive government policies. Research conducted in countries such as the United States, Canada, Australia, and several European nations shows that tele-counseling improves access to treatment, increases client satisfaction, supports continuity of care, and enhances mental health outcomes (Ghazanfarpour et al., 2021). Online counseling has also been especially helpful for people with mobility limitations, social anxiety, or fear of stigma associated with visiting mental health centers in person.

However, global studies also highlight several challenges that affect the implementation of tele-counseling services. A systematic review by (Uscher-Pines et al., 2020) identified major barriers such as poor internet connectivity, limited access to technology, low digital literacy, co ncerns about confidentiality and cybersecurity, inadequate reimbursement systems, and insu fficient counselor training. Similarly, (Pierce et al., 2021) found that some clients and counselors still prefer face-to-face counseling because they believe in-person sessions provide stronger emotional connection, better therapeutic relationships, improved privacy, and more effective communication. The literature further shows that digital inequality remains a significant c

hallenge in accessing tele-counseling services. People from low-income households, older adults, and marginalized communities often have limited access to smartphones, computers, stable internet connections, and digital skills needed to use online counseling services effectively (WHO, 2024). As a result, although tele-counseling has strong potential to expand mental healthcare access, unequal access to technology continues to create disparities in the use of these services.

### 2.1.3 Tele-Counseling and Digital Mental Health in Africa

Mental health systems in many African countries remain underdeveloped despite the growing number of people experiencing mental health problems. According to the (WHO, 2024), there is a serious shortage of psychiatrists, psychologists, counselors, and mental health facilities across the continent. In many countries, less than 1% of the national health budget is allocated to mental health services, which limits the availability and quality of care. At the same time, the rapid expansion of mobile phones and internet access in Africa has created new facilitators for digital mental health services and tele-counseling. Mobile technology is becoming more accessible, even in low-income communities, making tele-counseling a potentially affordable and scalable way to provide psychological support. Studies conducted in countries such as South Africa, Kenya, Nigeria, and Ghana show that tele-counseling can reduce geographical barriers, lower transportation costs, and improve continuity of mental healthcare services (Nakimuli-Mpungu et al., 2025).Despite these facilitators, tele-counseling implementation in Africa still faces many challenges.

(Waluyanti et al., 2022) identified poor internet connectivity, unreliable electricity supply, low digital literacy, weak policy frameworks, and a shortage of trained professionals as major b

arriers to telemedicine and tele-counseling adoption in many African low- and middle-income countries (LMICs). In addition, social stigma related to mental illness continues to discourage many people from seeking professional mental health support, including online co unseling services. Another major concern is trust and confidentiality in digital counseling platforms. Many users worry about privacy, data protection, and the security of personal information shared during online counseling sessions. In some African countries, limited regulations and weak cybersecurity systems increase fears about unauthorized access to confide ntial mental health information (Equatora et al., 2021). However, the literature also highlights several factors supporting the growth of tele-counseling services in Africa. Increasing smartphon e ownership, expanding mobile internet coverage, growing awareness about mental health, and greater youth engagement with digital technologies have encouraged the use of tele-mental h ealth services in several countries (Waluyanti et al., 2022). In addition, governments and international organizations are increasingly investing in digital health programs to improve healthcare accessibility and strengthen health systems across Africa.

### 2..1.4 Tele-Counseling in Sub-Saharan Africa

Sub-Saharan Africa faces serious mental health challenges linked to poverty, unemployment, conflict, substance abuse, rapid urbanization, and public health emergencies. Although the need for mental health services is increasing, access to professional counseling and psychiatric care remains very limited across many countries in the region. According to the (WHO, 2024), mental health treatment gaps in several Sub-Saharan African countries exceed 75%, meaning that many people who need psychological support do not receive professional care.

Tele-counseling is increasingly viewed as an important approach to improving access to mental h ealthcare in the region. Studies conducted in low- and middle-income countries (LMICs) show

that tele-counseling can reduce geographical barriers, provide more flexible services, and improve continuity of care, especially for young people and urban populations (Herbert, 2022). It may also help reduce stigma related to mental health treatment because individuals can receive counseling privately from their homes. Despite these benefits, several challenges continue to affect tele-counseling service delivery in Sub-Saharan Africa. Research has identified b arriers such as weak healthcare infrastructure, unreliable internet connectivity, low digital literacy, affordability problems, limited institutional preparedness, and poor integration of mental health services into national healthcare systems (Okal et at., 2022). In addition, language differences and cultural beliefs about mental illness can influence communication and reduce acceptance of tele-counseling services. The literature also shows that research specifically foc used on tele-counseling in Sub-Saharan Africa is still limited. Most existing studies focus more broadly on telemedicine, eHealth, or mobile health services rather than digital counseling services. This indicates an important research gap regarding the factors that influence the implementation and use of tele-counseling services within African contexts.

### 2.1.5 Mental Health and Tele-Counseling in Ethiopia

Mental health disorders are becoming major public health concerns in Ethiopia (Sendek et al., 2025). Conditions such as depression, anxiety, trauma-related disorders, substance abuse, and psychosocial stress are increasing due to factors such as rapid urbanization, economic instability, unemployment, academic pressure, migration, and social change (Alemu et al., 2021). Despite the growing demand for mental health services, Ethiopia still faces serious shortages of trained mental health professionals, counseling centers, psychiatric facilities, and other mental health resources (Yasmin, 2025). Most mental health services in Ethiopia are concentrated in urban

areas, especially in Addis Ababa, which makes access difficult for many people living in other parts of the country (Gemeda et al., 2026). In addition, mental illness is often linked to stigma, spiritual beliefs, and cultural misunderstandings, which discourage individuals from seeking professional counseling services (Atewologun et al., 2025).

Public awareness about counseling and mental health support also remains limited (Molebatsi et al., 2021). In recent years, the Ethiopian healthcare system has shown growing interest in digital health and telemedicine initiatives (Mekurianew et al., 2024). The Ethiopian Ministry of Health has introduced digital health strategies to improve healthcare accessibility and strengthen health information systems (Abera, 2025). However, most of these initiatives mainly focus on tel emedicine, electronic medical records, and general digital healthcare systems rather than tele-co unseling services specifically. Studies conducted in Ethiopia have mostly examined telemedicine readiness, eHealth systems, and challenges related to digital healthcare implementation. (Woldemichael et al., 2026) reported that poor infrastructure, weak internet connectivity, limited technical support, inadequate training, and organizational challenges negatively affect the sustainability of eHealth systems in low- and middle-income countries, including Ethiopia. However, there is still limited empirical research specifically focused on tele-counseling service delivery and utilization in the Ethiopian context. In Addis Ababa, increasing internet access, growing smartphone ownership, and greater use of digital technologies have created opportunities for tele-counseling services. Some private counseling centers and mental health professionals have started offering online counseling through telephone calls, Zoom, Tele gram, WhatsApp, and other digital platforms (Daka et al., 2025). Nevertheless, tele-counseling services in Addis Ababa continue to face challenges such as limited institutional support,

affordability problems, low public awareness, limited digital literacy, and concerns about privacy and confidentiality.

## 2.2 Barriers Affecting Tele-Counseling Service Delivery

### 2.2.1 Technological and Infrastructure Barriers

Technological and infrastructure challenges are among the major barriers to effective tele-counseling service delivery, particularly in low- and middle-income countries (LMICs). Poor internet connectivity, unstable electricity supply, limited access to smartphones or computers, i nadequate digital platforms, and weak technological infrastructure can reduce the quality and continuity of counseling services (Adem et al., 2025). In Ethiopia, frequent internet disruptions and high mobile data costs may interrupt counseling sessions and limit access to tele-counseling services.

### 2.2.2 Socioeconomic Barriers

Socioeconomic inequalities also affect access to tele-counseling services. Effective participation in tele-counseling often requires smartphones, internet access, electricity, and basic digital l iteracy. Individuals from low-income households may face difficulties affording internet services and digital devices, which limits their ability to use tele-counseling platforms (WHO, 2024). Limited education and low digital skills may further reduce utilization of online mental health services.

### 2.2.3 Cultural and Stigma-Related Barriers

Cultural beliefs and mental health stigma remain important barriers to counseling service u tilization in many African countries, including Ethiopia (Woldemichael et al., 2026). In some

communities, mental illness may be associated with spiritual weakness, curses, or supernatural causes, discouraging individuals from seeking professional mental health support. Fear of discrimination, social judgment, and lack of awareness about mental health services may also reduce willingness to use tele-counseling platforms (Ayambire, 2026).

### 2.2.4 Institutional and Policy Barriers

Institutional and policy-related challenges also affect the implementation of tele-counseling services. These include limited institutional support, lack of standardized tele-counseling guidelines, inadequate training for counselors, and weak regulatory frameworks (Saltar et al., 2025). In addition, concerns related to confidentiality, privacy, informed consent, and data sec urity may complicate the delivery of online counseling services and reduce trust among users (Sanieemanesh and Bahonar, 2025).

