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Original Research Article

Challenges in communication between mothers and adolescent daughters concerning sexual and reproductive health issues, Puducherry

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ABSTRACT

Background: Mothers play a key role as an educator for adolescent girls especially with respect to sexual and reproductive health (SRH). However, these conversations are affected largely by the socio-cultural context and the rapport between them. Studying the communication between mother, daughter dyad would give key insights for planning interventional strategies. This study aims to explore challenges in communication between mothers and adolescent daughters regarding SRH issues and to assess mothers' perceptions of the extent, barriers and facilitating factors influencing such communication.
Methods: An exploratory mixed-methods study (Qual→QUAN) was conducted in an urban slum of Puducherry. The qualitative component included four focus group discussions (two with mothers and two with adolescent girls), analysed using an inductive thematic approach. Findings informed the development of a semi-structured questionnaire for the quantitative cross-sectional survey among 210 mothers selected through cluster sampling. Data were analyzed using descriptive statistics.
Results: Four major themes of barriers emerged: maternal factors (perception that daughters are too young, embarrassment, poor knowledge), daughter-related factors (fear of disapproval and judgment), relationship issues (lack of trust, educational divide) and socio-cultural influences (restrictive norms, time constraints).While more than 90% of mothers reported talking about menstruation and sexual abuse, there was little discussion on contraception (7%), reproductive tract diseases (34%) or pregnancy. There was a significant discrepancy between perceived and real communication. Trust, friendly relationship, exposure to neighbourhood events and health worker involvement were the facilitating factors.
Conclusions: Complex interpersonal and sociocultural factors influence mother-daughter communication on SRH and there are differences between perceived and actual practices. To facilitate efficient communication, interventions should concentrate on improving parental understanding, building relationships based on trust and incorporating community and health system support.

Keywords: Adolescent girls, Parents, Reproductive health communication, Sexual and reproductive health

INTRODUCTION

Over a billion people worldwide and 30 million people in India are in adolescent age group. Adolescents constitute to more than 30% of India's population. Adolescent, a period of 10-19 years of age, is an important stage in life which alters and shapes physical, mental and social characteristics of a person.[1] Physical and social challenges faced by adolescents make them anxious and confused. This is likely to be higher in adolescent girl due to process of menstruation, body changes and social norms. They face addition stress and discomfort due to poor menstrual

hygiene management. In India, it was noted that the knowledge on menstruation is low among adolescent girls. Less than half of girls are informed about menstruation by their parents prior to menarche and only one-fourth of them know about the source of bleeding.[2,3] The situation is worse with communication on sexual and other reproductive issues. Insufficient and inaccurate information to adolescent girls leads to unhygienic unsafe sexual practices and risky behaviour. This is also supported by fact that over 35% of all reported HIV infection occurs among 15–24 years age group.[4] Educating and freely discussing sexual and reproductive health (SRH) issues with adolescents positively impacts young people's health and personal development and their transition to sexual life. Parents are the best persons to educate adolescents. Mothers are a reliable source of information and avenue for discussion for adolescent girls. However, literature shows variable level of communication between the mother and daughter. Because of the workload mother and daughter spend less time connecting with each other. Although some communications take place on some reproductive health issues, there is evidence that parents fail to communicate with their daughters on sensitive issues of sexuality like puberty, sexually transmitted infections, physical development and condom use.[5]

In Indian culture, there exist strong social norm which is against discussion on sexual behaviour. It is observed that parental control and closeness with parents is related to healthy sexual behaviour among adolescents.6 Hence, there is a need to actively engage parents in enabling adolescents to make safe and healthy transitions to adulthood. Communication between parents and adolescent daughters are limited due to various reasons such as fear, shyness, perception that they are still young to discuss and cultural believes and lack of knowledge.[5-7] Evidence about parent-child communication, particularly with regard to sensitive matters such as the physical changes associated with puberty, sex, pregnancy and sexually transmitted infections, HIV is sparse. Evidence that is currently available comes largely from the perspectives of young people. Opinion of parents and their perceptions are not well studied. Studies on communication regarding SRH issue are limited in the Indian scenario. Hence, this current study was conducted with the objective to explore the challenges faced by mothers and adolescents' daughters in their discussion concerning sexual and reproductive health issues; and to determine the self-perception of mothers regarding the extent, facilitating factors and barriers to the discussion concerning sexual and reproductive health issues.

