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# Assessment of the Prevalence, Attitudes, and Barriers to Parent-Adolescent Sexual Communication in Osun State

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**Abstract**

Adolescent sexuality remains one of the most neglected areas of young people's development in Nigeria. Thus, adverse reproductive health outcomes such as sexually transmitted infections, unplanned pregnancies, unsafe abortion, maternal morbidity and mortality are recurrent deaths among this population. This study was anchored on Rational Choice Theory and investigated sexuality education among parent-adolescent dyads in-school adolescents in Ile-Ife with a view to understanding the magnitude, attitude and barriers to parent-child communication on sexual matters. Data were collected through 842 questionnaires administered to adolescents and their parents selected through a multi-stage sampling technique. Findings revealed that the prevalence of parent-adolescent communication on sexual matters was 55.8% among parents, while 43.0% of the adolescents indicated that they practised sexual and reproductive health communication. Both parents and adolescents had a positive attitude towards open and comprehensive sexual education. Prioritising sexuality education among adolescents can go a long way in demystifying unnecessary insensitivity that pervades sexuality discourses among Nigerian youth.

*Keyword*: Parent-Adolescent sexual communication, Attitude, Barriers

## Introduction

Adolescence is a critical human life cycle period marked by significant physical, psychological, and emotional changes. Defined by the United Nations as the period of life between the ages of 10 and 19, it is the transition period between childhood and adulthood; and is usually characterized by significant growth and development, heightened curiosity, and experimentation, particularly regarding sexual and reproductive health, of which parents play a key role in bridging this gap. More than ever, 1.3 billion adolescents in the world today make up 16 per cent of the world's population (Partnership for Maternal Newborn and Child Health UHL, 2023). As children up to the age of 18, most adolescents are protected under the Convention on the Rights of the Child. Yet, their vulnerabilities and needs, especially sexual and reproductive health, are distinctly different from those of children and therefore often remain unaddressed. Maintaining and improving Adolescent Sexual and Reproductive Health (ASRH) continues to be of global public health importance, particularly as over a sixth of the world's population is aged 10–19 years (World Health Organisation., 2023).

In Sub-Saharan Africa (SSA), young people aged 10–24 years account for a third of the population (Bello et al., 2017). It was estimated that 15 million adolescents get married before 20 years of age each year, out of which 90% of births within marriage were recorded among 15 to 19-year-olds ((United Nations, 2013 & Malhotra & Elnakib, 2021)). In the same vein, adolescents living in SSA also bear the greatest burden of HIV/AIDS (89%) globally (Bastien et al., 2011; World Health Organisation., 2023). Other sexual and reproductive health (SRH) issues affecting adolescent girls in SSA, and which may

contribute to high morbidity and mortality rates, include unsafe abortions, complications during pregnancy and childbirth, and gender-based violence, including female genital mutilation (Kulkarni, 2016). High-risk sexual behaviour amongst adolescent boys in SSA lead to fatherhood during their adolescent years, which can adversely affect mental health and wellbeing, as well as occupational and educational opportunities (Madiba & Nsiki, 2017).

In many African countries, sexual communication is often considered taboo, and parents may be hesitant or uncomfortable discussing these topics with their children. This can be due to cultural, religious, or social norms that stigmatize open discussions about sex. As a result, many adolescents turn to peers or other unreliable sources for information, which increases their vulnerability to misinformation and risky behaviourIn Nigeria, adolescent sexual health is a crucial issue (Akuiyibo et al., 2021). Adolescents often lack proper sexual education, leading to risky behaviours such as early sexual debut, unprotected sex, teenage pregnancies, and sexually transmitted infections (STIs), including HIV (Omona & and Ssuka, 2023). One of the key preventive measures is effective communication between parents and adolescents about sexual health. Parent-adolescent sexual communication plays a vital role in promoting healthy sexual behaviours among young people, reducing the risk of early sexual activity, teenage pregnancies, sexually transmitted infections (STIs), and unsafe sexual practices. However, in many cultural settings, particularly in African societies, such discussions remain limited due to cultural, social, and religious barriers (Okpalaku & Ogubuike, 2025). Understanding the dynamics of parent-adolescent sexual communication in this context is, therefore, critical for promoting sexual health education and improving adolescent health outcomes (Nyathi et al., 2020))

In Osun State, as in other parts of Nigeria, adolescence is a critical period where young people face increasing exposure to peer pressure, social media, misinformation, and experimentation regarding sexual health. Parents, as primary caregivers, are ideally and strategically positioned to provide accurate information and guidance to their adolescents and help them make informed decisions. However, cultural norms often discourage open discussions about sexuality, with parents fearing that such conversations may encourage sexual experimentation or violate cultural and religious values and norms. Many parents may feel uncomfortable or ill-equipped to initiate these discussions, thereby leaving adolescents to seek information from less reliable and more dangerous sources, such as peers or the internet, which increases their vulnerability to risky behaviours with attendant deadly consequences and disastrous outcomes. (Chidinma & Ogubuike, 2024)

This study seeks to explore the attitudes of parents and adolescents toward sexual communication, the barriers that prevent open and effective dialogue between parents and adolescents, and the role of cultural and religious beliefs in shaping these attitudes. Some common barriers to parent-adolescent sexual communication that will be explored in the study include Cultural Taboos, in which talking about sex is considered inappropriate, especially with young people (Chidinma & Ogubuike, 2024). Parenting Styles, in which, some parents may adopt an authoritarian approach, where open communication is discouraged; Lack of Knowledge, in which, parents may feel ill-equipped to discuss sexual health because of their lack of education or understanding (Zheng, 2023); Fear of Encouragement, in which, some parents believe that discussing sex might encourage adolescents to engage in sexual activity (Aventin et al., 2020). Gender Dynamics, in which, there may be differences in how communication occurs depending on whether the adolescent is male or female, with girls often facing stricter restrictions (Adetokunbo et al.,2022.)

