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Assessment of the Usability, Acceptability, and Perceived Influence of the YAhealth App: A Multiplatform Sexual and Reproductive Health and Mental Health Intervention for Youth in Rwanda

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Abstract

Background

Across low- and middle-income countries (LMICs), young people face persistent barriers to reliable, youth-friendly sexual and reproductive health (SRH) and mental health information, as well as pathways to appropriate care. Although digital platforms could bridge information and service-navigation gaps, evidence on users' experiences of integrated, youth-centred approaches remains limited. YAhealth, developed in Rwanda through human-centred design, combines health information, mental health self-screening, expert support and service-location tools across mobile, web and toll-free hotline channels. We assessed its usability, acceptability, use patterns, and perceived contribution to health-service seeking.

Methods

We conducted a descriptive cross-sectional survey of 384 existing YAhealth users recruited through youth centres in five districts of Rwanda. Trained interviewers administered a context-adapted questionnaire, and responses were analysed descriptively.

Results

Participants had a mean age of 22.3 years (SD 2.79); 52.3% were female. SRH (90.9%) and mental health (84.6%) were the most frequently accessed topics. Reported feature use included reading health information (97.9%), locating services (82.4%), and mental health self-screening (79.4%). Most respondents rated navigation as easy (94.5%), expressed satisfaction (98.7%), and indicated willingness to recommend YAhealth (99.5%). Notably, 85.2% (327/384) reported seeking or accessing health services because of information obtained through YAhealth. However, 16.9% disagreed that the platform functioned without technical issues or crashes.

Conclusions

Among surveyed users, YAhealth received favourable usability and acceptability ratings, with substantial self-reported health-service seeking linked to information obtained through the platform. Integrating health information, self-assessment and service navigation may be a promising approach to addressing youth health-information and care-navigation gaps in resource-constrained settings. These findings support further technical refinement and rigorous research on equitable reach, verified service use and adaptation across LMIC contexts; the cross-sectional, self-reported data do not demonstrate causal effects or generalisability beyond the study sample.

Background

Young people in low- and middle-income countries (LMICs) often navigate fragmented health information, stigma surrounding sensitive health concerns, unequal digital access, and barriers to timely, confidential and youth-friendly services. Sexual and reproductive health (SRH) and mental health needs are especially consequential during adolescence and early adulthood, when timely information and supportive pathways to care can shape decisions and wellbeing. International health agencies continue to highlight the disproportionate HIV burden among adolescent girls and the importance of improving access to youth mental health care [1] [2]. A systematic review of rural LMIC settings found that young people value the convenience, privacy and affordability of mobile health (mHealth) channels, while network connectivity, device costs, literacy and sociocultural norms continue to limit equitable use [3]. Systematic reviews of mobile interventions for adolescent SRH and digital approaches to mental health in LMICs likewise point to opportunities for expanding reach while highlighting the need for higher-quality effectiveness evidence and context-sensitive implementation [4] [5].

The challenge extends beyond making health content available. Young people also need understandable information, trusted interactions, and practical guidance to locate appropriate services. In its youth-centred digital health framework, the World Health Organization (WHO) and partner UN agencies advocate meaningful youth participation, responsiveness to users' needs and responsible implementation [6]. WHO's guidance on digital interventions for health-system strengthening likewise emphasises acceptability, feasibility, equity and integration with functioning health services rather than viewing technology as a substitute for care [7]. The WHO global digital health strategy similarly calls for people-centred, coordinated digital health investment that strengthens rather than fragments health systems [8].

In Rwanda, adolescents and young adults face locally specific versions of these wider challenges. National demographic and health data have documented persistent adolescent childbearing and differences in sexual and reproductive health outcomes across population groups [9]. The country's youthful population creates opportunities for youth-oriented health communication while also underscoring the need for accessible and relevant delivery channels [10]. Information relating to HIV and sexually transmitted infections, contraception, menstrual health and psychosocial wellbeing may be difficult to seek openly in some settings; a range of digital and offline options can therefore complement existing services.

YAhealth is a youth-centred health intervention developed in Rwanda using human-centred design approaches with young people. Its mobile application and web platform offer health information on SRH, HIV and other sexually transmitted infections, mental health, life skills and related topics. Features include menstrual cycle tracking, self-administered mental health screening, live expert chat, community interaction and a service locator; a toll-free hotline provides another access channel. Together, these components are intended to connect accessible information and self-directed support with awareness of services, rather than replace professional clinical assessment or treatment. The importance of

combining technology design with the social and health-service context is also reflected in established eHealth development frameworks [11].