## 2.3 Facilitators of Tele-Counseling Service Delivery

Several factors support the successful implementation and use of tele-counseling services (Ignacio, 2023). Increasing smartphone ownership, improved internet access, growing digital eng agement in urban areas, and rising awareness about mental health contribute positively to the adoption of tele-counseling services. Government investment in digital health infrastructure and supportive policies can also strengthen tele-mental health service delivery (Ukoaka et al., 2024). Research shows that tele-counseling provides flexibility, convenience, reduced transportation costs, and greater privacy for service users (Herbert., 2022). Online counseling may also reduce the stigma associated with visiting mental health facilities in person. In addition, tele-counseling enables counselors to reach individuals living in remote areas and clients with mobility challenges (Tomasone et al., 2017). Training and capacity building for mental health

professionals further improve the quality and effectiveness of tele-counseling services. Studies indicate that counselors with strong technological skills and digital communication competence adapt more effectively to online counseling environments (Tangco-Siason, 2022).

## 2.4 Empirical Literature and Research Gap

Previous empirical studies on telemedicine and digital healthcare in low- and middle-income countries (LMICs) have mainly focused on technological readiness, eHealth implementation, ele ctronic health systems, and telemedicine adoption. Although some studies discuss digital mental health services in general, limited research has specifically examined tele-counseling service delivery in Ethiopia, particularly in Addis Ababa. Existing studies provide valuable information on barriers affecting digital mental health services, including poor technological infrastructure, digital inequality, mental health stigma, confidentiality concerns, and limited policy support. However, there is still limited evidence on how technological, institutional, socioeconomic, cultural, and behavioral factors interact to influence the implementation and utilization of tele-counseling services in the Ethiopian urban context. In addition, few studies have explored the experiences, perceptions, and readiness of counselors, mental health professionals, and service us ers regarding tele-counseling services in Addis Ababa.

Previous research has also given limited attention to the facilitators that support tele-counseling adoption and the context-specific factors influencing the sustainability and effectiveness of tele-counseling services in Ethiopia. Therefore, this study aims to address these gaps by comprehensively assessing the barriers and facilitators affecting tele-counseling service delivery in Addis Ababa, Ethiopia. The study is expected to generate context-specific evidence

that can help policymakers, healthcare institutions, counselors, and digital health stakeholders improve the accessibility, quality, and sustainability of tele-counseling services.

## 2.5 Theoretical Framework

In line with the principles of descriptive phenomenology, this study does not apply a strict theoretical model to guide data collection or to categorize participants' experiences in advance. Instead, the Technology Acceptance Model (TAM) developed by (Davis, 1989) and the Unified Theory of Acceptance and Use of Technology (UTAUT) proposed by (Venkatesh et al., 2003) are used only as general conceptual reference points for understanding tele-counseling service de livery. Both TAM and UTAUT were originally developed within quantitative research traditions to explain and predict technology adoption using measurable variables. However, in this study, they are not used for measurement or hypothesis testing. Rather, they are adapted within a descriptive phenomenological approach to help explore the lived experiences, perceptions, barriers, and facilitators of tele-counseling services among clients and counselors in Addis Ababa. From the perspective of the Technology Acceptance Model (TAM), two key concepts are considered in an experiential way: perceived usefulness and perceived ease of use (Davis, 1989). Perceived usefulness refers to participants' lived experiences of how tele-counseling services support their emotional, psychological, and therapeutic needs.

This includes how they experience counseling effectiveness, emotional connection, trust in the counselor, convenience, and accessibility during online or phone-based sessions. Perceived ease of use refers to how participants experience the process of engaging with digital counseling platf orms, including whether the technology feels simple, manageable, confusing, stressful, or difficult during real counseling interactions. Rather than examining statistical relationships, this phenomenological approach focuses on how everyday conditions shape these experiences. For

example, challenges such as unstable internet connections, high data costs, power interruptions, and lack of private space at home are explored in terms of how they influence participants' feelings about the usefulness and ease of tele-counseling in their daily lives. To further under stand the broader social and institutional context, the study also draws on selected concepts from the Unified Theory of Acceptance and Use of Technology (UTAUT), particularly social influence and facilitating conditions (Venkatesh et al., 2003).

Social influence refers to how cultural beliefs, mental health stigma, community expectations, and professional attitudes in Addis Ababa shape individuals' willingness to use and experience tele-counseling services. For instance, concerns about being judged, cultural misunderstandings of mental health, or doubts about the legitimacy of online counseling may affect both clients and counselors. Facilitating conditions refer to the organizational, technical, and institutional supports or limitations that influence tele-counseling services. These include access to reliable internet, digital literacy, availability of technical support, institutional readiness, privacy protection, counseling guidelines, and digital infrastructure. These factors may either enable effective service delivery or create additional challenges for users and providers. TAM and UTAUT are not used as rigid theoretical frameworks in this study. In line with Colaizzi's descriptive phenomenological method and the principle of bracketing (Epoché), they are applied only as contextual lenses rather than tools for coding or interpreting data in a predetermined way (Morrow et al., 2015). Instead, they provide a broad conceptual background for understanding how technological, cultural, socioeconomic, and institutional factors shape the lived experiences of tele-counseling services in Addis Ababa, Ethiopia.

# 3. CHAPTER THREE

## 3.1 Method

### 3.1.1 Research Design

This study employed a descriptive phenomenological qualitative research design to understand the genuine experiences of those who directly participate in tele-counseling services. Following principles established by foundational scholars and supported by (Neubauer et al., 2019), qualitative research methods cannot function as standalone approaches. Therefore, descriptive phenomenology was specifically chosen as the working framework (Almusaed et al., 2025). The selection of this descriptive phenomenological approach is methodologically sound given the study's primary goals, which aim to describe the psychological and practical "essence" of tele-counseling without altering variables or establishing broad statistical patterns.

(Berger, 2022) notes that descriptive phenomenology demands researchers describe human experiences exactly as people live them, without prematurely imposing external psychological theories or statistical simplifications. This design allows the researcher to examine closely how clients experience remote support and how counselors handle digital therapeutic relationships within Addis Ababa's urban context. To ensure the complete empirical rigor this design demands, the researcher follows the fundamental principle of Bracketing (Epoché). (Elsherif, 2024) explained that bracketing requires researchers to actively recognize, record, and "suspend" their

existing assumptions, clinical prejudices, and professional expectations about digital mental health services. During both data collection and analysis phases, the researcher keeps a reflexive journal to separate personal beliefs, guaranteeing that the final structural descriptions come purely from participants' actual narrative experiences rather than the researcher's personal biases.

### 3.1.2. Population and Sampling

#### 3.1.2.1 Target Population

The target population for this study is divided into two distinct groups who possess direct, firsthand experience with the phenomenon under investigation. The first group comprises tele-c ounselors and mental health professionals, specifically practicing clinical psychologists, counse ling psychologists, psychiatrists, or psychiatric nurses currently operating within Addis Ababa who utilize information and communication technologies such as telephone lines, Zoom and Telegram platforms to deliver therapeutic interventions. The second group consists of tele-counseling service users, or clients, defined as individuals aged 18 years or older residing in Addis Ababa who have completed or are actively participating in at least three remote counseling or psychosocial support sessions via telephonic or digital platforms.

#### 3.1.2.3. Sampling Technique and Practical Implementation

To select study participants, this study utilized purposive sampling combined with a secondary snowball sampling approach. Descriptive phenomenology study requires information-rich participants who have intensely lived the phenomenon under investigation (Palmer, 2023). To ensure the sample yields high-quality, relevant data, explicit inclusion criteria are strictly enforced for both session. For counselors, the criteria require a minimum of three years of

continuous experience providing tele-counseling services, active clinical or academic practice within Addis Ababa, and formal registration with an active counseling facility, university bureau, or professional association (those are counselors from Aha psychological services , ministy of health and Ubuntu psychological services) . For clients, the inclusion criteria mandate that indiv iduals are at least 18 years of age, have participated in a minimum of three digital or telephonic counseling sessions hosted by an Addis Ababa-based practitioner or platform, and possess the ability to articulate their experiences clearly in either Amharic or English.

The practical implementation of this sampling strategy begins with securing institutional access. The researcher was physically visit counselors from Aha psychological services , ministry of health and Ubuntu psychological services. Upon presenting an official institutional support letter from the university, administrative coordinators at these sites were formally requested to identify eligible practitioners on their rosters. Direct client access pathways require alternative, mediated strategies due to strict patient confidentiality mandates. The researcher was not directly access c lient name lists; instead, the administrative gatekeepers of the cooperating clinics were serve as neutral intermediaries. These coordinators were provided with physical and digital Participant Recruitment Packs containing a detailed study information flyer and the researcher's direct contact details. The administrative staff will pass these packs directly to clients who meet the study's inclusion criteria, allowing interested clients to contact the researcher directly. To supplement this recruitment process, a snowball chain-referral mechanism was deployed. Clients and counselors who complete the interview process were asked to share the study recruitment with peers, friends, or colleagues who fit the identical inclusion criteria, thereby establishing an ethical, participant-driven referral loop (Ofori-Asenso, 2025).

