

Original Research Article

Parent-adolescent communication on sexual and reproductive health among mothers of adolescent girls in Bengaluru urban area: an exploratory study

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Received: 06 July 2026

Revised: 12 August 2026

Accepted: 17 August 2026

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ABSTRACT

Background: Effective parent-adolescent communication about sexual and reproductive health (SRH) promotes accurate knowledge, dispels misconceptions, and encourages healthy behaviors. Early and open discussions can help reduce teenage pregnancy, sexually transmitted infections, and risky sexual behaviors. However, such communication remains limited, necessitating the exploration of barriers to effective SRH discussions between parents and adolescent girls.

Methods: This exploratory study was conducted with 100 mothers of adolescent girls residing in urban Bengaluru using convenience sampling techniques. A structured questionnaire, derived from relevant literature, was developed to collect data from the participants. The data was analyzed using SPSS V20.0, employing descriptive statistics, and chi-square tests.

Results: Our findings indicate a low level of communication between parents and adolescent girls, with the majority of communication occurring regarding puberty (13.23 ± 4.28) and secondary sexual characteristics changes (8.09 ± 4.07). However, the lowest level of communication was observed in relation to teenage pregnancy (1.37 ± 0.96). Additionally, the study revealed that 16% of parents and adolescent daughters engaged in poor communication, while only 30% exhibited good communication skills. Furthermore, a significant correlation was identified between age and communication levels ($r^2=0.1019$, $p=0.04^*$) educational status ($r^2=13.97$, $p=0.05^*$) family type ($r^2=15.34$, $p=0.01^{**}$) Source of information ($r^2=7.13$, $p=0.03^*$) at a significance level of 0.05.

Conclusions: Our study revealed inadequate parent-adolescent communication on sexual and reproductive health (SRH), influenced by cultural barriers, limited knowledge, and family dynamics. Early, open communication on SRH may strengthen parent-adolescent relationships and reduce unsafe sexual practices.

Keywords: Sexual and Reproductive health, Mother and adolescent daughter communication, Exploratory study, Bengaluru

INTRODUCTION

According to the World Health Organization (WHO), adolescents are individuals between the ages of 10 and 19, who are in the developmental stage of life,

transitioning between puberty and legal adulthood. The transition from childhood to adulthood was once relatively swift. During this stage, various physical and emotional developmental changes occur, with the appearance of secondary sexual characteristics being the

most significant change observed among teenagers.^{1,2} Adolescents worldwide face various challenges, including early pregnancy and parenthood, limited access to contraception and safe abortion services. Healthcare providers often act as barriers to care by failing to provide young people with supportive, nonjudgmental, and youth-appropriate services. Adolescents require information about sexual life from diverse sources, including parents, siblings, peers, magazines, books, and the mass media.³ Parents can assist teenagers in navigating the challenges associated with physical changes that may pose risks for their well-being. For early maturing adolescents, particularly girls, it is crucial to monitor their body changes. Adolescents should prioritize building authentic self-esteem and acquiring knowledge to address internal conflicts and body image issues such as breast enlargement, the development of auxiliary and pubic hair, attraction towards the opposite sex, pre-marital sexual activity, sexually transmitted infections (STIs), and teenage pregnancy.^{1,4} Adolescent pregnancy continues to be a global concern. In 2021, approximately 14 million girls worldwide became pregnant. While there has been a gradual decline in adolescent pregnancies over time, progress has been uneven across regions. For instance, South Asia has experienced the most significant reduction in adolescent pregnancies, yet one in five adolescent girls in the region gives birth before the age of 18. In India, national estimates indicate that 6.8% of women aged 15-19 began childbearing between 2019 and 2021.^{5,6} In India, Maharashtra, Tripura, West Bengal, Chhattisgarh, and Bihar have the highest percentages of teenage pregnancy, placing them at higher risk of maternal health complications such as eclampsia, pre-eclampsia, unsafe abortion, infections, pre-term birth, and low birth weight.⁷ Adolescent birthrates are higher in middle- and low-income countries compared to high-income countries, primarily due to marginalized and poverty-driven countries where poverty, low levels of education, and unemployment are significant factors. However, in India, along with these factors, societal norms and customs also play a crucial role.

