Access to Sexual and Reproductive Health Information among Adolescent Girls in the Sipepa Community, Tsholotsho District, Zimbabwe

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ABSTRACT

This study examines access to sexual and reproductive health (SRH) information among adolescent girls in the Sipepa Community, Tsholotsho District, Zimbabwe, from which there were high rates of early teenage pregnancy at the time of the study. Using Buckland's six factors of information access, a qualitative cross-sectional design was employed to gain deeper insights into the research question. Teachers and health workers were selected purposively for the study, because they were mandated to provide SRH services to the target population. The study ascertained that SRH information was moderately available. Various organisations and programmes were named as the pathways in availing SRH information to the adolescent girls in the Sipepa Community. In spite of this, adolescent girls in the community still struggled to effectively access SRH information. The information resources packaged in a foreign language (English) and inadequately focused SRH programmes were among the causal factors of this inability to effectively access SRH information. Therefore, the study recommends that SRH information providers be trained to be culturally sensitive when delivering SRH education, senior students be empowered to mentor peers, and community awareness initiatives at health facilities be enhanced to meet the community's information needs.

Keywords: Information Access, Adolescent Girls, Sexual and Reproductive Health, Health Information, Qualitative Study, Sipepa Community, Tsholotsho District, Michael Buckland.

INTRODUCTION

Access to complete sexual and reproductive health (SRH) information is of great importance. It enables people to shield their rights, make informed decisions, and maintain overall well-being. Mbizvo *et al.* (2023) observe that people with access to complete SRH information are more likely to engage in safer sexual practices, which reduces rates of sexually transmitted infections (STIs) and unintended pregnancies. However, Pandey *et al.* (2019) indicate that this access to SRH information can vary depending on the availability, sources, and utilisation. In poverty-stricken populations, there are more hindrances people can face when accessing reliable SRH information than other privileged groups or communities (Akazili *et al.*, 2020; Gomez *et al.*, 2020). According to the World Health Organisation (WHO), approximately 214 million women in developing countries have continued to endure shortcomings due to the lack of SRH information, which includes limited access to modern contraception methods, leading to unintended pregnancies and unsafe abortions (WHO, 2019). In Africa, access to SRH information has further challenges, which explains why the continent grapples with high rates of adolescent pregnancies, maternal mortality and new HIV infections (UNFPA, 2019).

The adolescence phase occurs between the ages of 10 and 19, and it is a crucial stage for health information provision and education (WHO, 2024). Providing access to SRH information can empower adolescent girls, yielding positive results for their well-being (Liang *et al.*, 2019; WHO, 2018). The United Nations Sustainable Development Goals (UNSDGs) advocate for universal access to SRH services. It emphasises the importance of information in promoting individual and societal progress (UNDESA, 2016). The 3.7 target of SDG 3 states explicitly that by "2030, ensure universal access to SRH care services, including for family planning, information and education and the integration of reproductive health into national strategies" (UNDESA, 2016). This shows how the United Nations values access to SRH information in attaining a better and healthier society.

BACKGROUND TO THE STUDY

Access to information is a fundamental human right, and it includes seeking, receiving, and sharing information, especially from public bodies (UNGA, 1948). In line with this right, Zimbabwe, with a 93.7% national literacy rate, 97.1% for urban areas and 91.3% for rural areas (ZIMSTAT, 2022), has prioritised education and information access as vital components for fostering a sustainable, well-informed and healthy society (Chowdhury, 2014; MOHCC, 2018). Demonstrating commitment to this cause, the education sector has formulated the Zimbabwe School Health Policy (MOHCC, 2018) that compels primary and secondary schools to provide age-appropriate SRH information. Additionally, adolescents are protected in terms of Section 131 (6) of the Constitution of Zimbabwe as well as the Criminal Laws Amendment (Protection of Children and Young Persons) Act, 2024 (No. 1), which makes it a criminal offence for one to engage in sexual activity with children below 18 years of age.