Osun State, like many regions in Nigeria, is deeply influenced by traditional and religious values. These values can either support or inhibit sexual communication between parents and adolescents. For example, religious beliefs may encourage abstinence and promote moral teachings, but they might also discourage detailed conversations about sexual health. Understanding

these influences is critical to addressing the barriers to effective communication. This approach, therefore, enables a comprehensive understanding of the factors influencing parent-adolescent communication, ranging from cultural and religious beliefs to personal discomfort and lack of knowledge. In the same vein, by identifying the attitudes and barriers to sexual communication, the study could provide potential recommendations for improving sexual health education in families.

Given the importance of family communication in shaping adolescents' sexual health behaviours, this study aims to shed light on a critical area of adolescent health, with implications for public health policy, family dynamics, and educational interventions; and also provide valuable insights that could inform interventions, such as parent education programs and community-based strategies, to encourage more open and effective sexual health communication within families. Also, by addressing the underlying barriers and attitudes, the study has the potential to contribute to the development of culturally sensitive approaches that promote the well-being of adolescents globally.

Sexual orientation of young people in Nigeria exposes them to a serious public health challenge owing to lack of disposition of parents and guardians to undertake this important parental obligation. This is couched in the low comfort level of older family members to engage in sexuality discourse with adolescents, inordinate preoccupation with economic activities at the expense of young people's sexual orientation, lack of experience of sexuality education, the notion that ignorance of young people about sexual matters will enhance chastity while sex education predisposes young people to sexual exploration. Thus, sexual orientation among adolescents is either not prioritised or not given completely by the older family members. Yet, sexual activities start very early in Nigeria, especially among adolescents with more than 18% of girls having had sex before age 15 years (National Population Commission (NPC) [Nigeria] & ICF, 2019)).

Furthermore, a vast majority of adolescents in Nigeria are not informed about sexual matters, including menstruation, ovulation, breast development, self-esteem and agency to resist unsolicited sexual overtures (ref). However, most of these adolescents are sexually active to the dismay of their parents. Meanwhile, comprehensive sexuality education, which should start primarily from home is beneficial to both adolescents who had never had sex and those who had had sex. The adolescents who are virgins could help to promote abstinence while those sexually active could be well-informed of positive sexual and reproductive health decisions in future. The consequences of lack of discussion of sexuality education, especially between parents and adolescents may lead to adverse health outcomes, including early premarital sex, unwanted pregnancy, unsafe abortion, sexually transmitted infections, maternal morbidity and mortality. (Alukagberie et al., 2023). However, there is lack of evidence on studies which investigate parent-adolescent

## Methods

*Study settings*

This study was conducted in Osun State, located in the southwestern region of Nigeria. Osun State is characterized by a mix of urban and rural areas, with the capital city, Osogbo, serving as the administrative and economic hub. The state has a diverse population, comprising various ethnic groups but predominantly Yoruba and various religious groups, which influence the cultural norms and family structures. This socio-cultural diversity plays a critical role in shaping parental attitudes and communication patterns, especially regarding sensitive topics such as sexual health. The state's projected population is about 4.3 million people, with 23.7% being adolescents and 55.5% living in rural areas (Bamidele et al., 2025). The state comprise 30 local government areas stratified into 3 senatorial districts with 10 LGAs each. Osun State was selected because adolescents and parents in the state were not communicating much about topics related to sexual and reproductive health (Fehintola et al., 2021). Results related to sexual and reproductive health (SRH) can (Fehintola et al., 2021) be negatively impacted by secondary school

students, who generally feel uncomfortable talking to their parents or guardians about sexual matters. Parental struggles might often lead to discussions about sexuality with their teenagers. The study was conducted between February and April 2024.

*Research design*

The study adopted a cross-sectional quantitative research design.

*Population and Sample Size*

The study population involved in-school adolescents and parents of the adolescents. The study included male and female adolescents aged 10- 19 in selected senior secondary school classes and their respective parents or guardians in selected private and public schools in Osun State. Both adolescents and their parents were involved in the study. Eligibility was based on parental consent, adolescent assent, and the availability of the respondents in the selected schools. Adolescents who were borders and those who didn't give their assent were excluded from the study.

The sample size for the quantitative aspect was determined using Cochran's formula:

$$n = \frac{z^2pq}{d^2}$$

Where n =the desired sample size.

z = the standard normal deviation, usually set at 1.96, corresponding to a 95% confidence level.

P = parents-adolescents' communication prevalence rate of 48.5% (Ojebuyi et al., 2019)

q = 1 – p = 1 – 0.46 = 0.54

d = degree of accuracy desired, usually set at 0.05.

n= 381.7. Adding an attrition rate of 10%, the minimum sample size was estimated at 421.

*Sampling Procedure*

Multistage sampling was used for the quantitative data collection. In the first stage, Ile-Ife was purposively selected for the study due to the large population of adolescents in the town owing to the presence of higher institutions. In stage two, random sampling was used to select two local government areas (Ife North and Ife Central) from four LGAs in Ile-Ife. In the third stage, the schools were stratified into private and public schools, and two (2) schools were randomly selected in each of the strata. The final stage involved the random selection of eligible respondents (parents and adolescents) based on parental consent (the parents were invited to the school for a meeting where they gave their consent and participated in the study) and the availability of respondents in the selected schools. The eligible students were recruited as well as their respective parents.