In an external environmental scan of 2,165 adolescent SRH apps identified in LMICs, eight applications were formally appraised using the Mobile App Rating Scale; YAhealth ranked third among those evaluated, with an overall score of 3.63 out of 5 [12]. Such an expert appraisal provides a useful independent perspective on app quality, but does not measure how target users experience the intervention, whether they continue using it, or whether they seek care after engaging with its information. These questions are important for decision-makers considering further development, partnerships or implementation research.

This study therefore examined patterns of engagement with YAhealth and surveyed users' assessments of its usability, acceptability, information quality and perceived influence. It also described respondents' self-reported health-service seeking associated with information obtained from the platform. By situating a Rwanda-based user evaluation within issues common to LMIC digital health programmes, the study aims to inform iterative product improvement and generate hypotheses for more rigorous research on service navigation and equitable reach.

Methods

Study design and setting

A quantitative descriptive cross-sectional survey was undertaken among existing YAhealth users recruited through selected youth centres in five districts in Rwanda: Gakenke, Ngororero, Nyagatare, Nyanza and Nyarugenge. These centres provide youth engagement opportunities and connect young people to sexual and reproductive health information and other support. Data were collected at one point in time; the design describes participants' experiences and perceptions, not the causal effects of YAhealth. Reporting is structured to describe key observational-study elements consistent with the STROBE statement [13].

Participants and sample size

The eligible population comprised young people aged 15–25 years who had used YAhealth at least once. Individuals who had not used the platform or declined participation were excluded. The target sample size of 384 was obtained using a single-population-proportion formula with an assumed proportion of 50%, 95% confidence level and 5% margin of error. The achieved survey included 384 respondents.

Sampling and recruitment

A multistage sampling approach was used: one youth centre was selected in each of Rwanda's five provincial-level administrative areas, followed by allocation proportional to centre-level eligible youth

populations and random selection of individuals from centre records. Recruitment of existing YAhealth users through these centres means the resulting sample should not be interpreted as nationally representative of all young people or of those without digital access.

Data collection

Data were collected by trained interviewers using a structured questionnaire in private spaces within participating youth centres. The YAhealth-specific instrument drew on previously published mHealth measurement approaches reviewed by Hajesmaeel-Gohari et al. [14]. Its domains of engagement, functionality, aesthetics, information quality and subjective quality are broadly aligned with the user Mobile App Rating Scale (uMARS) framework [15] and overlap with quality domains identified in the original Mobile App Rating Scale and a systematic review of mHealth app-assessment criteria [16] [17]. Published conceptual work also distinguishes experienced engagement and acceptability from objective intervention effectiveness [18] [19]. These additional publications provide interpretive context: neither the full validated uMARS/MARS instruments nor a theory-based acceptability scale were administered, and no validated total app-rating score was calculated. The questionnaire also addressed demographic characteristics, channels and frequency of YAhealth use, topics accessed, feature use, and self-reported service seeking. For the evaluative statements, participants responded on a five-point agreement scale (strongly disagree, disagree, neutral, agree, strongly agree). The wording was adapted to YAhealth and the instrument was pre-tested before data collection. The complete YAhealth study questionnaire is provided as Additional file 1

Data management and analysis

Research assistants received training in study procedures, standardised questionnaire administration, data quality assurance and confidentiality. Completed questionnaires were checked daily, and data were securely stored with routine backups. Data were entered, cleaned, and analysed in Stata version 17 using frequencies, percentages, means, and standard deviations. District information was complete for all 384 participants. All items reported in Tables 2–6 had 384 valid responses, and their percentages were calculated using the full sample. Responses to five-point evaluative statements were grouped into three categories for descriptive reporting: Agree (strongly agree or agree), Neutral, and Disagree (disagree or strongly disagree). Questions on health information topics, access channels and feature use allowed multiple responses, so percentages could exceed 100% across response options. The context-adapted questionnaire was pre-tested but was not independently psychometrically validated in this sample. No between-group comparative effect estimates or causal analyses were conducted.

Ethical considerations

Ethical approval

was obtained from the University of Rwanda, College of Medicine and Health Sciences Institutional Review Board (approval No. 753/CMHS IRB/2025). Informed consent was obtained in accordance with study procedures; for participants younger than 16 years, a parent or legal guardian provided informed consent before participation. Participation was voluntary, and participants could decline questions or withdraw. Interviews were private, study identifiers replaced names, and records were stored on password-protected devices. Findings are presented in aggregate. Procedures involving human participants were conducted in accordance with the Declaration of Helsinki and applicable institutional and national ethical requirements.