### 3.1.2.4. Sample Size and Determination

In qualitative descriptive phenomenological research, the final sample size is not determined by a fixed statistical formula. Instead, it depends on the achievement of data saturation. Data saturati on occurs when additional interviews no longer produce new ideas, meanings, themes, or categories, and the information collected becomes repetitive (Ahmed, 2025); (Polat, 2025). Phenomenological studies commonly recommend 6 to 8 participants within each participant grou p to achieve an in-depth understanding of lived experiences (Ndame, 2023); (Dukes, 1984). Accordingly, this study proposes an initial sample size of 12 to 14 participants, consisting of 6 - 7 counselors and 6 - 7 clients. However, the final sample size remained flexible and was det ermined during the data collection process. Participant recruitment and interviews continued un til thematic analysis confirms that complete narrative saturation has been achieved.

## 3.2. Data Collection Instruments

To obtain rich and detailed information, this study used primary qualitative data collection instruments developed by the researcher based on established methodological literature and aligned with the study objectives. The first instrument is a semi-structured in-depth interview guide prepared for counselors. It contain open-ended and non-leading questions designed to explore counselors' experiences in providing tele-counseling services, as well as the barriers and facilitating factors they encounter from the service provider perspective. The second instrument is a semi-structured in-depth interview guide designed for clients. This guide focuses

on clients' experiences in accessing and using tele-counseling services, together with their perceptions of the barriers and facilitating factors related to these services. Open-ended questions were used to for clients to explain their experiences of receiving counseling at home, challenges related to privacy in crowded or multi-generational households, the affordability of internet or phone data costs, and cultural attitudes toward discussing personal or traumatic issues through digital platforms.

### 3.3. Data Collection Procedure

The data collection process for this study was conducted in three main phases: obtaining institutional permission, recruiting participants, and conducting interviews. In the first phase, the researcher obtained an official support letter from the College of education and language studies y at Addis Ababa University. Using this letter, the researcher visited counselors from Aha psychological services , ministy of health and Ubuntu psychological services to explain the pur pose of the study, confirm that tele-counseling services are provided, and obtain permission to re cruit participants. The second phase involves participant recruitment and informed consent. Interested counselors and clients contacted the researcher after receiving recruitment information through professional associations or cooperating clinics. The researcher will then arrange an introductory phone call to explain the study, confirm eligibility based on the inclusion criteria, and answer any questions. After agreement is reached, an interview appointment was scheduled at a time and location preferred by the participant. The third phase involves conducting the i nterviews. Interviews took place in quiet and private settings to ensure confidentiality and good audio quality. Participants who prefer remote participation may join through phone call or online platforms such as Zoom or Google Meet. Each interview session followed three main steps.

First, the researcher  explained the consent form, including information about audio recording, confidentiality, anonymity, and the participant's right to withdraw at any time. Written or digital consent was obtained. second, the researcher conducted the semi-structured interview using open-ended questions and non-leading probes to encourage detailed responses. Each interview is expected to last approximately 45 to 60 minutes. Finally, the session ended with a short de briefing, where participants had an opportunity to share additional comments or reflections.

### 3.4. Data Analysis

Since this study follows a descriptive phenomenological approach, the qualitative data was analyzed manually using Colaizzi's Seven-Step Phenomenological Method which is widely used to identify and describe the essence of participants' lived experiences which is inductive analysis (Morrow et al., 2015); (Wirihana et al., 2018). The analysis process began with data familiarization. First, the researcher transcribed all interview recordings verbatim and translate the Amharic transcripts into English. The transcripts were read several times to help the researcher gain a deep understanding of the participants' experiences. In the second step, the re searcher identified significant statements by reviewing each transcript line by line.

Statements and quotations related to experiences, barriers, and facilitators of tele-counseling services were extracted for further analysis. The third step involves formulating meanings from the significant statements. The researcher interpreted the underlying meaning of participants' responses while maintaining a bracketing process to minimize personal bias and avoid imposing personal assumptions on the data. In the fourth step, similar meanings were grouped into categ ories and organized into theme clusters and broader themes. The researcher continuously c ompared the themes with the original transcripts to ensure that the findings accurately reflect the

participants' experiences. The fifth step involves developing an exhaustive description of the phenomenon by integrating all themes and categories into a detailed narrative explaining the ex periences of tele-counseling service delivery in Addis Ababa. In the sixth step, the researcher developed the fundamental structure of the phenomenon. This involved summarizing the ex haustive description into a concise statement that captures the core essence of participants' lived experiences regarding tele-counseling services.

## 3.5 Validity and Reliability

Before the main data collection begins, a pilot study was conducted with two counselors and two tele-counseling clients who meet the study criteria but were not be included in the final analysis. The pilot study helped assess the clarity, flow, and cultural appropriateness of the Amharic interview questions, evaluate the effectiveness of audio-recording and online communication tools, estimate interview duration, and improve the researcher's interviewing skills. Based on feedback from the pilot interviews, unclear, repetitive, or leading questions were revised before the actual data collection starts.

## 3.6. Ethical Considerations

This study followed strict ethical standards in line with the World Medical Association Declaration of Helsinki (Wen et al., 2025), due to its focus on mental health services and s ensitive personal experiences. Institutional permission obtained from the Addis Ababa University College of education and language studies before any data collection begins. Participation was fully voluntary. Each participant were given a clear informed consent form explaining the purpose of the study, data protection procedures, and their rights. Participants

were not forced, misled, or unfairly encouraged to take part. They had the right to refuse to answer any question or withdraw from the study at any time without any negative consequences. Confidentiality and anonymity strictly maintained. No real names or identifying information is used in any transcripts or reports. Instead, participants were assigned codes. All data was securely protected. Printed materials and consent forms were stored in locked cabinets accessible only to the researcher. Digital audio recordings and transcripts were stored on password-protecte d and encrypted devices. After the study is completed and the thesis is defended, all audio files and raw data will be permanently deleted. Care was taken to minimize any emotional distress d uring interviews. Because discussions may involve sensitive psychological experiences, pa rticipants were monitored for signs of discomfort.

# 4. CHAPTER FOUR

## 4.1 DATA PRESENTATION, ANALYSIS, AND DISCUSSION

### 4.1.1 Presentation and Analysis of the Data

The qualitative data generated from twenty in-depth, semi-structured interviews (n=10 clients; n=10 counselors) were systematically analyzed. To isolate the core psychological essence of tele-counseling service delivery in Addis Ababa, the data was processed manually using Colaizzi's seven-step descriptive phenomenological method.

**Step-by-Step Theme Generation Process:**

1. **Familiarization:** All twenty audio recordings were transcribed verbatim and read multiple times to acquire a deep, holistic understanding of the participants' experiences.
2. **Extracting Significant Statements:** The transcripts were coded line-by-line. Statements directly related to the research questions (mentions of internet costs, fear of clinics, or home environments) were extracted.
3. **Formulating Meanings:** The extracted statements were translated into generalized clinical and structural meanings without losing the original context ("sitting in a parked car" was formulated as "spatial privacy deficits").
4. **Clustering into Themes:** The formulated meanings were grouped into overarching, coherent clusters based on shared characteristics (grouping internet drops, data costs, and power outages under "Infrastructure").
5. **Developing Exhaustive Descriptions:** A comprehensive narrative was written for each cluster, detailing the exact barriers and facilitators experienced by both groups.

6. **Producing the Fundamental Structure:** The exhaustive descriptions were condensed into four definitive, single-word thematic headers representing the core phenomena: *Stigma*, *Infrastructure*, *Privacy*, and *Facilitators*.

**Member Checking:** Preliminary findings were cross-referenced with a subset of participants to validate that the themes accurately reflected their lived experiences.

### 4.1.2. Demographic and Institutional Profiles of Participants

Table 1 Demographic Profile of Tele-Counseling Clients (n=10)

| Respondents | Gender | Age | Occupational / Socioeconomic Status |
|---|---|---|---|
| Client 1 | Female | 24 | Undergraduate University Student |
| Client 2 | Male | 32 | Private Bank Accountant |
| Client 3 | Female | 28 | Stay-at-Home Mother |
| Client 4 | Male | 45 | High School Teacher |
| Client 5 | Male | 21 | Construction / Manual Laborer |
| Client 6 | Female | 26 | Freelance Graphic Designer |
| Client 7 | Male | 54 | Retail Market Merchant (Merkato) |
| Client 8 | Female | 35 | Public Hospital Nurse |
| Client 9 | Male | 29 | Ride-Hailing Transit Driver |
| Client 10 | Female | 23 | Undergraduate University Student |

Table 2 Demographic Profile of Mental Health Counselors (n=10)

| Respondents | Gender | Age | Professional Role |
|---|---|---|---|
| Participant 01 | Female | 38 | Senior Counseling Psychologist |
| Participant 02 | Male | 45 | Senior Counseling Psychologist |
| Participant 03 | Male | 34 | Clinical Counselor |
| Participant 04 | Male | 29 | Counselor |
| Participant 05 | Male | 36 | Addiction Specialist / Counselor |
| Participant 06 | Female | 32 | Child and Adolescent Counselor |
| Participant 07 | Male | 37 | Senior Trauma Counselor |
| Participant 08 | Female | 40 | Psychologist |
| Participant 09 | Female | 28 | Crisis Hotline Counselor |
| Participant 10 | Male | 42 | Psychiatric Nurse / Counselor |

### 4.2. Theme 1: Stigma

The data explicitly identified socio-cultural stigma as the primary barrier preventing clients from accessing traditional face-to-face mental health care. Because mental health struggles in Addis Ababa are frequently attributed to spiritual weakness or result in public shaming, clients actively avoided physical psychiatric clinics. Consequently, tele-counseling functioned as a critical "digital shield," granting clients absolute anonymity and protecting them from community exposure, peer gossip, and professional labeling.