*Study instrument*

A self-administered questionnaire was developed using previous studies to answer the study objectives. The content validity was assessed by professionals in Reproductive Health and the reliability test was 0.710 for the adolescent questionnaire and 0.817 for the parent questionnaire after piloting. A total of 421 questionnaires were administered on parents and adolescents. A sample questionnaire was designed and pre-tested in locations other than those selected for the data collection. The final questionnaire included closed and open-ended items, addressing parent-adolescent sexual communication, attitudes and barriers.

*Data Collection*

The data were collected using structured questionnaires by 6 trained fieldworkers, administered to the adolescents and their parents. The instrument was prepared in the English language and translated into Yoruba. The instrument was pretested in a secondary school in another state for modification and then finalized for the actual study. The consent and permission of the participants were sought before the research questionnaire was given. Participants were asked to sign a well-written consent form on the questionnaire after the study had been explained to them to show their voluntary participation. The questionnaires for the adolescents were administered by visiting their classes, and those of the parents were administered based on the identification number

attached to each adolescent and their parents, who were invited to a parent-teacher association meeting (PTA). The questionnaires were collected after being completed, and the participants were appreciated for their contribution and time.

*Measures*

The question of whether the parents or adolescents had a Parent-Adolescent discussion of sexual issues was used as the prevalence of parent-adolescent communication. Attitudes toward parent-adolescent sexual communication were measured using 6 questions on a scale of 4 (ranging from strongly disagree (1) to strongly agree (4)). Scores below the mean score were categorized as "poor attitude," while scores ≥ mean score were categorized as "good attitude." Barriers to parent-adolescent sexual communication were measured using 7 questions, which were answered dichotomously.

*Data analysis*

Quantitative data were edited and cleaned to eliminate inconsistencies that could undermine the validity and reliability of data. Data were entered into Excel Software for effective data management and finally exported to the Statistical Package for Social Sciences for analysis at univariate, bivariate and multivariate to indicate percentage distribution and test of association.

*Ethical consideration*

Ethical approval for the study was obtained from the Institute of Public Health Review Board, Obafemi Awolowo University (HREC NO: IPH/OAU/12/2436). Permission was obtained from the school authorities of the selected schools before the study was conducted. The consent of both parents and adolescents was sought prior to their participation in the study, the right to withdraw at any point or withhold information perceived to impinge on their privacy was fully acknowledged and respected. Additionally, their confidentiality was guaranteed to the extent that information would never be traced to these respondents.

## Results

**Table 1: Socio-demographic characteristics (Adolescents)**

| Variable | Frequency | Percentage |
|---|---|---|
| **Age group** | | |
| 10-14 years | 180 | 42.8 |
| 15-19 years | 241 | 57.2 |
| **Gender** | | |
| Male | 168 | 39.9 |
| Female | 253 | 60.1 |
| **Ethnic group** | | |
| Hausa | 6 | 1.4 |
| Igbo | 28 | 6.7 |
| Yoruba | 387 | 91.9 |
| **Religion** | | |
| Christianity | 361 | 85.7 |
| Islam | 60 | 14.3 |
| **Level of religiosity** | | |
| Religious | 403 | 95.7 |
| Not religious | 18 | 4.3 |
| **Current class level** | | |
| Junior class | 250 | 59.4 |

| | | |
|---|---|---|
| Senior class | 171 | 40.6 |
| **Parents have male adolescent children** | | |
| Yes | 330 | 78.4 |
| No | 91 | 21.6 |
| **Parents have female adolescent children** | | |
| Yes | 353 | 83.8 |
| No | 68 | 16.2 |
| **Number of adolescent children in the house** | | |
| 1 | 79 | 18.8 |
| 2 and above | 342 | 81.2 |
| **Living arrangement with parent** | | |
| Living with parents | 364 | 86.5 |
| Not living with parents | 57 | 13.5 |

Table 1 shows the socio-demographic characteristics of adolescents. More than half (57.2%) of them were between the age of 15-19 years while 42.8% were between the age of 10-14 years. Similarly, about 60% of them were female and 39.9% were males, the majority of them were Yoruba (91.9), more than four-fifths were Christians (85.7%), the majority of them were religious (95.7%), about half (59.4) of them were in junior class, while 40.6% were in senior secondary class. More than three-quarters (78.4%) reported that their parents have male adolescent children, and the majority (83.8%) said their parents have female adolescent children. More than four-fifths of them said there was more than one adolescent in their house and 86.5% of them lived with their parents.

**Table 2: Parents' socio-demographic characteristics**

| Variable | Frequency | Percentage |
|---|---|---|
| **Age group** | | |
| 30-39 years | 25 | 5.9 |
| 40-49 years | 293 | 69.6 |
| >/=50 years | 103 | 24.5 |
| **Sex** | | |
| Male | 82 | 19.5 |
| Female | 339 | 80.5 |
| **Ethnic group** | | |
| Hausa | 9 | 2.1 |
| Igbo | 30 | 7.1 |
| Yoruba | 382 | 90.7 |
| **Religion** | | |
| Christianity | 365 | 86.7 |
| Islam | 56 | 13.3 |
| **Religious level** | | |
| Religious | 405 | 96.2 |