In implementing the SRH policies and statutes, Zimbabwe has established structures at different societal levels. This includes the Sipepa Community, a small village in the Tsholotsho District in Matabeleland North Province of Zimbabwe. The village is approximately 45 km west of Tsholotsho town and 143.7 km from Bulawayo. It covers an area of 154 km^2 (Geonet, 2024) and, in 2022, had a population of about 2302 people (ZIMSTAT, 2022). Sipepa Community has a health facility, the Sipepa Rural Hospital, and a primary and secondary school. Concerning SRH information, the community had an array of health and educational facilities and other informal social support systems that targeted and provided SRH information to adolescents. Notably, for community health information that included SRH information, the people in Sipepa depended on the village health workers from Tsholotsho District Hospital (Kubatana 2018); mass broadcasting from radio and television that were a common feature in most homes in the community (Nwagwu, 2007); churches; and Plan International, a non-governmental organisation (NGO) that operated in the community (Plan International Zimbabwe, 2024).

Adolescents also accessed SRH information from family members, Sipepa Primary and Secondary School (School Health Policy, 2018; Wakjira and Habedi, 2022). The Zimbabwe Republic Police (ZRP) was a key stakeholder in SRH issues in the district. Despite these social support systems operating in the Sipepa Community and the whole of the Tsholotsho District, the district experienced a rise in teenage pregnancies for three consecutive years from 2019 to 2022 (Mlevu, 2023; The Economist, 2022). In 2023, Tsholotsho District Hospital, the referral hospital that serves communities in the district, recorded 71 cases of teenage pregnancies, and in November 2022, had an extreme case of a 9-year-old who was reported pregnant (Mazingaidzo, 2022; Mlevu, 2023). These events raised concerns about the effectiveness of the dissemination and accessibility of SRH information by adolescents in the district. However, the researchers could not get information on the distribution of the cases for each community. This study also focused on one community in the district, the Sipepa Community, because of resource limitations. This community was chosen during a preliminary enquiry on the presence of the study problem in the district because it seemed to have a fair share of institutions conducting health initiatives and sharing SHR information.

The high rate of pregnancies experienced in Tsholotsho District was assumed to have resulted from, among other factors, the failure of institutions operating in the community to identify, delineate or consider the local factors that influenced the accessibility of SRH information among adolescents. The need to tailor SRH information to this age group's specific needs and preferences is highlighted by Müller *et al.* (2016) in their examination of adolescents' perspectives on their SRH information needs. These needs and contextual factors are not standard and are conceived differently (Le Mat *et al.*, 2019). For instance, Mhlanga *et al.* (2024) observed that the COVID-19 pandemic had significantly increased adolescent pregnancies in Zimbabwe. As such, the sexual health outcomes of the group were poor because adolescents were not accessing or using SRH information and services because of reasons unique to the group, like "heightened stigma and discrimination by peers, communities and service providers themselves" (Mhlanga *et al.,* 2024). Individual influences, sexual reproductive health rights (SRHR), information-seeking behaviour, age of initiating SRHR education, relationship factors, sources of SRHR information, religious beliefs, parent-child interaction, peer pressure and social factors were some of the factors drawn by Mbarushimana *et al*. (2022). In some regions, especially in remote or underserved areas, access to information can be curtailed by inadequate infrastructure and resources (Salemink *et al.,* 2017).

Jones *et al*. (2020) factored in gender inequality and socioeconomic disparities as significant in impacting access to SRH information in Ethiopia. He concluded that women and girls, particularly in marginalised communities, could face additional barriers due to discrimination, lack of education, and limited resources. Also, Ninsiima *et al. (*2021) observe that the availability of SRH information varied across different channels, including healthcare facilities, educational institutions, online platforms, community centres, and outreach programmes. Shariat *et al.* (2014) classified the main barriers to the accessibility of SRH information into four categories: social and cultural barriers, structural and administrative barriers, and political barriers. These main factors cut across issues related to taboos, inappropriate structure of the health system, and lack of an adopted strategy by the government.

