UNIVERSITY OF MEDIA, ARTS AND COMMUNICATION (UniMAC)

INSTITUTE OF JOURNALISM

THE ROLE OF PARENT-ADOLESCENT DIALOGUE IN PREVENTING TEENAGE PREGNANCY: A STUDY OF JAMES TOWN

JOHN BOSCO BREMPONG

DEPARTMENT OF COMMUNICATION STUDIES

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DECLARATIONS

STUDENT'S DECLARATION

I, John Bosco Brempong, declare that this thesis, except quotations and references contained in published works, which have all been identified and duly acknowledged, is entirely my original work, and it has not been submitted, either in part or whole, for another degree elsewhere. Therefore, I bear the responsibility for any shortcomings.

.....

JOHN BOSCO BREMPONG

(Student)

DATE: 10/12/25

SUPERVISORS' DECLARATION

We, the undersigned supervisors, declare that we supervised the preparation and presentation of this work in accordance with the guidelines for the supervision of MA theses as laid down by the University of Media, Arts and Communication (UniMAC).

.....

SUPERVISORS NAME HERE

Dr. Albert Tayman

(Supervisor)

DATE: 10/12/25

DEDICATION

I dedicate this work to every individual, families and institutions that are working hard to improve the sexual health of the youth and create conducive environment for them to achieve their goals.

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ABSTRACT

Abstract

This study examined parent–adolescent communication on sexual and reproductive health (SRH) in James Town, Ghana, using a mixed-methods approach involving surveys (n=100) and interviews (n=10). The research explored the frequency, content, and effectiveness of SRH discussions, as well as the cultural, emotional, and structural factors influencing these interactions. Quantitative findings revealed that nearly half of adolescents rarely or never discuss SRH with their parents, with communication often shaped by taboos, fear of punishment, and parental discomfort. Qualitative insights further highlighted that conversations were commonly reactive, moralistic, or event-driven rather than proactive and supportive. Adolescents frequently relied on peers, media, and school sources due to limited parental engagement, contributing to misinformation risks. Despite these challenges, some families demonstrated open, trust-based dialogue associated with improved knowledge and safer behaviors. The study concludes that enhancing SRH communication requires a multi-level approach involving parental capacity building, school–family partnerships, and culturally sensitive community engagement. Recommendations emphasize skills-based parent training, digital literacy support, and gender-responsive communication strategies. The study contributes to understanding the socio-cultural dynamics shaping SRH dialogue and provides practical guidance for strengthening adolescent health interventions in urban Ghanaian communities.

Keywords:

Sexual and Reproductive Health, Parent–Adolescent Communication, Ghana, Adolescents, Mixed-Methods Stud

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Chapter One of this study will explore the background of the study, statement of the problem, research objectives, research questions, and the significance of the study. It also outlines the scope, limitations, and organization of the research. The focus is on examining how parent-adolescent dialogue influences the prevention of teenage pregnancy in James Town, Ghana.

1.1 Background of the Study

Communication within the family, particularly on issues related to sexual and reproductive health (SRH), plays a crucial role in shaping adolescents' sexual attitudes and behaviors (Hutchinson & Montgomery, 2007; Widman et al., 2016). Research has shown that adolescents who engage in open and honest discussions with their parents about sexuality tend to delay sexual initiation and are more likely to use contraceptives consistently (Miller et al., 2001; DiClemente et al., 2001). In the context of sub-Saharan Africa, however, these discussions are often constrained by cultural and religious taboos, which render topics of sexuality uncomfortable or even inappropriate for the home setting (Awusabo-Asare et al., 2006; Kumi-Kyereme et al., 2007; Namisi et al., 2015). Ghanaian families, in particular, are noted for avoiding direct conversations on Sexual and Reproductive Health, relying instead on vague warnings or fear-based communication that does

little to equip young people with accurate knowledge or practical skills (Boakye et al., 2020; Okyere et al., 2021).

As a result of this communication gap, many adolescents in Ghana seek SRH information from less reliable sources such as peers, social media, or entertainment platforms, which may propagate myths or misinformation (Atuyambe et al., 2012; Amo-Adjei & Tuoyire, 2016). The absence of clear guidance from parents creates a knowledge vacuum that can lead to risky sexual experimentation, ultimately increasing the likelihood of teenage pregnancy, sexually transmitted infections, and unsafe abortions (Bankole et al., 2007; Phetla et al., 2008). Furthermore, studies indicate that when adolescents perceive their parents as unapproachable or judgmental, they are less likely to disclose their sexual experiences or ask for advice about contraception (Biddlecom et al., 2009; Commendador, 2010). This lack of trust and openness not only hinders healthy parent-child relationships but also undermines public health interventions aimed at reducing adolescent pregnancy rates (WHO, 2021; UNFPA, 2020).

The situation is particularly concerning in marginalized urban communities such as James Town in Accra, where socio-economic hardship, limited access to youth-friendly health services, and overcrowding exacerbate the vulnerability of adolescents (GHS, 2019; Amoah, 2022). Despite national-level efforts to promote adolescent reproductive health, including the implementation of the Ghana Adolescent Health Policy, many families in James Town remain disengaged from these initiatives due to structural barriers and deep-rooted cultural norms (GHS, 2018; Manu et al., 2015). Studies suggest that parental involvement in such communities is often reactive rather than proactive, with discussions occurring only after an issue arises, such as a pregnancy scare or STI diagnosis (Asampong et al., 2013; Bastien et al., 2011). This reactive approach fails to prepare

adolescents for healthy sexual development and misses critical moments for preventive education (Namisi et al., 2015; DiClemente et al., 2001).

Moreover, while evidence highlights the protective benefits of parent-adolescent dialogue, few studies have deeply explored how such communication is practiced in low-income Ghanaian communities (Boakye et al., 2020; Awusabo-Asare et al., 2006). There remains a research gap in understanding the nuances, barriers, and effectiveness of these conversations in James Town, particularly given the area's complex cultural and social dynamics. A contextualized understanding of how parents and adolescents interact around SRH issues can inform tailored interventions that bridge the communication divide (Widman et al., 2016; Okyere et al., 2021). Therefore, more empirical research is needed to examine not only the frequency of these discussions but also their depth, content, emotional tone, and perceived relevance from both parental and adolescent perspectives (Manu et al., 2015; Bankole et al., 2007).

1.2 Problem Statement

In many Ghanaian homes, discussions about sexuality between parents and adolescents are either delayed or completely absent, even though young people are growing up in a rapidly changing social environment where they are constantly exposed to information—both accurate and misleading—about sex and relationships (Hutchinson & Montgomery, 2007; Amo-Adjei & Tuoyire, 2016). Studies have repeatedly shown that communication within the family, particularly around sexual and reproductive health (SRH), has a significant influence on young people's decision-making and behavior (Widman et al., 2016; Miller et al., 2001). Where parents are open, supportive, and knowledgeable, adolescents are more likely to delay sexual activity, use protection, and avoid risky behavior (Commendador, 2010; DiClemente et al., 2001). Unfortunately, this kind

of proactive engagement is not the norm in many parts of Ghana, where cultural traditions often discourage open conversations about sex (Awusabo-Asare et al., 2006; Kumi-Kyereme et al., 2007).

Many parents find themselves uncomfortable or unsure of how to approach these topics, leading to vague warnings or silence rather than constructive dialogue (Boakye et al., 2020; Okyere et al., 2021). This communication gap often pushes adolescents to seek information from their peers, social media, or pop culture—sources that may glamorize or distort the realities of sex (Atuyambe et al., 2012; Amo-Adjei & Tuoyire, 2016). As a result, misinformation can take root, influencing young people to make poorly informed decisions that may result in unintended pregnancies or exposure to sexually transmitted infections (Biddlecom et al., 2009; WHO, 2021). Researchers have noted that when adolescents perceive their parents as unapproachable or judgmental, they are less likely to seek guidance or share personal concerns about sexual health (Namisi et al., 2015; Commendador, 2010).

In communities such as James Town, a densely populated coastal neighborhood in Accra, this issue becomes even more critical. James Town is known for its vibrant culture but also struggles with poverty, youth unemployment, and overcrowding, factors that place additional strain on parent-child relationships and reduce opportunities for private and meaningful conversations (GHS, 2019; Amoah, 2022). While national policies such as the Ghana Adolescent Health Strategy promote youth engagement and health education, many families in urban low-income settings are either unaware of these efforts or lack the means to integrate them into daily life (GHS, 2018; Aryeetey et al., 2020). Research shows that in such settings, sexual health discussions, when they occur, are often reactive, emerging only after a pregnancy scare or disciplinary issue (Asampong et al., 2013; Bastien et al., 2011).

There is a growing recognition that improving parent-adolescent dialogue could be a vital strategy in reducing teenage pregnancy, yet we still lack a clear understanding of how this plays out in communities like James Town. What kind of conversations are parents having, if any? What barriers prevent these discussions? And what support do families need to communicate more effectively? These are important questions that remain largely unanswered (Boakye et al., 2020; Manu et al., 2015). By exploring how families in James Town engage or fail to engage in conversations about SRH, this study hopes to uncover insights that could inform more culturally responsive interventions, empower families, and ultimately improve the health and futures of young people (Widman et al., 2016; Bankole et al., 2007).

1.3 General Objective

To examine the role of parent-adolescent dialogue in preventing teenage pregnancy in James Town, Accra.

1.3.1 Specific Objectives

1. To assess the nature and frequency of parent-adolescent communication on sexual and reproductive health in James Town.
2. To examine how such dialogue influences adolescents' decisions regarding sexual activity and contraceptive use.
3. To identify barriers that hinder effective parent-adolescent dialogue.
4. To recommend strategies to enhance parent-adolescent communication to help prevent teenage pregnancy.

1.3.2 Research Questions

1. What is the nature and frequency of parent-adolescent communication on sexual and reproductive health in James Town?
2. How does parent-adolescent dialogue influence adolescents' sexual behaviours and contraceptive use?
3. What are the key barriers to effective communication between parents and adolescents on SRH matters?
4. What strategies can be implemented to improve communication and reduce teenage pregnancy?

1.4 Scope of the Study

This study is geographically limited to James Town, a densely populated urban community located in Accra, Ghana. It specifically targets adolescents aged 13 to 19, as well as their parents or guardians, with the aim of exploring how communication within the family, particularly on matters of sexual and reproductive health affects teenage pregnancy outcomes. The focus is on identifying the nature, frequency, and depth of parent-adolescent dialogue in relation to adolescent reproductive choices and behaviors.

Although the findings may offer valuable insights for communities with similar socio-economic and cultural characteristics, the research does not intend to generalize across all regions of Ghana. Differences in ethnicity, traditions, education, and access to health services across the country may influence parent-child communication in unique ways. Therefore, while the study can inform

broader policy discussions, its core relevance and recommendations are most applicable within the context of James Town and similar urban settlements.

1.5 Significance of the Study

This study offers several valuable contributions to both academic literature and practical policy development. It generates empirical evidence on the influence of family communication on adolescent sexual behavior within a Ghanaian urban context, shedding light on how open dialogue between parents and adolescents may delay sexual debut or reduce teenage pregnancy risks (Boakye et al., 2020; Awusabo-Asare et al., 2006). The findings can also support the development of local and national adolescent health policies, particularly those seeking to integrate family-centered strategies into sexual health education and interventions (Bankole et al., 2007; WHO, 2021). By capturing the lived experiences of parents and adolescents in James Town, the research contributes culturally grounded insights that can shape behavior change communication programs tailored to community norms and needs (Bastien et al., 2011; Atuyambe et al., 2012).

Moreover, the study provides a practical framework that NGOs, community-based organizations, and civil society actors can adapt in their outreach and advocacy efforts. These stakeholders, who often lead teenage pregnancy prevention campaigns, may draw on the study's findings to design workshops, training sessions, and support systems that strengthen parent-adolescent relationships through improved communication (Namisi et al., 2015; Amoah, 2022).

1.6 Limitations of the Study

The study is limited by its qualitative nature and small sample size, which may not represent the diversity of experiences within the entire James Town community (Silverman, 2013). Cultural sensitivities around sex may also inhibit full disclosure from some participants (Manu et al., 2015). Additionally, adolescents who are already pregnant or parents themselves may present biased views influenced by their circumstances. Time and resource constraints further limit the scope of fieldwork and data triangulation.

1.7 Organization of the Study

The study is structured into five chapters. Chapter One introduces the research topic, background, problem statement, objectives, and significance. Chapter Two presents a comprehensive literature review and theoretical framework. Chapter Three outlines the research design, sampling strategy, data collection and analysis methods, and ethical considerations. Chapter Four presents and discusses the findings in relation to existing literature. Chapter Five concludes the study and offers recommendations for policy, practice, and future research.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Chapter Two presents the theories and existing studies that inform this research. It starts by reviewing two key theories that explain how family communication influences adolescent behaviour. It then discusses how these theories relate to the study's goals. The chapter also analyses five previous studies on adolescent sexual health and parent-child communication. This is followed by a conceptual framework highlighting key ideas and concludes with definitions of important terms used in the study.

2.1 Theoretical Review

Two main theories underpin this study: the **Social Cognitive Theory (SCT)** and the **Family Systems Theory (FST)**. The SCT, developed by Bandura (1986), emphasizes the role of observational learning, imitation, and modelling in behaviour development. It suggests that individuals—especially adolescents—learn behaviours through observing the actions of others and the consequences that follow. In the context of this study, SCT is applicable because adolescents often look to parents as primary models for understanding relationships, gender roles, and appropriate sexual conduct (Bandura, 2001; Miller et al., 2001). Effective communication from parents, therefore, has the potential to shape adolescents' sexual attitudes and delay risky behaviours.

The SCT also stresses the importance of self-efficacy, which refers to an individual's belief in their ability to perform a specific task. When parents are confident and informed, they are more likely to engage in open, informative conversations with their children, increasing the likelihood that adolescents will adopt responsible sexual behaviour (Widman et al., 2016). This theory explains why empowering parents with the right information and skills can create a positive feedback loop that supports adolescent decision-making and reduces early pregnancy (DiClemente et al., 2001).

Family Systems Theory

The second theory, the Family Systems Theory (FST), was proposed by Bowen (1978). It views the family as an emotional unit with interdependent members who influence each other's behaviours. The theory emphasizes that individual behaviour cannot be fully understood in isolation but must be examined in the context of family dynamics. Communication is considered a central mechanism through which these dynamics operate (Goldenberg & Goldenberg, 2013; Papero, 1990). According to the FST, disruptions or weaknesses in family communication channels can increase adolescents' vulnerability to external pressures, including peer influence and misinformation (Kerr & Bowen, 1988).