METHODS

Study type

Exploratory mixed methods study.

Qualitative

Descriptive focus group discussion (FGD).

Quantitative

Community based cross-sectional observational study.

Study setting

This study was done in a Coastal Urban Slum in Puducherry District of Puducherry State.

Study duration

The study duration was from January 2017–August 2017.

Inclusion criteria

Adolescent girls and mothers of adolescent girls residing in the service area of JIPMER selected for quantitative survey and urban health centre has been selected for the qualitative focus group discussion.

Exclusion criteria

The mother who could not be contacted after making two attempts to contact the mother and adolescent girls not staying with mothers for any reason.

Procedure

Qualitative component

The objective of qualitative component was to explore the communication pattern between mother and child and identify challenges they face in the communication concerning reproductive health. Authors conducted two FGD among adolescent girls and two FGD among mothers of adolescent girls. Each FGD included 8-10 participants. The vocal participants were selected purposively in consultation with the Anganwadi worker. The FGDs were done by researchers trained in qualitative research. The interview guide was prepared by the investigators and were reviewed by the field staff and Anganwadi workers. FGD has been conducted in a place and time which was comfortable for the participants.

After consent from the participants, the FGD was audio recorded. Field notes were also taken. At the end of the FGD, the key discussion points were summarized to the participant for participant validation.

The contents were transcribed English by the interviewer within a week. Based on the transcript and field notes the themes, codes were generated. Using these codes, a semi-structured questionnaire was developed. It was reviewed by three experts and was pretested among 3-4 mothers.

Quantitative component

Mothers of adolescent girls residing in the selected urban slum were included in the survey. Mothers who were unreachable despite two contact attempts, as well as mothers whose adolescent daughters are not residing with them for any reason were excluded from the study. Based on the qualitative results questionnaire was developed and used for the cross-sectional survey. The sample size was calculated using OpenEpi software version 3.03. The sample size was calculated as 210 assuming that the values, proportion of mother's who communicate with their child about reproductive health=46% (2), absolute precision of 10% for 95% confidence interval, with dropout rate of 10% and design effect of 2. Cluster sample was followed to select the study participants. Each Anganwadi area was considered as a cluster. Two streets in each Anganwadi were selected randomly and all eligible mothers in the selected street were included for the survey. The mothers were interviewed with the semi-structured questionnaire developed at the end of the qualitative component. The semi-structured interview captured the socio-demographic factors, extent, nature, facilitating and hindering factors for communication concerning reproductive health.

Ethical approval

Approval was obtained from the institute Scientific Committee and Institution's Ethics Committee (JIP/IEC/2017/0200).

Data analysis

Qualitative

Braun and Clarkes six steps of data analysis was followed for qualitative data analysis. Inductive approach was followed during the data analysis. From the transcript and field notes codes were generated inductively. Similar codes were clubbed into categories and then into themes. Based on those themes and codes questionnaire for the quantitative survey was generated.

Quantitative

Data was entered in EpiData entry client version4. Data analysis has been done in SPSS version 19.0. All categorical variables were summarized as frequency and percentage. 95% confidence interval was calculated for key outcome variables. Continuous variable such mother's age was calculated as mean and standard deviation (SD). were reported as proportion and 95% confidence interval.