| | | |
|---|---|---|
| Not religious | 16 | 3.8 |
| **Marital status** | | |
| Single | 14 | 3.3 |
| Married | 375 | 89.1 |
| Separated | 22 | 5.2 |
| Widowed | 10 | 2.4 |
| **Age as at first marriage** | | |
| </=19 years | 2 | 0.5 |
| 20-29 years | 307 | 72.9 |
| >/=30 years | 112 | 26.6 |
| **Marriage type** | | |
| Monogamy | 344 | 81.7 |
| Polygamy | 77 | 18.3 |
| **Highest level of education** | | |
| None | 8 | 1.9 |
| Primary | 20 | 4.8 |
| Secondary | 183 | 43.5 |
| Tertiary | 210 | 49.9 |
| **Employment status** | | |
| Unemployed | 63 | 15.0 |
| Employed | 358 | 85.0 |
| **Partner employment status** | | |
| Unemployed | 66 | 15.7 |
| Employed | 355 | 84.3 |
| **Have male adolescent children** | | |
| Yes | 339 | 80.5 |
| No | 82 | 19.5 |
| **Have female adolescent children** | | |
| Yes | 353 | 83.8 |
| No | 68 | 16.2 |
| **Number of adolescent children** | | |
| 1 | 70 | 16.6 |
| 2 and above | 351 | 83.4 |
| **Living arrangement with partner** | | |
| Living with spouse | 355 | 84.3 |
| Not living with a spouse | 66 | 15.7 |

Table 2 shows the socio-demographic characteristics of the parents. A higher proportion of them (69.6%) were between the age of 40-49 years, more than three-quarters (80.5%) were mothers, and 90.7% were Yoruba. More than four-fifths (86.7%) practiced Christianity; most were religious (96.2%). About ninety of 100 (89.1%) were married, 3.3% were single parents, 5.2% were separated and 2.4% were widowed. About three-quarters (72.9%) of them got married first between the age of 20-29 years, the majority of them have a monogamous family (81.7%),

about 43.5% of them had secondary education and 49.9% of them had tertiary education, indicating that the parents were educated., also a majority of them were employed (85.0%), 80.5% and 83.8% of them said they have male and female adolescents respectively. The majority of them reported having more than one adolescent child (83.4%) and 84.3% of them live with their spouse

**Table 3: Prevalence of Parent-Adolescent Sexual Communication**

| Discussion of SRH Issues | Parent (N=445) | Adolescent(N=445) | Statistics |
|---|---|---|---|
| Yes | 235(55.8) | 181(43.0 | Kappa=0.243 |
| No | 186(44.2) | 240(57.0) | P<0.001 |
| | 127(30.2) | | |

As shown in Table 3, respondents were asked if they practised parent-adolescent SRH communication. of 421 respondents, more than half of the parents (55.8%) reported that they practice SRH communication, and lower than half (43.0%) of the adolescents said they practiced Parent-Adolescent SRH communication. Of the 421 Parent-Adolescents dyads slightly lower than one-third (127/421) of them practiced Parent-Adolescent SRH communication. Although the level of agreement between the practice of Parent-Adolescent SRH communication was statistically significant, the level of agreement is quite low (Kappa=0.243, $p<0.001$).

**Table 4: Attitude towards Parent-Adolescent Sexual Communication**

| | **Parents** | | | | **Adolescents** | | | |
|---|---|---|---|---|---|---|---|---|
| | **SD** | **D** | **A** | **SA** | **SD** | **D** | **A** | **SA** |
| Never say anything that relates to sexuality even if adolescent ask for information | 227(53.9) | 111(26.4) | 56(13.3) | 27(6.4) | 169(40.1) | 117(27.8) | 78(18.5) | 57(13.5) |
| Because sex outside the marriage relationship is a sin, a parent should not discuss this issue with their adolescent child | 222(52.7) | 101(24.0) | 59(14.0) | 39(9.3) | 196(46.6) | 109(25.9) | 67(15.9) | 49(11.6) |
| Postpone any parent-child discussion about sexuality until the marriage of the child. | 231(54.9) | 107(25.4) | 46(10.9) | 37(8.8) | 207(49.2) | 111(26.4) | 76(18.1) | 27(6.4) |
| Relegate sexual education to someone else with professional training such as a health worker or teacher. | 166(39.4) | 96(22.8) | 116(27.6) | 43(20.2) | 133(31.6) | 120(28.5) | 95(22.6) | 73(17.3) |
| Limit sexual discussion to the biological aspects of sexuality (e.g. body parts, genitals and menstruation | 139(33.0) | 152(36.1) | 102(24.2) | 28(6.7) | 129(30.6) | 117(27.8) | 111(26.4) | 64(15.2) |
| Incorporate other elements such as dating, romantic love, and fidelity while discussing with adolescents | 128(30.4) | 73(17.3) | 127(30.2) | 93(22.1) | 121(28.7) | 103(24.5) | 110(26.1) | 87(20.7) |

Table 4 shows the attitude towards parent-adolescent sexual communication. More than half of the adolescents strongly disagreed that parents should never say anything that relates to sexuality even if adolescents ask for information which is quite higher than the proportion of adolescents who strongly disagreed (40.1%). Both parents and the adolescents had a tie as regards religious belief of sex outside marriage to be a sin, so a parent shouldn't discuss SRH issues, 52.7% of the parents strongly disagreed and 46.6% of the adolescents strongly disagreed. Similarly, postponing discussion on SRH issues until marriage was clearly disagreed by both parents and the adolescents. Delegating sexual education to expert such as teachers and healthcare workers was strongly disagreed and disagreed by 39.4% and 22.8% of the parents similar to 31.6% and 28.5% of the adolescents who strongly disagreed and disagreed respectively. More than half of the parents strongly disagreed and disagreed that sexual discussion should be limited to biological aspects which is similar to about three-fifth of the adolescents who strongly disagreed and disagreed. Slightly more than half of the respondents strongly disagreed and disagreed with incorporating other elements such as dating in parent-adolescent communication similar to about half of the adolescent that strongly disagreed and disagreed