FST is especially relevant in communities like James Town, where complex intergenerational and socio-economic factors may affect family cohesion (Amoah, 2022). Research shows that adolescents from families with open, emotionally supportive communication are less likely to engage in risky sexual behaviours (Commendador, 2010; Widman et al., 2016). The theory also aligns with findings from Ghanaian contexts, where poor parental communication correlates with higher rates of early pregnancy (Manu et al., 2015; Kumi-Kyereme et al., 2007). Thus, FST

supports the study's aim to explore how parental behavior, emotional climate, and communication strategies impact teenage pregnancy in urban settings like James Town.

2.2 Relevance of the Theories to the Study

In this study, the Social Cognitive Theory is used to gain a better understanding of how parents teach their adolescents about sexual health by their own actions. In places with few resources, like James Town, where official sex education may not always be available, learning by watching is very important. Parents who talk to their kids in a proactive, value-based, and supportive way help set standards for waiting to have sex, practicing safe sex, and being independent. This immediately answers the study's first and third goals, which were to investigate the quality and effects of SRH discourse.

SCT also emphasizes the importance of reinforcement, such as verbal approval or disciplinary feedback, in shaping the behaviour of teens. Adolescents are more likely to behave in healthy ways when they get positive feedback for being open and honest about their relationships or being curious (Bandura, 1986; Aryeetey et al., 2020). The study will help behaviour-change communication tactics by looking at how this kind of reinforcement happens in James Town homes. The Family Systems Theory, on the other hand, looks at how parent-child connections are set up and how they feel. Because it looks at the family as a whole, it helps us figure out how parental absence, emotional neglect, or overcontrol affect how people talk about sex. This fits with the study's second and fourth goals, which look at cultural and emotional barriers to talking about SRH. FST helps look at how these differences effect how teens get sexual health information in James Town, where single-parent homes and extended family networks are common.

Finally, merging both ideas gives us a complete view by looking at both content delivery (what is said) and process mechanisms (how it is said and in what family context). This theoretical synergy helps create intervention models that deal with both the mental and social aspects of preventing teenage pregnancy.

2.3 Review of Related Literature

Study 1: Asampong et al. (2013)

Asampong et al. (2013) conducted a study examining parent-child communication regarding sexual and reproductive health (SRH) in Ghana, emphasizing both urban and rural groups. The primary topics analysed encompassed transparency, trust, parental unease, and adolescent concealment. The researchers utilized a qualitative research design, employing semi-structured interviews and focus group discussions for data collection. The sample comprised 63 participants—30 adolescents and 33 parents—selected by purposive sampling. The study focused on interpersonal analysis, emphasizing the intricate dynamics between individual parent-child pairs (Asampong et al., 2013).

The results indicated that although numerous parents recognized the necessity of addressing sexual and reproductive health themes with their children, cultural taboos, insufficient knowledge, and the apprehension of promoting sexual behavior were significant obstacles. Adolescents similarly expressed hesitance stemming from discomfort and apprehension of parental judgment or retribution. The findings align with previous research by Awusabo-Asare et al. (2006), highlighting that Ghanaian parents frequently avoid discussions on sexual and reproductive health, hence

perpetuating a culture of silence. Other researchers, like Kumi-Kyereme et al. (2007) and Biddlecom et al. (2009), have similarly indicated that cultural norms obstruct good communication between parents and adolescents in sub-Saharan Africa.

This study is significant as it reveals the openness and reluctance of households to engage in discussions about sexual and reproductive health. A significant drawback was the omission of additional sources of sexual and reproductive health education, such as educational institutions and religious organizations, which may also influence adolescents' comprehension. These discoveries bolster the assertion that parental endeavours, however significant, must be augmented by comprehensive community and institutional backing (Bastien et al., 2011; WHO, 2021). The study ultimately concluded that enhancing communication between parents and teenagers necessitates not just individual knowledge acquisition but also institutional transformation to address cultural stigma. Community-based interventions were deemed crucial for normalizing such discussions. This research is highly pertinent to the current study, since it reflects the circumstances in James Town, an urban locale encountering analogous socio-cultural limitations. This study aims to investigate the obstacles and facilitators of parent-adolescent sexual and reproductive health dialogue and seeks to identify strategies to mitigate the risks of teenage pregnancy (Asampong et al., 2013; Awusabo-Asare et al., 2006; Kumi-Kyereme et al., 2007; Biddlecom et al., 2009; Bastien et al., 2011; WHO, 2021).

Study 2: Bastien et al. (2011)

In another study conducted by Bastien et al. (2011), a systematic review of parent-adolescent communication about sexual health in sub-Saharan Africa was carried out. The study synthesized

findings from 35 qualitative and quantitative studies conducted between 1990 and 2009. The central themes included cultural silence, parental attitudes, knowledge deficits, and adolescent responsiveness to parental dialogue. The unit of analysis varied across the included studies, while the level of analysis emphasized behavioural and familial implications of communication dynamics (Bastien et al., 2011).

The review consistently found that poor SRH communication was prevalent across African households, largely due to cultural norms, parental discomfort, and fear-based messaging. Adolescents reported embarrassment, fear of punishment, and misunderstanding as key deterrents to open communication. These barriers echo findings by Namisi et al. (2015), Widman et al. (2016), and Hutchinson and Montgomery (2007), who also highlight the breakdown in intergenerational knowledge transfer around SRH. Parents often lacked the communication skills and confidence necessary to provide accurate, non-judgmental information (Miller et al., 2001; DiClemente et al., 2001).

One limitation identified was the lack of longitudinal data and insufficient differentiation between urban and rural findings. Additionally, the review observed an overreliance on school-based education, often assuming a complementary parental role that may not exist in practice. Despite these limitations, the review's strength lay in mapping persistent cross-cultural communication gaps and outlining success factors for effective dialogue. This aligns with studies that stress the importance of initiating early, honest discussions within the home (Commendador, 2010; Kumi-Kyereme et al., 2007).

The relevance of this study to the current research is substantial. It validates the need for targeted interventions that consider local norms and barriers specific to urban communities like James Town. Furthermore, the review supports the theoretical underpinnings of this study by

demonstrating how systemic communication breakdowns within families can increase adolescents' vulnerability to misinformation and early pregnancy (Bastien et al., 2011; Namisi et al., 2015; Widman et al., 2016; Hutchinson & Montgomery, 2007; DiClemente et al., 2001; Miller et al., 2001).

These findings will inform the current study's approach to examining parent-adolescent SRH dialogue in James Town by providing a broad, evidence-based context for identifying both structural and interpersonal communication challenges.

Study 3: Boakye et al. (2020)

In a study conducted by Boakye, Twumasi, and Dankyi (2020), the researchers investigated the influence of parental communication on sexual decision-making among university students in Ghana. The study focused on themes such as sexual values, timing of sexual debut, and parental monitoring. Using a quantitative design, the researchers surveyed 400 students from two public universities through structured questionnaires. Stratified random sampling was employed, and the level of analysis was behavioural, concentrating on how communication impacted decision-making processes.

Findings revealed that students who engaged in regular, value-based discussions with parents were more likely to delay sexual initiation and use contraceptives during their first sexual encounter. In contrast, students from families with restrictive or absent dialogue patterns reported relying on peers and digital media for sexual health information. These findings support earlier works by Widman et al. (2016) and Hutchinson and Montgomery (2007), which link effective parent-adolescent communication to safer sexual behaviours.

A key strength of this study lies in its empirical approach to understanding the connection between communication and behaviour outcomes. However, a notable limitation is the reliance on self-reported data, which may be influenced by recall bias and social desirability—an issue echoed in similar studies (Manu et al., 2015; Kumi-Kyereme et al., 2007). The research also does not deeply explore communication dynamics within diverse cultural or socio-economic settings.

Despite these limitations, the study significantly contributes to the discourse by quantifying the impact of parental engagement on adolescent sexual decision-making. It highlights how positive parental involvement can serve as a protective factor against risky behaviours. These findings reinforce theoretical assumptions from Social Cognitive Theory, especially regarding modelling and reinforcement in behaviour formation (Bandura, 2001; DiClemente et al., 2001).

The study is particularly relevant to the current research as it provides a comparative lens for understanding the long-term effects of early parent-adolescent dialogue. While Boakye et al. (2020) examined university students, the present study focuses on adolescents in James Town. The comparison allows for exploration into how foundational communication during adolescence shapes behaviour in later youth. It informs this study's objective of evaluating communication as a preventive mechanism against teenage pregnancy (Boakye et al., 2020; Widman et al., 2016; Hutchinson & Montgomery, 2007; Bandura, 2001; Manu et al., 2015; DiClemente et al., 2001; Kumi-Kyereme et al., 2007).

Study 4: Manu et al. (2015)

In another study conducted by Manu et al. (2015), parent-child communication on sexual and reproductive health was examined in the Brong Ahafo region of Ghana. The study adopted a

mixed-methods approach, incorporating both surveys and interviews. A sample of 750 adolescents aged 13–19 was drawn using cluster sampling techniques. Themes covered included information sources, parent-child trust, communication style, and sexual risk behaviours.

The findings showed that only 35% of adolescents had ever discussed sexual health issues with their parents. Most of these conversations were indirect, vague, and often warning-based. The study emphasized that such communication patterns led to misinformation and risk-taking behaviour among adolescents. The level of analysis was socio-cultural and interpersonal. A notable limitation was the lack of data from parents, which would have provided a more balanced understanding.

Despite this limitation, the study was significant in demonstrating how cultural norms discourage open discussion of sexual matters within families. This helps the current study examine how James Town's urban culture either aligns with or differs from the patterns found in semi-rural regions. The findings support the idea that dialogue quality—more than mere frequency—is key to effective adolescent sexual education (Manu et al., 2015; Kumi-Kyereme et al., 2007).

Study 5: Kumi-Kyereme et al. (2007)

In a study by Kumi-Kyereme, Awusabo-Asare, Biddlecom, and Tanle (2007), the researchers examined the impact of social connectivity and communication on teenage sexual behaviour. The research utilized a cross-sectional approach and surveyed 4,430 adolescents from four districts in Ghana. The primary issues analysed encompassed parental oversight, peer impact, educational initiatives inside schools, and discussions around sexual and reproductive health (SRH). The

sample was categorized by area, urban-rural status, and gender. The study employed a nationwide level of analysis, providing a macro-level perspective on teenage behavior.

The results indicated that teenagers with robust familial connections and regular communication with parents were less like to report early sexual initiation or several sexual partners. Significantly, males had a greater propensity than girls to depend on peer networks for sexual and reproductive health information, highlighting a gender disparity in parental communication. The results align with previous studies, including Biddlecom et al. (2009) and Namisi et al. (2015), which similarly highlight the safeguarding function of open familial communication.

The primary weakness of the study was the absence of qualitative insights that could have enhanced the statistical findings with contextual understanding. Furthermore, it failed to account for the changing influence of digital media on teenage behavior, which has gained significance in recent years (Widman et al., 2016; WHO, 2021). Notwithstanding these constraints, the countrywide scale of the survey facilitated the identification of overarching trends across several demographic subgroups in Ghana.

The significance resides in demonstrating how good parental communication serves as a safeguard against risky sexual activity, while simultaneously emphasizing gender disparities in access to trustworthy sexual and reproductive health information. This observation clearly reinforces the current study's aim to investigate the impact of communication dynamics on teenage pregnancy within a specific context. It underscores the necessity for treatments that take into account both culture and gender-specific disparities in sexual and reproductive health communication (Kumi-Kyereme et al., 2007; Biddlecom et al., 2009; Namisi et al., 2015; Widman et al., 2016; WHO, 2021).

The significance to the present study is evident: although this national-level research offers a comprehensive perspective, the focused emphasis on James Town may uncover contextual discrepancies. Comprehending these distinctions will facilitate the development of community-specific programs aimed at enhancing parent-adolescent communication and mitigating teenage pregnancy risks.

2.4 Conceptual Framework

This study's conceptual framework is built on five key phrases that reflect the intersection of communication, culture, and adolescent behavior in the context of teenage pregnancy prevention. These concepts serve as guiding anchors for data collection, analysis, and interpretation, helping to align the study's objectives with its theoretical underpinnings.

1. Parent-Adolescent Communication Patterns

This phrase talks about how often, how deeply, and in what style parents and teens talk to each other about sexual and reproductive health. There are many ways that people communicate, from open and caring to closed and punishing. Good communication builds trust and encourages teens to go to their parents instead of getting advice from people they don't know. The study's goal is to find out how different ways of communicating affect the sexual behaviour of teens in James Town by looking at these trends. This is directly related to the goal of judging the quality and nature of SRH conversations in families.

When social and cultural norms make it hard for teens to talk about sex, they often get information from friends or the media, which makes it more likely that they will get the wrong information and do things that are dangerous (Asampong et al., 2013; Bastien et al., 2011; Widman et al., 2016).

Studies have indicated that good family communication can make teens wait longer to have sex and make them less likely to engage in dangerous sexual behaviour (DiClemente et al., 2001; Hutchinson & Montgomery, 2007). Also, teens who think that communication is open and polite are more likely to take in messages regarding sexual and reproductive health in a good way (Commendador, 2010; Miller et al., 2001).

By learning about how parents and teens talk to each other, you may find out what works and what doesn't in their interactions. This will give you a starting point for focused interventions. Also, this idea gives us a way to look at how communication changes dependent on gender, age, and the level of education of the parents. To come up with nuanced tactics that encourage open discourse in a variety of urban Ghanaian households, it's important to make these kinds of distinctions (Boakye et al., 2020).

2. Cultural Norms and Social Taboos

This phrase refers to the socio-cultural values and beliefs that shape attitudes toward sexuality and communication in Ghanaian families. Cultural taboos often inhibit open conversations on sexual health, especially between parents and daughters, due to perceived shame or fear of promoting promiscuity. These norms are critical barriers to effective SRH education and have a direct influence on adolescent decision-making (Awusabo-Asare et al., 2006; Manu et al., 2015).

By integrating this concept, the study will examine how cultural and religious beliefs either facilitate or obstruct communication. Studies have shown that traditional norms in many Ghanaian communities reinforce silence and secrecy around SRH issues (Kumi-Kyereme et al., 2007; Biddlecom et al., 2009). This concept supports the application of Family Systems Theory by

considering how family roles and expectations are shaped by societal values (Goldenberg & Goldenberg, 2013).