Results

Participant characteristics

The mean respondent age was 22.3 years (SD 2.79), and 201 of 384 respondents (52.3%) were female. Most had completed secondary education (74.7%), lived in urban settings (58.1%), were single (94.5%) and reported smartphone ownership (100%). All 384 participants had a district recorded, with respondents drawn from Gakenke, Ngororero, Nyagatare, Nyanza and Nyarugenge (Table 1).

Table 1
Sociodemographic characteristics of respondents

Characteristic	n	%
Age, mean (SD), years	22.3 (2.79)	
Sex		
Male	183	47.7
Female	201	52.3
District (n = 384)		
Gakenke	65	16.93
Ngororero	74	19.27
Nyagatare	82	21.35
Nyanza	83	21.61
Nyarugenge	80	20.83
Education		
No education	2	0.52
Primary	21	5.47
Secondary	287	74.74
University	74	19.27
Residence		
Rural	161	41.93
Urban	223	58.07
Smartphone ownership		
Yes	384	100.0
Marital status		
Single	363	94.53
Married	21	5.47

The district variable was complete for all 384 participants; percentages are calculated from the full sample.

Engagement and usability

Most respondents agreed that YAhealth was interesting (95.1%), engaging (96.9%), and encouraged continued use (95.3%). Users also rated its tone as appropriate for young people (97.7%) and considered

its interactive features supportive of involvement (95.1%; Table 2). The share rating navigation as easy was 94.5%, and 93.5% considered menus logically organised. Although 85.7% reported smooth loading and responsiveness, 16.9% disagreed that the platform operated without technical difficulties or crashes (Table 3).

Table 2
Reported engagement with YAhealth

Statement	Agree n (%)	Neutral n (%)	Disagree n (%)
Fun and interesting	365 (95.05)	8 (2.08)	11 (2.86)
Engaging and keeps attention	372 (96.88)	6 (1.56)	6 (1.56)
Encourages regular use	366 (95.31)	4 (1.04)	14 (3.65)
Tone appropriate for youth	375 (97.66)	4 (1.04)	5 (1.30)
Interactive features increase involvement	365 (95.05)	5 (1.30)	14 (3.65)

Five response categories were collapsed into three for reporting, and each item has n = 384

Table 3
Reported functionality of YAhealth

Statement	Agree n (%)	Neutral n (%)	Disagree n (%)
Functions without technical issues or crashes	295 (76.82)	24 (6.25)	65 (16.93)
Navigation is easy and intuitive	363 (94.53)	11 (2.86)	10 (2.60)
Design and menus logically organised	359 (93.49)	5 (1.30)	20 (5.21)
Loads quickly; features respond smoothly	329 (85.68)	11 (2.86)	44 (11.46)

All functionality items had 384 valid responses.

Visual presentation and perceived information quality

Ratings of layout, icons and overall presentation were favourable (94.3–97.9%; Table 4). Most respondents described YAhealth information as accurate and reliable (97.9%), consistent with health recommendations (99.0%), clear (96.1%), sufficiently detailed (96.6%) and relevant for young people in Rwanda (97.9%). A smaller proportion, though still the majority, agreed that sources or references were credible (91.9%; Table 5). These ratings represent participants' perceptions; the present study did not independently audit clinical accuracy.

Table 4
Reported aesthetics of YAhealth

Statement	Agree n (%)	Neutral n (%)	Disagree n (%)
Appealing layout and design	374 (97.39)	7 (1.82)	3 (0.78)
Attractive and consistent graphics, icons and colours	362 (94.27)	7 (1.82)	15 (3.91)
Professional and youth-friendly appearance	376 (97.91)	6 (1.56)	2 (0.52)

Table 5
Perceived quality of health information

Statement	Agree n (%)	Neutral n (%)	Disagree n (%)
Accurate and reliable information	376 (97.91)	8 (2.08)	0 (0.00)
Evidence-based and consistent with recommendations	380 (98.95)	4 (1.04)	0 (0.00)
Clear and easy to understand	369 (96.09)	15 (3.91)	0 (0.00)
Sufficient detail on SRH and mental health	371 (96.61)	2 (0.52)	11 (2.86)
Credible sources or references	353 (91.92)	12 (3.12)	19 (4.94)
Relevant and useful for young people in Rwanda	376 (97.91)	8 (2.08)	0 (0.00)

Percentages are based on 384 responses for each statement; zero values are displayed explicitly.

Satisfaction, perceived influence and reported service seeking

Overall, 96.6% rated the app as high quality, 98.7% reported satisfaction and 99.5% would recommend it to other young people. Perceived positive influence on SRH or mental health knowledge, attitudes or behaviour was reported by 99.0%. Crucially, 327 of 384 (85.2%) reported that they had sought or accessed health services because of information from YAhealth (Table 6). The questionnaire combined “seeking” with “accessing”; neither service use nor its attribution to the platform was independently verified.