It is projected that India will have approximately 95 million adolescent girls by 2030, which could potentially lead to an increase in teenage pregnancy rates.⁸

Statistics in India indicate that discussions about sexuality with young children are virtually non-existent. However, due to the gradual adoption of Westernized cultural norms, changes are primarily occurring in urban areas.⁹ Adolescence is often shrouded in myths and misconceptions regarding sexual health and sexuality. In Indian culture, discussing sex is considered taboo, resulting in inadequate information provided to adolescents about sexual health. Consequently, young individuals acquire more knowledge about sexual and reproductive health (SRH) from uninformed sources, perpetuating myths and misconceptions about puberty, menstruation, secondary sex characteristics, physiological and physical changes, masturbation, nocturnal emissions,

sexual intercourse, and sexually transmitted infections (STIs).¹⁰ Positive or supportive communication between parents and children fosters health, academic achievement, and self-esteem, promoting sexually healthy behaviors. Conversely, negative or inadequate communication can lead to negative or irresponsible lifestyle choices.

Therefore, it is crucial for parents to assist adolescents in navigating their physical changes and comprehending safe and healthy health practices. Consequently, this study aimed to elucidate mother-teen communication regarding sexual health in the urban areas of Bengaluru.

METHODS

Sampling and population

This was a non-experimental exploratory study conducted in the academic year 2024-2025. The study included 100 mothers of adolescent daughters aged between 10 and 19 years. Non-probability convenience sampling techniques were employed to select the sample based on the predefined inclusion and exclusion criteria.

Ethical consideration

Institutional ethical committee approval was obtained prior to the commencement of the study, with the reference number SIMS/IEC/2024/07/734. Subsequently, we have prepared a consent form in both English and Kannada, which includes a description and the significance of the study. These documents have been attached to the consent form.

Data collection instrument

The data collection instrument comprises two sections, which consist of demographic variables and the other of 31 items pertaining to parent-teen communication tools. The instrument underwent verification by experts from various disciplines, including psychiatric nursing, clinical psychology, family counseling psychotherapists, and statisticians. The demographic data encompasses various variables, such as age, marital status, education, occupation, religion, family type, housing type, family income, the number of adolescent daughters residing at home, and the source of information. The parent-teen communication items consist of 31 questionnaires based on secondary sexual changes, puberty, premarital sex, sexually transmitted diseases, and teenage pregnancy. These items employ a 5-point Likert scale ranging from never to always, as indicated by the columns labeled accordingly. Prior to the implementation of the tool, a sample of 10% of the total population underwent testing of the items. To assess the reliability of the tool, the split-half method was employed, and the Spearman-Brown's prophecy formula yielded a value of 0.98, indicating the instrument's reliability.

Data collection technique

Upon securing official approval, the researcher commenced the data collection process. Convenience sampling techniques were employed to select 100 mothers, ensuring their inclusion and exclusion criteria were adhered to.

Prior to data collection, the researchers provided a succinct summary of the study's objectives and attached a consent form to the questionnaires. Subjects were assured of the confidentiality and anonymity of their information provided, and their willingness to participate in the study was verified. The interview was conducted by administering the semi-structured interview schedule on parent-teen communication regarding sexual health resources (SRH). Each subject completed the entire session in approximately 35 minutes.

Data processing and analysis

SPSS V20.0 was employed to analyze the data. The demographic data and communication scores were analyzed using descriptive statistics. Additionally, a chi-square test was utilized to assess the level of association.

RESULTS

Table 1 depicts the demographic characteristics of the mothers. The data reveals that the majority of participants fall within the 31-40 years age group (53%), and an overwhelming number are married (93%). In terms of education, the highest percentage of respondents have completed graduation (29%). Occupation-wise, the majority are housewives (48%). Most participants identify as Hindu (75%) and live in their own houses (65%). Regarding family income, the highest proportion earn more than Rs. 5000 per month (71%). The nuclear family is the most common family type (68%). Most respondents have one adolescent daughter (48%), and the primary source of information is "all the above", including newspapers, magazines, radio, television, health personnel, and religious leaders, accounting for 39% of the responses.