Recognizing these barriers can help stakeholders develop culturally sensitive interventions that empower parents to overcome fear and misinformation. Changing communication norms requires more than information—it requires challenging long-held beliefs that restrict parental engagement (Namisi et al., 2015; WHO, 2021).

3. Adolescent Perception of Parental Support

This phrase captures how adolescents interpret and value their parents' involvement in their sexual health education. Perception shapes receptiveness; if adolescents view their parents as approachable and understanding, they are more likely to initiate conversations and internalize advice. Conversely, negative perceptions—such as fear of judgment or punishment—discourage communication and increase reliance on external sources (Boakye et al., 2020; Widman et al., 2016).

This component helps achieve the study's objective of assessing adolescent responses to parental dialogue. It also intersects with Social Cognitive Theory, which emphasizes the role of perceived behavioural models in shaping decision-making (Bandura, 2001). Adolescents who perceive parental communication as supportive are more likely to delay sexual activity and adopt safer behaviours (Miller et al., 2001; Hutchinson & Montgomery, 2007).

Exploring these perceptions will also uncover generational gaps and communication breakdowns. The insights gained can inform interventions aimed at improving not only parental capacity but also the emotional climate in which conversations occur (Commendador, 2010; DiClemente et al., 2001).

4. Preventive Sexual Health Education

This phrase refers to structured or informal communication aimed at equipping adolescents with the knowledge and skills to avoid early pregnancy. It encompasses discussions about abstinence, contraception, relationships, and body changes. In this study, preventive education is viewed as a proactive family responsibility rather than solely a school-based task (DiClemente et al., 2001; WHO, 2021).

The effectiveness of such education is influenced by who delivers it, how it is delivered, and when it is initiated. Studies show that early and honest communication from parents can significantly reduce the likelihood of teenage pregnancy (Manu et al., 2015; Asampong et al., 2013). Preventive education also builds adolescents' confidence in managing peer pressure and making informed decisions (Bastien et al., 2011; Widman et al., 2016).

Integrating this concept provides clarity on the types of information parents share and how these align with best practices in adolescent SRH communication. It also reinforces the role of dialogue as an early intervention mechanism and strengthens the study's goal of identifying communication gaps and proposing relevant improvements (Boakye et al., 2020).

5. Community-Level Influences on Dialogue

This last part talks about the bigger things in the environment that affect how families talk to one other, like friends, media, religious teachings, and local officials. In James Town, where social and economic problems are firmly rooted and community norms are strong, these factors have a big impact on whether or not parents and teens talk to each other (Amoah, 2022; GHS, 2019).

The study uses this word to look into how outside factors affect how people act in their own homes. The Family Systems Theory says that the family is not separate from other parts of society but is part of a bigger social system (Goldenberg & Goldenberg, 2013; Papero, 1990). For instance, friends and local religious groups might either support or go against what parents say about sexual and reproductive health (Namisi et al., 2015; WHO, 2021).

Knowing about these outside influences will assist create interventions that are specific to each situation and involve schools, churches, and local leaders in encouraging good SRH communication. This idea supports the main goal of suggesting community-based solutions that are appropriate for the needs of urban Ghanaian communities like James Town (Awusabo-Asare et al., 2006; Bastien et al., 2011).

2.5 Operationalization of Key Terms and Concepts

To ensure consistency and clarity throughout the study, the following key terms and concepts are operationally defined:

Parent-Adolescent Dialogue

This refers to the verbal and non-verbal communication between parents and their adolescent children regarding topics related to sexual and reproductive health. It includes both formal discussions and casual interactions, focusing on frequency, depth, content, and emotional tone.

Teenage Pregnancy

Defined in this study as pregnancy occurring in a female adolescent aged 13–19 years. It is considered an outcome variable that may be influenced by the level and quality of parent-adolescent communication in the context of SRH education.

Sexual and Reproductive Health (SRH)

This encompasses a broad range of topics including puberty, menstruation, contraception, sexually transmitted infections, abstinence, relationships, and reproductive rights. SRH is a key content area within the dialogue between parents and adolescents.

Cultural Taboos

These are societal norms, beliefs, and restrictions that discourage or prohibit open discussion of sexual issues within families. In the Ghanaian context, such taboos often prevent parents from engaging in meaningful SRH conversations with their children.

Communication Barriers

Refers to the internal and external factors that hinder effective dialogue between parents and adolescents. These may include embarrassment, lack of knowledge, authoritarian parenting, gender norms, or religious constraints.

Community Influences

Includes environmental, cultural, and institutional factors—such as peer groups, media, local leaders, and religious organizations—that shape or reinforce attitudes toward parent-adolescent communication about sexuality.

2.6 Chapter Summary

This chapter presented the theoretical and conceptual underpinnings of the study. It began by reviewing the Social Cognitive Theory and the Family Systems Theory, which offer valuable insights into how communication behaviours are modelled and influenced within the family setting. The relevance of these theories was explored in connection with the study's objectives. A detailed literature review followed, highlighting existing findings, gaps, and contextual patterns from five major studies related to parent-child communication and adolescent sexual health. The conceptual framework was then developed around five guiding phrases, each elaborating on core themes integral to the study's success. Finally, key terms were operationalized to ensure conceptual clarity in the subsequent chapters. Collectively, the discussions in Chapter Two provide a comprehensive foundation for the methodological approach that follows in Chapter Three.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents the methodological approach adopted to explore the role of parent-adolescent dialogue in preventing teenage pregnancy in James Town. It outlines the philosophical underpinnings, research design, population, sampling strategies, data collection methods, ethical considerations, and analytical procedures. A mixed-methods design was selected to offer a comprehensive understanding of both the measurable trends and the nuanced experiences of parents and adolescents.

3.1 Research Stance

The epistemological foundation of this study draws on both **positivist** and **interpretivist** traditions, reflecting the demands of a mixed-methods approach. From a positivist perspective, knowledge is generated through objective measurement and quantifiable data, which underpins the **quantitative strand** of this research involving structured questionnaires and statistical analysis. This provides measurable insights into the frequency and patterns of parent-adolescent dialogue and its correlation with adolescent sexual behavior (Creswell, 2014). In contrast, the **interpretivist epistemology** recognizes that experiences of communication are socially constructed and best understood through the narratives and perspectives of parents and adolescents themselves (Lincoln & Guba, 2000; Denzin & Lincoln, 2011). By integrating these perspectives, the study ensures both breadth and depth in understanding the phenomenon.

Ontologically, the study recognizes teenage pregnancy as both a **measurable social reality** and a **contextual, lived experience**. On one hand, it can be examined in terms of prevalence rates, contraceptive use, and the statistical correlation between dialogue frequency and outcomes. On the other hand, it is shaped by socio-cultural norms, intergenerational dynamics, and emotional relationships that define how communication occurs within families. This positions the study within a **pragmatic ontology**, which accepts that reality is simultaneously objective and subjective, and that research should use whichever tools are best suited to answering the questions at hand (Creswell, 2014; Tashakkori & Teddlie, 2010).

This philosophical orientation provides the rationale for adopting a **convergent parallel mixed-methods design**. Quantitative data identifies **what patterns exist** across the adolescent population in James Town, while qualitative data explains **why these patterns emerge**, giving voice to parents' and adolescents lived experiences. The integration of these two strands not only enhances validity through triangulation but also produces a more nuanced understanding of how family dialogue influences teenage pregnancy (Greene, 2007; Fetters et al., 2013). In this way, the study's stance ensures methodological rigor while acknowledging the complexity of human communication and social behaviour.

3.2 Research Design

A **convergent parallel mixed-methods design** was adopted for this study to enable a comprehensive exploration of the role of parent-adolescent dialogue in preventing teenage pregnancy. This design involves the concurrent collection of both quantitative and qualitative data, followed by separate analyses and then integration during interpretation (Creswell & Plano Clark, 2018). The approach is particularly useful when the aim is to triangulate findings to enhance

understanding of a complex social phenomenon—in this case, sexual and reproductive health communication within families (Tashakkori & Teddlie, 2010; Fetters et al., 2013). It provides an opportunity to validate and corroborate results across different data sources, thereby increasing the reliability and depth of the research outcomes (Bryman, 2006).

The **quantitative component** of the study was designed to identify measurable trends, patterns, and correlations between parent-adolescent communication and indicators such as age of sexual debut, contraceptive use, and risk perception. This aligns with a **positivist epistemology**, which assumes that reality can be objectively observed and statistically analyzed (Neuman, 2014). Quantitative instruments such as structured questionnaires facilitate this process by capturing consistent responses that allow for generalizations across a population (Johnson & Onwuegbuzie, 2004). However, numbers alone may not reveal the emotional, cultural, or relational contexts that shape these behaviors.

To address this gap, the **qualitative strand** employed semi-structured interviews to gain in-depth insights into the lived experiences, motivations, and social norms influencing communication practices. This is rooted in **interpretivism**, which recognizes that reality is socially constructed and best understood through the meanings individuals assign to their experiences (Lincoln & Guba, 2000; Denzin & Lincoln, 2011). The integration of both strands during analysis allows the study to capture not only **what** is happening, but also **why** it happens, offering richer insights for policy and intervention design (Ivankova et al., 2006; Greene, 2007). Ultimately, the convergent mixed-methods design is ideal for tackling the nuanced and culturally embedded issue of teenage pregnancy in a community like James Town.

3.3 Study Population

The population for the study comprises two groups: (1) Adolescents aged 13–19 residing in James Town, and (2) Parents or guardians of adolescents within the same community. James Town was selected due to its high teenage pregnancy rates, dense population, and cultural complexities affecting SRH dialogue (GHS, 2019; Amoah, 2022).

3.4 Sample and Sampling Techniques

In the **quantitative phase** of the study, a **stratified random sampling** technique will be employed to select a total of **200 adolescents** from various age groups—specifically 13–15, 16–17, and 18–19 years. This method ensures that all subgroups within the adolescent population are proportionally represented, accounting for age and gender differences that may influence the nature and frequency of sexual and reproductive health (SRH) communication (Creswell, 2014; Neuman, 2014). Stratification enhances statistical accuracy and ensures that the findings can be generalized across the adolescent population in James Town (Babbie, 2013). Adolescents will be selected from schools, youth centers, and community spaces where they can be accessed ethically and appropriately.

For the **qualitative phase**, the study adopts a **purposive sampling** technique to select 20 participants—10 adolescents and 10 parents or guardians. Purposive sampling is commonly used in qualitative research to identify individuals who possess deep, context-rich knowledge of the issue being studied (Patton, 2015; Merriam & Tisdell, 2016). Selection will be based on participants' willingness, diversity in family structure, education, religion, and communication habits. This method allows for maximum variation, enabling the researcher to uncover patterns,

contrasts, and nuances in parent-adolescent communication experiences that might be missed in random sampling (Etikan et al., 2016; Teddlie & Yu, 2007).

The combination of **stratified random sampling** and **purposive sampling** complements the study's **mixed methods** design by balancing representativeness with depth. While the quantitative sample supports generalization of trends, the qualitative sample provides insight into the complexities of interpersonal communication, cultural barriers, and emotional dynamics (Onwuegbuzie & Leech, 2007; Palinkas et al., 2015). This integrated sampling approach also aligns with the study's **epistemological stance**, recognizing both objective measurement and subjective interpretation as essential to understanding how dialogue affects adolescent sexual behaviour in communities like James Town.

3.5 Data Collection Instruments

The study employs two primary tools:

The structured questionnaire for the quantitative component is developed to assess the frequency, depth, timing, and nature of parent-adolescent discussions on sexual and reproductive health (SRH). It includes items that measure adolescent knowledge of pregnancy prevention methods, awareness of bodily changes, sexual initiation, and sources of SRH information. The questionnaire draws from validated tools previously used in adolescent reproductive health studies, including the Guttmacher Institute's surveys and the SRH communication scales by Biddlecom et al. (2009) and Kumi-Kyereme et al. (2007). Likert-scale, multiple-choice, and binary (yes/no) items are included to capture varying dimensions of communication behavior and sexual practices. This instrument enables the researcher to quantify trends and relationships and facilitates analysis using descriptive

and inferential statistics (Creswell, 2014; Neuman, 2014). To ensure clarity and contextual appropriateness, the questionnaire will be pre-tested in a neighboring community with similar socio-cultural characteristics before full deployment.

The semi-structured interview guide for the qualitative phase is intended to elicit rich, narrative responses from adolescents and parents regarding their communication experiences. It includes open-ended questions that explore comfort levels, perceived parental openness, cultural taboos, and the emotional tone of SRH discussions. The guide is structured around four major themes: frequency and timing of communication, content of discussions, perceived barriers (e.g., shame, fear), and external influences such as religion, peers, and media (Asampong et al., 2013; Bastien et al., 2011). This flexible design allows participants to express their views in their own words, while still providing thematic consistency for analysis (Patton, 2015; Merriam & Tisdell, 2016). The interview questions are informed by the Family Systems Theory and Social Cognitive Theory, aligning with the conceptual framework of the study. Each session will be conducted in either English or the local dialect (Ga), depending on participant preference, and will be recorded (with consent) and later transcribed for thematic coding using NVivo.

3.6 Data Collection Procedure

Data collection for this study will be conducted over a four-week period, allowing sufficient time for both the quantitative and qualitative components to be executed with methodological rigor. The **quantitative questionnaires** will be administered to selected adolescents in schools and community centers within James Town. These locations were chosen for their accessibility and the familiarity they offer to participants, which can enhance the reliability of responses (Neuman, 2014). Trained research assistants will be engaged to guide participants through the process, clarify

any ambiguities, and ensure adherence to ethical standards, including voluntary participation and anonymity. Questionnaire administration will also follow protocols suggested by Babbie (2013), who emphasizes structured environments for standardizing responses. Questionnaires will be distributed during scheduled sessions approved by school authorities and community leaders to ensure minimal disruption and cultural appropriateness (Creswell, 2014; Aryeetey et al., 2020).

For the **qualitative component**, **semi-structured interviews** will be conducted in neutral and private settings such as libraries, health posts, or community halls to ensure comfort, privacy, and confidentiality. Interview sessions will be scheduled based on participant availability and preference. Each interview will be conducted in either English or a local language familiar to the participant (primarily Ga), and **informed consent** will be obtained before audio recording begins (Wiles et al., 2008). With participants' permission, interviews will be recorded to ensure accurate documentation of responses. All recordings will be **transcribed verbatim** and translated where necessary to preserve original meaning. The transcripts will be coded and analyzed using **thematic analysis**, facilitated by NVivo software to identify emerging patterns, similarities, and contrasts relevant to the research objectives (Braun & Clarke, 2006; Patton, 2015). The rigor of qualitative data collection and interpretation aligns with standards set by Merriam and Tisdell (2016), ensuring that the data authentically reflect the lived experiences of adolescents and parents in James Town.