A study by Mutea *et al.* (2020) on access to information and use of adolescent SRH services in Kisumu and Kakamoga, Kenya, found hindrances to information accessibility to be negative health workers' attitudes, few facilitators of SRH services, long distance to the health facilities, high cost of services, negative social and cultural influences, lack of privacy and confidentiality. Also, under the guidance of Buckland's conceptual framework, Ram *et al.* (2020) observe that timely access to information plays a central role in adolescent's health and safe sexual practices. Wakjira and Habedi (2022) even justified the need and impact of access to SRH information after observing the absence of information as the main constraint in accessing SRH services among adolescents in Ethiopia's young population. Considering all the factors above, this study used Buckland's conceptual framework to explore access to SRH information among adolescent girls in the Sipepa Community. Buckland's conceptual framework has six factors to explore access to information, which include: "identification, availability, price to the user, cost to the provider, cognitive access and acceptability", as cited by Dahlberg (2021) and Ntsala and Dikotla (2019).

Statement of the Problem

Targeting access to SRH information services enhances information uptake among adolescents and young women because it allows for addressing "unique needs and circumstances" (Mhlanga *et al.*, 2024). Mhlanga *et al.* (2024) made this observation following a peer-based intervention project that they ran in Epworth District, Zimbabwe, that sought to "empower adolescent women through comprehensive sexuality education, engaging healthcare service providers, and improving parent-child communication". However, communities like the Sipepa Community have several institutions, such as a hospital, a primary school, and a secondary school, that directly provide adolescents with SRH information (Mlevu, 2023). Additionally, health information was also available in homes through different forms of media and social networks. With all these factors considered, a question arises: What are the unique factors pertaining to SRH information provision that could explain the high rate of adolescent pregnancies in the Sipepa Community in Tsholotsho District?

The objectives of the study

- To ascertain the availability of SRH information to adolescent girls in the Sipepa Community, Tsholotsho District.
- To determine whether adolescent girls can identify the sources of SRH information in the Sipepa Community, Tsholotsho District.
- To establish the cost to access SRH information by adolescent girls in the Sipepa Community, Tsholotsho District.
- To determine if the adolescent girls understand (cognitive access) and welcome (acceptability) the SRH information available in the Sipepa Community, Tsholotsho District.

LITERATURE REVIEW

Information Conceptualised

The concept of information is understood differently in different subject domains (Kosciejew, 2017:40; Rowley, 2007). In information science, Buckland (1991) conceptualises information from three points of view: information as a process, information as knowledge and information as a thing (Kosciejew, 2017:42; citing Buckland 1991:351). In the first view, information is treated as an act of communication. It is intangible and devoid of physical contact. This view treats information as a process of getting to know, meaning that the focus

is on the dynamics of knowledge in knowing. That is, for one to understand a phenomenon, one should engage with the knowledge embedded in the phenomenon through perception and interpretation, which results in recreating, restructuring or creating entirely new knowledge that is different from that which someone knew about at the start of the engagement (Pyrko *et al.*, 2017:391). In the second view, information is considered an intangible object of a communication process. Information is equated to knowledge (Kosciejew, 2017:42). In the third view, information is seen as an object. It is tangible, like a document that contains information and knowledge, requiring manipulation in one way or another for the information to be retrieved.

In the context of this research, the activities of disseminating SRH information are analysed from the information as a process view. The disseminated SRH information would fit into the information as a knowledge view, and the physical materials bearing the SRH information resonate with the information as a thing view. Thus, all the facets of the framework are of interest to the study. Using Buckland's information framework, as Kosciejew (2017:42) observes, helped "illuminate what it is that is being… interpreted, analysed, stored, retrieved, disseminated, transmitted, transformed, and used". Lastly, the conceptualisation of information closely aligned with Buckland's information framework is the Data-Information-Knowledge-Wisdom (DIKW) hierarchy (Rowley 2007). The hierarchy depicts relationships among its entities: data, information, knowledge and wisdom. Other hierarchies with higher-order entities like perception, understanding, and enlightenment are also available in the literature (Rowley 2007:166-168; Williams 2014). However, the hierarchies are not amenable to explaining the issues that affect access to information.