Table 2 depicts the parent-teen communication regarding SRH. The communication scores across various areas related to adolescent SRH reveal varying levels of awareness and discussion. The highest communication score was observed in the area of puberty, with a mean score of 13.23 ± 4.28 , translating to 66.2%, indicating relatively better communication and understanding in this domain. This is followed by secondary sexual characteristic changes (53.9%) and SRH (48.8%). In contrast, communication was notably lower in more sensitive topics such as pre-marital sex (37.8%), STD/HIV (33.2%), and teenage pregnancy, which had the

lowest score at 27.4%. Overall, the mean communication score across all areas was 71.38 ± 25.73 , representing 46.1%, suggesting a moderate level of communication, with significant gaps particularly in topics considered taboo or sensitive within many cultural contexts. The distribution of mean communication score can also be seen in the diagram below (Figure 1).

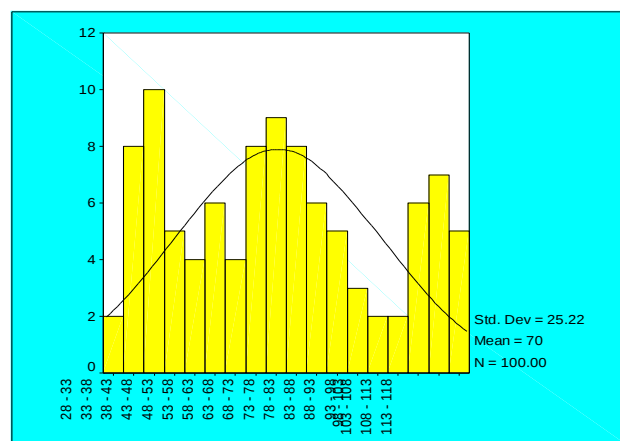


Figure 1: Histogram with normal curve shows the distribution of mean communication score among parents on parent teen communication regarding SRH.

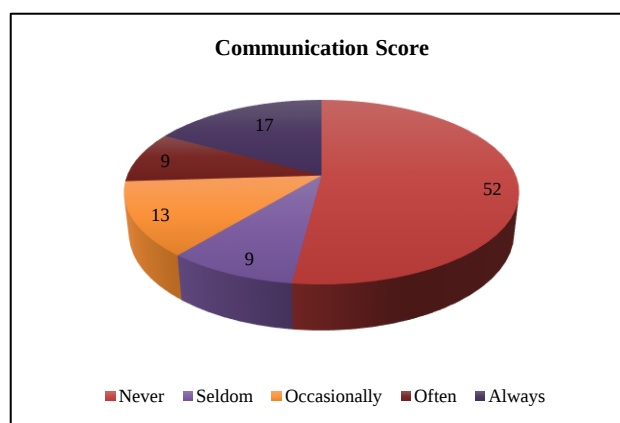


Figure 2: Communication score.

The data on the frequency of parental communication regarding SRH shows that a significant majority of parents, 52%, reported never engaging in such discussions. Only 17% of parents reported always communicating with their adolescent children on these topics, while 13% did so occasionally. Both seldom and often categories accounted for 9% each. This indicates that although a small proportion of parents are actively involved in consistent communication, the overall trend reflects a low level of parental engagement, with more than half of the parents not addressing these important topics at all (Figure 2).

Table 1: Description of demographic variables of the mothers of adolescent's daughters n=100.

Demographic variables		Frequency	Percentage
Age (years)	31-40	53	53
	41-50	34	34
	>50	13	13
Marital status	Married	93	93
	Divorced	1	1
	Widow	4	4
	Separated	2	2
Education status	Elementary	10	10
	SSLC	28	28
	Diploma	16	16
	Graduation	29	29
	Post-graduation	17	17
Occupation status	House wife	48	48
	Teacher	23	23
	Staff nurse	10	10
	IT company	10	10
	Garment worker	9	9
Religion	Hindu	75	75
	Christian	22	22
	Muslim	3	3
Type of house	Own	65	65
	Rented	35	35
Family income	<Rs.1000	13	13
	Rs.1000-2000	2	2
	Rs.2001-3000	2	2
	Rs3001-4000	5	5
	Rs4001-5000	7	7
	>Rs5000	71	71
Type of family	Nuclear family	68	68
	Joint family	22	22
	Extended family	6	6
	Broken family	4	4
Number of adolescent daughters	One	48	48
	Two	45	45
	Three	7	7
Source of information	Newspaper	5	5
	Magazine	4	4
	Radio	5	5
	Television	24	24
	Health personnel	10	10
	Religious leaders	2	2
	All the above	39	39
	No information	11	11