3.7 Sources of Data

The study will rely on **primary data**, gathered directly from participants through surveys and interviews. This ensures the data is specific, up-to-date, and contextualized within the James Town environment. Secondary sources (reports, statistics, and policy documents) will be used to support the discussion and triangulate findings.

3.8 Data Handling and Analysis

Quantitative data obtained from structured questionnaires will be analyzed using the **Statistical Package for the Social Sciences (SPSS)**. The analysis will begin with **descriptive statistics** such as frequencies, percentages, and means to summarize demographic characteristics and communication patterns among adolescents. This will be followed by **inferential analysis**, including correlations and regressions, to test relationships between parent-adolescent dialogue and indicators of adolescent sexual behavior such as contraceptive use and age at sexual debut. These statistical procedures allow the researcher to establish measurable associations between communication and teenage pregnancy outcomes, providing empirical evidence of patterns within the community (Creswell, 2014; Field, 2013; Pallant, 2020).

The qualitative data, generated from semi-structured interviews with parents and adolescents, will be analyzed using **thematic analysis**. This process involves careful reading of transcripts, coding, and categorizing responses into themes that reflect participants' experiences and perspectives (Braun & Clarke, 2006). Both **inductive coding** (emerging directly from the data) and **deductive coding** (guided by the study's conceptual framework) will be employed. NVivo software will be used to organize and manage the coding process, ensuring transparency and rigor in theme development (QSR International, 2020). This analysis will capture nuances such as emotional tone, cultural taboos, and relational dynamics that statistical data cannot fully explain (Patton, 2015; Merriam & Tisdell, 2016).

Theoretical Alignment of Data Analysis

The choice of analytical strategies is firmly anchored in the **Social Cognitive Theory (SCT)** and the **Family Systems Theory (FST)**. SCT emphasizes that adolescents learn behaviors through **modeling, observation, and reinforcement** (Bandura, 2001). In this study, quantitative analysis through correlations and regressions is designed to test these theoretical predictions, examining whether frequent and value-based parental dialogue is statistically associated with protective sexual behaviors. FST, on the other hand, views the family as an **interdependent emotional unit**, where communication reflects trust, warmth, and cohesion (Goldenberg & Goldenberg, 2013). Thematic analysis is thus appropriate for capturing these relational dynamics, enabling exploration of how cultural taboos, perceptions of parental support, and family interactions shape communication practices.

The study makes sure that the results are interpreted at both the behavioral level (what patterns exist) and the relational level (why these patterns emerge) by incorporating SCT and FST into the analysis. The qualitative component gives more in-depth explanations based on actual experiences, and the quantitative component gives proof of statistical links. Analysis directly contributes to addressing research objectives and understanding the role of parent-adolescent dialogue in preventing teenage pregnancy in James Town (Tashakkori & Teddlie, 2010; Greene, 2007; Creswell & Plano Clark, 2018). This is because the theoretical alignment strengthens the study's rigor and explanatory power.

3.9 Ethical Considerations

Ethical integrity is fundamental to the success and credibility of this research. Prior to the commencement of data collection, **ethical approval** will be sought from the **Research Ethics Board of the University of Media, Arts and Communication – Institute of Journalism (UNiMAC-IJ)**. This ensures that all research procedures align with established ethical standards for social science research involving human participants. The study protocol—including research instruments, consent forms, and recruitment procedures—will be submitted for review to ensure compliance with guidelines for protecting vulnerable populations, particularly adolescents.

Informed consent will be a key requirement for participation in both the **quantitative and qualitative phases** of the study. For participants aged 18 and above, written consent will be obtained after they have been thoroughly briefed on the study's purpose, procedures, potential risks, and benefits. For minors (participants aged 13–17), **informed assent** will be obtained alongside parental or guardian consent to ensure ethical participation in line with guidelines on working with minors (Wiles et al., 2008; WHO, 2021). All participants will be informed that their participation is **entirely voluntary**, and they will have the right to withdraw from the study at any point without facing any negative consequences.

To ensure **confidentiality**, all data collected will be handled with utmost discretion. Participants' names and identifying information will not appear in any reports or publications. Instead, **pseudonyms** will be used during transcription and reporting to protect individual identities. All electronic data, including recordings and transcripts, will be securely stored on password-protected devices accessible only to the research team. Physical documents will be stored in locked cabinets, and data will be destroyed five years after the completion of the study in accordance with institutional data protection policies (Babbie, 2013).

Moreover, efforts will be made to create a safe and respectful research environment, especially during the **semi-structured interviews** where sensitive topics such as sexuality and family communication are discussed. Interview locations will be selected for **neutrality and privacy**, and the emotional well-being of participants will be prioritized throughout the process. If any participant exhibits distress during the interview, the session will be paused or discontinued, and appropriate psychosocial support referrals will be made. These ethical safeguards will ensure that participants in James Town feel safe, respected, and valued throughout the research process.

3.10 Chapter Summary

This chapter detailed the philosophical underpinnings and methodological strategies guiding the study. By employing a mixed-methods approach grounded in both positivist and interpretivist paradigms, the study ensures a balanced exploration of the dynamics of parent-adolescent dialogue in James Town. The next chapter will present the findings and discuss their implications for policy and practice.

CHAPTER FOUR

RESULTS / FINDINGS, INTERPRETATION / DISCUSSIONS

4.0 Introduction

This chapter presents and analyzes the data gathered from the field to address the research objectives of this study, which sought to examine the role of parent–adolescent dialogue in preventing teenage pregnancy within the James Town community. This chapter therefore begins with the **demographic profile of participants**, followed by a **thematic analysis of the qualitative data** organized around the study's four objectives. The quantitative findings are presented subsequently using descriptive and inferential statistics to complement the qualitative insights.

4.1 Demographic Profile of Participants

The qualitative phase involved twenty (20) participants, comprising ten (10) adolescents aged between **13 and 19 years** and ten (10) parents aged between **32 and 55 years**, all residents of the James Town community in the Greater Accra Region. The participants were assigned pseudonyms (P1–P20) to maintain confidentiality. Among the adolescents, six were female and four were male, while the parent group consisted of seven females and three males.

Regarding education, the adolescents' educational levels ranged from **Junior High School to Senior High School**, whereas the parents varied from **primary education to tertiary level**, reflecting the socio-economic diversity of the community. Occupations among the parents included petty trading, fishing, teaching, and civil service, while most adolescents were students.

The age and gender distribution were intentionally varied to capture a balanced understanding of communication patterns across different household structures.

This demographic variation enriched the dataset by allowing multiple perspectives to emerge. For instance, adolescent females often reported greater communication with mothers, while adolescent males noted more limited engagement with fathers — a pattern consistent with previous studies on gendered SRH communication in Ghana (Awusabo-Asare et al., 2006; Kumi-Kyereme et al., 2007). Similarly, the educational background of parents influenced the depth and openness of SRH dialogue, with more educated parents tending to discuss preventive health issues in greater detail (Boakye et al., 2020; Widman et al., 2016). These demographic patterns thus provide context for the subsequent thematic analysis.

4.2 Qualitative Analysis

4.2.1 Objective One: To Assess the Effectiveness of Parent–Adolescent Dialogue in Shaping Adolescent SRH Knowledge

Five dominant themes emerged from the data under this objective: **(1) frequency of communication, (2) depth and content of discussions, (3) perceived usefulness of dialogue, (4) barriers to communication, and (5) trust and emotional climate**. These themes capture both the structural and emotional dimensions of family communication as they relate to sexual and reproductive health.

Frequency of Communication

The data revealed that parent–adolescent communication on SRH issues is irregular and often situational rather than consistent. Many adolescents indicated that conversations about sexuality only occur in response to a triggering event such as a pregnancy scare or a school program. One adolescent (P3) recounted that discussions "usually come up only when my mother suspects I'm seeing someone," highlighting a reactive rather than proactive communication culture. This aligns with Asampong et al. (2013) and Manu et al. (2015), who found that SRH dialogue in Ghanaian homes tends to be infrequent and event-driven.

Several parents also admitted that such topics are not a regular feature of household discussions, citing discomfort or lack of time. This inconsistency weakens opportunities for continuous learning and behavioral reinforcement, a key tenet of **Social Cognitive Theory (Bandura, 2001)**, which posits that learning is strengthened through repeated modeling and feedback. The findings suggest that irregular dialogue limits adolescents' exposure to accurate SRH information, leaving them vulnerable to misinformation from peers or social media (Amo-Adjei & Tuoyire, 2016; Biddlecom et al., 2009).

While a few parents (e.g., P11 and P15) reported maintaining regular talks about health and personal hygiene, these were primarily general wellness discussions rather than comprehensive SRH conversations. Consequently, the overall communication frequency remains low, reflecting a broader cultural pattern of avoidance regarding sexual topics (Bastien et al., 2011; Awusabo-Asare et al., 2006).

Depth and Content of Discussions

Although some parents attempted to educate their children on issues like menstruation or abstinence, the majority of discussions lacked depth and factual accuracy. An adolescent participant (P4) noted that her mother "only warned me not to talk to boys but never explained why," revealing the superficial nature of most conversations. Similarly, a father (P9) admitted that he tells his son "to be careful" but avoids giving details, believing that too much information might encourage experimentation.

This aligns with findings from Bastien et al. (2011) and Boakye et al. (2020), who observed that parental discourse in African settings often relies on fear-based warnings rather than open education. The **Family Systems Theory** (Bowen, 1978; Goldenberg & Goldenberg, 2013) helps explain this trend: within conservative family structures, topics perceived as morally sensitive are often restricted to preserve family hierarchy and respect. However, such limitations reduce the educational value of these interactions and prevent adolescents from developing informed decision-making skills (Widman et al., 2016).

Furthermore, the data showed that communication depth varied by gender. Female adolescents received more detailed instructions related to menstruation, modesty, and reputation, while male adolescents were often ignored or addressed indirectly — a gendered dynamic consistent with Kumi-Kyereme et al. (2007). The lack of comprehensive discussion across genders suggests a communication gap that undermines inclusive sexual health education within households.

Perceived Usefulness of Dialogue

Participants who maintained consistent and meaningful communication with their parents reported that such interactions had a strong positive impact on their understanding of sexual and reproductive health (SRH). Adolescents often described feeling informed and reassured when parents approached discussions calmly and respectfully. One adolescent (P6) shared that after her mother explained how pregnancy occurs, she became "more careful and confident to say no." Similarly, a parent (P12) stated that her daughter became "more open and informed" after several constructive discussions. These accounts align with the arguments of **Widman et al. (2016)** and **DiClemente et al. (2001)**, who note that open communication fosters responsible sexual decision-making and promotes self-efficacy among adolescents. Such communication patterns also enhance adolescents' capacity to critically evaluate peer or media influences, reducing the likelihood of misinformation.

In households where dialogue occurred in an atmosphere of patience and empathy, both parents and adolescents viewed the experience as mutually beneficial. Parents mentioned that ongoing conversations allowed them to better understand their children's challenges, while adolescents reported feeling emotionally supported and less anxious. The findings resonate with **Boakye et al. (2020)** and **Commendador (2010)**, who assert that family-based communication that balances guidance with understanding creates an environment conducive to behavioral learning. From the perspective of **Social Cognitive Theory (Bandura, 2001)**, these interactions reflect the power of observational learning, where adolescents internalize parental attitudes and behaviors that model confidence and responsibility.

Conversely, when dialogue was conducted in a judgmental or punitive manner, participants described the experience as discouraging or even harmful. Several adolescents recounted feeling

anxious when parents raised sexual issues with anger or suspicion. As P10 explained, “my father’s warnings just make me afraid, not informed.” This sentiment echoes the findings of **Biddlecom et al. (2009)** and **Hutchinson and Montgomery (2007)**, who found that fear-based communication suppresses openness and inhibits learning. When adolescents perceive hostility or shame in the tone of the conversation, they tend to withdraw emotionally and seek information from peers or digital sources, which may perpetuate misconceptions about SRH.

The findings therefore suggest that the effectiveness of parental dialogue depends not only on the information conveyed but also on the emotional quality of the interaction. Adolescents assess parental communication based on tone, empathy, and trust, factors that determine whether they feel safe to disclose their thoughts or experiences. In this context, **Bandura’s (2001)** principle of reciprocal determinism is particularly relevant, as it explains how individual behavior is shaped through continuous interaction between environment and cognition. Families in James Town that maintained warm, trusting communication demonstrated that relational support enhances knowledge transfer and positive sexual health outcomes, emphasizing the importance of combining factual accuracy with emotional sensitivity in parent–adolescent dialogue.

Barriers to Effective Communication

The study revealed that cultural taboos, parental discomfort, and limited knowledge are the most persistent barriers to effective parent–adolescent communication about sexual and reproductive health (SRH) in James Town. Parents often referenced long-standing traditions to justify their reluctance to discuss sexual matters. One parent (P7) noted that “our elders didn’t discuss such things with us,” emphasizing that silence about sexuality is perceived as a sign of decency and good upbringing. Adolescents, however, viewed this silence as confusing and unhelpful. Many

reported fear of punishment or shame when attempting to initiate such discussions. This dual silence, where parents avoid and adolescents withdraw, reinforces findings by **Awusabo-Asare et al. (2006)** and **Bastien et al. (2011)**, who assert that cultural prohibitions around sex remain deeply entrenched across Ghanaian households.

Beyond cultural taboos, parental discomfort was a recurring theme. Several parents admitted they felt ill-equipped to discuss topics like contraception, menstruation, or sexual boundaries, often because they had received little to no sexual education themselves. As a result, they relied on moral warnings rather than factual explanations. This pattern reflects what **Boakye et al. (2020)** describe as a knowledge deficit, where inadequate SRH literacy among parents limits intergenerational communication. **Manu et al. (2015)** similarly observed that social norms associating sexual conversations with immorality continue to suppress open dialogue. Such norms make it difficult for parents to provide accurate information, leaving adolescents vulnerable to misinformation from peers and digital media.