Access to Information

Buckland's (1991) three views of conceptualising information offer a multifaceted perspective. It emphasises how information is a communication act and highlights the importance of effective information exchange and dissemination, ensuring that knowledge is actively shared and transmitted (Savolainen, 2017). This expansive view recognises the transformative potential of information, encompassing the explicit knowledge conveyed through informational objects and the implicit, tacit knowledge that can be gained through experiences, interactions, and the integration of diverse informational sources (Walker, 2017). The increase in knowledge enhances understanding, and that information becomes an integral tool for empowering personal growth, ensuring better decision-making, and building learning capacity and development (Stonehouse and Pemberton, 1999). Thus, education and information access are interlocked and have become a huge part of striving towards a sustainable society with well-educated and informed citizens (Chowdhury, 2014). In relation to SRH, this access to accurate and comprehensive information helps to protect people's rights, make informed decisions, and maintain their overall well-being (WHO, 2022).

Access to Sexual and Reproductive Health Information

SRH information access remains a problem for marginalised populations (Akazili *et al.*, 2020). Gender inequality and socioeconomic disparities significantly impact access to SRH information (Jones *et al.*, 2020; Shariati *et al.*, 2014). Cultural, legal, or societal issues often worsen the challenges, which have to do with limited access to and readiness for SRH information (Woog *et al.*, 2015). These issues hinder open discussions and often cause stigma surrounding SRH issues. Other countries have started to follow the United Nations SDG 3 target 3.7 of integrating SRH education into their educational systems (UNDESA, 2016) by including SRH information in the curriculum. However, other countries do not have such mediating programmes (Habarland and Rogow, 2015). Other avenues where SRH information can be availed and accessible include healthcare facilities, educational institutions, online platforms, mobile applications, community centres, and outreach programs that offer many activities (Ninsiima *et al.*, 2021; Mangome, 2016). Regardless of these avenues, marginalised areas still face inadequate SRH information infrastructure and resources that curtail accessibility to SRH information (Salemink *et al.*, 2017).

Access to Sexual and Reproductive Health Information by Adolescent Girls

Young people sometimes depend on informal sources such as peers and the internet for SRH information due to a lack of access to formal SRH education (Müller *et al.*, 2016). The high risks that communities can face when the SRH topic is neglected among adolescents can be unmeasurable, yet it has not received that much attention

in most areas (Morris and Rushwan, 2015). This reliance on informal sources is caused by a number of factors, which include inadequate infrastructure and limited resources in formal institutions (Mbarushimana *et al.*, 2022).

Application of Buckland's (1991) Conceptual Framework for Information Access in Health Information Access

Buckland's (1991) conceptual framework on information access consists of six factors influencing an individual's ability to access information effectively. These factors are "identification, availability, price to the user, cost to the provider, cognitive access and acceptability", as depicted by Dahlberg (2021) and Ntsala and Dikotla (2019). Table 1 defines the six factors and shows how each has been used in the literature on SRH information and/or health information access.

Table 1: Application of Buckland's (1991) Six-factor Framework on Information Access