#### 4.2.1 The Client Perspective: Preserving Identity and Avoiding Judgment

Clients explicitly stated that seeking in-person psychological support risked their social standing. Male clients, in particular, emphasized that traditional masculine expectations of emotional

strength made them fear being labeled as weak. Client 2, a private bank accountant, explained: *"Going to a physical clinic carries a heavy social stigma; remote therapy allowed me to seek help without anyone knowing."* Similarly, Client 7, a 54-year-old merchant in Merkato, stated: *"It allowed me to preserve my social status as a strong businessman while secretly getting support."*

For female participants and students, the digital shield protected against family interference and campus gossip. Client 3, a mother experiencing postpartum depression, noted: *"In our community, postpartum struggles are dismissed as 'yeras mitch' or spiritual weakness; I turned to phone counseling to find validation without family interference."* Client 10, an undergraduate, added: *"The privacy from campus gossip allowed me to receive care without risking my academic reputation."*

### 4.2.2 The Counselor Perspective: Lowering Barriers to Entry

Counselors corroborated that remote therapy successfully dismantles the entry barriers for highly stigmatized populations. Participant 01 highlighted how tele-counseling pivoted from a COVID-19 emergency measure into a permanent necessity: *"Even after the pandemic ended, we realized we had to keep this format because it provides an essential shield for clients who are terrified of being seen walking into a psychiatric clinic."* Participant 09, a Crisis Hotline Counselor, emphasized the critical nature of this anonymity at the public level: *"Our 952 hotline receives calls from individuals who would never visit a public hospital psychiatric ward because the fear of public shame is simply too high."*

## 4.3. Theme 2: Infrastructure

The findings identified severe technological deficits as the primary barrier actively disrupting the clinical efficacy of tele-counseling. The exact barriers explicitly cited by both groups included

frequent electrical power outages (*yemebrat mftat*), unstable mobile network connections (dropped calls), and the prohibitive financial cost of internet data packages.

### 4.3.1 The Client Perspective: Frustration, Costs, and Disconnected Sessions

Clients reported that technical failures frequently severed the therapeutic alliance during highly vulnerable emotional moments. Client 6 explicitly detailed this disruption: *"My electricity cut out ten minutes before a session; switching to my phone's hotspot turned a therapeutic hour into a stressful technical troubleshooting exercise."* Furthermore, dropped network signals caused psychological distress. Client 2 noted: *"Ethio Telecom networks would randomly drop, and those brief moments of sudden silence felt like falling off an emotional cliff."*

Economically, the cost of sustained video or audio data packages acted as a direct barrier to consistent care. Client 10 stated: *"Buying internet data packages for weekly video calls was an economic strain that often forced me to miss meals just to afford therapy airtime."*

### 4.3.2 The Counselor Perspective: Managing Technical Breaks and Safety Challenges

Counselors highlighted that infrastructural disruptions generate acute safety risks, particularly regarding crisis management. Participant 02 explained: *"When a call drops right as a client is crying or processing severe trauma, it disrupts the therapeutic workflow. You are left in suspense, wondering if the disconnect was due to a tower failure or if the client hung up because of an emotional crisis."*

Furthermore, managing severe psychological emergencies remotely is severely hindered by infrastructural gaps. Participant 10 stated: *"When a crisis happens, families often switch off their phones entirely... Our public emergency services are stretched thin, and we lack a coordinated system to dispatch a mental health crisis team based on a phone call."* To mitigate these barriers,

counselors (Participant 03) explicitly adopted low-bandwidth standard voice calls over video platforms to prevent disconnections and save clients money.

### 4.4. Theme 3: Privacy

A major physical barrier identified in the data was the absence of safe, confidential spaces within the densely populated, multi-generational households typical of Addis Ababa. Thin walls and shared rooms actively suppressed clients' ability to communicate freely, forcing them to seek makeshift physical spaces to safely engage in remote therapy.

#### 4.4.1 The Client Perspective: Shared Housing and Creative Workarounds

Clients explicitly reported censoring their clinical disclosures due to spatial limitations. Client 4 explained: *"My house is small and the walls are thin. I constantly worried that my children would overhear me, which caused me to self-censor certain parts of my life."*

To bypass this barrier, clients engaged in extreme spatial workarounds. Client 2 utilized his vehicle: *"I sat in my parked car on a quiet side street. I rolled up the windows for complete privacy."* Client 5, a manual laborer in shared housing, resorted to harsh outdoor environments: *"I walked far away into an open, unfinished building site late at night just to have a quiet place to make the call, standing in the cold wind."* Client 10 had to leave her dormitory to hide *"behind the library near some quiet trees."*

#### 4.4.2 The Counselor Perspective: Verifying Safety and Managing Distractions

Counselors reported that environmental noise (cooking, family arguments, crying babies) regularly contaminated the clinical space. Participant 04 noted: *"I regularly hear family conversations... This requires me to explicitly ask the client if they are truly alone and feel safe to speak freely."* When clients were forced to call from parked cars or public spaces, counselors had

to pivot their therapeutic methods entirely. Participant 07 explained: *"When a client is calling from a parked car... If the environment becomes too distracted, we shift our focus to supportive listening rather than deep trauma processing."*

### 4.5. Theme 4: Facilitators

Despite the structural and spatial barriers, the data explicitly identified functional facilitators that enhanced tele-counseling. These included extreme scheduling flexibility, the circumvention of urban transit barriers, the protective nature of audio-only anonymity, and the clinical utilization of culturally appropriate communication and family collectivism.

#### 4.5.1 The Client Perspective: Beating Traffic and Embracing Anonymity

Clients cited the avoidance of Addis Ababa's severe traffic congestion as a massive facilitator. Client 1 explicitly stated: *"Compared to traveling across the heavy traffic of Addis Ababa, remote counseling saved me an immense amount of time and emotional energy."*

Furthermore, extreme scheduling flexibility allowed gig-economy workers to access care. Client 9, a ride-hailing driver, noted: *"My car became my private clinic room. I could log off the app after midnight and speak directly with my counselor without losing a day of work."* The audio-only format itself facilitated deeper emotional disclosure. Client 7 noted: *"As an older, traditional man, it was much simpler to admit to crying over the phone than looking directly at a therapist in an office."*

#### 4.5.2 The Counselor Perspective: Reaching Demographics and Leveraging Culture

Counselors explicitly identified the Ethiopian collectivist culture as a powerful clinical facilitator. Rather than viewing family solely as a privacy barrier, counselors utilized trusted

family members to ensure treatment adherence. Participant 10 explained: *"The major facilitator is the strength of family collectivism in Ethiopia... Once I build trust with a mother or a sibling over the phone, they become excellent partners on the ground, helping ensure medication adherence."*

Counselors also actively facilitated better therapeutic alliances by adapting their digital communication. Participant 03 identified linguistic simplicity as a facilitator: *"I make a conscious effort to speak in plain Amharic, avoiding complex academic terms, which helps clients feel respected and comfortable."* Participant 06 noted that in the absence of video, leveraging *"vocal tone, pacing, and culturally respectful expressions"* became the primary tool to build trust over the phone.

### 4.6. Discussion

The qualitative findings of this study provide a nuanced understanding of how tele-counseling functions in a rapidly growing urban setting like Addis Ababa, Ethiopia. The adoption of digital mental health services is not merely a technical transition; rather, its effectiveness is deeply shaped by local cultural values, social expectations, and infrastructural realities. To contextualize these findings, this discussion is structured directly around the core research questions guiding the study, comparing the lived experiences, barriers, and facilitators identified by participants against existing literature and foundational frameworks.

#### 4.6.1 Lived Experiences of Clients and Counselors (Answering RQ1 & RQ2)

The lived experiences of participants highlighted a major gap between Western-designed digital mental health models and the physical realities of urban African communities. Berger (2021) and Simpson et al. (2021) premise the success of online therapy on the assumption that clients have

access to quiet, private spaces. However, this study revealed that in Addis Ababa, crowded multi-generational households severely compromise confidentiality, forcing clients into extreme spatial workarounds, such as attending sessions from parked cars or isolated outdoor construction sites. This aligns with James et al. (2023) and Barker et al. (2022), who observed that in low-resource settings, the heavy burden of securing therapeutic confidentiality falls entirely on the client. Furthermore, these shared living environments create chronic environmental distractions, supporting Garett et al.'s (2021) assertion that spatial limitations induce additional stress and diminish clinical concentration.

From the counselor's perspective, navigating this remote environment required significant clinical adaptation. The findings agree with Feijt et al. (2020), who stated that mental health professionals must actively adjust their communication styles when working remotely. To compensate for the lack of physical interaction, counselors in this study relied heavily on careful vocal pacing, culturally respectful expressions, and the use of plain Amharic. This reflects the arguments of Inchausti et al. (2020), who highlighted that the absence of non-verbal physical cues requires counselors to implement explicit verbal reassurance to maintain the therapeutic alliance.