Table 6
Subjective quality and perceived influence

Statement	Agree/Yes n (%)	Neutral n (%)	Disagree/No n (%)
Overall, YAhealth is high quality	371 (96.61)	6 (1.56)	7 (1.82)
Satisfied with content and usability	379 (98.69)	3 (0.78)	2 (0.52)
Would recommend YAhealth	382 (99.47)	2 (0.52)	0 (0.00)
Positive perceived influence on SRH or mental health	380 (98.95)	4 (1.04)	0 (0.00)
Sought or accessed services because of YAhealth information	327 (85.15)	—	57 (14.84)

The final service-seeking measure was dichotomous and is shown as Yes/No, not as a three-category agreement item.

Use frequency, access channels, topics and features

During the two months before survey administration, 57% reported using YAhealth weekly, 24% monthly and 17% daily; 2% had not used it in that interval (Fig. 1). The mobile app was the most common access channel (92.2%), followed by the web platform (22.7%) and toll-free hotline (12.5%; Fig. 2). Participants most frequently accessed SRH (90.9%), mental health (84.6%) and HIV/STI (74.7%) content, whereas lifestyle content was less frequently accessed (24.5%; Fig. 3).

Respondents could report more than one channel; percentages may sum to more than 100%.

Multiple responses were permitted.

Reading health information was the most commonly reported feature (97.9%), followed by the service locator (82.4%), mental health self-screening (79.4%), menstrual cycle tracking (65.6%), community interactions (61.6%) and Talk to Expert live chat (42.5%; Fig. 4). These figures reflect reported ever-use and do not quantify intensity, frequency or verified feature usage.

Multiple responses were permitted.

Discussion

Principal findings and broader relevance

This study provides user-reported evidence on a Rwanda-developed, multiplatform intervention that integrates youth health information, mental health self-screening and pathways to support. Existing YAhealth users recruited through youth centres expressed favourable views of navigation, aesthetics, information and overall satisfaction. Of particular interest, 85.2% reported seeking or accessing a health

service because of information obtained from the platform. That finding does not demonstrate effectiveness, but it points to an important question for the wider LMIC digital health field: whether well-designed youth-facing information platforms can facilitate the transition from awareness to appropriate service contact.

The finding is relevant to documented barriers in LMIC settings, including privacy concerns, costs, sociocultural constraints and intermittent connectivity [3]. YAhealth's combination of several health areas and access channels may appeal to users who seek different types of support within a single service. However, a positive assessment in one country cannot establish transferability to others; language, affordability, digital infrastructure, safeguarding protocols, local service capacity and governance would all require examination before adaptation. Reviews of adolescent SRH mobile interventions and digital mental health in LMICs similarly indicate that acceptability and access must be distinguished from demonstrated effects on health outcomes [4] [5].

Acceptability, engagement and trust

High reported satisfaction (98.7%), ease of navigation (94.5%) and willingness to recommend the platform (99.5%) suggest that participants generally found the experience accessible and useful. Such measures are important in early-stage digital health evaluation, because a system that users cannot navigate or trust is unlikely to support sustained engagement; an earlier systematic review of digital adolescent sexual-health interventions also underscores the relevance of the digital delivery context [20]. The user-centred design principles promoted by WHO and partner UN agencies are consistent with the rationale for iterative consultation with young people [6]. Yet the especially high agreement levels in the present survey could also reflect selection, interviewer or social-desirability biases. These results should not be read as a validated overall usability score or an estimate of acceptability among all Rwandan youth. Engagement encompasses both users' subjective experiences and patterns of actual use [18]; acceptability is likewise a multidimensional judgement rather than a direct measure of efficacy [19]. In digital interventions, willingness to recommend does not establish continued use, and attrition may be substantial when evaluated longitudinally [21].

The substantial use of SRH and mental health content illustrates participants' interest in complementary domains of health information. In addition to written content, commonly used functions such as the service locator and mental health self-screening indicate that respondents explored tools with potential practical utility. Notably, self-screening reflects engagement with an informational screening feature, not a clinical diagnosis, and the present study did not determine whether users subsequently received professional assessment or treatment. The mental health literature in resource-constrained settings supports testing such tools as components of broader care pathways rather than treating a digital screen as clinical care [5].