RESULTS

Qualitative results

Two focus group discussions were done among mothers of adolescent girls and two among adolescent girls. Four broad themes emerged from the analysis discussion. They are barriers in the communication between mother and daughter on sexual and reproductive health issues facilitating factors in the communication between mothers and daughters on sexual and reproductive health issues. Barriers of communication related to SRH were categorized into those related to mother, related to daughter, mother and daughter relationship issues, socio-cultural environment (Table 1 and 2).

Mother-related factors

Noteworthy that even if the children are at 14-15 years mothers felt that they are young to discuss about sexual and reproductive health. They also felt they will come to know of SRH automatically as they grow up and need not be discussed. There were additional fears that it would direct the child toward sexual desires and experimentation. Additional mothers were uncertain of correct information and were not confident in using appropriate words while discussing about SRH. All these adds to the mother being embarrassed to talk about SRH.

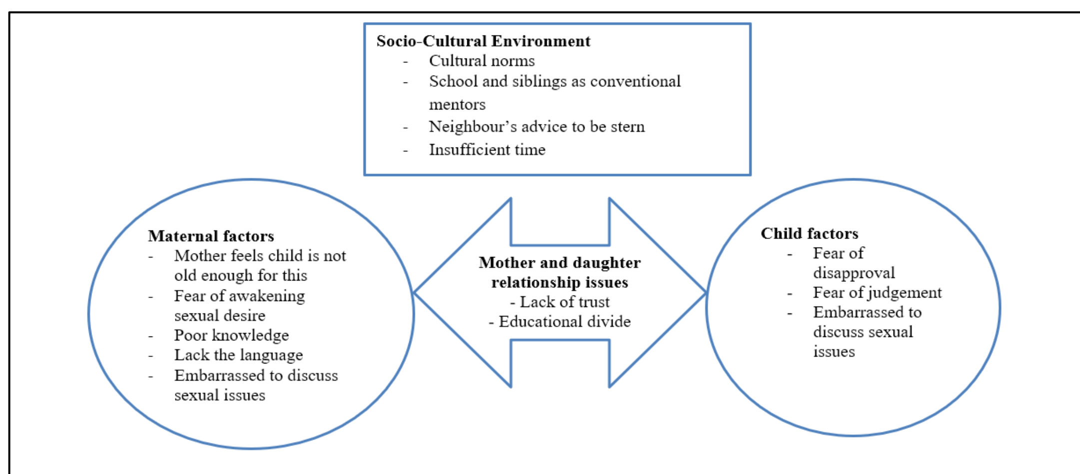

Figure 1: Barriers in communication between mother and daughter.

Daughter-related factors

In addition to embarrassment on talking about SRH, daughters fear parents' disapproval, judgement and punishment from parents. The mother and daughter relationship issues are lack of trust and educational gap. Some daughter's feel that since their mother lack formal education, they lack the right knowledge and they disrespect the mothers. A mother quotes a instance where the daughter belittles the mother by using derogatory language "padikatha pattikadu" meaning illiterate in a disrespectful manner (Table 1).

Socio-cultural environment

Cultural norms discouraging mother talking to children about SRH and considering teaching and elder siblings as conventional mentors was identified as a barrier. Neighbourhood environment of the urban slum, where friendly open conversation with children is considered to spoil the child in terms of discipline. In the urban environment both the child and parents are busy and giving them relative less time to talk beyond the day-to-day needs.

Facilitating factors in the communication between mothers and daughters on sexual and reproductive health issues were categorized into mother and daughter relationship neighbourhood instances, health, centers involvement. Trust between mother and daughter is one of the facilitating factors told by mothers and daughters. Daughter felt that only mother will maintain the confidentiality of the discussion. Daughters would share everything with a friendly mother. Mothers also used untoward events reported in neighbourhood or media as an opportunity to impart sexual health. Mothers had been taught the importance of sanitary napkins, menstrual hygiene during house visits by health workers, which they transfer to their daughters (Table 2).

Quantitative results

In the quantitative survey 210 mothers were surveyed. Most of them were below poverty line (61%). Half of the mothers had secondary education and 16% of mothers were not formally educated. Among the daughters, majority were in late adolescence (57%) and around 37% of mothers were employed (Table 3).