**Table 5: Barriers to Parent-Adolescent Sexual Communication**

| Variable | Parent | | Adolescent | |
|---|---|---|---|---|
| | Yes | No | Yes | No |
| Children may not want to talk about sexual health | 334(79.3) | 87(20.7) | 371(88.1) | 50(11.9) |
| Find it difficult to explain sexual and reproductive health issues | 12329.2) | 298(70.8) | 257(61.0) | 164(39.0) |
| Feel adolescents may become sexually active after open discussion of sexual issues | 209(49.6) | 212(50.4) | 223(53.0) | 198(47.0) |
| Have poor knowledge of sexual and reproductive health contents | 111(26.4) | 310(73.6) | 184(43.7) | 237(56.3) |
| Cultural barrier is the problem | 139(33.0) | 282(67.0) | 155(36.8) | 266(63.2) |
| Fear of social disapproval | 141(33.5) | 280(66.5) | 226(53.7) | 195(46.3) |
| Feel ashamed or embarrassed to discuss it | 108(25.7) | 313(74.3) | 271(64.4) | 150(35.6) |

As regards barriers to parent-adolescent sexual communication as shown in table 5, both, adolescents and parents agreed on children not wanting to talk about their sexual health (parent= 79.3%, adolescent=88.1%) and adolescents becoming sexually active after open discussion of sexual issues (parent= 49.6%, adolescent=53.0%) as major barriers to parent-adolescent communication. More than three-fifth of the adolescents said difficulty in explaining SRH issues as a barrier while only 29.2% of the parents saw it as a problem, 43.7% of the adolescents said poor knowledge of SRH contents is a barrier to the communication while 26.4% of the parent don't think it's a barrier. More than half of the adolescents (53.7%) said fear of social acceptance was a barrier while one-third of the parent had the same thought. Both parents and adolescents said embarrassment discussing SRH issues also is a barrier to parent-adolescent communication.

**Table 6a: Association between socio-demographic characteristics and prevalence of parent-adolescent sexual communication**

| Variable | Prevalence of sexual communication | | Statistics |
|---|---|---|---|
| | Yes | No | |
| **Age group** | | | |
| 10-14 years | 94(52.2) | 86(47.8) | $X^2$=10.928 |
| 15-19 years | 87(36.1) | 154(63.9) | **p=0.001** |
| **Gender** | | | |

| | | | |
|---|---|---|---|
| Male | 38(22.6) | 130(77.4) | $X^2$=47.347 |
| Female | 143(56.5) | 110(43.5) | **P<0.001** |
| **Ethnic group** | | | |
| Hausa | 5(83.3) | 1(16.7) | $X^2$=5.728 |
| Igbo | 15(53.6) | 13(46.4) | p=0.057 |
| Yoruba | 161(41.6) | 226(58.4) | |
| **Religion** | | | |
| Christianity | 162(44.9) | 199(55.1) | $X^2$=3.662 |
| Islam | 19(31.7) | 41(68.3) | P=0.056 |
| **Level of religiosity** | | | |
| Religious | 175(43.4) | 228(56.6) | $X^2$=0.176 |
| Not religious | 6(33.3) | 12(66.7) | p=0.398 |
| **Current class level** | | | |
| Junior | 108(43.2) | 142(56.8) | $X^2$=0.011 |
| Secondary | 73(42.7) | 98(57.3) | P=0.917 |
| **Parents have male adolescent children** | | | |
| Yes | 138(41.8) | 192(58.2) | $X^2$=0.860 |
| No | 43(47.3) | 48(52.7) | p=0.354 |
| **Parents have female adolescent children** | | | |
| Yes | 158(44.8) | 195(55.2) | $X^2$=2.782 |
| No | 23(33.8) | 45(66.2) | p=0.095 |
| **Number of adolescent children in the house** | | | |
| 1 | 36(45.6) | 43(54.4) | $X^2$=0.263 |
| 2 and above | 145(42.4) | 197(57.6) | p=0.608 |
| **Living arrangement with parent** | | | |
| Living with parents | 168(46.2) | 196(53.8) | $X^2$=10.960 |
| Not living with parents | 13(22.8) | 44(77.2) | **p=0.001** |

**Table 6b: Association between socio-demographic characteristics and prevalence of parent-adolescent sexual communication (Parent)**

| **Variable** | **Prevalence of sexual communication** | | **Statistics** |
|---|---|---|---|
| | **Yes** | **No** | |
| **Age group** | | | |
| 30-39 years | 19(76.0) | 6(24.0) | $X^2$=4.700 |
| 40-49 years | 159(54.3) | 134(45.7) | p=0.095 |
| >/=50 years | 57(55.3) | 46(44.7) | |
| **Sex** | | | |
| Male | 50(61.0) | 32(39.0) | $X^2$=1.098 |
| Female | 185(54.6) | 154(45.4) | p=0.295 |
| **Ethnic group** | | | |
| Hausa | 5(55.6) | 4(44.4) | $X^2$=2.730 |
| Igbo | 21(70.0) | 9(30.0) | p=0.255 |
| Yoruba | 209(54.7) | 173(45.3) | |
| **Religion** | | | |
| Christianity | 201(55.1) | 164(44.9) | $X^2$=0.628 |
| Islam | 34(60.7) | 22(39.3) | p=0.428 |
| **Religious level** | | | |
| Religious | 225(55.6) | 180(44.4) | $X^2$=0.301 |
| Not religious | 10(62.5) | 6(37.5) | p=0.583 |
| **Marital status** | | | |