From information to service navigation

The reported 85.2% service-seeking/access figure is the study's most policy-relevant observation. It may indicate that young people perceive a link between the information they obtain digitally and their

decisions to pursue additional support. However, the underlying item pooled seeking a service with actually accessing one, contained no confirmed records of visits or referrals, and did not establish whether service contact would have happened without YAhealth. Accordingly, the result should be interpreted as self-attributed service-seeking experience, rather than an increase in service utilisation or a health impact attributable to the intervention.

A logical next step is to separate stages of the service-navigation pathway: identifying a need, viewing a referral option, contacting a provider, attending a service, and receiving appropriate care. With suitable informed consent and privacy safeguards, future studies could link self-reported outcomes with anonymised usage data, verified referral completion or service records. Comparative or longitudinal designs could also investigate whether use is associated with better knowledge, timely support and sustained engagement, particularly among vulnerable young people. These outcome measures would provide a stronger evidence base for implementation decisions than satisfaction ratings alone. This would distinguish implementation indicators (such as adoption and reach) from service and clinical outcomes, as recommended in implementation-outcomes research [22]. Reporting technology characteristics and delivery context transparently would also support interpretation and reproducibility [23].

Implementation, technical reliability and equity

Despite favourable functionality ratings, 16.9% of respondents disagreed that the platform worked without crashes or technical issues. Technical reliability matters particularly when information is time sensitive or when users access digital services under connectivity constraints. Future product improvement should therefore prioritise robustness, performance across device types and bandwidth conditions, accessible interface design, language suitability, and transparent support routes when digital functions fail. Long-term engagement should be tested with real-world analytics because usability concerns and participant attrition can emerge after an initial positive experience [21]. Technological sustainability also depends on organisational and service-system readiness [24].

A key equity concern is that every surveyed participant owned a smartphone. Recruiting current users through youth centres makes it difficult to understand how YAhealth serves young people without devices, affordable data or proximity to participating institutions. The use of web and hotline channels suggests possible complementary routes, but their equity advantages were not demonstrated in this sample. Future implementation research should actively include rural and out-of-school youth, participants with disabilities, younger adolescents, and populations with low digital literacy, while evaluating gender, geography, costs and service-system readiness. WHO guidance recommends assessing these feasibility and equity conditions alongside anticipated benefits [7]. Global digital health strategy and technology scale-up research underline that accessibility, system integration and institutional context should be evaluated before expanding a service [24] [8].

Implications for research and partnership

For public-health institutions and implementing organisations, these findings offer an empirical baseline for refining a youth-centred platform already in use. For researchers, the combination of favourable usability indicators, substantial self-reported health-service seeking and identified reliability challenges suggests concrete areas for prospective evaluation. For prospective implementation partners, priorities should include documenting cost and sustainability, co-designing adaptations with intended users, validating measurement instruments, formalising referral and safeguarding pathways, and evaluating outcomes independently before scaling. Future studies should report implementation reach, retention, verified services accessed and possible unintended consequences, as well as acceptability and equity. Implementation frameworks specifically distinguish acceptability, feasibility, adoption, costs and sustainability, providing a useful structure for future multicentre evaluation [22]. A holistic eHealth approach also requires attention to stakeholder involvement, technology design and health-system context [11], while the NASSS framework highlights complexity that can impede wider adoption and sustained use [24].

Strengths and limitations

The study contributes a relatively large sample of current users (n = 384) and considers multiple aspects of one integrated platform: engagement, functionality, aesthetics, perceived information quality, health topics, feature use and service navigation. It also contributes context-specific findings from five geographically dispersed districts. Its cross-sectional design, however, cannot establish temporality or causation. Responses are self-reported and subject to recall, social-desirability and common-method biases; satisfaction and perceived influence were not corroborated through objective metrics or outcomes. Recruitment among existing users at selected youth centres, with universal smartphone ownership in the sample, limits generalisability to non-users and digitally excluded young people. Moreover, the survey did not independently verify reported clinical encounters or feature use and did not distinguish health services sought from those accessed.

The study-administered instrument was adapted for YAhealth and not psychometrically validated in this sample. Combining five response categories for reporting may obscure response distributions, and the strongly positive item ratings deserve cautious interpretation. Neither a formal clinical accuracy audit of the health content nor a technical benchmark of platform performance was performed. These constraints indicate the need for replication with mixed data sources, independently observed outcomes and samples beyond existing users. Validated acceptability instruments are available, but this study did not administer them; prospective studies should consider a defined theoretical model, transparent adaptation procedures and psychometric evaluation [25].