Factors	**Definition (Buckland, 1991)**	**Parameter**	**Applicability in access to SRH information**
Identification	The ability of users to identify a suitable source through understanding the context and meaning of the information.	Attributing the label information to certain things. It helps discover and describe information resources (Dahlberg, 2021; Ntsala and Dikotla, 2019).	Women in Senegal cited the school, television, friends, internet and hospital as their main source of SRH information, and others identified campaigns and informational sessions organised by NGOs (Soule and Sonko, 2022; Dahlberg, 2021)
Availability	Accessibility of information resources by users.	Availability of supporting organisations access points through physical and digital resources (Ndayishimiye et al., 2020).	Availability included the presence of special schools and welfare-oriented or disability-friendly enterprises which offered SRH information (Grenon *et al., 2*023; Dahlberg, 2021)
Price to the User	Cost incurred to access and use information or service by a user	It relates to the economic cost borne by the user to access information. This includes money, time, effort, discomfort, and psychological and emotional factors in acquiring the source. These emphasise that price is a barrier to information access. (Alchian et al., 1969; Crocker and Park, 2004).	Women highlight that financial constraints affect the accessibility of SRH information and services. Additionally, clinicians usually judge adolescents and people who are not yet married when they ask for SRH information, such as birth control. This is emotionally taxing (Soule and Sonko, 2022; Dahlberg, 2021)
Cost to the Provider	The expenses incurred by information providers or organisers facilitating information access.	This includes expenses such as creating, processing, storing, and disseminating information in making information (Curtis and Burns, 2015).	It encompasses various resources, such as financial investments, infrastructure, personnel, and technology, required to support health information access (Curtis and Burns, 2015; Abualoush *et al.*, 2018; Dahlberg, 2021).
Cognitive Access	The intellectual and cognitive abilities necessary to understand and utilise information effectively.	This includes skills necessary to comprehend the language used, recognise the relevance and accuracy of information, identify the context and relationships between ideas, analyse and evaluate the information, and synthesise. It may be influenced by the user's previous knowledge, skills, language proficiency, literacy levels, and cultural background and apply the knowledge gained (Madhusudhana, 2017).	Limited health literacy or unfamiliarity with medical terminology can significantly impede one's ability when accessing and utilising health information, even if the means of access are available (Turner, 2017; Dahlberg, 2021; Hammel *et al.*, 2015).

Acceptability	Social, cultural, and ethical aspects of information access.	Legal restrictions, privacy concerns, ethical considerations, and societal norms may impact the acceptability of accessing certain types of information (Dahlberg, 2021; Ntsala and Dikotla., 2019).	Accepting SRH information involves acknowledging its relevance, importance, and potential impact on personal well-being. Adolescent girls must perceive this information as valuable and apply it to their lives to improve decision-making regarding SRH (Dahlberg, 2021).

METHODOLOGY

The study adopted the qualitative research method and the case study research design. It was guided by Buckland's (1991) Six-factor Framework on Information Access. The study had 26 participants: 13 teachers from Sipepa Secondary School and 13 health workers from Sipepa Rural Hospital. These were purposively sampled because they were involved in activities pertaining to delivering health information in the Sipepa Community.

The positions held by the participants officially mandated them to provide health information to the community. Thus, these individuals were well-positioned to offer relevant and detailed information regarding adolescent girls' access to SRH information because they served and interacted with the girls regularly. The authors acknowledge that sampling adolescent girls could have minimised institutional bias. However, their exclusion from the population sample was due to unmitigable ethical considerations.

Firstly, the chieftaincy (local leadership) was unavailable to grant permission to the researchers for them to approach parents in order to seek consent from the parents of the adolescent girls, hence their exclusion and institutionalisation of the study.

Data Collection and Analysis

Data for the study was collected in two phases. Initially, a preliminary enquiry was done to assess the feasibility of the study's problem. At this stage, data was collected using unstructured interviews with the Headman, staff members from the Tsholotsho District Schools Inspector's Office, Sipepa Secondary School and Sister-in-Charge's Office at the Sipepa Rural Hospital Office.

Permission to collect data and conduct the study was granted by the Matabeleland North Provincial Education Director and the Provincial Medical Director for Matabeleland North. In the second stage, the data was collected using questionnaires deductively structured along the six factors of Buckland's Access to Information Framework.

Some of the questions were open-ended, and others were close-ended and focused on activities of all institutions like NGOs, churches, and the ZRP, which in their operations worked through the school structures or the hospital to reach the adolescent girls in the community.