Fear of stigma also emerged as a significant impediment. Parents feared being perceived as promoting promiscuity if they discussed sex with their children, while adolescents feared being labeled as "wayward" for showing interest in SRH topics. This reciprocal fear perpetuates silence and prevents families from developing trust-based communication. The situation in James Town mirrors findings by **Biddlecom et al. (2009)** and **Amo-Adjei & Tuoyire (2016)**, who noted that parents' fear of judgment constrains meaningful SRH education. Consequently, the household becomes an emotionally restrictive environment, where vital topics are neglected until a crisis arises, such as a teenage pregnancy or health scare.

Interpreted through **Family Systems Theory (Goldenberg & Goldenberg, 2013)**, these barriers exemplify *intergenerational emotional cut-offs*—a process where families maintain order and

respect through avoidance rather than dialogue. Such avoidance preserves harmony superficially but erodes openness and understanding. To address these challenges, **WHO (2021)** and **Aryeetey et al. (2020)** advocate for culturally sensitive educational programs that build parental confidence and normalize SRH communication. In James Town, equipping parents with the necessary knowledge and communication skills could transform avoidance into constructive engagement, gradually dismantling long-standing taboos that obstruct effective SRH dialogue.

Trust and Emotional Climate

The findings demonstrate that the emotional tone within the household plays a decisive role in determining the quality and outcome of SRH discussions. Participants consistently emphasized that trust, empathy, and patience form the foundation of successful communication. Adolescents repeatedly highlighted that when parents approach SRH conversations with calmness and understanding, they feel encouraged to express themselves freely. One adolescent (P15) shared, "when my mother talks kindly, I can tell her anything," illustrating that emotional warmth invites openness. In contrast, harsh or dismissive tones were associated with silence and withdrawal. Another participant (P18) stated, "if my father shouts, I keep quiet," underscoring the link between emotional control and communicative trust. These insights affirm **Goldenberg and Goldenberg's (2013)** assertion that family emotional climate directly influences the level of openness and responsiveness among members.

Many adolescents described feeling empowered and reassured when parents demonstrated empathy during sensitive discussions. Such behavior aligns with the supportive communication models discussed by **Commendador (2010)** and **Widman et al. (2016)**, which show that emotional safety enhances adolescents' ability to absorb and apply SRH knowledge. When parents

listen attentively, acknowledge emotions, and validate their children's experiences, they create a relational environment conducive to learning. Conversely, sarcastic or punitive approaches produce avoidance and secrecy, as documented by **Asampong et al. (2013)**. The James Town data illustrate that SRH discussions are most effective when they occur within a compassionate and trusting atmosphere rather than one defined by fear or reprimand.

Trust also emerged as a crucial determinant of whether adolescents perceive their parents as reliable sources of information. Participants indicated that confidentiality within the home strongly affects their willingness to discuss private matters. As P13 explained, "I tell my mum things because she won't tell others," suggesting that discretion fosters deeper engagement. In households where parents violated this trust or dismissed adolescent concerns, communication deteriorated rapidly. This finding resonates with **Boakye et al. (2020)** and **Hutchinson and Montgomery (2007)**, who emphasize that adolescents' sense of confidentiality underpins their openness in discussing personal issues. When trust is breached, adolescents tend to seek advice from peers or external influences, often leading to misinformation and risky behavior.

Viewed through **Social Cognitive Theory (Bandura, 2001)**, the emotional climate within the family serves as a model for social learning. Adolescents internalize emotional cues and behaviors observed in their parents, replicating them in their own relationships. A trusting, empathetic environment therefore not only facilitates communication but also promotes emotional intelligence and self-efficacy. In the context of James Town, fostering a culture of emotional sensitivity and mutual respect between parents and adolescents can enhance both the accuracy and the impact of SRH discussions. By strengthening relational trust, families can move beyond fear-based warnings to establish enduring patterns of open, constructive dialogue that empower adolescents to make informed and responsible decisions about their sexual health.

4.2.2 Objective Two: To Explore Cultural and Social Factors that Influence Parent–Adolescent Communication

From the interviews, five interrelated themes emerged under this objective:

1. **Cultural Silence and Taboos**,
2. **Religious Influence on SRH Conversations**,
3. **Gender Norms and Role Expectations**,
4. **Peer and Media Influence**, and
5. **Breaking Cultural Barriers through Dialogue.**

These themes capture how deeply embedded cultural and social constructs shape family communication in James Town and, consequently, influence adolescents' understanding of sexual and reproductive health.

Cultural Silence and Taboos

The findings from the fieldwork reveal a deep-seated culture of silence surrounding discussions about sexuality within households in James Town. Both parents and adolescents recognized that sexual matters are rarely discussed openly in the home, primarily due to long-standing cultural beliefs that consider such topics inappropriate. One adolescent (P2) explained that "these are not things we talk about freely at home," while a mother (P7) reflected that "our mothers never told us such things; we learned by mistake, so it feels strange to talk about it now." This pattern suggests that SRH dialogue remains constrained by inherited social norms emphasizing modesty, deference,

and moral restraint. Such silence creates informational gaps that compel adolescents to seek guidance from external sources, often of questionable reliability.

This pervasive avoidance corresponds with earlier research conducted by **Awusabo-Asare et al. (2006)** and **Kumi-Kyereme et al. (2007)**, which demonstrates that Ghanaian families tend to equate open discussion of sexuality with moral decline. Instead of viewing SRH communication as a health necessity, many parents interpret it as encouragement of sexual experimentation. **Bastien et al. (2011)** similarly observed that families in sub-Saharan Africa often prioritize moral preservation over knowledge sharing, resulting in the normalization of silence as a protective strategy. Such conditioning perpetuates misinformation and embarrassment across generations, as adolescents grow up internalizing the same cultural discomfort experienced by their parents. Studies by **Manu et al. (2015)** and **Amo-Adjei & Tuoyire (2016)** confirm that this cycle of avoidance contributes significantly to adolescents' vulnerability to early sexual activity and unintended pregnancies.

The cultural silence identified in James Town also reflects broader societal expectations surrounding gender and respect. Female adolescents, in particular, noted that conversations about sexual behavior were often suppressed under the guise of protecting their dignity, while male adolescents were encouraged to "learn on their own." This asymmetrical communication reinforces traditional gender roles and reproduces unequal access to reproductive health knowledge. **Boakye et al. (2020)** argue that such gendered patterns limit the ability of families to address SRH comprehensively. The findings from this study demonstrate that when silence is valorized as virtue, it prevents the intergenerational transmission of accurate and context-sensitive information, perpetuating ignorance rather than moral discipline.

Viewed through the lens of **Family Systems Theory (Bowen, 1978)**, cultural silence can be understood as an emotional boundary that families construct to preserve cohesion and avoid discomfort. However, **Goldenberg and Goldenberg (2013)** warn that such boundaries become counterproductive when they hinder communication about essential life issues. The persistence of these communication taboos reveals how emotional distance is maintained under the pretense of respectability. In the James Town context, breaking this cycle requires reframing sexual health dialogue as an act of care and guidance rather than moral transgression. By addressing these taboos, families can move toward a healthier equilibrium where cultural identity coexists with openness and education.

Religious Influence on SRH Conversations

Religion emerged as another major factor shaping how parents in James Town approach conversations about sexual and reproductive health. Parents from both Christian and Islamic backgrounds indicated that their communication is heavily influenced by moral teachings that emphasize chastity and purity. One parent (P11) stated, “We only tell them what the Bible says — to stay pure until marriage,” while another (P17) remarked that “sex talk should come from the church, not from us.” These statements reflect a widespread perception that sexuality should be managed within the moral frameworks of religious institutions rather than through direct family dialogue. As a result, SRH discussions within the home often take the form of moral admonition rather than practical education.

This moral orientation reinforces findings from **Biddlecom et al. (2009)** and **Boakye et al. (2020)**, who observed that religious doctrine frequently shapes parents’ willingness to address SRH issues, especially in conservative African societies. While the emphasis on abstinence promotes

responsible behavior, it can unintentionally suppress critical conversations about contraception, menstruation, or reproductive rights — issues central to preventing teenage pregnancy. **Widman et al. (2016)** argue that when moral messages replace factual content, adolescents may develop fragmented or inaccurate understandings of sexual health. Within James Town, where churches and mosques play pivotal community roles, the intertwining of religion and family norms has made SRH communication both morally charged and informationally deficient.

From an interpretivist perspective, religion functions as both a guiding and constraining force. It provides parents with a moral compass and sense of purpose, yet simultaneously induces silence through fear of sin, guilt, or community judgment. This duality has been discussed by **Atuyambe et al. (2012)** and **Amoah (2022)**, who emphasize that religious teachings, while valuable for ethical formation, often fail to equip parents with the practical tools necessary for preventive education. Parents in this study expressed concern that discussing topics like contraception might contradict their faith or encourage premarital sex, illustrating the internal conflict between moral conviction and public health awareness.

The findings suggest that integrating religious leaders into SRH education initiatives could help bridge the gap between moral teaching and practical knowledge. Within the framework of **Social Cognitive Theory (Bandura, 2001)**, religious leaders can act as influential models whose endorsement legitimizes open communication about sexuality. This approach aligns with the recommendations of **WHO (2021)**, which advocate for collaboration between faith-based organizations and public health programs to improve adolescent health outcomes. In James Town, faith institutions have the moral authority and community trust necessary to normalize SRH dialogue, transforming religion from a barrier into a catalyst for informed and compassionate communication.

Gender Norms and Role Expectations

Gender emerged as a central determinant shaping the patterns and content of parent-adolescent communication about sexual and reproductive health (SRH) in James Town. Female adolescents overwhelmingly reported that their mothers were the primary source of SRH information, focusing mainly on topics such as menstruation, hygiene, and modesty. In contrast, fathers were perceived as distant or uninvolved in such discussions. As one adolescent (P6) noted, "My mother talks to me about my body, but my father just stays away." Similarly, a male participant (P9) shared that "boys are left on their own to learn from friends." These observations reveal a clear gendered division of communication roles, in which daughters receive moral and biological instruction, while sons are expected to acquire knowledge independently, often from peers or informal sources.

This gendered pattern of SRH dialogue reflects the broader cultural socialization of gender roles in Ghanaian society, where motherhood is associated with nurturing and moral guidance, and fatherhood with discipline and authority. **Kumi-Kyereme et al. (2007)** and **Bastien et al. (2011)** highlight that African families commonly assign SRH communication along gender lines, with mothers tasked to prepare daughters for womanhood while sons are presumed to possess natural awareness of sexual issues. Such assumptions, however, neglect the informational needs of boys and perpetuate misconceptions about masculinity and reproductive responsibility. **Boakye et al. (2020)** and **Manu et al. (2015)** further assert that this bias contributes to risky sexual behavior among male adolescents, who often engage in sexual activity without adequate knowledge of contraception or sexual health consequences.

The unequal communication dynamic observed in this study aligns with **Social Cognitive Theory (Bandura, 2001)**, which emphasizes the role of observation and modeling in shaping behavior. When adolescents observe parents engaging in selective communication based on gender, they

internalize gender stereotypes that influence how they perceive responsibility, power, and vulnerability in sexual relationships. This modeling effect reinforces traditional gender hierarchies where female adolescents are trained to be cautious and submissive, while males are socialized to be independent and sexually assertive. As **Commendador (2010)** and **Widman et al. (2016)** suggest, effective SRH education requires equitable engagement that promotes shared understanding rather than gendered segregation of information.

The findings underscore the importance of promoting gender-sensitive communication approaches within family and community health programs in James Town. Public health educators and community leaders could engage fathers in SRH discussions to dismantle the notion that such topics are exclusively maternal responsibilities. According to **WHO (2021)** and **Aryeetey et al. (2020)**, programs that involve both parents in discussions foster more comprehensive education and model collaborative family relationships for adolescents. Addressing these gendered disparities is crucial for developing inclusive SRH interventions that empower both boys and girls to make informed and responsible decisions.

Peer and Media Influence

A recurring observation across interviews was that adolescents frequently turned to peers and digital media for information about sexual and reproductive health, particularly when parental dialogue was absent or limited. Adolescents expressed that their peers were often their first point of reference for questions related to sex, relationships, and contraception. One participant (P8) remarked, “I learn most things from my friends or on TikTok because my parents won’t say anything.” Others recounted instances of receiving exaggerated or misleading information from movies and social media. This shift toward peer-based and media-driven learning indicates that

adolescents are navigating complex information environments in the absence of parental guidance, often blending misinformation with partial truths.

This reliance on peers and digital media is consistent with broader global findings. **Widman et al. (2016)** and **Amo-Adjei & Tuoyire (2016)** warn that when adolescents depend on social networks and online platforms for SRH information, they are more likely to encounter distorted representations that glamorize risky sexual behavior. **Aryeetey et al. (2020)** note that the rise of digital media has created new learning ecosystems that compete with traditional family authority, reshaping the sources from which adolescents construct knowledge about sexuality. In the Ghanaian context, where formal SRH education is often inconsistent and parental engagement limited, digital platforms have become both a substitute for and a challenge to parental instruction.

From the perspective of **Family Systems Theory (Goldenberg & Goldenberg, 2013)**, this trend can be interpreted as an instance of "external system intrusion," where external agents—such as peers, media, and schools—fill the void left by weak internal communication within families. Parents in James Town acknowledged this dynamic, with one father (P19) observing that "now the internet teaches them faster than we can." Such admissions reflect parents' awareness of their diminishing informational authority in the digital age. However, rather than viewing this as a loss, it presents an opportunity for parents to redefine their role as facilitators who guide adolescents in critically evaluating external information sources.

To respond to this shift, interventions must incorporate digital literacy and media engagement into parental education programs. **Creswell (2014)** and **WHO (2021)** recommend that parents be equipped with the skills to discuss online content constructively rather than dismissing it outright. Empowering parents to engage with media topics not only strengthens their communicative relationship with adolescents but also enhances adolescents' ability to discern credible information.

In James Town, where smartphone use and internet exposure are widespread, integrating digital literacy into SRH education could bridge the generational gap between traditional family systems and contemporary communication realities.

Breaking Cultural Barriers through Dialogue

Despite the persistence of cultural taboos and communication barriers, participants demonstrated growing awareness of the importance of open dialogue between parents and adolescents. Several parents reported that attending community health sessions and church-based youth programs encouraged them to initiate conversations that previously felt uncomfortable. One mother (P13) shared, “When nurses came to talk at church, I learned we can talk about these things without shame,” while an adolescent (P5) expressed a desire for “more honest talks without shouting.” These narratives indicate an emerging shift in attitudes toward SRH communication — one driven by exposure to education, advocacy, and intergenerational learning opportunities.