Conclusion

In this cross-sectional study of 384 existing YAhealth users in Rwanda, respondents reported favourable usability and acceptability, strong interest in SRH and mental health information, and frequent use of service-navigation and self-screening features. More than four in five respondents self-reported seeking or accessing health services because of information received through the platform; this is a signal

warranting follow-up rather than evidence of a causal improvement in utilisation. YAhealth offers a relevant case for examining how integrated, youth-centred digital tools might connect information with service navigation in resource-constrained settings. Future investment in research and implementation should be accompanied by technical refinements, explicit equity and safeguarding considerations, and independent, prospective evaluations of verified health-service and other outcomes before drawing conclusions about effectiveness or broader scalability. Decisions about broader implementation should be informed by prospective evidence on service outcomes, feasibility, sustainability and cost, not satisfaction alone [22] [24].

Abbreviations

AGYW
adolescent girls and young women
HIV
human immunodeficiency virus
HPV
human papillomavirus
IRB
Institutional Review Board
LMICs
low- and middle-income countries
mHealth
mobile health
NCDs
noncommunicable diseases
PPS
probability proportional to size
SRH
sexual and reproductive health
STIs
sexually transmitted infections
uMARS
user Mobile Application Rating Scale
WHO
World Health Organization.

Declarations

Ethics approval and consent to participate

The University of Rwanda, College of Medicine and Health Sciences Institutional Review Board approved this study (No. 753/CMHS IRB/2025). Age-appropriate informed consent procedures were followed, including parental or legal guardian consent for participating individuals younger than 16 years. Participation was voluntary and privacy safeguards were applied. All procedures involving human participants were conducted in accordance with the Declaration of Helsinki and applicable institutional and national guidelines and regulations.

Consent for publication

The manuscript presents aggregated data without identifiable information from individual participants; separate consent for publication was not applicable.

Competing interests

The authors declare no competing interests.

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Author Contribution

Anaclet Ahishakiye contributed to study conceptualization and coordination, interpretation of findings, manuscript preparation, and critical revision. Israel Cyubahiro Munyambaraga contributed to study design, data collection, data analysis, interpretation of results, and drafting and revision of the manuscript. Nadine Rujeni provided academic supervision, methodological guidance, and critical review of the manuscript. All authors reviewed and approved the final manuscript and agree to be accountable for their contributions.

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Data Availability

The data supporting the findings of this study were collected directly from YAhealth users through study questionnaires. The individual-level dataset is not publicly available because it includes potentially sensitive information about sexual and reproductive health, mental health, and health-seeking experiences. Requests for access to appropriately de-identified data may be directed to the corresponding author and will be considered subject to applicable ethical approval, confidentiality safeguards, and institutional data-sharing requirements.