The questionnaires were pre-tested with two participants, each from the school and the hospital and were physically distributed to the participants during data collection. Thereafter, the questionnaires were concurrently distributed to the two institutions, and participants were given a period of two weeks to respond. For the rigour, the conceptual framework conferred construct validity and credibility (Adom, Hussein and Adu Agyem, 2018:438).

The adolescent girls were excluded from the participants for ethical reasons. Data from the questionnaires was uploaded to the Kobocollect toolbox Data and analysed thematically. Themes and codes were developed from the research objectives and validated by the authors independently. The findings were presented in text format.

Ideally, structured questionnaires are often used in quantitative studies, in qualitative studies they may pose limits in depths of findings when. However, to ensure that qualitative depth was maintained in the study the structured questionnaires were as well open ended in order to give room for the participants to exhaust issues in answering to the study.

RESEARCH FINDINGS

The research findings presented below are categorised thematically as per Buckland's (1991) Information Access framework employed in the study.

Availability

To ascertain the availability of SRH information to adolescent girls in the Sipepa Community, Tsholotsho District, the study showed that SRH information was moderately available in the Sipepa Community. This is highlighted in the response by Participant 5, who stated:

"SRH information is shared at school. The school plays a great role as some of the adolescents come from homes where discussing SRH information is taboo."

Organisations that avail SRH information include AfricAid, Bantwana Zimbabwe, the Campaign for Female Education (CAMFED), Dreams, the Ministry of Health and Childcare (MoHCC), Pangaea Zimbabwe AIDS Trust, and the ZRP. The programmes run by these organisations include guidance and counselling, girl empowerment workshops, pamphlet distribution, family planning, HIV testing services, a young mentor mother programme and awareness campaigns on abuse, girl child rights and sexual health.

Identification

Sources of Information – To determine whether adolescent girls can identify the sources of SRH information in the Sipepa Community, Tsholotsho District, the study found that adolescents in the Sipepa Community struggle to identify available SRH information sources. While the literature does not emphasise consulting other people as a significant reference for SRH information, this study found that adolescents often turned to family members, and mainly friends or peers, for SRH information. Participant 3 emphasised that:

"We have many SRH resources, but most of the time, adolescents prefer to ask their age mates for advice."

Communication with parents, particularly mothers, was also acknowledged as an important source of SRH information. Formal organisations were not greatly recognised as a source.

Price to the user

To establish the cost of accessing SRH information by adolescent girls in the Sipepa Community, Tsholotsho District. We learned that financial and psychological costs affect adolescents in the Sipepa Community, Tsholotsho District, who must have access to SRH information.

Financial Cost – It was noted that the community was low-resourced, and there was no way that the participants would see the families of adolescents purchasing literature on SRH. Participant 17 also indicated that funding SRH programmes in the community was difficult. Participant 17 stated that:

"Many health initiatives and campaigns need funding, including SRH programmes. It is challenging to secure ongoing funding to facilitate access to SRH information for adolescent girls."

Psychological Costs – Participants pointed out stigma-related aspects as psychological costs associated with accessing SRH information among the girls in the Sipepa Community. They stated that girls in the community often get labelled as promiscuous if they ask for SRH information or are seen visiting family planning services. Thus, fear of stigma was a challenge in accessing SRH information.

Language and resource barriers arose because information resources in the community were mainly written in English. It was reported that this created comprehension challenges for adolescents and their families. Simplification or readability services are financially and psychologically costly as some SRH terms and meanings may be lost. In addition, barriers such as local cultural beliefs and social events, such as 'galas' and 'after-parties', instil bad SRH practices, hence cancelling the efforts made when disseminating SRH information.

Cost to the Provider

Additionally, it was determined that families, hospitals, and organisations regarded as providers incur a cost for adolescent girls in the Sipepa Community, Tsholotsho District, to access SRH information.