More than 90% of mother's felt that they had to communicate about menstruation, menstrual hygiene, genital hygiene and sexual abuse. However, lesser percentage discussed these issues to the daughter in the last one year. The gap was higher for menstruation and menstrual hygiene. Noteworthy that 90% of mothers talked about sexual abuse to their daughters. Mothers felt that it is not essential to communicate about reproductive tract infection, marriage/pregnancy or contraception. The highest gap between the felt need and actual practice was for topic on white discharge per vaginum, reproductive tract infection and marriage/pregnancy. Most mothers were satisfied with their communication on reproductive and sexual health with their daughter (Table 4). Majority of the mothers felt that their daughters are too young to know about sexual and reproductive health issues (65%) which were the main barrier to communicating SRH to their daughters. The other barriers were reported by less than 40% of the mothers. The next important barrier was poor relationship with the child expressed as lack of trust by comparing them with their peers, siblings and neighbours (36%). This was followed by fear of awakening sexual desire in the child which was reported by 29% of mothers. Around 22% of mothers were embarrassed and fear talking to their daughter about SRH. This was followed by unsure of the appropriate language used for talking about SRH, insufficient time, educational gap, lack of trust. Majority of mothers (63%) reported absence of restrictive cultural norm on discussion about SRH and they communicate with their daughters in an open and friendly manner (Table 5).

Most of the mothers (65%) felt that they are the best person to teach their daughter about sexual and reproductive health. Around 30% of the mothers wanted peers, teachers and health workers to teach about sexual and reproductive health. Only a few mothers (2%), felt that Anganwadi workers could teach their daughter. This is also discordant with the code that mothers feel teacher and elder sibling are the conventional mentors on SRH. Also 11% of the mothers reported that they would scold their daughter if they asked doubts on SRH issues, whereas the rest would try to clarify their doubts (Table 6).

Table 1: Barriers in the communication between mother and daughter on sexual and reproductive health issues.

Categories/codes	Statements
Category 1: Mother related factors	
Mother feels child is not old enough for this	Mother of a 15 years old girl: "This is not the right age to teach her, she is studying. Let her study. She will come to know automatically." Daughter, age 14 years: "when I ask my mother about menses, she says 'You are a small girl, you should not know about these things…you go inside'"
Fear of awakening sexual desire	Mother: "If we teach her about sexual health, she might get interested in it (sexual activity) and start doing wrong things."
Embarrassed to discuss sexual issues	Mother: "In my family, everybody used to talk about menses, sexual abuse freely. But I feel shy to talk to my daughter about this." "I feel shy to tell my daughter to clean her genitalia"

Continued.