### 4.6.2 Perceived Barriers to Tele-Counseling (Answering RQ3)

When analyzing the barriers to tele-counseling, infrastructural deficits and economic constraints emerged as the most disruptive factors. Unstable internet connections, frequent power interruptions, and the high cost of mobile data routinely fractured therapeutic sessions. This directly aligns with Asemahagn (2021) and Shiferaw et al. (2021), who emphasized that technology adoption in urban Ethiopian settings is continuously hindered by physical infrastructural realities.

Financially, low-income workers and students in this study reported being forced to choose between purchasing internet data from Ethio Telecom or meeting basic survival needs. This supports Chitungo et al. (2021), who warned that the digital divide in sub-Saharan Africa actively perpetuates unequal healthcare access. Theoretically, these barriers strongly validate the Unified Theory of Acceptance and Use of Technology (UTAUT) model discussed by Katusiime and Pinkwart (2019). The UTAUT model posits that "facilitating conditions" such as affordable internet and reliable electrical infrastructure are absolute prerequisites for continued technology use. Additionally, the acute clinical risks created by dropped calls during emotional crises validate the concerns of Uscher-Pines et al. (2020) and Wen et al. (2025), who argue that resilient infrastructure and backup communication plans are non-negotiable requirements for remote psychiatric safety.

### 4.6.3 Perceived Facilitators of Tele-Counseling (Answering RQ4)

Despite the severe barriers, the study identified powerful facilitators that enable tele-counseling, most notably its function as a "digital shield" against socio-cultural stigma. Abera et al. (2018) noted that Ethiopian society frequently interprets mental illness as a spiritual curse or moral weakness rather than a medical condition, leading to intense public shaming. The participants in this study utilized the anonymity of remote counseling to bypass this exact judgment, supporting the findings of Bifftu and Mohee (2019), who found that stigma is the primary deterrent to seeking direct psychiatric treatment in Addis Ababa. By removing the need to physically walk into a clinic, tele-counseling successfully circumvented this cultural roadblock.

This finding critically expands the Technology Acceptance Model (TAM) proposed by Venkatesh et al. (2003). While traditional TAM emphasizes "usefulness" strictly in terms of workplace efficiency and productivity, this study supports the adaptation by Kaba et al. (2020):

in collectivist societies, the "usefulness" of a technology is heavily defined by its capacity to protect personal privacy and mitigate social risk. This echoes Kamal et al. (2020), who argued that telemedicine's primary value often lies in navigating cultural taboos.

Finally, institutional facilitators, such as the Ministry of Health's toll-free 952 helpline, proved vital in overcoming the financial barriers identified earlier. By removing the cost of mobile airtime, government-supported helplines provided an essential lifeline, directly supporting the "public equity model" proposed by Asangansi et al. (2022), which argues that free digital health services are the only way to ensure vulnerable populations are not priced out of psychological care.

# 5. CHAPTER FIVE

## 5.1 SUMMARY, CONCLUSION, AND RECOMMENDATIONS

### 5.1.1 Summary of Findings

This study employed a descriptive phenomenological research approach and Colaizzi's analytical method to explore the lived experiences, barriers, and enabling factors associated with tele-counseling service delivery among ten clients and ten professional counselors in Addis Ababa. The findings revealed that tele-counseling has become an important mental health support o ption, particularly in a social environment where stigma surrounding mental illness remains widespread. Many participants explained that traditional beliefs and negative social attitudes toward mental health problems discourage individuals from seeking face-to-face counseling serv ices. In this context, tele-counseling provides a private and anonymous environment that enables clients to access professional help while protecting their social image, family reputation, and professional status.

The study also identified significant infrastructural barriers affecting the effectiveness of tele-counseling services. Frequent electrical power interruptions (yemebrat mftat), unstable mobile network connections during peak hours, and weak signal quality during heavy rainfall regularly disrupted counseling sessions. These interruptions created stress for both clients and counselors and negatively affected the continuity and quality of therapeutic interactions.

The findings further showed that many participants experienced difficulties in securing private and quiet spaces for counseling sessions due to crowded, multi-generational living arrangements commonly found in urban settings. As a result, some clients were forced to seek alternative locations such as parked vehicles, unfinished construction sites, or open campus areas in order to

maintain confidentiality during sessions. In addition to spatial challenges, the study found that the high cost of mobile internet data created a serious financial burden, especially for students and individuals with low income.

Participants reported that maintaining regular tele-counseling sessions often required difficult financial sacrifices. Despite these challenges, the findings demonstrated that successful digital therapeutic relationships could still be established when counselors used active listening skills, clear vocal communication, accessible language, and culturally respectful interactions. Counselors emphasized the importance of adapting their communication style to compensate for the absence of face-to-face contact and non-verbal cues.

Finally, the study identified important opportunities for strengthening remote mental health care services in Ethiopia. Institutional initiatives such as the Ministry of Health's toll-free 952 helpline were viewed as promising models for improving equitable access to mental health support. Participants also highlighted the positive role of traditional family and social support sy stems in encouraging individuals to seek and continue treatment.The findings suggest that while tele-counseling faces significant infrastructural, economic, and environmental barriers, it also offers valuable facilitators to expand mental health care access in culturally sensitive and socially acceptable ways.

### 5.1.2. Conclusion

This descriptive phenomenological study explored the lived experiences of ten clients and ten professional counselors involved in tele-counseling service delivery in Addis Ababa. The fin dings reveal that tele-counseling in this urban Ethiopian context is characterized by both opportunity and challenge. On one hand, it provides an empowering and confidential way for individuals to access mental health support without fear of social judgment. On the other hand, th

e service remains highly vulnerable to infrastructural problems, economic limitations, and the lack of private spaces for counseling sessions.

The study concludes that tele-counseling has developed beyond a temporary response to the COVID-19 pandemic and has become an important mental health support system within the healthcare environment of Addis Ababa. The study further concludes that tele-counseling acts as a “digital shield” against the strong social stigma surrounding mental illness in Ethiopia. In many communities, mental health problems are often misunderstood and associated with spiritual causes, moral weakness, or personal failure. Because tele-counseling is conducted remotely, clients can avoid the fear and embarrassment often associated with visiting psychiatric clinics in person. This confidential approach allows individuals, including students, professionals, and men concerned about social expectations, to seek mental health care while protecting their personal dignity, social status, and professional reputation. In addition, the study contributes to the understanding of the Technology Acceptance Model (TAM) by showing that, within a collecti vist society such as Ethiopia, the usefulness of health technology is not based only on convenience or technical efficiency. Instead, people value tele-counseling because it helps them manage social risks, maintain privacy, and avoid stigma. Therefore, the acceptance of tele-counseling is closely connected to its ability to protect human dignity and provide socially safe access to care. At the same time, the study highlights a major gap between internationally d esigned tele-health systems and the realities of daily life in developing urban settings. Many tele-counseling models assume that clients have access to quiet, private, and comfortable spaces for therapy sessions. However, the findings show that crowded multi-generational households and densely populated living conditions in Addis Ababa make privacy difficult to achieve. As a resu lt, many clients are forced to search for alternative locations such as parked vehicles, const

ruction areas, or isolated outdoor spaces in order to participate in counseling sessions confidentially. These conditions introduce additional emotional, physical, and financial stress into the therapeutic process.

The study also found that unreliable infrastructure creates major barriers to continuous mental health care. Frequent electrical power interruptions (yemebrat mftat), unstable network connections, and the high cost of mobile internet data make it difficult for many individuals to maintain regular counseling sessions. These challenges particularly affect students and low-income populations, who often have to sacrifice other basic needs in order to continue therapy. From the perspective of the Unified Theory of Acceptance and Use of Technology (UTAUT), the lack of reliable facilitating conditions significantly limits the sustainability of tele-counseling services. Regarding the counseling process itself, the study concludes that building a strong the rapeutic relationship through remote communication requires counselors to make careful adjustm ents in their communication style. Because face-to-face interaction and non-verbal cues are absent, counselors must rely more heavily on active listening, vocal tone, verbal reassurance, and culturally respectful communication.

The findings show that counselors who use understandable Amharic language and culturally appropriate expressions are more successful in building trust and emotional connection with clients despite the digital distance. Furthermore, the study highlights the positive role that family support systems can play in remote mental health care. In the Ethiopian collectivist context, family members can assist counselors by helping clients follow treatment plans, take medications regularly, and maintain personal safety during difficult situations. This demonstrates that traditional social support systems can become valuable resources in strengthening tele-counseling services. In conclusion, tele-counseling serves as a critical mental health support

mechanism within the healthcare system of Addis Ababa. However, to fully realize its potential, there is a need for stronger institutional and policy support. Future interventions should focus on improving digital infrastructure, reducing internet and service costs, strengthening public mental health programs, and creating equitable access to remote counseling services. By addressing these structural and economic barriers, tele-counseling can evolve from a limited private service i nto a resilient and accessible public mental health resource for broader communities.