Cost to Family – It was reported that the provision of SRH information was costly when the family was already expected to bear existing costs associated with their children's health. The costs would arise from looking for adequate resources, funding trips to places to access SRH information and participating in activities where their children would get educated on SRH issues. In addition, four participants working with the Sipepa Rural Hospital indicated that they always involved family members when dealing with adolescents. This is also a cost in the form of effort and time spent for the family. Family emotional and psycho-social support was found to be limited. Participant 6 noted that:

"Of late, families rarely sit down to discuss SRH with adolescent girls. This used to be quite common, but as the world changes, the family's role has diminished."

This shows that the nature of family involvement is important and helps monitor adolescent girls and provide SRH information with psychological and emotional support.

Cost to School and Hospital – Most participants confirmed that their institutions incurred costs and played an important role in providing SRH information. The activities that enhanced information provision in the community included educating adolescent girls on SRH issues, providing youth-friendly corners where the adolescents could visit for private consultation, keeping records of STI prevalence, and providing guidance and counselling sessions.

Cost to Organisations – 20 participants highlighted collaborations between different institutions and organisations in educating and providing access to SRH information to adolescent girls. Organisations mentioned include AfricAid, Bantwana Zimbabwe, CAMFED, Dreams, the MoHCC, Pangaea Zimbabwe AIDS Trust, and the ZRP. These organisations face operational costs when providing SRH information to the Sipepa Community.

Cognitive Access

Understanding and Reception – To determine if the adolescent girls understand and welcome the SRH information available in the Sipepa Community, Tsholotsho District, the study found that participants expressed scepticism about adolescents' peers' understanding of SRH information. They highlighted a need to understand SRH information, suggesting that knowledge alone may not translate into improved practices. A further question was asked to the participants to know whether they had noticed any changes in attitudes or behaviour concerning SRH among adolescent girls after receiving SRH information. Most of the responses indicated that the changes were unsatisfactory. Participant 1 mentioned that:

"It has become worse as adolescents start experimenting with the learnt information."

Nonetheless, Participant 16 stressed that:

"Students now know their rights and are confident to report any abuse, even from peers. There has been moderate change. Learners are open to learning about SRH."

Six participants indicated changes in attitudes towards SRH among adolescents after receiving information. In addition, participants stated that some behaviour changes could be noted among adolescent girls, such as clearing myths and misconceptions surrounding SRH.

Acceptability

Acceptance of SRH information – Additionally, to determine if the adolescent girls understand (cognitive access) and welcome (acceptability) the SRH information available in the Sipepa Community, Tsholotsho

District., the study found that participants were sceptical about the degree of acceptance of SRH information. Participant 1 highlighted that even if the adolescent girls were exposed to SRH information, they did not practice what was taught instead, they would experiment. Sharing SRH information clearly to ensure acceptability through interactive sessions, using visual aids, and guiding towards referrals of youth-friendly SRH services was recommended.

Table 2: Summary of Findings

Buckland's Factors (Dimension)	Key Finding	Primary Challenge
Availability	Moderately available via schools/NGOs.	Home environment is often restrictive (taboo)
Identification	Girls rely on peers/friends.	Formal sources are not easily identified.
Price to the user	High psychological "cost."	Stigma (fear of being called promiscuous).
Cost to the provider	High operational and time costs.	Diminishing role of the family unit.
Cognitive Access	Moderate change in attitude.	Knowledge does not always lead to better practice.
Acceptability	Scepticism regarding behavior change.	Information is often ignored or used for experimentation.

The "Seventh" Factor (Environmental Interference)

The study found that the environmental factor is so powerful that it "cancels the efforts made when disseminating SRH information…" between the provider and the users. The environmental factors consist of cultural taboos, galas, peer pressure, and local beliefs. These are environmental anti-education occurrences in the community. Thus, even if the SRH information is available and understood, the physical and social environment of the community provides a stronger, opposing behavioural cue.