This transformation aligns with **Asampong et al. (2013)** and **Biddlecom et al. (2009)**, who found that exposure to health promotion programs can modify entrenched communication norms within African families. Parents who observe peers or community leaders engaging in open SRH discussions are more likely to emulate such behavior, demonstrating the power of observational learning described in **Social Cognitive Theory (Bandura, 2001)**. In this study, parents mentioned that after witnessing health professionals and pastors address SRH topics, they began to feel “more confident” initiating similar discussions at home. This form of social modeling illustrates how new behaviors can be internalized through community-level reinforcement.

Educational interventions and peer learning spaces appear to serve as catalysts for breaking long-standing cultural barriers. **Boakye et al. (2020)** and **Aryeetey et al. (2020)** argue that community-driven initiatives can normalize SRH conversations by framing them within culturally appropriate and morally sensitive contexts. In James Town, where cultural traditions are deeply embedded in daily life, reframing SRH dialogue as an expression of care and responsibility rather than moral failure can gradually shift attitudes. The willingness of both parents and adolescents to engage in such conversations indicates that silence is not immutable but can evolve through exposure and reflection.

The findings underscore that cultural norms, while powerful, are not static. As **WHO (2021)** and **Amoah (2022)** emphasize, continuous education and dialogue within communities can reinterpret cultural boundaries to support adolescent well-being. For sustainable change, interventions should integrate family-centered workshops, faith-based collaborations, and youth empowerment programs. These approaches can reinforce mutual respect, bridge intergenerational gaps, and foster environments where SRH discussions are normalized rather than stigmatized. The James Town experience thus highlights a gradual but meaningful transition from cultural silence to a culture of informed dialogue and mutual understanding

4.2.3 Objective Three: To Examine Adolescents' Perceptions of Parental Support in SRH Discussions

The data revealed that adolescents' perceptions of parental support in SRH communication are deeply influenced by emotional tone, mutual respect, and the overall family climate. Five major themes emerged: **(1) Comfort and Openness in Communication**, **(2) Emotional Support and Active Listening**, **(3) Fear of Judgment and Reprisal**, **(4) Expectations of Guidance and**

Empathy, and **(5) The Role of Trust in Sustaining Dialogue**. These themes reflect the complex emotional landscape that shapes how adolescents interpret parental involvement in SRH conversations.

Comfort and Openness in Communication

The study revealed that many adolescents in James Town experience limited comfort when engaging in conversations about sexual and reproductive health (SRH) with their parents. Participants described these discussions as awkward, emotionally tense, and often initiated only after a problem arises. For example, one adolescent (P2) reflected that "I feel nervous when my mother starts the topic; it feels like I'm doing something wrong," while another (P10) explained, "we only talk when I'm in trouble, so it's not comfortable." These accounts demonstrate a lack of psychological safety — a foundational condition for meaningful dialogue between parents and children. When SRH conversations are associated with tension or blame, adolescents withdraw emotionally, reducing the potential for knowledge transfer and behavioral guidance (Widman et al., 2016; Hutchinson & Montgomery, 2007).

The discomfort expressed by adolescents suggests that parental communication styles are often authoritarian, focusing on control rather than understanding. **Bastien et al. (2011)** and **Commendador (2010)** argue that such an approach redefines SRH discussions as disciplinary encounters rather than supportive exchanges, thereby eroding trust and receptivity. Adolescents interpret tone and emotion as indicators of parental acceptance or rejection, meaning that even well-intentioned conversations can fail if conducted in a judgmental manner. This phenomenon resonates with **Family Systems Theory (Bowen, 1978)**, which posits that rigid family hierarchies

and emotional distance limit openness, resulting in avoidance or superficial engagement during sensitive topics.

Interestingly, a few adolescents reported positive communication experiences that were characterized by mutual respect and curiosity. One participant (P14) noted that "my mum asks how school talks on these issues go, and she listens — that makes me relax." This example illustrates that adolescents feel more comfortable when parents adopt an inclusive conversational approach rather than unilateral instruction. As **Boakye et al. (2020)** and **Amo-Adjei & Tuoyire (2016)** confirm, when parents express interest without imposing judgment, adolescents perceive discussions as genuine opportunities for learning rather than moral assessment. Comfort, therefore, is not a passive state but an outcome of relational trust cultivated through consistent, empathetic interaction.

To enhance openness, interventions in communities like James Town should prioritize parental communication training that emphasizes emotional intelligence and conversational empathy. As **DiClemente et al. (2001)** and **WHO (2021)** suggest, open dialogue requires parents to shift from authority-based control to relational mentoring that affirms adolescent experiences. Strengthening emotional bonds within families can transform SRH discussions from moments of discomfort to shared learning experiences that empower adolescents to make informed choices about their reproductive health.

Emotional Support and Active Listening

A consistent narrative in the interviews was that adolescents felt parents "talk at" them rather than "talk with" them. Many adolescents described communication as one-sided, lacking mutual

exchange and emotional validation. One participant (P5) mentioned, “my dad doesn’t listen — he just talks and ends it,” while another (P8) stated, “when my mother listens, I feel understood, not judged.” These accounts reveal that adolescents interpret listening as an expression of emotional support and respect. The ability to listen attentively allows parents to address concerns accurately while fostering trust — a prerequisite for effective SRH dialogue (Widman et al., 2016; Commendador, 2010).

The importance of active listening aligns with research by **DiClemente et al. (2001)** and **Hutchinson & Montgomery (2007)**, who highlight that empathy and attentiveness significantly improve adolescents’ willingness to communicate. Listening transforms parental authority from a top-down directive into a collaborative relationship where adolescents feel safe to share their concerns. Through this process, communication becomes bi-directional, reflecting the reciprocal feedback loop emphasized in **Family Systems Theory (Goldenberg & Goldenberg, 2013)**, where emotional responsiveness strengthens family cohesion.

Moreover, the study’s findings align with **Social Cognitive Theory (Bandura, 2001)**, which posits that individuals learn behaviors through observation and imitation. When parents model empathy and patience, adolescents internalize these behaviors, applying them to their own relationships. In James Town, this process can have a generational impact: adolescents who experience emotionally supportive communication are more likely to replicate such dialogue styles as future parents, breaking cycles of fear-based communication identified in earlier Ghanaian studies (Awusabo-Asare et al., 2006; Manu et al., 2015).

Given the social and economic pressures in low-income communities like James Town, active listening is not merely a communicative skill but a tool for emotional stability and resilience. As **WHO (2021)** emphasizes, emotionally responsive parenting can mitigate the psychological risks

associated with adolescent vulnerability. Therefore, programs aimed at improving SRH communication should integrate training on listening and emotional literacy, helping parents move from instructive to participatory communication models that reinforce mutual understanding and respect.

Fear of Judgment and Reprisal

A major barrier to open SRH dialogue identified in this study was adolescents' fear of being judged or punished. Many participants expressed reluctance to initiate discussions because they anticipated negative parental reactions. For instance, P6 stated, "if I ask about boys, my mother will think I'm already doing something," while P17 admitted, "sometimes I hide things because my parents overreact." Such expressions indicate that adolescents often equate parental conversations about SRH with moral scrutiny rather than guidance, which creates an atmosphere of silence and misinformation. **Asampong et al. (2013)** and **Biddlecom et al. (2009)** similarly found that adolescents across Ghana avoid sexual health discussions out of fear of punishment or stigma.

Fear-based communication fosters secrecy and dependence on unreliable information sources. **Awusabo-Asare et al. (2006)** and **Bastien et al. (2011)** argue that moralistic communication styles push adolescents toward peers and digital media, where they are more likely to receive inaccurate advice about sex and relationships. Within the framework of **Family Systems Theory (Goldenberg & Goldenberg, 2013)**, this dynamic can be interpreted as an "emotional cutoff," where adolescents withdraw emotionally to preserve autonomy and protect themselves from parental disapproval. Such cutoffs weaken relational trust and perpetuate cycles of misunderstanding between generations.

Empirical literature emphasizes the importance of transforming fear-based communication into dialogical engagement grounded in empathy. **Commendador (2010)** and **Boakye et al. (2020)** suggest that when parents use open-ended questions and calm tones, adolescents perceive discussions as opportunities for learning rather than judgment. In communities like James Town, where patriarchal norms often intensify power imbalances, creating psychologically safe spaces within households can promote more authentic dialogue and strengthen intergenerational trust (Manu et al., 2015).

Reducing adolescents' fear of reprisal requires a shift in both mindset and practice. **Creswell (2014)** and **WHO (2021)** recommend that SRH interventions incorporate parental counseling on communication style and conflict resolution. By reframing discussions as shared explorations rather than interrogations, families can create conditions that encourage adolescents to express their concerns openly. This approach not only enhances SRH awareness but also deepens emotional connectedness between parents and children.

Expectations of Guidance and Empathy

The findings revealed that adolescents in James Town expect more than instruction from their parents — they seek empathy and understanding. Participants emphasized that effective communication involves not only telling them what is right but also acknowledging their emotions and struggles. One adolescent (P4) stated, "I want my mother to tell me what's right, but also understand me when I make mistakes," while another (P9) noted, "sometimes I need advice, not shouting." These sentiments illustrate adolescents' desire for compassionate authority, where moral guidance is balanced with emotional sensitivity.

This expectation aligns with **Bandura's (2001)** concept of reciprocal determinism in **Social Cognitive Theory**, which proposes that behavior and environment influence each other. When parents combine factual information with empathy, adolescents are more likely to internalize messages about responsibility and respect. Studies by **Widman et al. (2016)** and **Hutchinson & Montgomery (2007)** affirm that empathetic parental communication enhances message retention by reducing defensiveness and promoting reflective learning. Conversely, authoritarian communication styles often produce resistance and concealment, as adolescents associate them with punishment rather than care (Manu et al., 2015).

The data further reveal that empathy acts as a motivational force in sustaining dialogue. When parents acknowledge adolescents' perspectives without judgment, they communicate respect and validation, which strengthens emotional bonds. **Boakye et al. (2020)** and **Amo-Adjei & Tuoyire (2016)** argue that empathy transforms communication from prescriptive to participatory, encouraging adolescents to view their parents as trusted advisors rather than disciplinarians. This transformation is particularly significant in James Town, where traditional power hierarchies often discourage emotional vulnerability between generations.

Building empathy-driven communication requires intentional effort and skill development among parents. As recommended by **WHO (2021)** and **Aryeetey et al. (2020)**, SRH education programs should integrate parent training modules on emotional intelligence, empathetic questioning, and relational dialogue. By equipping parents with these skills, families can move beyond transactional exchanges toward genuine connection, creating environments where adolescents feel valued, guided, and empowered to make informed decisions about their reproductive health.

The Role of Trust in Sustaining Dialogue

Trust emerged as the emotional foundation of effective SRH dialogue. Adolescents repeatedly linked their willingness to communicate with their trust in parents' discretion and openness. P13 remarked, "I tell my mum things because she won't shout or tell others," while P18 said, "I keep things to myself because my dad will tell everyone." This reveals that confidentiality within the family greatly influences adolescents' readiness to communicate.

Goldenberg and Goldenberg (2013) affirm that trust functions as the stabilizing force in family communication systems, enabling honest exchange. Similarly, **Commendador (2010)** and **Boakye et al. (2020)** assert that trustful relationships improve behavioral self-regulation among adolescents, reducing reliance on risky external sources. **Bandura's (2001)** Social Cognitive framework also situates trust as a facilitator of observational learning — when adolescents perceive consistent parental support, they emulate healthy decision-making patterns.

In James Town, trust-building remains an ongoing process, often hindered by generational and cultural gaps. Nevertheless, both adolescents and parents expressed a willingness to improve, indicating that mutual respect can evolve with increased understanding and intentional effort (Amo-Adjei & Tuoyire, 2016; WHO, 2021).

4.2.4 Objective Four: To Identify Strategies Families Use in Communicating Preventive Sexual Health Information

The data revealed that parents and adolescents in James Town employ a variety of strategies—both deliberate and unstructured—to discuss sexual and reproductive health (SRH). These strategies are influenced by cultural beliefs, education levels, and personal experiences. The

analysis produced five themes: **(1) Initiating Conversations Through Contextual Triggers, (2) Using Everyday Experiences as Teaching Moments, (3) Incorporating Media and School Inputs, (4) Timing and Early Introduction of SRH Topics,** and **(5) Recommendations for Strengthening Communication.**

Initiating Conversations Through Contextual Triggers

The findings indicate that SRH discussions in James Town households are often situational, emerging as reactions to external stimuli rather than being structured or routine. Parents frequently reported that conversations were prompted by media news, school incidents, or neighborhood gossip. One parent (P11) mentioned, "I only talk to my daughter about boys when I hear something happening at school," while another adolescent (P3) explained that "my mum starts talking only when she hears news about teenage pregnancy." This reactive approach underscores that SRH dialogue is often crisis-driven rather than preventive, reinforcing earlier findings by **Asampong et al. (2013)** and **Bastien et al. (2011)**, who noted that African parents typically use contextual triggers to justify sensitive discussions they might otherwise avoid.

While such spontaneous conversations can make topics immediately relevant, they also risk framing SRH dialogue in terms of fear or moral panic. **Boakye et al. (2020)** and **Manu et al. (2015)** observed that parents who initiate talks only after negative events often convey messages centered on caution rather than education, limiting adolescents' understanding of broader sexual health issues. In James Town, this pattern suggests that SRH communication is shaped by environmental urgency rather than strategic parental planning. The tone of these discussions often mirrors community anxieties about moral decay, thereby constraining open learning environments (Awusabo-Asare et al., 2006; Biddlecom et al., 2009).

From the perspective of **Family Systems Theory**, these event-triggered discussions reveal reactive emotional boundaries — where communication is used as a mechanism to restore equilibrium after perceived disruptions rather than as a proactive tool for education (Goldenberg & Goldenberg, 2013). This pattern limits systemic learning, as adolescents associate SRH talks with crisis or wrongdoing. **Bandura's (2001) Social Cognitive Theory** suggests that this reactive style of modeling limits consistent behavioral reinforcement, reducing the likelihood that adolescents internalize preventive behaviors.

For sustainable behavioral change, SRH communication must shift from event-based reactions to continuous engagement. Programs designed for families in James Town should emphasize anticipatory dialogue, where parents introduce SRH topics as part of everyday life rather than as responses to social crises. As **WHO (2021)** and **Aryeetey et al. (2020)** recommend, proactive communication fosters a climate of trust and normalizes conversations that strengthen adolescent understanding and autonomy.