Categories/codes	Statements
	"My child may share our discussion with her friends. I am afraid that her friends would form a bad opinion about me."
Poor knowledge	"I myself don't know about reproductive tract infections, how will I teach my daughter?"
Lack the language	Mother: "I don't know what to say, what not to say her. Till now I haven't talked to her about menses. I am afraid to talk" (mother of 12-year girl).
Category 2: Daughter related factors	
Fear of disapproval	Daughter: "I fear that my mother will scold and beat me if I ask her about sexual health." Daughter: "Once I shared a problem with my mother which I had with a boy and since then she is scolding me frequently for that."
Fear of judgements	Daughter: "when I tell my mother about my troubles with a boy, she asks me why I am looking at him. How will I discuss these issues with my mother if she doesn't believe me?" Daughter: "She compares me with other girls from our neighborhood in front of our relatives, it irritates me. I hate her habit of discussing my mistakes in front of others."
Embarrassed to discuss sexual issues	Mother: "when I discuss sexual abuse with my daughter, she says 'why ma? Why are you talking like this? You are always thinking and talking about bad things.' "
Category 3: Mother and daughter relationship	
Lack of trust	Mother: "when I tell my daughter to be careful with boys, she says 'I know how to behave, you shut your mouth. You always doubt me, you never believe me.' She feels that I am torturing her." Daughter: "When my aunt says something against me, my mother believes her and scolds me."
Educational divide	Mother: whenever I advise my daughter, she says, 'you are an uneducated village lady (padikadha pattikadu), shut your mouth, I know what is right and what is wrong.' "
Category 4: Socio-cultural environment	
Cultural norms	Mother: "We should not discuss these issues with children, especially this generation." Mother: "We were not told these things when we were young, then why should I discuss about it with my daughter?"
School and siblings as conventional mentors	Mother: "They will learn about it in school. Teachers are there to teach. When teachers teach, they will understand and will not feel shy." Mother: "Nowadays, girls know more than us since their schoolbooks have a lot of information on menstruation and contraception. She will learn about it in school, so I didn't think it was necessary to talk to her about it." Mother: "She shares everything with her elder sister"
Neighbor's advice to stern	Daughter: "My aunt from neighborhood tells my mother, 'Don't be close with daughters, otherwise they will not be under your control, it may lead them astray. Be Strict!' My mother follows whatever she says."
Insufficient time	Mother: "I have a job, she goes to school and has tuition in the evening, after that if I want to talk to her, she says, 'I am sleepy ma, don't disturb'."

Table 2: Facilitating factors in communication between mothers and daughters on sexual and reproductive health issues.

Category/code	Statements
Category 1: Mother and daughter relationship	
Trust between mother and daughter	Daughter: "If I have a problem I share it with my mother, I know she will keep it to herself. If I say to somebody else, it might spread." Daughter: If anybody complains about me, she says 'I know my daughter, she is not capable of doing something like this.' "
Friendly relationship with mother	Daughter: "If mothers are friendly, we will share everything with them and also listen to what they say."
Good knowledge of mother	Mother: "We can't believe anybody these days. When I was young, I faced certain problems. I teach her so that she does not have to face the same things." Daughter: "There is nothing my mother doesn't know. I cannot hide anything from her, she comes to know something is wrong just by looking at my face."
Category 2: Neighborhood	
Untoward instances in the neighborhood	Mother: "If anything happens in my neighborhood, I take it as an example to teach my daughter. I ask her to be careful." Daughter: These days news about harassment and rape are more common. My mother says 'look at this world, it is not good. You must be careful.'

Continued.

Category/code	Statements
Category 3: Health centers	
Health education during house visits by health workers	Mother: "Sisters (Health workers) from PHC, visit every house and teaches us about menstrual hygiene and sanitary pads, we teach our daughters what we learn from them."

Table 3: Socio-demographic characteristics of the sample of the mothers of adolescent girls residing at selected urban slum.

Characteristics	Number	(%)
Total	210	(100)
Mean age of the mothers (SD)	39.8	(8)
Marital status		
Married	178	(85)
Widow	25	(12)
Divorced	7	(3)
Education status		
No formal education	34	(16)
Primary (less than class 5)	31	(15)
Secondary (class 6 to class 10)	105	(50)
Higher secondary (class 11, 12)	19	(9)
Graduate and post-graduate	21	(10)
Employment status		
Employed	78	(37)
Not employed	132	(63)
Socio-economic status*		
Below poverty level	129	(61)
Above poverty level	69	(33)

SD= Standard Deviation, *missing information in 12.

Table 4: Mother's perceived need, practice and level of satisfaction regarding mother adolescent daughter communication on Sexual and Reproductive Health, (n=210).