DISCUSSION OF FINDINGS

The study's findings reveal crucial insights about access to SRH information among adolescent girls in the Sipepa Community. Using Buckland's (1991) framework of information access, the study identifies several barriers and facilitators that shape the SRH information landscape.

The Psychosocial Burden

The study reveals that while information is available the 'Price to the User' is socially expensive. In small communities like Sipepa, reputation and belonging are a valued currency. This aligns with Buckland (1991) and Dahlberg (2021), who argue that cultural and social factors impact the acceptability and accessibility of SRH information, leading to poor health outcomes. In addition, these findings also align with Ninsiima *et al.* (2021), who point out that factors such as value perception influence how information can be accepted greatly. Accessing SRH information by visiting Sipepa Rural Hospital carries a psychosocial tax for adolescent girls with a risk of being labelled. The long term of health knowledge for adolescent girls is abstract and delayed. While the social death which comes from stigma is immediate and valid. Ultimately adolescent girls end up with a choice of avoiding formal sources in order to preserve social image regardless of staying uninformed. To associate with seeking SRH information is an unaffordable social price.

Peer Mediated Accuracy Erosion

There is a trust gap between SRH information providers and the adolescent girls. This study shares the sentiments of Dahlberg (2021), who states that identifying suitable sources is important, especially for SRH information. In

this study adolescents use peer SRH information which may be empathic and as well anonymous even if it is of low accuracy. Peers can act as a filter by removing clinical or boring parts and add myths or personal opinions. The adolescent girls know that the SRH information exist but still likely associate or accept the peer-validated version which can lead to experimentation instead of protection.

Linguistic and Symbolic Exclusion

The study found that available SRH information sources are in the English language. Language is not just a tool for communication; it is a symbol of authority and belonging. The provided SRH information which is in English may unintentionally signal that information is an external/foreign construct rather than a local necessity. This creates a cognitive distance. If adolescent girls fail to conceptualise SRH information terms in their mother tongue, risk internalisation will be impossible. The information remains something the NGOs say rather than something that can be useful in adolescent girls' life. This explains why knowledge alone does not translate into improved practices the knowledge is stored in a mental compartment that is disconnected from the real-life compartment.

Environmental Counter-Socialisation

The study showed that social events like 'galas' and 'after-parties' instil practices that cancel the efforts of SRH dissemination. There is a conflict between what adolescent girls formally learn and what they see rewarded in their community. Mbizvo *et al.* (2023), asserts that accessing comprehensive SRH information is crucial for promoting safer sexual practices. Whilst the "galas" mentioned in the study represents a powerful environmental cue where social status is tied to behaviours that contradict SRH advice. When the environment provides immediate rewards for bad SRH practices (popularity, excitement, peer acceptance), it creates a feedback loop that is much stronger than a pamphlet from Sipepa Rural Hospital or a school lesson from Sipepa High School. The barrier here is structural dissonance the community's social calendar is working in direct opposition to its health goals.

CONCLUSION

In conclusion, the study showed that SRH information was moderately available to adolescent girls. Girls in the Sipepa Community often rely on their peers for SRH information, while communication with parents regarding SRH is limited. The psychological stigma associated with seeking SRH information seems to prevent girls from accessing SRH information. It was determined that comprehensive information dissemination strategies are required to improve the accessibility of SRH information in the Sipepa Community. Other strategies suggested by the study include open communication between adolescents and their families, introducing peer-led initiatives on SRH, providing resources that are simple to read, resources in local languages, and resources that are culturally acceptable and relevant. Costs that affect access to SRH information also need to be investigated in research to explore the psychological and financial barriers. When these investigations are conducted, research will develop solutions to assist adolescent girls in accessing SRH information. Lastly, it was determined that collaboration among institutions, communities, health services workers and other stakeholders is important to improve SRH information access for adolescent girls. These solutions create a collective effort that guarantees further improvement of SRH information accessibility and improves the health of adolescent girls in the Sipepa Community.

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