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Figures

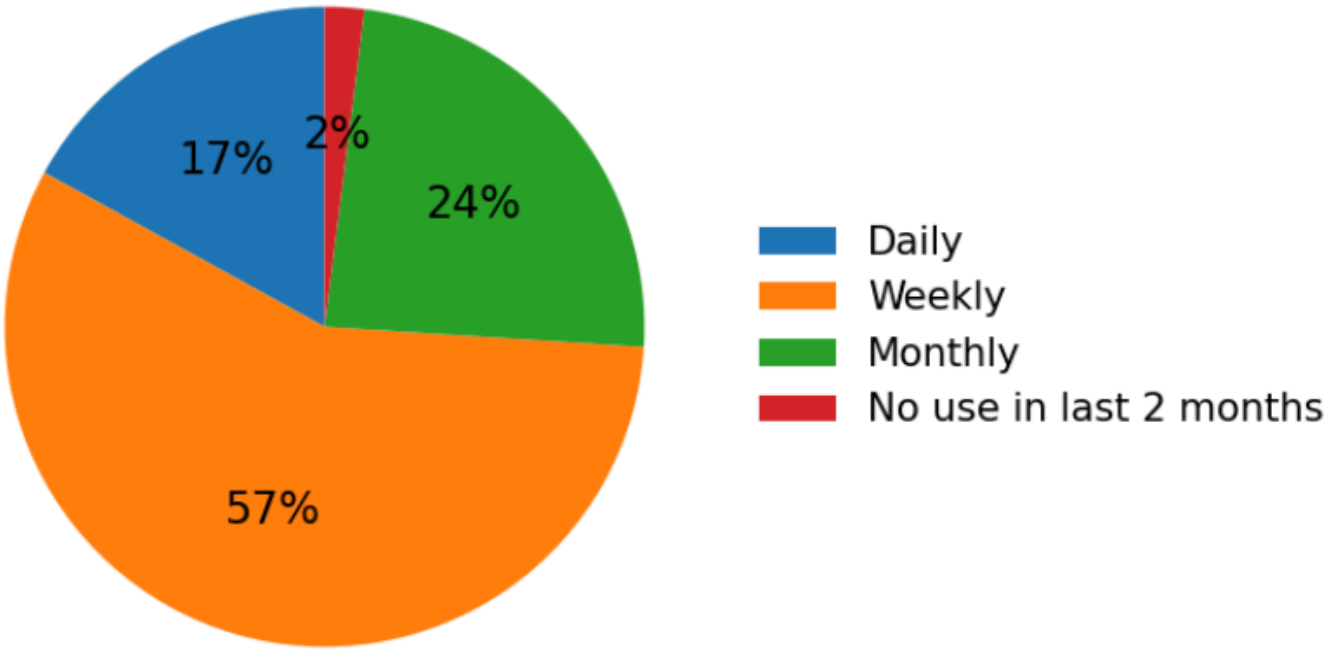


Figure 1

Self-reported YAhealth use frequency in the preceding two months.

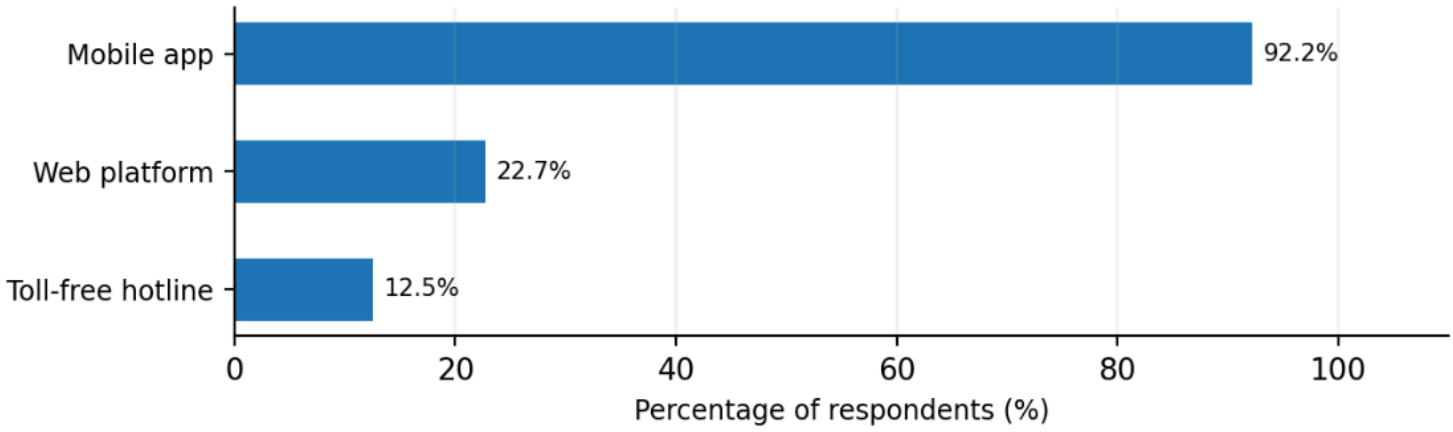


Figure 2

YAhealth access channels reported by respondents.

Respondents could report more than one channel; percentages may sum to more than 100%.