| | | | |
|---|---|---|---|
| Single | 8(57.1) | 6(42.9) | $X^2$=14.014 |
| Married | 201(53.6) | 174(46.4) | **p=0.003** |
| Separated | 20(90.9) | 2(9.1) | |
| Widowed | 6(60.0) | 4(40.0) | |
| **Age as at first marriage** | | | |
| </=19 years | 1(50.0) | 1(50.0) | $X^2$=0.618 |
| 20-29 years | 168(54.7) | 139(45.3) | p=0.734 |
| >/=30 years | 66(58.9) | 46(41.1) | |
| **Marriage type** | | | |
| Monogamy | 197(57.3) | 147(42.7) | $X^2$=1.599 |
| Polygamy | 38(49.4) | 39(50.6) | p=0.206 |
| **Highest level of education** | | | |
| None | 5(62.5) | 3(37.5) | $X^2$=2.798 |
| Primary | 10(50.0) | 10(50.0) | p=0.424 |
| Secondary | 110(60.1) | 73(39.9) | |
| Tertiary | 110(52.4) | 100(47.6) | |
| **Employment status** | | | |
| Unemployed | 36(57.1) | 27(42.9) | $X^2$=0.053 |
| Employed | 199(55.6) | 159(44.4) | p=0.819 |
| **Partner employment status** | | | |
| Unemployed | 43(65.2) | 23(34.8) | $X^2$=2.333 |
| Employed | 192(54.1) | 163(45.9) | p=0.127 |
| **Have male adolescent children** | | | |
| Yes | 195(57.5) | 144(42.5) | $X^2$=2.046 |
| No | 40(48.8) | 42(51.2) | p=0.153 |
| **Have female adolescent children** | | | |
| Yes | 205(58.1) | 148(41.9) | $X^2$=4.503 |
| No | 30(44.1) | 38(55.9) | **p=0.034** |
| **Number of adolescent children** | | | |
| 1 | 32(45.7) | 38(54.3) | $X^2$=3.477 |
| 2 and above | 203(57.8) | 148(42.2) | p=0.062 |
| **Living arrangement with partner** | | | |
| Living with spouse | 189(53.2) | 166(46.8) | $X^2$=6.112 |
| Not living with a spouse | 46(69.7) | 20(30.3) | p=**0.013** |

Table 6 shows a significant association between adolescents' age group and prevalence of sexual communication ($X^2$=10.928, p=0.001) and between gender and prevalence of sexual communication ($X^2$=47.347, p<0.001). Also, parents' marital status (p=0.003), having female adolescent child (p=0.0034), and living arrangement with partner (p=0.0013) was significantly associated to prevalence of sexual communication **(Tables 6a and 6b)**

**Table 7: Association between attitude towards sexual communication and prevalence of sexual communication (Adolescent)**

| **Variable** | **Prevalence of sexual communication** | | **Statistics** |
|---|---|---|---|
| | **Yes** | **No** | |
| **Attitude to sexual communication** | | | |
| Positive | 18(34.6) | 34(65.4) | $X^2$=1.699 |
| Negative | 163(44.2) | 206(55.8) | p=0.192 |

**Table 8: Association between attitude towards sexual communication and prevalence of sexual communication (Parent)**

| Variable | Prevalence of sexual communication | | Statistics |
|---|---|---|---|
| | **Yes** | **No** | |
| **Attitude to sexual communication** | | | |
| Positive | 21(8.9) | 16(8.6) | $X^2$=0.014 |
| Negative | 214(91.1) | 170(91.4) | p=0.904 |

Tables 7 and 8 show no significant association between adolescents' and parents' attitudes towards sexual communication and the prevalence of sexual communication.

**Table 9: Association between barriers and prevalence of sexual communication (Adolescents)**

| Variable | Prevalence of sexual communication | | Statistics |
|---|---|---|---|
| | **Yes** | **No** | |
| **Children may not want to talk about sexual health** | | | |
| Yes | 64(44.2) | 207(55.8) | $X^2$=1.872 |
| No | 17(34.0) | 33(66.0) | p=0.171 |
| **Find it difficult to explain sexual and reproductive health issues** | | | |
| Yes | 100(38.9) | 157(61.1) | $X^2$=4.486 |
| No | 81(49.4) | 83(50.6) | **p=0.034** |
| **Feel adolescents may become sexually active after open discussion of sexual issues** | | | |
| Yes | 93(41.7) | 130(58.3) | $X^2$=0.321 |
| No | 88(44.4) | 110(55.6) | p=0.571 |
| **Have poor knowledge of sexual and reproductive health contents** | | | |
| Yes | 71(38.5) | 113(61.4) | $X^2$=2.589 |
| No | 110(46.4) | 127(53.6) | p=0.108 |
| **Cultural barrier is the problem** | | | |
| Yes | 69(44.5) | 86(55.5) | $X^2$=0.232 |
| No | 112(42.1) | 154(57.9) | p=0.630 |
| **Fear of social disapproval** | | | |
| Yes | 102(45.1) | 124(54.9) | $X^2$=0.912 |
| No | 79(40.5) | 116(59.5) | p=0.340 |
| **Feel ashamed or embarrassed to discuss it** | | | |
| Yes | 112(41.3) | 159(58.7) | $X^2$=0.860 |
| No | 69(46.0) | 81(54.0) | p=0.354 |