### 5.1.3. Limitations of the Study

Although this study provides important qualitative insights into tele-counseling service delivery, limitations should be considered. The study was conducted only among participants living and working in Addis Ababa. Therefore, the findings may not fully represent the experiences of individuals in rural or semi-urban areas of Ethiopia, where internet connectivity, technological in frastructure, and literacy levels may differ significantly.

### 5.1.4. Recommendations

Based on the findings of this study, recommendations are proposed to improve the accessibility, quality, and effectiveness of tele-counseling services in Ethiopia.

Governmental bodies such as the Ministry of Health and the Ministry of Innovation and Technology should collaborate with Ethio Telecom to establish toll-free and secure national mental health hotlines. Providing zero-rated tele-counseling services would help reduce the financial burden of internet and data costs for students, low-income individuals, and other vulnerable populations. In addition, remote counseling services should be integrated with local health extension programs so that community health workers can provide immediate support,

follow-up care, and crisis intervention when serious mental health emergencies are identified through digital platforms.

Academic institutions, including Addis Ababa University and other higher education institutions, should create private and sound-insulated counseling spaces within campuses, libraries, or student centers. These spaces would help students living in crowded dormitories or shared housing environments access confidential tele-counseling services without fear of being overheard. Universities should also collaborate with digital health providers to offer affordable or zero-rated tele-mental health packages for students to ensure that financial difficulties do not prevent them from receiving psychological support.

Corporate organizations and employer networks should also play an active role in supporting employee mental health. Private companies, public institutions, schools, and industrial organizations should integrate confidential tele-counseling services into their employee assistance programs (EAPs). Providing anonymous counseling services can help reduce workplace stress, burnout, anxiety, and other mental health challenges while protecting employee privacy and encouraging early help-seeking behavior.

Tele-psychology platforms and clinical practitioners should prioritize culturally sensitive counseling approaches. Mental health professionals providing remote counseling should receive training on local cultural values, respectful communication styles, and the use of understandable local languages and dialects. This would help clients from different age groups and so cial backgrounds feel respected, comfortable, and understood during counseling sessions. Tele-counseling platforms should also develop flexible technical systems that can adapt to unstable int ernet conditions. For instance, when video calls fail because of weak network connections,

counselors should be able to continue sessions through audio-only communication or voice calls to maintain continuity of care.

Specialized remote mental health programs should be designed for vulnerable groups such as stay-at-home mothers, economically disadvantaged individuals, and people with demanding family responsibilities. Flexible scheduling systems and tailored counseling approaches should be introduced to accommodate the daily realities and responsibilities of these populations.

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## ANNEXES

## ANNEX 1: CONSENT FORM (English Version)

**ADDIS ABABA UNIVERSITY**

**COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES**

**SCHOOL OF PSYCHOLOGY**

My name is __. I am a data collector for the study entitled: "Assessment of the Barriers and Facilitators of Tele-Counseling Service Delivery in Addis Ababa, Ethiopia." This study is being conducted by Mrs. Abyssinia Beshada, as part of a Master's research effort to better understand the real-life experiences of those who provide and receive counseling services remotely. The study will take place from February 1 to March 1, 2026.You are invited to participate after you have read and understood the following information and voluntarily give your consent.

1. What is the study about?

This study aims to explore the real-life experiences, challenges, and successes of both counselors and clients with tele-counseling (counseling done by video call or telephone) in Addis Ababa. The study seeks to:

• Understand what makes tele-counseling work well or present difficulties from the perspective of those directly involved.

• Identify practical factors that support or hinder effective remote counseling.

• Generate recommendations to improve the quality and accessibility of tele-counseling services in our context.

2. Why are you invited to participate?

You are invited to participate because you have direct, personal experience with tele-counseling

in Addis Ababa, either as a trained counselor who provides these services or as a client who has received them. Your unique insights are crucial for understanding this important service delivery method.

3. What is expected from you?

If you agree to participate, I will conduct a one-on-one interview with you. This will take approximately 45–60 minutes. The interview will be conducted in a private, quiet setting or via a secure video platform, at your convenience. With your permission, the conversation will be audio-recorded to ensure I accurately capture everything you share. I will also take brief notes.

4. What are the benefits of participating in this study?

Your participation will provide valuable, firsthand knowledge that can help counselors, clinics, and policymakers make tele-counseling services more effective, accessible, and supportive for everyone in Addis Ababa. There is no direct financial benefit for participating.

5. What are the risks of participating?

The main commitment is your time (45-60 minutes). Discussing your counseling experiences might bring up personal reflections. You have the right to skip any question, take a break, or stop the interview at any time without any negative consequences. A list of local mental health support resources will be provided to you at the end of the interview as a standard support measure.

6. What are your rights as a participant?

Your participation is completely voluntary.

You have the right to refuse to participate or to withdraw from the study at any time without any penalty or effect on any services you receive.

You may decline to answer any specific question without providing a reason.

7. How will your information be kept confidential?

Your privacy is our top priority. All information you provide will be kept strictly confidential. Your name and any other identifying details will be removed from the interview transcripts and replaced with a code (e.g., Counselor-01, Client-03).

Audio recordings will be stored on a password-protected device and will be permanently deleted after they are transcribed.

All paper forms and notes will be kept in a locked cabinet.

Findings will be reported in a way that ensures no individual can be identified.

8. Whom to contact if you have concerns or questions?

For questions about the study:

Principal Investigator: Abyssinia Beshada

Research Ethics Committee of the School of Psychology, Addis Ababa University

**INFORMED CONSENT STATEMENT**

Are you willing to participate in this study? (Please circle one)

1. Yes (Consent is obtained and the interview continues)
2. No

Participant's Declaration:

I, the undersigned, confirm that I have read this information sheet, or it has been read to me. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand that my participation is voluntary. I agree voluntarily to participate in this study.

Participant's Signature: _____

Date: _____

Data Collector's Declaration:

I confirm that I have accurately explained the nature, purpose, benefits, and risks of this study to the participant.

Data Collector's Signature: _____

Name: _____

Date:

# ANNEX 2: INTERVIEW GUIDE ENGLISH

## PART I: INTERVIEW GUIDE FOR TELE-COUNSELORS

A. Opening and Context

1. To begin, could you tell me about your professional background and your general experience with counseling?
2. What motivated you or your institution to begin offering counseling services remotely?

B. Lived Experience of Service Delivery

3. Please describe what a typical tele-counseling session looks like for you, from preparation to follow-up. In what ways is it similar to or different from an in-person session?
4. What are the most significant adjustments you have had to make in your counseling practice to work effectively via phone or video?
5. Can you describe a specific experience that stands out to you as particularly rewarding or particularly challenging in tele-counseling?

C. Perceived Barriers

6. From your perspective, what are the main challenges or barriers to providing high-quality counseling remotely?

Probes:

- Challenges related to technology or internet connectivity

- Difficulties in building rapport or interpreting non-verbal communication
- Managing client crises or emergencies from a distance
- Issues related to workspace, privacy, or maintaining work–life boundaries

D. Perceived Facilitators

7. On the other hand, what factors or conditions help make tele-counseling effective and successful?

Probes:

- Convenience or accessibility for you or your clients
- Skills, strategies, or techniques you have developed that work well online
- Institutional support such as training, supervision, or access to appropriate technology

E. Closing and Recommendations

8. Based on your experience, what do you think is needed at the individual, institutional, or policy level to improve tele-counseling services in Ethiopia?
9. Is there anything important about your experience with tele-counseling that we have not discussed but you believe is essential to understand?

**PART II: INTERVIEW GUIDE FOR TELE-COUNSELING CLIENTS**

A. Opening and Context

1. Could you tell me what led you to seek counseling support?

2. What were your initial thoughts or feelings when you learned that your counseling sessions would be conducted remotely rather than in person?

B. Lived Experience of Access and Engagement

3. Please describe your experience of finding, contacting, and scheduling tele-counseling sessions. Was the process easy or difficult for you?
4. Thinking back to your first remote counseling session, what was that experience like? How did it compare with what you expected?
5. As you continued with tele-counseling, what helped you feel connected and engaged with your counselor? What factors, if any, made you feel disconnected?

C. Perceived Barriers

6. What were the main difficulties or frustrations you experienced while receiving counseling remotely?

Probes:

- Problems with technology, internet access, or finding a private space
- Feeling that something was missing compared to face-to-face counseling
- Concerns about privacy or confidentiality

D. Perceived Facilitators and Outcomes

7. What aspects of tele-counseling did you find helpful, convenient, or beneficial?

Probes:

- Saving time or transportation costs
- Feeling more comfortable or less stigmatized when attending sessions from home

8. Overall, how do you feel tele-counseling affected you? Do you believe it was effective in addressing your needs?

E. Closing and Suggestions

9. Based on your experience, what advice would you give to someone considering tele-counseling?
10. Is there anything else you would like to share about your experience that you think is important for me to know?

**PART III: INTERVIEW GUIDE FOR STAKEHOLDERS / POLICY MAKERS**

**A. Opening and Context**

1. To begin, could you tell me about your professional role and your experience related to mental health, counseling services, digital health, or policy making?
2. What led you or your institution to become involved with tele-counseling or remote mental health services?