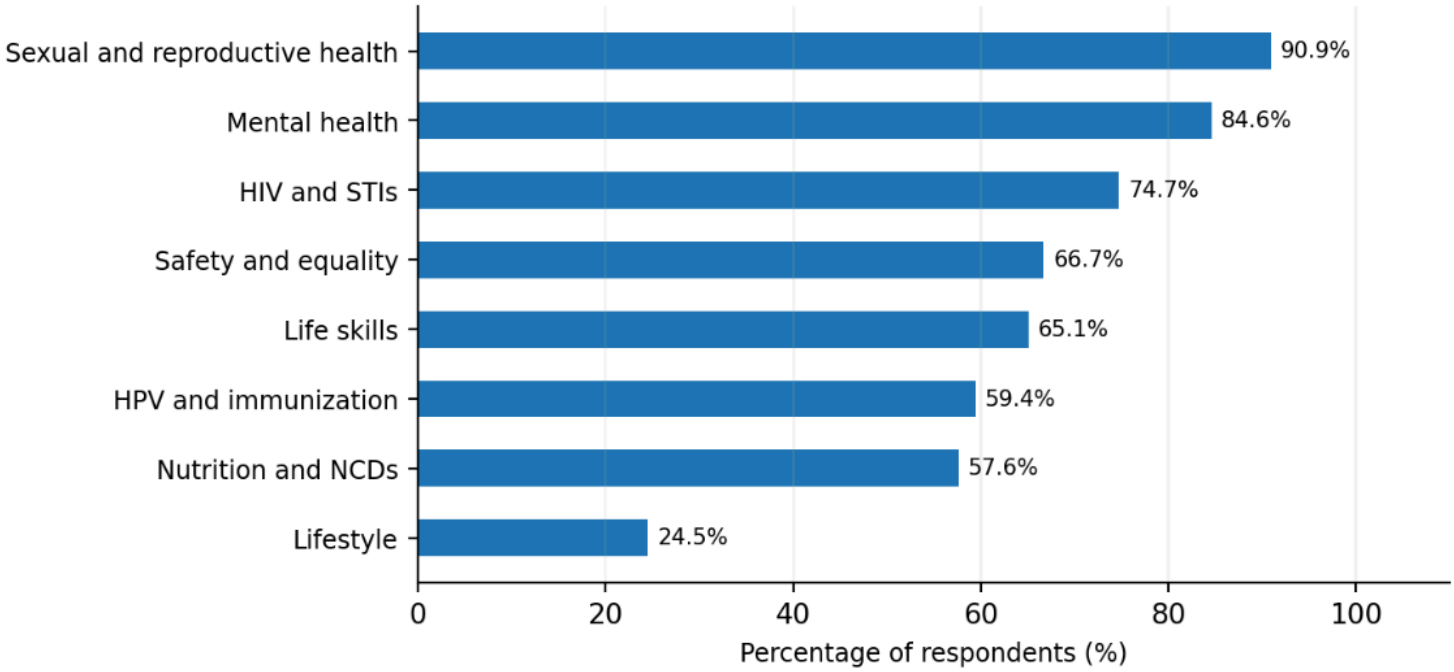


Figure 3

Health information topics accessed through YAhealth.

Multiple responses were permitted.

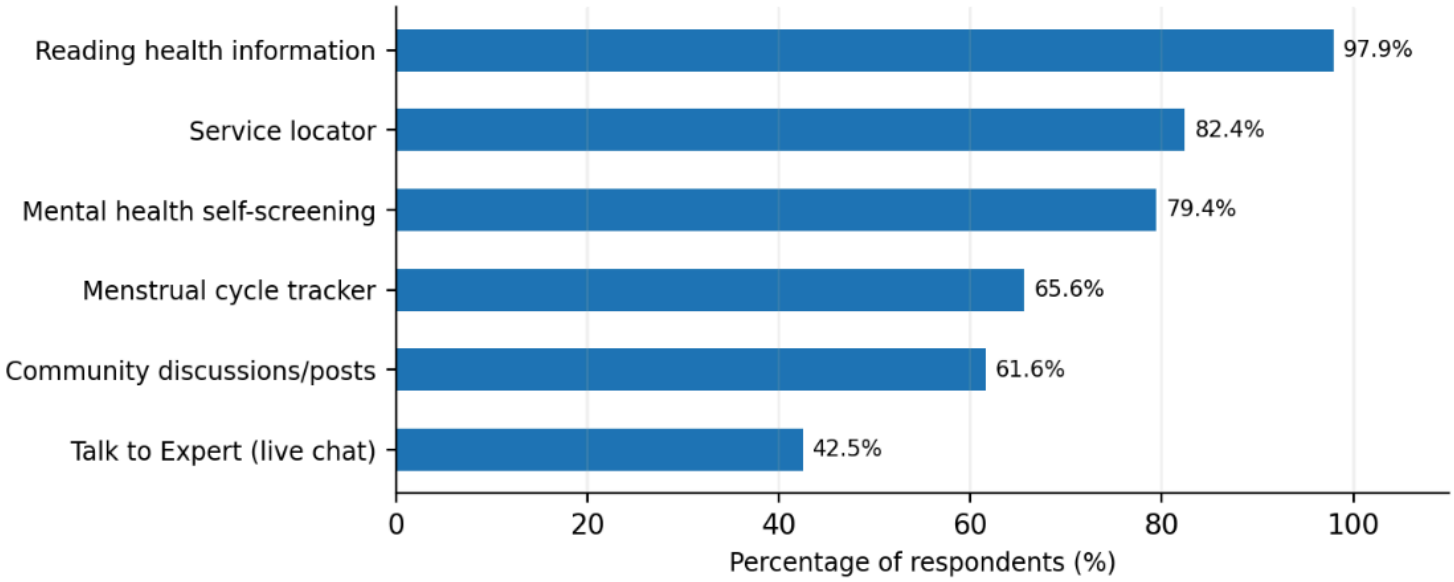


Figure 4

YAhealth features reported as used by survey respondents.

Multiple responses were permitted.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- YAhealthAppStudyQuestionnaire.pdf