Sexual and reproductive health topics	Number (%) of mothers with felt need to communicate with their daughters (a)=total 210	Of (a) number who communicated with their daughter in the last one year, (%) (b)	Of (b) number of mothers who are satisfied with their communication (%) (c)
Physical changes	114 (54)	103 (90)	92 (89)
Menstruation	190 (91)	180 (95)	173 (96)
Menstrual hygiene	193 (92)	184 (95)	180 (98)
Genital hygiene	207 (99)	205 (99)	197 (96)
White discharge per vaginum	171 (81)	150 (88)	148 (99)
Sexual abuse	194 (92)	189 (97)	178 (94)
Reproductive tract infection	73 (34)	41 (56)	39 (95)
Marriage/pregnancy	70 (33)	48 (68)	45 (94)
Contraception	15 (7)	8 (53)	8 (100)

Table 5: Barriers in communicating sexual and reproductive health (SRH) between mother and daughter from the perspective of mothers.

Barriers on discussion SRH qualitative codes	Statement to quantify the barriers	Disagree (%)	Neutral (%)	Agree (%)
Mother feels child is too young for this	I feel my daughter is young, hence no need to know these (SRH)	59 (28)	5 (2)	138 (67)
Lack of trust and poor relationship with the child	I used to compare her with friends, siblings, neighbors	133 (63)	1 (<1)	76 (36)

Continued.

Barriers on discussion SRH qualitative codes	Statement to quantify the barriers	Disagree (%)	Neutral (%)	Agree (%)
Fear of awakening sexual desire	I worry that discussing sexual health with my child might lead to inappropriate thoughts and behaviour	131(62)	4 (2)	62 (29)
Embarrassed to discuss sexual issues	I am afraid that she will perceive it wrongly if I say about SRH	168 (80)	1 (<1)	46 (22)
Lack the language	I don't know how to talk with her	177 (85)	0 (0)	33 (16)
Insufficient time	I don't have enough time to spend with my daughter	176 (84)	5 (2)	29 (14)
Educational gap	She used to blame that I am uneducated	181 (86)	3 (1)	26 (13)
Lack of trust	My child never listens to my words/ accept my advice	179 (85)	6 (3)	25 (12)
Neighbor's advice not to be open	My neighbors advise against communicating about SRH to my child	188 (90)	1 (<1)	21 (10)
Uncertain	I don't know what to talk with her	191 (91)	0 (0)	19 (9)
Cultural norms	My child & me consider we as friends and discuss SRH (positively worded statements)	11 (5)	52 (25)	133(63)

Table 6: Mother's perception that who should teach their daughter on sexual and reproductive health, total=210 (multiple response).

SRH should be taught by	Frequency	(%)
Mother	137	65
Teachers	67	32
Health worker	66	31
Friends	62	30
Relatives	26	12
Siblings	21	10
Anganwadi worker	4	2
Neighbors	1	<1

DISCUSSION

In this exploratory mixed method study, we conducted two focus group discussion among adolescent girls and two among mothers of adolescent girls. It identified barriers for communication between mother and daughter on sexual and reproductive health issues. These were broadly classified into four categories such as maternal factors child factors, socio-cultural environment, mother and daughter relationship issues. Mothers opined that many of them communicate with their daughters, but adolescent girls said that their mothers mostly don't discuss about SRH. Quantitative survey among 210 mothers found that mothers felt the need to discuss about sexual and reproductive health and as per their perception they communicate regularly and adequately with their child.

In the study, approximately 86–90% of mothers reported having a satisfactory discussion with their daughters about SRH in the past year. However, studies have highlighted that only around 50% of adolescents discussed SRH issues with their parents.[8-10] These highlight the difference in the perception of parents and adolescents. The qualitative findings further support this discrepancy many mothers felt their daughters were too young to engage in conversations related to SRH, suggesting that mothers have not fully attuned to their daughters' evolving information needs. It is mandatory to orient parents on the information needs of adolescent and encourage for a more detailed and responsive communication. Additional social desirability bias could have also added to the discrepancy in the responses of the mother and daughter.