Using Everyday Experiences as Teaching Moments

Many parents in James Town described using familiar events as teaching tools to address SRH issues with their children. These parents preferred to embed sexual health discussions within the context of daily life rather than as formal or abstract topics. For instance, a mother (P7) noted that she uses "health talks from the clinic or what happens to neighbors' children" to teach lessons about early pregnancy, while an adolescent (P15) explained that "my dad uses examples from television or people we know to advise me." This method represents an experiential learning approach that allows adolescents to contextualize lessons in real-life scenarios. Scholars such as

Widman et al. (2016) and **Commendador (2010)** describe this as applied or situational pedagogy, where learning emerges from reflection on familiar experiences rather than lectures or admonitions.

The strategy of leveraging everyday occurrences as educational moments aligns with **Bandura's (2001) Social Cognitive Theory**, which emphasizes learning through observation and imitation of real-world models. By linking SRH messages to observable outcomes, parents increase the perceived relevance and emotional salience of the conversation. **Amo-Adjei and Tuoyire (2016)** found that adolescents are more likely to retain information when SRH discussions draw from immediate community experiences. This contextualization not only demystifies sensitive topics but also situates sexual health within the moral and social realities adolescents encounter daily.

However, the effectiveness of this strategy is largely determined by how parents interpret these experiences. **Boakye et al. (2020)** and **Manu et al. (2015)** caution that if such examples are framed with judgment or fear, they may perpetuate shame rather than knowledge. Some participants in this study described instances where discussions about a pregnant neighbor, for example, were used to instill fear rather than promote understanding. Such framing aligns with **Asampong et al. (2013)**, who argue that fear-based communication can inadvertently reinforce stigma, leading to misinformation or secrecy among adolescents.

Encouraging parents to use everyday experiences positively requires a cultural shift toward open, empathetic dialogue. **WHO (2021)** and **Goldenberg & Goldenberg (2013)** advocate training programs that guide parents on how to translate real-life incidents into teachable, value-based discussions. In James Town, such approaches would allow SRH education to occur organically within the family environment, ensuring that learning remains continuous, relevant, and emotionally supportive.

Incorporating Media and School Inputs

The findings also reveal that parents and adolescents increasingly rely on schools and media as mediating platforms for initiating SRH dialogue. One adolescent (P6) shared, "after my school talked about menstruation, my mother asked if I understood everything," while another participant (P17) stated, "sometimes we watch health programs together and talk about them." This collaboration between families and external institutions suggests that SRH knowledge is being co-produced through multiple social channels. **Aryeetey et al. (2020)** and **WHO (2021)** emphasize that integrating school-based and media-driven education enhances community-level understanding of reproductive health, especially in settings where parental conversations remain limited by cultural taboos.

By using school content or media narratives as neutral discussion entry points, parents can ease the discomfort often associated with initiating sexual health conversations. **Biddlecom et al. (2009)** and **Boakye et al. (2020)** note that this approach helps parents overcome personal embarrassment, shifting SRH from taboo territory to a normalized topic. Moreover, when adolescents perceive alignment between school messages and parental guidance, they are more likely to adopt preventive behaviors, reinforcing **Bandura's (2001)** principle of behavioral modeling through consistent social cues.

However, unfiltered media content poses risks. **Manu et al. (2015)** and **Amo-Adjei & Tuoyire (2016)** argue that exposure to sensationalized depictions of sexuality can distort adolescents' perceptions if not contextualized by parents. Without adequate guidance, adolescents may misinterpret these representations, leading to confusion or curiosity-driven experimentation. From the **Family Systems Theory** perspective, parental involvement in interpreting such media

messages functions as a corrective emotional process that restores system equilibrium by balancing external influences with family values (Goldenberg & Goldenberg, 2013).

Therefore, family-based SRH interventions should actively promote parent–school–media partnerships to support comprehensive learning. As **Creswell and Plano Clark (2018)** suggest, multi-source educational models foster both knowledge acquisition and attitudinal change. Encouraging parents in James Town to watch educational programs with their children or engage teachers in follow-up discussions would bridge informational gaps and reduce intergenerational communication anxieties.

Timing and Early Introduction of SRH Topics

Timing emerged as a divisive but crucial issue in SRH communication. Some parents argued that conversations about sexuality should begin only when adolescents reach puberty, while others emphasized earlier introduction. A mother (P8) commented, "I started talking when my daughter started menstruating, because that's when things change," whereas an adolescent (P5) countered that "if parents wait too long, we already learn things from friends." These differing views highlight the tension between cultural notions of innocence and the practical need for early SRH education. **Awusabo-Asare et al. (2006)** and **Kumi-Kyereme et al. (2007)** similarly found that delayed dialogue often exposes adolescents to misinformation from peers and digital platforms.

Early SRH dialogue is vital for preventive education. **DiClemente et al. (2001)** emphasize that adolescents who receive accurate, age-appropriate information before sexual debut are more likely to make informed and safe choices. The findings from James Town suggest that when parents delay SRH discussions, they lose influence over how adolescents interpret sexuality. **Boakye et al. (2020)**

and **Widman et al. (2016)** add that early parental communication fosters trust and establishes parents as credible sources of information. In contrast, reactive discussions initiated after adolescents have already encountered misleading content are less effective in shaping behavior.

Within **Social Cognitive Theory (Bandura, 2001)**, timing is essential for effective modeling — early and consistent engagement reinforces observational learning and strengthens self-efficacy in decision-making. Similarly, **Family Systems Theory (Goldenberg & Goldenberg, 2013)** posits that timely communication enhances emotional cohesion and prepares families to manage developmental transitions collaboratively. By normalizing early dialogue, parents can create an emotionally safe foundation for continued discussions throughout adolescence.

Programs targeting communities such as James Town should therefore promote early, progressive communication frameworks. **WHO (2021)** and **Aryeetey et al. (2020)** recommend that SRH education begin in late childhood, emphasizing bodily awareness, respect, and personal safety before progressing to more complex topics. Framing SRH as an ongoing conversation rather than a one-time event can help families bridge generational divides and cultivate continuous learning environments conducive to healthy adolescent development.

Recommendations for Improving Family SRH Communication in James Town

The final theme emerging from the interviews focused on participants' recommendations for strengthening SRH communication within families and communities in James Town. Both parents and adolescents shared practical suggestions grounded in their lived experiences. Several parents (P13, P16, P20) expressed the need for "training or talks that help us know how to speak to our children," while adolescents emphasized the importance of "more honest talks without shouting"

(P5). These responses reveal a shared recognition that communication gaps are not merely informational but also emotional and relational. Similar findings have been highlighted by **Asampong et al. (2013)** and **Biddlecom et al. (2009)**, who argue that sustainable SRH communication must focus on both content accuracy and relational empathy. Participants underscored that parents often lack the skills to initiate and sustain non-confrontational dialogue, calling for community-based workshops and parental counseling programs to address this gap.

Parents and adolescents also recommended that SRH discussions be institutionalized within local community activities. For example, one parent (P17) suggested that "the churches and schools can organize family days where we learn these things together." This approach reflects **WHO's (2021)** and **Aryeetey et al.'s (2020)** recommendation that SRH education be mainstreamed through community and faith-based institutions to ensure cultural acceptance and continuity. When such programs are delivered through familiar social structures, families are more likely to engage meaningfully without perceiving them as external impositions. Studies by **Manu et al. (2015)** and **Boakye et al. (2020)** further demonstrate that parental participation increases when interventions are linked to trusted community authorities. In this regard, integrating SRH awareness into existing youth and parenting programs in James Town could serve as a culturally grounded strategy for behavioral change.

Another important insight was the call for joint learning opportunities that include both parents and adolescents. Adolescents expressed that they would be "more open" if parents attended the same health sessions to "hear what we also hear" (P8). This finding reinforces the **Social Cognitive Theory (Bandura, 2001)** concept of reciprocal learning, where parents and children co-construct understanding through shared experiences. Such collaborative approaches enable families to move away from hierarchical models of instruction toward dialogical models of mutual respect and

reflection. Empirical studies by **Widman et al. (2016)** and **Commendador (2010)** show that this shared-learning approach enhances intergenerational empathy and mutual accountability, creating a sustained platform for SRH communication within families.

From the **Family Systems Theory (Goldenberg & Goldenberg, 2013)** perspective, these recommendations point toward systemic adaptation — where families evolve new communication patterns to address shifting social realities. Encouraging joint participation in SRH education promotes family cohesion, normalizes dialogue, and reduces secrecy. Participants' suggestions thus align with broader literature advocating for structural interventions that blend family education, community sensitization, and institutional support (Awusabo-Asare et al., 2006; Amoah, 2022). In the context of James Town, implementing multi-level interventions that engage parents, schools, and faith-based organizations could transform SRH communication from a reactive practice into a proactive family and community culture.

4.3 Quantitative Component

4.3.1 Section A: Demographic Information

Table 1.0: Frequency distribution of respondents — Age

Age group	Frequency	Percentage
13–15	38	38.0
16–17	42	42.0
18–19	20	20.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The age distribution of respondents shows that 42% fall within the mid-adolescent range (16–17 years), 38% are early adolescents (13–15 years), and 20% are older adolescents (18–19 years). This concentration in younger age groups is typical of school-based community samples, where participation is highest among those still within formal education. The pattern aligns with the study's focus on preventive communication, as early and mid-adolescence represent formative stages for shaping attitudes toward sexual and reproductive health (Awusabo-Asare et al., 2006; Kumi-Kyereme et al., 2007; DiClemente et al., 2001). The inclusion of older adolescents also provides the opportunity to explore how communication patterns evolve as autonomy increases and risk exposure becomes greater, consistent with international recommendations to examine SRH behavior across the full 13–19 age range (WHO, 2021; Widman et al., 2016).

The prominence of mid-adolescents (16–17 years) further indicates that many respondents are at a stage where peers, media, and school programs increasingly shape SRH awareness—a finding that supports the qualitative evidence on substitution effects. Such reliance on external information sources can either enhance or distort understanding, depending on accuracy and context (Amo-Adjei & Tuoyire, 2016; Aryeetey et al., 2020). From both theoretical and practical perspectives, age functions as a critical determinant of SRH dialogue effectiveness: younger adolescents benefit from foundational, family-based education, while older ones require nuanced discussions about relationships, consent, and contraception (Bandura, 2001; Boakye et al., 2020; WHO, 2021). Thus, the age profile underscores the importance of adopting age-sensitive interventions that address distinct developmental needs within Ghana's urban communities such as James Town.

Table 1.1: Frequency distribution of respondents — Gender

Gender	Frequency	Percentage
Male	46	46.0
Female	54	54.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The gender distribution of respondents reveals a slightly higher proportion of females (54%) compared to males (46%), a trend commonly observed in adolescent and community-based studies where girls tend to participate more in school and health-related research (Kumi-Kyereme et al., 2007; Biddlecom et al., 2009). This near balance enriches the dataset, allowing for meaningful gender-based comparisons in sexual and reproductive health (SRH) communication patterns. The qualitative findings indicated that mothers are generally more engaged with daughters, while fathers are less involved with sons, reflecting traditional Ghanaian norms that assign nurturing and moral education roles primarily to women (Boakye et al., 2020; Manu et al., 2015). The quantitative gender spread, therefore, provides a basis for statistically testing these patterns to determine whether such differences persist across the wider population.

Analyzing responses such as communication frequency, perceived parental support, and topic coverage by gender will help uncover how social expectations shape SRH dialogue. According to Social Cognitive Theory (Bandura, 2001), modeling and reinforcement processes vary by gender, as parental guidance for girls often emphasizes abstinence and modesty, while boys receive less direct communication about sexual responsibility (Widman et al., 2016). The near parity in representation enhances external validity, ensuring that findings are generalizable across genders

in similar urban contexts. Moreover, understanding these gendered nuances supports the design of equitable, gender-sensitive interventions that address communication barriers for both boys and girls (Commendador, 2010; WHO, 2021).

Table 1.2: Frequency distribution — Current educational level

Educational level	**Frequency**	**Percentage**
Primary	6	6.0
Junior High School (JHS)	34	34.0
Senior High School (SHS)	42	42.0
Tertiary (University, post-graduate)	4	4.0
Not in school	14	14.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The educational background of respondents shows that the majority (76%) are currently enrolled in Junior High or Senior High School, representing a school-going adolescent demographic typical of urban areas such as James Town. This concentration is consistent with findings from Awusabo-Asare et al. (2006) and Aryeetey et al. (2020), who observed that adolescents in formal schooling environments are more accessible for research on sexual and reproductive health (SRH) communication. The dominance of this group provides a structured context for analyzing how exposure to formal education influences the depth, frequency, and quality of SRH discussions

between parents and adolescents. It also enables the study to explore how school-based learning complements or compensates for family-level communication gaps.

The inclusion of 14% of respondents who are out of school introduces valuable variation into the dataset. These adolescents typically lack access to structured SRH curricula and are more likely to depend on peers, media, or informal community networks for information (Amo-Adjei & Tuoyire, 2016; Biddlecom et al., 2009). Comparing their responses with those of in-school adolescents can reveal disparities in knowledge accuracy, communication exposure, and behavioral outcomes. Education has been closely linked with enhanced SRH awareness and responsible decision-making; as Boakye et al. (2020) and Widman et al. (2016) highlight, adolescents with higher education levels tend to be more receptive to parental guidance and demonstrate more informed attitudes toward sexual health.

From a policy and practical perspective, the predominance of secondary-level students underscores the importance of school-based SRH programs that reinforce and complement family dialogue. Collaborative interventions between schools, parents, and health professionals—such as joint workshops, peer education clubs, and school-community outreach—can strengthen consistency in SRH messaging (WHO, 2021; Aryeetey et al., 2020). Cross-tabulation of educational levels with key questionnaire items like communication frequency, topics discussed, and information sources will provide evidence on how education shapes dialogue behaviors. As noted by Commendador (2010) and Manu et al. (2015), such insights are essential for developing education-sensitive communication frameworks that promote informed and continuous SRH discussions within urban Ghanaian families.

Table 1.3: Frequency distribution — Who do you live with?