The data on levels of communication between parents and adolescents regarding SRH indicates that the majority, 54%, fell under the average category, suggesting moderate engagement in communication. 30% of parents demonstrated a good level of communication, reflecting a more proactive approach. However, 16% showed a poor

level of communication, highlighting a significant gap in awareness or willingness to engage in these discussions. Notably, none of the parents reached the very good level, indicating that there is substantial room for improvement in the depth and frequency of communication on SRH matters (Figure 3).

Table 2: Parent-teen communication regarding SRH.

Area of communications	No. of questions	Min-Max score	Communication score	
			Mean±SD	%
SRH	12	12-60	29.28±11.11	48.8
Secondary sexual characteristic changes	3	3-15	8.09±4.07	53.9
Puberty	4	4-20	13.23±4.28	66.2
Pre-marital sex	5	5-25	9.45±5.88	37.8
STD/HIV	6	6-30	9.96±5.86	33.2
Teenage pregnancy	1	1-5	1.37±0.96	27.4
Overall	31	31-155	71.38±25.73	46.1

Table 3: Association between demographic variables and parent-teen communication n=100.

Demographic variables		Level of communication						Total	Chi square test
		Poor		Average		Good			
		N	%	N	%	N	%		
Age (years)	31-40	14	26.4	26	49.1	13	24.5	53	$\chi^2=10.19$ p=0.04* DF=4 (S)
	41-50	2	5.9	21	61.8	11	32.3	34	
	>50	0	0.0	7	53.8	6	46.2	13	
Marital status	Married	15	16.1	49	52.7	29	31.2	93	$\chi^2=3.24$ p=0.77 DF=6 (NS)
	Divorced	0	0.0	1	100.0	0	0.0	1	
	Widow	1	25.0	3	75.0	0	0.0	4	
	Separated	0	0.0	1	50.0	1	50.0	2	
Education status	Elementary	4	40.0	6	60.0	0	0.0	10	$\chi^2=13.97$ p=0.05* DF=8 (S)
	SSLC	8	28.6	13	46.4	7	25.0	28	
	Diploma	0	0.0	11	68.8	5	31.3	16	
	Graduation	3	10.3	16	55.2	10	34.5	29	
	Post-graduation	1	5.8	8	47.1	8	47.1	17	
Occupation status	House wife	7	14.6	23	47.9	18	37.5	48	$\chi^2=12.88$ p=0.12 DF=8 (NS)
	Teacher	7	30.4	9	39.1	7	30.4	23	
	Staff nurse	0	0.0	8	80.0	2	20.0	10	
	IT company	2	20.0	7	70.0	1	10.0	10	
	Garment worker	0	0.0	7	77.8	2	22.2	9	
Religion	Hindu	13	17.3	38	50.7	24	32.0	75	$\chi^2=2.97$ p=0.56 DF=4 (NS)
	Christian	2	9.1	14	63.6	6	27.3	22	
	Muslim	1	33.3	2	66.7	0	0.0	3	
Type of house	Own	11	16.9	37	56.9	17	26.2	65	$\chi^2=1.30$ p=0.52 DF=2 (NS)
	Rented	5	14.3	17	48.6	13	37.1	35	
Family income	<Rs.1000	3	23.1	5	38.5	5	38.5	13	$\chi^2=5.94$ p=0.20 DF=6 (NS)
	Rs.1000-3000	0	0.0	3	75.0	1	25.0	4	
	Rs.3001-5000	1	8.3	4	33.3	7	58.3	12	
	>Rs.5000	12	16.9	42	59.2	17	23.9	71	
Type of family	Nuclear family	17	25.0	38	55.9	13	19.1	68	$\chi^2=15.34$ p=0.01** DF=6 (S)
	Joint family	1	4.5	13	59.1	8	36.4	22	
	Extended family	0	0.0	1	16.7	5	83.3	6	
	Broken family	2	50.0	2	50.0	0	0.0	4	
Number of adolescent daughters	One	8	16.7	25	52.1	15	31.3	48	$\chi^2=3.24$ p=0.52 DF=6 (NS)
	Two	8	17.8	23	51.1	14	31.1	45	
	Three	0	0.0	6	85.7	1	14.3	7	
Source of information	Yes	15	16.9	47	52.8	27	30.3	89	$\chi^2=7.13$ p=0.03* DF=2 (S)
	No	1	9.1	7	63.6	3	27.3	11	

*Significant at <0.05% level, χ^2 : Chi square.