Barrier other than mothers feeling that the child is too young, lack of trust, fear of awakening sexual desires was reported by less than 25% of the mothers. Despite low prevalence of these barriers as reported by the mothers, it is essential to provide the information to children, particularly in an environment where misinformation is readily accessible online. A qualitative study in India identified the following barriers to parent-adolescent communication on SRH such as embarrassment in discussing sexual issues, belief that these discussions are not age-appropriate and poor knowledge of parents.[11,12] Similar concerns were identified in our study. Noteworthy were that it is a taboo and not essential to talk about SRH before marriage. Even for older adolescents' parents feel that these contents are not age appropriate. Another strong belief is that talking about SRH would wrongly perceived by the adolescents that parents have given license to experiment with sex.[12] These prevailing perceptions of gatekeepers especially parents have to be addressed when

planning for health education interventions to adolescent either through the primary health centres or the schools otherwise it would culminate in lot of criticism.

The additional barriers identified in our study were the socio-cultural environment such as the neighbourhood culture that discourages open friendly communication with daughters; and time constraints due to the children's demanding academic schedules and working parent's limited availability in the context of urban slums. Similar, poor-quality time with child was observed as a barrier in Tanzania as well.[13] SRH being a sensitive topic the relationship between the parent and child plays a huge role.[14] We also identified that a quality parent-child relationship with mutual trust and respect paves the foundation for discussing sensitive topics of SRH. Parents should be supported to move from a hierarchical parenting style to a relationship which fosters trust and mutual respect. This relational shift creates safe space where the adolescents feel comfortable to initiate discussions on SRH. These are crucial as both mother and daughters commented that such talk is uneasy and embarrassing for them. The educational divide and widening generation gap had added to the challenge. Some children also disregard their mothers advise as they feel mother don't know much as they lack formal education. Additionally, parents also believe that school will provide adequate knowledge on SRH to their children. To bridge this gap primary health centres should hold joint session with both the parent and adolescents. Such initiatives not only promote accurate SRH knowledge but also encourage open, respectful communication by bringing both parties onto a common ground. In Indian study, Southern Indian states have better communication as compared to northern Indian states and they talked openly with their parents. Communication was better with the mothers, with major talks related to day-to-day needs and education. Though daughters had better communication than son's majority of the talk was related to menstruation was largely restricted.[12] Very less percentage discussed about reproductive process, pregnancy & STD.

In most instances advice on SRH to the child were indirect.[12] Similar observations were noted in the study. Only half of the mothers felt the need to communicate (49%) about physical changes which are necessary to discuss. We found similar results in the study done in Tanta city. However, the percentage of communication was better in our study as compared that in Tanta city.[15] Parents have a perception that girls can get information from their friends and siblings, 65% of adolescent urban parents while imparting sex knowledge believed verbal communication was efficient, whereas others used different methods to provide related information like television, magazines etc.[16] Parents felt these days children are aware of sexual matters on their own through interactions in the school setting, television, friends and books and less likely through family elders, siblings and relatives.[12]

The strength of the study was using qualitative formative research to develop the questionnaire for the survey to capture the culturally relevant barriers. Limited generalisability and non-inclusion of adolescent girls for the quantitative survey. Variations across groups suggest context-specific influences that warrant targeted interventions. Overall, the results underscore the importance of strengthening systems, addressing identified barriers and leveraging existing facilitators to enhance communication between mother and daughter.

CONCLUSION

This study highlights the complex interaction of maternal perspectives, adolescent concerns, relationship dynamics and sociocultural influences that influence communication regarding sexual and reproductive health (SRH) between mothers and adolescent daughters. Interventions that go beyond raising awareness and concentrate on communication skills, trust-building and age-appropriate sexual and reproductive health teaching are necessary, as evidenced by the reported discrepancy between mothers' perceived communication and the actual range of topics conveyed. Future studies should include both mothers and teenage daughters in larger, representative quantitative studies across different rural and urban contexts to determine effective communication strategies. Additionally, research on parent education, school-family collaborations, health worker involvement and digital health initiatives is required to improve generalizability and capture dyadic perspectives.

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