**B. Lived Experience of Tele-Counseling Services**

3. Please describe your experience with tele-counseling services in Ethiopia. What has it been like from your professional perspective?

4. How would you describe the current experience of implementing or supporting tele-counseling services in Addis Ababa?
5. Can you describe a specific experience that was particularly meaningful, successful, or challenging regarding tele-counseling services?
6. In your experience, how does tele-counseling compare with traditional face-to-face mental health services?

**C. Perceived Barriers**

7. From your perspective, what are the main barriers affecting tele-counseling services in Addis Ababa?

***Probes:***

- Policy or regulatory limitations
- Internet and technology-related challenges
- Shortage of trained professionals
- Public awareness and stigma
- Ethical, privacy, or confidentiality concerns
- Financial or institutional limitations

8. Can you describe how these challenges affect the accessibility or quality of tele-counseling services?
9. What has been your experience in trying to address or manage these barriers?

**D. Perceived Facilitators**

10. On the other hand, what factors or conditions help tele-counseling services function effectively in Ethiopia?

11. Can you describe an experience where tele-counseling services worked particularly well? What contributed to that experience?
12. What strengths within the Ethiopian mental health system could support the growth of tele-counseling services?

**E. Closing and Recommendations**

13. Based on your experience, what do you think is needed at the institutional, professional, or policy level to improve tele-counseling services in Ethiopia?
14. How do you see the future of tele-counseling services in Ethiopia?
15. Is there anything important about your experience with tele-counseling services that we have not discussed but you believe is essential to understand?

**ANNEX 3: CONSENT FORM (Amharic Version)**
አባሪ 3፡ የጥናቱ የተሳትፎ ፈቃድ ፎርም (የአማርኛ ቅጂ)

**አዲስ አበባ ዩኒቨርሲቲ**

**የትምህርትና የባህሪ ጥናት ኮሌጅ**
**የስነ-ልቦና ትምህርት ቤት**

ስሜ _____- ይባላል። “በአዲስ አበባ፣ ኢትዮጵያ በስልክና በሕዝብ ግንኙነት መስመሮች የሚሰጡ የማማከር አገልግሎቶች (Tele-Counseling) አቅርቦትን የሚያግዙና የሚያስተጓጉሉ ሁኔታዎች ግምገማ” በሚል ርዕስ ለሚካሄደው ጥናት መረጃ ሰብሳቢ ነኝ። ይህ ጥናት በወይዘሮ አቢሲኒያ በሻህ የሚካሄድ ሲሆን፣ የማስተርስ ድግሪ ምርምር ሥራ አካል ነው። ጥናቱ በሩቅ ሆነው የማማከር አገልግሎት የሚሰጡ እና የሚቀበሉ ሰዎችን ተጨባጭ የሕይወት ተሞክሮ በተሻለ ሁኔታ ለመረዳት ያለመ ነው። ጥናቱ ከየካቲት 1 እስከ የካቲት 22 ቀን 2025 ዓ.ም (ከፌብሩዋሪ 1 እስከ ማርች 1፣ 2025) ባለው ጊዜ ውስጥ ይካሄዳል። የሚከተለውን መረጃ አንብበው ከተረዱ በኋላ በራስዎ ፈቃድ ስምምነትዎን በመስጠት በጥናቱ ላይ እንዲሳተፉ ተጋብዘዋል።

1. ጥናቱ ስለ ምንድን ነው?

ይህ ጥናት በአዲስ አበባ ውስጥ በቪዲዮ ጥሪ ወይም በስልክ የሚሰጠውን የማማከር አገልግሎት (Tele-Counseling) በተመለከተ የባለሙያዎችን (አማካሪዎችን) እና የአገልግሎት ተጠቃሚዎችን (ተማካሪዎችን) ተጨባጭ የሕይወት ተሞክሮ፣ ተግዳሮቶች እና ስኬቶች ለመመርመር ያለመ ነው። ጥናቱ የሚከተሉትን ዓላማዎች ያካትታል፡-

በቀጥታ ተሳታፊ ከሆኑት ወገኖች አንጻር፣ በሩቅ የሚሰጥ የማማከር አገልግሎት በጥሩ ሁኔታ እንዲሠራ የሚያደርጉትን ወይም ችግር የሚፈጥሩትን ሁኔታዎች መረዳት።
በሩቅ የሚሰጠውን የማማከር አገልግሎት ውጤታማ የሚያደርጉ ወይም የሚያስተጓጉሉ ተግባራዊ ሁኔታዎችን መለየት።
በአገራችን ሁኔታ በሩቅ የሚሰጡ የማማከር አገልግሎቶችን ጥራት እና ተደራሽነት ለማሻሻል የሚረዱ ምክረ-ሀሳቦችን ማመንጨት።

2. በጥናቱ ላይ ለመሳተፍ ለምን ተጋበዙ?

በአዲስ አበባ ውስጥ በሩቅ የሚሰጥ የማማከር አገልግሎትን በተመለከተ (አገልግሎቱን በመስጠት እንደሰለጠነ አማካሪ ወይም አገልግሎቱን እንደተቀበለ ተማካሪ) ቀጥተኛ እና የግል ተሞክሮ ስላሎት በጥናቱ ላይ እንዲሳተፉ ተጋብዘዋል። የእርስዎ ልዩ ግንዛቤ ይህንን ጠቃሚ የአገልግሎት አሰጣጥ ዘዴ ለመረዳት በጣም አስፈላጊ ነው።

3. ከእርስዎ ምን ይጠበቃል?

በጥናቱ ላይ ለመሳተፍ ከተስማሙ፣ ከእርስዎ ጋር የአንድ ለአንድ ቃለ-መጠይቅ አደርጋለሁ። ይህ ቃለ-መጠይቅ በግምት ከ45-60 ደቂቃዎች ይወስዳል። ቃለ-መጠይቁ እርስዎ በሚመርጡት ምቹ ጊዜ፣ በግልና ጸጥ ባለ ቦታ ወይም ደህንነቱ በተጠበቀ የቪዲዮ መስመር (Platform) አማካኝነት ይካሄዳል። የሚያካፍሉትን መረጃ ሁሉ በትክክል መቅረፅ እንድችል፣ በእርስዎ ፈቃድ ውይይቱ በድምፅ የተቀረጻል። እኔም አጭጭር ማስታወሻዎችን እይዛለሁ።

4. በዚህ ጥናት ላይ መሳተፍ ምን ጥቅም አለው?

የእርስዎ ተሳትፎ በአዲስ አበባ ውስጥ የሚሰጡ በሩቅ የማማከር አገልግሎቶችን የበለጠ ውጤታማ፣ ተደራሽ እና ለሁሉም ሰው ደጋፊ ለማድረግ ለአማካሪዎች፣ ለሥነ-ልቦና ማዕከላት እና ለፖሊሲ አውጭዎች ጠቃሚ የሆነ የመጀመሪያ እጅ እውቀት ይሰጣል። በጥናቱ ላይ በመሳተፍዎ የሚገኝ ቀጥተኛ የገንዘብ ጥቅም የለም።

5. የመሳተፍ ግዴታ ምንድን ናቸው?

ዋናው ግዴታ የእርስዎ ጊዜ (45-60 ደቂቃ) ነው። ስለ ማማከር ተሞክሮዎ መወያየት የግል ትውስታዎችን ሊቀሰቅስ ይችላል። ማንኛውንም ጥያቄ የመዝለል፣ ዕረፍት የመውሰድ ወይም ቃለ-መጠይቁን በማንኛውም ጊዜ ያለምንም ቅጣት ወይም አሉታዊ ተጽዕኖ የማቆም መብት አለዎት። እንደ መደበኛ የድጋፍ መስፈርት፣ በቃለ-መጠይቁ መጨረሻ ላይ የአገር ውስጥ የአእምሮ ጤና ድጋፍ ሰጪ ተቋማት ዝርዝር ይሰጥዎታል።

6. እንደ ተሳታፊ መብቶችዎ ምንድን ናቸው?

የእርስዎ ተሳትፎ ሙሉ በሙሉ በራስዎ ፈቃድ ላይ የተመሠረተ ነው።
በጥናቱ ላይ ለመሳተፍ ፈቃደኛ አለመሆን ወይም በማንኛውም ጊዜ ከጥናቱ የመውጣት መብት አለዎት፤ ይህም ምንም ዓይነት ቅጣት ወይም በሚያገኙት ማናቸውም አገልግሎቶች ላይ ተጽዕኖ አይኖረውም።
ለተወሰኑ ጥያቄዎች ምክንያት ሳይሰጡ ምላሽ ከመስጠት መቆጠብ ይችላሉ።

7. መረጃዎ እንዴት በሚስጥር ይጠበቃል?