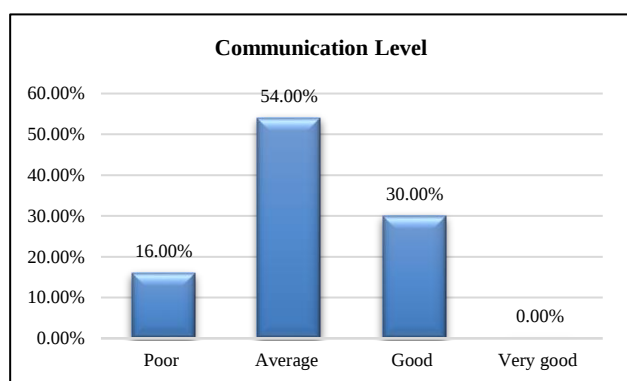


Figure 3: communication level.

Table 3 depicts the association between psychological well-being and demographic variables. In this study, we found age was significantly associated with communication levels ($\chi^2=10.19$, $p=0.04$), indicating that older parents tend to communicate more effectively, with 46.2% of those above 50 years showing good communication compared to only 24.5% in the 31-40 age group. Education status also had a significant influence ($\chi^2=13.97$, $p=0.05$), as parents with higher educational qualifications, particularly postgraduates, demonstrated better communication (47.1%) than those with only elementary education (0%). A strong association was observed with type of family ($\chi^2=15.34$, $p=0.01$), where parents from extended families showed the highest level of good communication (83.3%), while those from broken families exhibited poorer communication. Additionally, access to sources of information significantly impacted communication ($\chi^2=7.13$, $p=0.03$), as parents with exposure to various information sources were more likely to have better communication with their daughters. In contrast, other variables such as marital status, occupation, religion, type of house, family income, and number of adolescent daughters did not show statistically significant associations, indicating they may have less influence on the level of parent-adolescent communication in this context.

DISCUSSION

Open communication between parents and teenagers regarding sexuality can lead to safer sexual practices among young people, including the use of modern contraceptives. By discussing sexual activities, parents can influence their teenagers' attitudes, values, and beliefs, which can help reduce risky sexual behaviors. For this communication to be effective, parents must be able to engage in open and honest conversations and provide accurate information on sexual health education as their children become more aware and active sexually. Additionally, teenagers should feel comfortable discussing sexual health education with their parents, covering topics such as puberty-related physical changes, the menstrual cycle, nocturnal emissions, birth control pills, and condom use.^{11,12} In this study, we aimed to understand the communication gap between parents and

adolescent girls. Our findings revealed that communication regarding sexual health education can vary between mothers and their daughters depending on the subject matter. The highest level of communication occurred during puberty (13.23 ± 4.28), approximately 66.2%. Conversely, communication regarding sexual health education (29.28 ± 11.11) and secondary sexual changes characteristics (8.09 ± 4.07) was relatively low, amounting to 48.8% and 53.9%, respectively. The lowest level of communication was observed in terms of sexual transmitted diseases (9.96 ± 5.86) and teenage pregnancy (1.37 ± 0.96), which were 33.2% and 27.4%, respectively, and are concerning. These findings are consistent with studies conducted in Ethiopia, Bangladesh, and Tanzania where the study also found relatively low levels of communication regarding sexual health education.¹³⁻¹⁵