**Table 10: Association between barriers and prevalence of sexual communication (Parents)**

| Variable | Prevalence of sexual communication | | Statistics |
|---|---|---|---|
| | **Yes** | **No** | |
| **Children may not want to talk about sexual health** | | | |
| Yes | 191(57.2) | 143(42.8) | $X^2$=1.223 |
| No | 44(50.6) | 43(49.4) | p=0.269 |
| **Find it difficult to explain sexual and reproductive health issues** | | | |
| Yes | 66(53.7) | 57(46.3) | $X^2$=0.329 |
| No | 169(56.7) | 129(43.3) | p=0.641 |

| | | | |
|---|---|---|---|
| **Feel adolescents may become sexually active after open discussion of sexual issues** | | | |
| Yes | 100(47.8) | 109(52.2) | $X^2$=10.697 |
| No | 135(63.7) | 77(36.3) | p=**0.001** |
| **Have poor knowledge of sexual and reproductive health contents** | | | |
| Yes | 63(56.8) | 48(43.2) | $X^2$=0.054 |
| No | 172(55.5) | 138(44.5) | p=0.817 |
| **Cultural barrier is the problem** | | | |
| Yes | 85(61.2) | 54(38.8) | $X^2$=2.392 |
| No | 150(53.2) | 132(46.8) | p=0.122 |
| **Fear of social disapproval** | | | |
| Yes | 89(63.1) | 52(36.9) | $X^2$=4.582 |
| No | 146(52.1) | 134(47.9) | **p=0.032** |
| **Feel ashamed or embarrassed to discuss it** | | | |
| Yes | 67(62.0) | 41(38.0) | $X^2$=2.277 |
| No | 168(53.7) | 145(46.3) | p=0.131 |

Table 9 shows a significant association between adolescents finding it difficult to explain sexual and reproductive health issues and communicating sexual issues (p=0.034). While the feeling that adolescents may become sexually active after open discussion of sexual issues (p=0.01), and fear of social disapproval (p=0.032) highlighted by the parents were significantly associated to the prevalence of sexual communication **(Table 10)**

**Table 11: Predictors of parent-adolescent sexual communication among adolescents**

| **Variable** | **Odds-ratio** | **P-value** | **95% confidence interval** | |
|---|---|---|---|---|
| | | | **Lower** | **Upper** |
| **Age group** | | | | |
| 10-14(Ref) | | | | |
| 15-19 | 0.482 | **0.001** | 0.315 | 0.737 |
| **Sex** | | | | |
| Male(Ref) | | | | |
| Female | 4.816 | **<0.001** | 3.063 | 7.573 |
| **Find it difficult to explain sexual and reproductive health issues** | | | | |
| Yes(Ref) | | | | |
| No | 1.636 | **0.025** | 1.063 | 2.517 |

Table 11 shows the predictors of sexual communication among adolescents. Respondents who were between 15-19 years are less likely to have sexual communication compared to those within the age of 10-14 years (aOR=0.482, p=0.001, C.I=0.315-0.737). Female respondents were more likely to have sexual communication (aOR=4.816, p<0.001, C.I=3.063-7.573). Lastly, respondents who doesn't find it difficult to explain SRH issues were more likely to have sexual communication compared to those who find it difficult (aOR=1.636, p=0.025, C.I=1.063-2.517)

**Table 12: Predictors of parent-adolescent sexual communication among parents**

| Variable | p-value | Odds-ratio | 95% confidence interval | |
|---|---|---|---|---|
| | | | Lower | Upper |
| **Marital status** | | | | |
| Single | | | | |
| Married | 0.963 | 0.947 | 0.317 | 2.924 |
| Separated | 7.190 | **0.037** | 1.128 | 45.824 |
| Widowed | 1.000 | 1.000 | 0.175 | 5.695 |
| **Have female adolescent child** | | | | |
| Yes | | | | |
| No | 0.432 | **0.003** | 0.247 | 0.755 |
| **Living arrangement with partner** | | | | |
| Living together | | | | |
| Not living together | 1.415 | 0.289 | 0.744 | 2.690 |
| **Feel adolescents may become sexually active after open discussion of sexual issues** | | | | |
| Yes | | | | |
| No | 2.902 | **<0.001** | 1.851 | 4.551 |
| **Fear of social disapproval** | | | | |
| Yes | | | | |
| No | 0.432 | **0.001** | 0.267 | 0.700 |

Table 13 shows the predictors of sexual communication among parents. Respondents who were separated were more likely to have sexual communication compared to those who were single (aOR=7.190, p=0.037, C.I=1.128-45.824). Respondents who do not have a female child were less likely to discuss sexual issues compared to those who have (aOR=0.432, p=0.003, C.I =0.247-0.755). Also, respondents who do not feel adolescent will become sexually active after open sexual discussion were more likely to engage in sexual communication compared to tose who holds that believe (aOR=2.902, p<0.001, C.I= 1.851-4.551). Lastly, those who do not think the society doesn't smile at sexual communication with adolescent were less likely to have sexual discussions with adolescents compared to those who held that belief (aOR=0.432, p=0.001, C.I=0.267-0.700)

## Discussion

Adolescence is a critical period when young people face increasing exposure to peer pressure, social media, misinformation, and experimentation regarding sexual health. Parents, as primary caregivers, are inclined to provide accurate information and guidance to their adolescents and help them make informed decisions regarding their sexual behaviour (Onyeodi et al., 2022). However, there are numerous barriers to parent-adolescent sexual communication. This study explored the attitudes of both parents and adolescents towards sexual communication as well as the barriers that prevent open and effective dialogue between parents and adolescents. Related studies have explored quality, barriers, and attitudes towards sexual communication between parents and adolescents (Agbeve et al., 2022; Ariyo et al., 2020; Azie et al., 2023). Regarding prevalence, this study's findings indicate that fewer than one-third of the respondents engage in parent-adolescent SRH communication. Regarding attitude, findings reveal that parents and adolescents have a positive attitude towards SRH communication because they strongly disagree with the lack of communication about SRH issues. As regards barriers, the majority of the respondents, both parents and adolescents, agreed that children not wanting to talk about their sexual health and the early sexual debut of adolescents are major barriers to parent-adolescents' SRH communication. Other barriers were also identified in this study, such as difficulty in

explaining SRH issues, poor knowledge of SRH, fear of social acceptance, and embarrassment.