የእርስዎ ግላዊነት ለኛ ዋነኛ ቅድሚያ የሚሰጠው ጉዳይ ነው። የሚሰጡት መረጃ ሁሉ ጥብቅ ምስጢራዊነቱ ይጠበቃል።

ስምዎ እና ማናቸውም እርስዎን ሊለዩ የሚችሉ ዝርዝር መረጃዎች ከቃለ-መጠይቁ ጽሑፍ ላይ የሚወገዱ ሲሆን፣ በኮድ (ለምሳሌ፡ አማካሪ-01፣ ተማካሪ-03) ይተካሉ።
የድምፅ ቅጂዎች በይለፍ ቃል በተጠበቀ መሣሪያ ላይ የሚቀመጡ ሲሆን፣ በጽሑፍ ከተገለበጡ በኋላ በቋሚነት ይሰረዛሉ።
ሁሉም የወረቀት ቅጾች እና ማስታወሻዎች በተቆለፈ ካቢኔ ውስጥ ይቀመጣሉ።
የጥናቱ ውጤት ሪፖርት በሚደረግበት ጊዜ ማንኛውንም ግለሰብ መለየት በማይቻልበት መልኩ ይቀርባል።

8. ቅሬታ ወይም ጥያቄ ቢኖርዎት ማንኛውንም ማነጋገር ይችላሉ?

ስለ ጥናቱ ጥያቄ ካለዎት፡-

ዋና ተመራማሪ፡ አቢሲኒያ

የፈቃደኝነት መግለጫ

በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ነዎት? (እባክዎን አንዱን ያክብቡ)

1. አዎ (ፈቃድ ተገኝቷል እና ቃለ-መጠይቁ ይቀጥላል)
2. አይደለም

**የተሳታፊው ማረጋገጫ፡-**

እኔ ስሜ ከዚህ በታች የተመለከተው፣ ይህንን የመረጃ ወረቀት እንዳነበብኩ ወይም እንደተነበበልኝ አረጋግጣለሁ። ጥያቄዎችን ለመጠየቅ ዕድል አግኝቻለሁ፣ እና ለጥያቄዎቼ አጥጋቢ ምላሽ ተሰጥቶኛል። ተሳትፎዬ በፈቃደኝነት ላይ የተመሠረተ መሆኑን እረዳለሁ። በዚህ ጥናት ላይ ለመሳተፍ በራሴ ፈቃድ ተስማምቻለሁ።

የተሳታፊው ፊርማ፡- _____

ስም (በግልፅ ጽሑፍ)፡- _____

ቀን፡- _____

**የመረጃ ሰብሳቢው ማረጋገጫ፡-**

የዚህን ጥናት ባህሪ፣ ዓላማ፣ ጥቅሞች እና አደጋዎች ለተሳታፊው በትክክል ማብራራቴን አረጋግጣለሁ።

የመረጃ ሰብሳቢው ፊርማ፡- _____
ስም _____

ቀን፡- _____

## ANNEX 4: INTERVIEW GUIDE (Amharic Version)

አባሪ 2፡ የቃለ-መጠይቅ መመሪያ ክፍል ፡ በሩቅ ላማክሩ ባለሙያዎች የተዘጋጀ የቃለ-መጠይቅ መመሪያ

ሀ. መግቢያ እና አጠቃላይ ሁኔታ (

1. ለመጀመር ያህል፣ ስለ ሙያዊ መነሻዎ (ዳራዎ) እና በአጠቃላይ ስለ ማማከር አገልግሎት ያለዎትን ተሞክሮ ሊነግሩኝ ይችላሉ?

2. እርስዎ ወይም ተቋምዎ የማማከር አገልግሎትን በሩቅ (በስልክ ወይም በቪዲዮ) መስጠት እንድትጀምሩ ያነሳሳችሁ ምንድን ነው?

ለ. የአገልግሎት አሰጣጥ ተጨባጭ የሕይወት ተሞክሮ

3. ለእርስዎ መደበኛ የሆነ የሩቅ ማማከር (Tele-counseling) ክፍለ-ጊዜ ከዝግጅት እስከ ክትትል ምን እንደሚመስል እባክዎን ይግለጹልኝ? ይህ አገልግሎት በአካል ከሚደረግ የካውንስሊንግ ክፍለ-ጊዜ ጋር የሚመሳሰልባቸው እና የሚለይባቸው መንገዶች ምንድን ናቸው?

4. በስልክ ወይም በቪዲዮ ውጤታማ በሆነ መንገድ ለመሥራት በማማከር ልምምድዎ ላይ ማድረግ ካለብዎት ማስተካከያዎች መካከል ዋና ዋናዎቹ ምንድን ናቸው?

5. በሩቅ ማማከር ሂደት ውስጥ በተለየ ሁኔታ ጠቃሚ/አርኪ ወይም በጣም ፈታኝ ሆኖ የሚታወስዎትን አንድ የተወሰነ ተሞክሮ ሊገልጹልኝ ይችላሉ? ሐ.

እንደ ማነቆ የሚታዩ እንቅፋቶች

3. ከእርስዎ እይታ አንጻር፣ ከፍተኛ ጥራት ያለው የማማከር አገልግሎትን በሩቅ ለመስጠት ዋናዎቹ ተግዳሮቶች ወይም እንቅፋቶች ምንድን ናቸው?

መ. እንደ አጋዥ የሚታዩ ሁኔታዎች

4. በሌላ በኩል፣ በሩቅ የሚሰጥ የማማከር አገልግሎት ውጤታማ እና ስኬታማ እንዲሆን የሚያግዙ ሁኔታዎች ወይም ምቹ ሁኔታዎች ምንድን ናቸው?

ሠ. ማጠቃለያ እና ምክረ-ሀሳቦች

8. በእርስዎ ተሞክሮ ላይ በመመስረት፣ በአጠቃላይ በኢትዮጵያ ውስጥ የሩቅ ማማከር አገልግሎትን ለማሻሻል በግለሰብ፣ በተቋም ወይም በፖሊሲ ደረጃ ምን ያስፈልጋል ብለው ያስባሉ?

9. ስለ ሩቅ ማማከር ተሞክሮዎ እኛ ያልተወያየንበት ነገር ግን ለመረዳት በጣም አስፈላጊ ነው ብለው የሚያምኑት ማንኛውም ሌላ ቁልፍ ጉዳይ አለ?

**ክፍል II፡ ለተማካሪዎች/ደንበኞች የተዘጋጀ የቃለ-መጠይቅ መመሪያ**

ሀ. መግቢያ እና አጠቃላይ ሁኔታ

1. የማማከር (የካውንስሊንግ) ድጋፍ እንድንፈልጉ ስላደረገዎት ሁኔታ ሊነግሩኝ ይችላሉ?

2. የማማከር ክፍለ-ጊዜዎ በአካል ከመሆን ይልቅ በሩቅ (በቴክኖሎጂ የታገዘ) እንደሚሆን ሲረዱ መጀመሪያ ላይ የተሰማዎት ሀሳብ ወይም ስሜት ምን ነበር?

ለ. የአገልግሎት አጠቃቀም እና ተሳትፎ ተጨባጭ የሕይወት ተሞክሮ

3. የሩቅ ማማከር ክፍለ-ጊዜዎችን የመፈለግ፣ የመገናኘት እና ቀጠሮ የማስያዝ ተሞክሮዎ ምን ይመስል ነበር? ሂደቱ ለእርስዎ ቀላል ነበር ወይስ ከባድ?

4. የመጀመሪያውን የሩቅ ማማከር ክፍለ-ጊዜዎን ወደኋላ መለስ ብለው ሲያስቡ፣ ያ ተሞክሮ ምን ይመስል ነበር? ከጠበቁት ነገር ጋር እንዴት ይነጻጸራል?

5. የሩቅ ማማከር አገልግሎቱን ሲቀጥሉ፣ ከአማካሪዎ ጋር የተገናኙ እና ንቁ ተሳታፊ የሆኑ እንዲመስልዎት የረዳዎት ምንድን ነው? የተቆራረጡ ወይም የተለዩ እንዲሰማዎት ያደረጉ ሁኔታዎች (ካሉ) ምንድን ናቸው?

ሐ. እንደ ማነቆ የሚታዩ እንቅፋቶች

3. አገልግሎቱን በሩቅ በሚቀበሉበት ጊዜ ያጋጠሙዎት ዋና ዋና ችግሮች ወይም የሚያበሳጩ ሁኔታዎች ምን ምን ነበሩ?

መ. እንደ አጋዥ የሚታዩ ሁኔታዎች እና ውጤቶች

7. በጥናቱ ከተካተቱት የሩቅ ማማከር ገጽታዎች መካከል የትኛውን አጋዥ፣ ምቹ ወይም ጠቃሚ ሆኖ አገኙት?

8. ባጠቃላይ፣ የሩቅ ማማከር አገልግሎት በእርስዎ ላይ ምን ዓይነት ተጽዕኖ ያሳደረ ይመስልዎታል? የእርስዎን ፍላጎቶች በማሟላት ረገድ ውጤታማ ነበር ብለው ያምናሉ?

ሠ. ማጠቃለያ እና የአስተያየት ጥቆማዎች

9. ባጋጠመዎት ተሞክሮ ላይ በመመስረት፣ የሩቅ ማማከር አገልግሎትን ለመጠቀም ለሚያስብ ሌላ ሰው ምን ምክር ይሰጣሉ?

10. ስለ እርስዎ ተሞክሮ እኔ ባውቀው ጥሩ ነው ብለው የሚያስቡት እና ሊያካፍሉት የሚፈልጉት ሌላ ማንኛውም ተጨማሪ ነገር አለ?