Our study revealed that 52% of parents have never communicated with their daughters regarding sexual reproductive health (SRH) issues, potentially limiting the accessibility of protective sexual information and services to adolescents. This lack of communication can lead to adolescents' ignorance of sexual and reproductive matters, increasing their susceptibility to unsafe sexual practices. A study conducted in Tanzania¹⁵ indicated that 73.3% of adolescents never communicated with their parents regarding SRH issues, which is significantly higher than our study's findings. These discrepancies may be attributed to inadequate education levels and limited access to healthcare services. Furthermore, we have identified parental education as a crucial factor in fostering effective parent-daughter communication. However, mothers, often fulfilling the role of housewives, may lack parenteral knowledge regarding reproductive health information, resulting in inadequate provision of this information to adolescents. A qualitative study conducted by Likith in urban Bengaluru revealed five core themes related to reproductive health, including knowledge, gender-based needs, cultural influences, family roles, partner involvement, and familial inhibition.¹⁶ Considering these factors can enhance communication between parents and daughters.

One of the most important topics of SRH is conducting discussions regarding pre-marital sexual activity, safe sexual practices, and comprehensive information about HIV/AIDS, which is only 37.8% and 33.2%, respectively. In the current era, pre-marital sexual activity has become a prevalent practice, leading to an increase in HIV and other sexually transmitted diseases. Consequently, it has become imperative to establish parent-adolescent communication, which can effectively reduce unsafe sexual practices among adolescents.¹⁷ Numerous studies have demonstrated that adolescents who engage in open and honest communication about sexuality with their parents exhibit a decreased incidence of sexually transmitted diseases and are more likely to utilize contraceptive services.^{18,19}

One of the objectives of our study was to determine the correlation between parent-teen communication and demographic variables. The results indicate a significant association between age, educational attainment, family structure, and sources of information. However, our findings are somewhat inconsistent with the study conducted in Nepal which revealed that parent knowledge, having two or more adolescent daughters, and residing in hostels were significant factors.²⁰ Additionally, our results align with a study conducted in Ethiopia which demonstrated a significant correlation between female children, adolescents' academic performance, and student knowledge about puberty.²¹

It is noteworthy that our study revealed a critically low level of communication between parents and adolescent girls regarding sexual reproductive health (SRH). Only 30% of parent-adolescent girls engaged in effective communication, while 54% engaged in average communication. This data is concerning, as the majority of parents and daughters rarely discuss SRH, which can lead adolescent girls astray and endanger their lives. Consequently, we observed an increase in pre-marital sex, abortion, teen pregnancy, unsafe sexual practices, and suicidal tendencies. Low communication levels have also been observed in other countries, including Nepal, Bangladesh, Tanzania, India, Ethiopia, etc.^{13-16,20,21}

A study conducted by Downing et al posited that parent-teen communication regarding SRH could be more effective if it occurs prior to the sexual debut.²² Consequently, it is crucial for parents to initiate communication with their children at a younger age to prevent high-risk sexual behavior. Additionally, we have identified that culturally, it is considered taboo to discuss children's sexual and SRH matters. Consequently, cultural norms hinder parents from directly addressing these issues with their children.²³ Finally, the study's finding suggested that social norms and conservative attitudes create an unhealthy environment for both parents and adolescent girls to engage in open discussions about SRH and parental guidance, resulting in the missed opportunity to obtain vital and beneficial information.

The primary limitation of the study was its small sample size and limited geographical representation, as it was conducted exclusively in urban areas of Bengaluru. Additionally, the study did not compare between urban and rural areas of Bengaluru, which restricts the generalizability of the findings to a broader population.

CONCLUSION

This study aimed to investigate the parent-adolescent communication regarding SRH in Bengaluru urban areas. The study revealed a low level of communication between parents and adolescent girls regarding SRH. It is crucial to address topics such as physical changes during puberty, premarital sexual activity, teenage pregnancy, and sexually transmitted diseases when discussing SRH.

Additionally, it is essential to deconstruct the sociocultural norms surrounding adolescents' SRH. By engaging in early initiation and open, understandable discussions between mother and adolescent daughters, we can foster their healthier future well-being.

ACKNOWLEDGEMENTS

The authors would like to thank all the participants who have participated in the study.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee reference number SIMS/IEC/2024/07/734

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Cite this article as: Rashmi S, Shil R, Das S. Parent-adolescent communication on sexual and reproductive health among mothers of adolescent girls in Bengaluru urban area: an exploratory study. *Int J Community Med Public Health* 2026;13:5259-66.