The research findings indicate that most respondents practice parent-adolescent sexual and reproductive health (SRH) communication. In a study conducted in Rwanda, parent-adolescent communication about sexual issues was measured using a Likert scale ranging from 1 to 5, where 1 is strongly disagree and 5 is strongly agree (Nyirandegeya et al., 2022). The respondent disagreed with not discussing SRH issues as a result of religious beliefs, and postponing these discussions until marriage. They also disagreed with delegating sexual education to experts such as teachers and health workers, although studies show that adolescents reported positive experiences about sex education received in schools (Usonwu et al., 2021). In addition, the respondents strongly disagreed and disagreed with incorporating other elements such as dating in parent-adolescent communication.

Regarding barriers to parent-adolescent sexual communication, parents assume that sexual education will lead to the initiation of sexual intercourse, and it could expose them to sexual exploitation (Okpalaku & Ogubuike, 2025). Difficulty in explaining SRH issues and poor knowledge of SRH content were also barriers to the parent-adolescent sexual communication. A qualitative study conducted by Yibrehu & Mbwele (2020) revealed lack of knowledge, cultural factors, embarrassment of parents and adolescents, fear of early sexual engagement, busy parents, young age of adolescents, among others, as barriers to parent-adolescent sexual and reproductive health communication. In a scoping literature review, the barriers reported were socio-cultural barriers and gender barriers (Agbeve et al., 2022).

In this study, there exists a significant association between adolescents' age group and the prevalence of sexual communication, as well as between gender and the prevalence of sexual communication. Studies reveal that the older the adolescents become, the less frequently they interact with their parents (Nyirandegeya et al., 2022) Some parents do not discuss sexual issues with children of the opposite sex, and several studies have documented that sexual communication is directed towards adolescent girls than boys (Agbeve et al., 2022). Also, parents' marital status, having a female adolescent child, and living arrangement with partner were significantly associated with the prevalence of sexual communication. Findings show that parents who have good SRH knowledge are more likely to discuss SRH issues with their adolescents (Malango et al., 2022) Based on the results, there is no significant association between adolescents' and parents' attitudes towards sexual communication and the prevalence of sexual communication.

Findings revealed a significant association between adolescents finding it difficult to explain sexual and reproductive health issues and communicating sexual issues. Adolescents feel embarrassed to talk to their parents about sex, but they feel comfortable talking about menstruation and wet dreams (Ariyo et al., 2020). While the feeling that adolescents may become sexually active after open discussion of sexual issues and fear of social disapproval, emphasised by the parents, was significantly associated with the prevalence of sexual communication (Bamidele et al., 2025; Muse, 2025; Yibrehu & Mbwele, 2020). Respondents who were separated are more likely to have sexual communication compared to those who were single. Also, respondents who do not feel adolescent will become sexually active after open sexual discussion were more likely to engage in sexual communication compared to those who hold that belief. Lastly, those who do not think society smiles at sexual communication with adolescents were less likely to have sexual discussions with adolescents compared to those who held that belief. Parents with formal education and high income are more likely to discuss SRH issues with their adolescents (Malango et al., 2022; Rimamnunra. et al., 2021). Regarding predictors of parent-adolescent communication, study findings revealed that private school students are more likely to discuss SRH issues with their parents than their public school counterparts

*Strengths of the Study*

This study is conducted from the perspectives of both parents and adolescents, unlike other studies which focus their research on either parents or

adolescents. This provides a valuable insight into the attitudes and barriers to parent-adolescent sexual communication using regression analysis. In addition, this study employed the sequential exploratory mixed-method approach to unveil the complexity of parent-adolescent sexual communication. By first exploring parent-adolescent sexual communication qualitatively and then quantifying it, both readers and researchers can gain a comprehensive understanding of the topic. The study explicates the predictors of sexual communication among parents and adolescents, such as marital status, living arrangement, age group, sex, and difficulty in explaining SRH issues.

*Limitations of the Study*

Despite the efficacy of this study, there exist a few limitations. One of the limitations is that this study did not extend beyond Ile-Ife, which hinders the generalization to other populations. Another limitation is that the study focuses on Ile-Ife, which is an urban area and does not consider rural areas where parent-adolescent communication might be lacking. An extension to a rural area might be more exploratory.

*Conclusion*

Adolescents, when they reach puberty, face so many physical, emotional, and psychological changes that need serious attention. Parents are expected to discuss sexual and reproductive health issues with their children. Findings in this study revealed a positive attitude to the discussion of SRH issues by parents and adolescents. However, there are certain existing barriers to communication of SRH issues, such as embarrassment, lack of knowledge, early sexual debut, fear of social approval, and difficulty in explaining SRH issues. This study shows a significant association between adolescents' difficulty in discussing SRH issues and SRH communication, as well as parents' fear of adolescents engaging in sexual activities, and SRH communication. Findings also revealed that adolescents who do not find it difficult to discuss SRH issues are more likely to engage in SRH communication than those who find it difficult to discuss SRH issues.

*Recommendations*

Parents should be more open and attentive to the needs of their adolescent children without instilling in them the fear of judgment, to ensure better and more effective communication. There is a need to address religious and cultural beliefs that discourage detailed sexual health discussions. Also, investments in parent education programs and community-based strategies will encourage more open and effective sexual health communication within families.

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