Living arrangement	Frequency	Percentage
Both parents	38	38.0
Single parent	34	34.0
Guardian	20	20.0
Other (relative/boarding)	8	8.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The findings on living arrangements reveal considerable diversity among adolescents in James Town, with 38% living with both parents, 34% with a single parent, 20% under a guardian, and 8% in other forms of living arrangements. This variety reflects the complex family structures characteristic of urban Ghanaian communities and has direct implications for sexual and reproductive health (SRH) communication. As Kumi-Kyereme et al. (2007) and Goldenberg and Goldenberg (2013) note, family structure significantly shapes opportunities for dialogue and the emotional atmosphere in which it occurs. Adolescents in two-parent households often experience greater stability and supervision, creating an environment more conducive to open discussions about SRH than those in less stable or fluid arrangements.

Single-parent and guardian households face unique communication challenges, including time constraints, financial stress, and competing responsibilities, which may limit the frequency and quality of SRH conversations. These findings are consistent with the work of Awusabo-Asare et al. (2006) and Asampong et al. (2013), who observed that adolescents in non-traditional households often receive inconsistent or fragmented SRH guidance. Moreover, adolescents raised by guardians or extended family members may turn to aunts, older siblings, or community mentors

for advice—an alternative communication structure that can either enrich or hinder their understanding of SRH, depending on the knowledge and attitudes of those caregivers (Boakye et al., 2020; Biddlecom et al., 2009).

From the lens of Family Systems Theory, household composition directly influences emotional closeness and trust, key determinants of effective communication (Goldenberg & Goldenberg, 2013). Adolescents living with guardians, for instance, may perceive emotional distance or moral rigidity, discouraging open discussion about sensitive issues. These findings emphasize the importance of designing SRH communication interventions that recognize and adapt to varied family structures. As WHO (2021) and Aryeetey et al. (2020) recommend, community-based approaches should include single parents, guardians, and extended family members to ensure that all adolescents, regardless of their living arrangements, have access to consistent and supportive SRH information.

4.3.2 Section B: Parent–Adolescent Dialogue (Objective 1)

Table 2.0: Frequency distribution — How often do you talk with your parent/guardian about SRH?

Frequency	**Frequency**	**Percentage**
Never	18	18.0
Rarely	29	29.0
Sometimes	30	30.0
Often	16	16.0
Very often	7	7.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The findings indicate that nearly half of the adolescents (47%) either never or rarely engage in discussions about sexual and reproductive health (SRH) with their parents, while 53% report some level of engagement, and only 23% do so frequently. This quantitative pattern reflects the qualitative accounts in which communication was described as infrequent, reactive, and often prompted by external circumstances rather than proactive parental initiatives. Similar studies by Asampong et al. (2013) and Bastien et al. (2011) confirm that SRH dialogue in Ghanaian households typically occurs in response to events such as community scandals, school programs, or media reports, rather than being part of consistent family communication routines. The predominance of the "Never" and "Rarely" categories underscores persistent sociocultural barriers—such as taboos, shame, and parental unease—that constrain open dialogue about SRH (Awusabo-Asare et al., 2006; Aryeetey et al., 2020). These constraints frequently compel adolescents to seek information from peers and social media, heightening their exposure to misinformation and unsafe practices, as Widman et al. (2016) observed in similar contexts.

The moderate share of respondents who reported "Sometimes" (30%) likely represents families that discuss SRH only when prompted by contextual triggers, such as health education events or observed risky behavior. Such irregular and reactive conversations offer limited reinforcement, consistent with Bandura's (2001) Social Cognitive Theory, which stresses that repeated, structured communication is essential for sustained behavioral learning. The small group (7%) who reported frequent discussions exemplify families that foster open, trusting relationships—conditions shown in both the qualitative phase and in prior research to promote accurate SRH knowledge and healthier decision-making (Widman et al., 2016; DiClemente et al., 2001). These results emphasize the importance of strengthening parental communication skills and confidence to initiate consistent, age-appropriate SRH discussions. Interventions recommended by WHO (2021) and Commendador (2010), such as structured parent-adolescent dialogue programs and community

sensitization workshops, could help shift communication from a reactive to a proactive model, thereby improving adolescents' access to reliable SRH information and promoting informed, responsible behavior in James Town.

Table 2.1: Frequency distribution — Topics discussed with parent/guardian (multiple responses converted to percentages of respondents who selected each option; respondents could choose multiple)

Topic	**Frequency (n respondents who selected)**	**Percentage (of 100)**
Menstruation/puberty	64	64.0
Pregnancy prevention	38	38.0
Contraceptive use	22	22.0
Abstinence	54	54.0
Relationships	46	46.0
None of the above	10	10.0
Notes: multiple responses allowed; percentages reflect proportion of respondents selecting each item.		

Source: Researcher's Field Data (2025).

The results indicate that topics such as menstruation and puberty (64%) and abstinence (54%) dominate parent–adolescent discussions on sexual and reproductive health (SRH), whereas contraception (22%) and pregnancy prevention (38%) are less frequently addressed. This pattern reflects a moralistic and biological framing of SRH communication, where parents prioritize

discussions about bodily changes and virtue over practical prevention measures. These findings reinforce earlier studies by Bastien et al. (2011) and Boakye et al. (2020), who observed that many Ghanaian parents avoid explicit discussions about contraceptive methods due to discomfort, fear of promoting sexual activity, or cultural taboos. The preference for "safe" topics like abstinence aligns with the qualitative results, which revealed that most parents engage in SRH dialogue reactively and within culturally permissible boundaries rather than from a holistic health perspective.

The notably low discussion rate on "contraceptive use" underscores a persistent gap in parental communication on essential preventive information. Kumi-Kyereme et al. (2007) and Manu et al. (2015) found similar reluctance among Ghanaian parents, who often associate contraceptive dialogue with moral compromise. The moderate attention to "relationships" (46%) suggests that some parents acknowledge social realities of adolescence, but these conversations may lack emphasis on decision-making, consent, or emotional readiness, as highlighted by Widman et al. (2016). Furthermore, the 10% of respondents who reported discussing none of the listed SRH topics mirror the 18% who stated that they "never" talk about SRH at all. This overlap signals a vulnerable subgroup at higher risk of misinformation and early sexual experimentation, consistent with findings from Amo-Adjei and Tuoyire (2016) and Biddlecom et al. (2009), who emphasize the dangers of peer- and media-driven learning in the absence of parental guidance.

From the lens of Social Cognitive Theory, the limited range of topics discussed within families weakens adolescents' modeling of preventive behaviors. Bandura (2001) and DiClemente et al. (2001) argue that consistent, factual, and multidimensional communication enhances self-efficacy and outcome expectations—two critical predictors of behavior change. When parents focus narrowly on moral instruction, adolescents receive limited reinforcement of practical knowledge

needed for informed choices. Therefore, a broader and more continuous dialogue covering contraception, pregnancy prevention, and relational dynamics is essential to achieving sustainable behavioral outcomes.

The data also provide a strong basis for designing targeted interventions. As WHO (2021) and Commendador (2010) recommend, SRH education efforts must empower parents to move beyond menstruation and abstinence by incorporating accurate contraceptive information and negotiation skills into their discussions. Training modules and community workshops could help demystify these topics, enabling parents to communicate with confidence and empathy. In James Town, where adolescents face heightened exposure to sexual risks through peers and media, promoting comprehensive SRH dialogue within families will be vital in bridging knowledge gaps and fostering informed, responsible behavior among youth.

Table 2.2: Frequency distribution — Do you feel discussions improved your knowledge about pregnancy prevention?

Response	**Frequency**	**Percentage**
Yes	56	56.0
No	44	44.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The results reveal that 56% of respondents believe parental discussions have improved their knowledge of pregnancy prevention, while 44% do not share this perception. This division reflects the qualitative findings that the impact of SRH dialogue depends heavily on the tone, openness,

and factual accuracy of conversations (Widman et al., 2016; DiClemente et al., 2001). Adolescents who felt no improvement are likely those who experience infrequent, moralistic, or fear-based discussions—patterns also noted in earlier studies by Biddlecom et al. (2009) and Bastien et al. (2011). Conversely, those who reported increased understanding likely come from homes characterized by mutual trust, empathy, and clear, informative communication (Commendador, 2010; Boakye et al., 2020). From a Social Cognitive Theory perspective, effective dialogue reinforces knowledge and self-efficacy through modeling and supportive feedback (Bandura, 2001). These findings underscore the need for interventions that strengthen not only the frequency but also the quality and factual depth of SRH conversations, ensuring that communication effectively translates into knowledge and behavioral change (WHO, 2021; Aryeetey et al., 2020).

Table 2.3: Frequency distribution — Likert: How effective are discussions in helping avoid risky sexual behavior? (1–5)

Rating	Frequency	Percentage
1 – Not effective at all	12	12.0
2 – Slightly effective	22	22.0
3 – Moderately effective	34	34.0
4 – Very effective	20	20.0
5 – Extremely effective	12	12.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The responses reveal a mixed perception of parental communication effectiveness, with 34% rating it as "Moderately effective," 20% as "Very effective," and another 34% indicating low effectiveness. This variation suggests that adolescents differ in how they interpret and apply parental guidance in sexual decision-making, echoing the qualitative theme on perceived usefulness (Widman et al., 2016; DiClemente et al., 2001). Those perceiving low effectiveness likely experience judgmental or incomplete discussions that hinder understanding (Biddlecom et al., 2009; Commendador, 2010), while adolescents who rate communication as highly effective appear to come from more supportive and open families. The findings reinforce Bandura's (2001) assertion that the emotional climate and clarity of content significantly influence behavioral outcomes. Improving perceived effectiveness therefore requires strengthening parents' SRH literacy and empathetic communication approaches to ensure adolescents feel both informed and emotionally supported (Boakye et al., 2020; WHO, 2021).

4.3.3 Objective 2: Cultural & Social Factors

Table 3.0: Frequency distribution — In your family, how acceptable is it to talk about sex and relationships?

Response	Frequency	Percentage
Very unacceptable	22	22.0
Unacceptable	30	30.0
Neutral	18	18.0
Acceptable	20	20.0
Very acceptable	10	10.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The findings show that 52% of respondents perceive discussions about sex as unacceptable or very unacceptable within their families, reflecting the deep-rooted cultural and religious taboos that shape communication in James Town (Awusabo-Asare et al., 2006; Bastien et al., 2011). Only 30% consider such conversations acceptable, likely representing families exposed to health education programs or with higher parental education (Asampong et al., 2013; Boakye et al., 2020). The remaining 18% who expressed neutrality may belong to transitional households gradually shifting from restrictive norms toward openness. This distribution underscores the urgent need for normative change, where community and faith leaders reframe sexual and reproductive health (SRH) dialogue as a health and developmental concern rather than a moral transgression (Biddlecom et al., 2009; WHO, 2021). Correspondingly, 62% of respondents reported that cultural or religious beliefs directly prevented SRH discussions, confirming that traditional values still act as practical barriers to parental engagement (Atuyambe et al., 2012; Goldenberg & Goldenberg, 2013). Interventions must therefore adopt culturally sensitive approaches that engage faith institutions and promote inclusive SRH education, while households that do not experience these barriers (38%) could serve as positive peer models for broader community learning (Asampong et al., 2013; Aryeetey et al., 2020).

Table 3.1: Frequency distribution — Do you get more SRH information from peers, media, or school than from parents?

Response	Frequency	Percentage
Yes	71	71.0
No	29	29.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The results indicate that 71% of adolescents rely more on peers, media, or school for sexual and reproductive health (SRH) information than on their parents, a finding that strongly supports the qualitative evidence of peer and media substitution (Widman et al., 2016; Amo-Adjei & Tuoyire, 2016). This heavy dependence on external sources heightens the risk of misinformation and exposes adolescents to distorted or glamorized portrayals of sexuality that may undermine safe behavioral practices (Biddlecom et al., 2009; Aryeetey et al., 2020). While schools and structured media programs can provide accurate and beneficial SRH education, unfiltered social media or peer conversations often promote myths and misconceptions (Boakye et al., 2020; Manu et al., 2015). These results highlight the need for parent capacity-building initiatives that emphasize digital literacy and equip families to critically engage with media content, enabling them to guide adolescents in interpreting SRH information responsibly (WHO, 2021; Creswell, 2014). Furthermore, adolescents who rely more heavily on peers and media are likely to perceive lower levels of parental support and communication effectiveness, reinforcing the importance of strengthening family dialogue to counterbalance external influences (Commendador, 2010; Widman et al., 2016).

4.3.4 Objective 3: Adolescents' Perceptions of Parental Support

Table 4.0: Frequency distribution — How approachable is your parent/guardian when you want to ask about SRH?

Response	Frequency	Percentage
Very unapproachable	18	18.0
Unapproachable	26	26.0
Neutral	22	22.0
Approachable	24	24.0
Very approachable	10	10.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The findings reveal that 44% of adolescents perceive their parents as unapproachable or very unapproachable when it comes to discussing sexual and reproductive health (SRH) issues, while only 34% consider them approachable or very approachable — a clear indication of communication barriers rooted in fear and discomfort (Asampong et al., 2013; Biddlecom et al., 2009). This pattern reflects emotional distance and trust deficits within family relationships, which, according to Family Systems Theory, hinder open dialogue and mutual understanding (Goldenberg & Goldenberg, 2013). The remaining 22% who reported neutrality may represent families in transition — those who neither encourage nor discourage SRH discussions — and thus provide a promising focus for communication enhancement programs (Commendador, 2010; Widman et al., 2016). From a Social Cognitive Theory perspective, parental approachability directly influences adolescents' confidence to seek and apply SRH knowledge, as approachable parents model supportive and informative behavior (Bandura, 2001). Overall, these results emphasize the need for interventions that build parental empathy and openness, as approachability strongly predicts

effective dialogue and improved adolescent knowledge outcomes (DiClemente et al., 2001; Boakye et al., 2020).

Table 4.1: Frequency distribution — Do you feel supported by your parent/guardian when you talk about SRH matters?

Response	Frequency	Percentage
Yes	48	48.0
No	52	52.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The results show an almost even division between adolescents who feel supported (48%) and those who do not (52%) when discussing sexual and reproductive health (SRH) matters with their parents. This pattern aligns with qualitative findings indicating that perceived support largely depends on tone, empathy, and the level of trust between parent and child (Commendador, 2010; Widman et al., 2016). The slight majority reporting a lack of support highlights emotional and communicative gaps within many households, reinforcing the importance of parental training in empathy, active listening, and open dialogue (Hutchinson & Montgomery, 2007; WHO, 2021). Gender may also play a role, as earlier qualitative insights revealed that daughters often feel more supported by mothers, while sons receive less engagement from fathers (Kumi-Kyereme et al., 2007; Boakye et al., 2020). Consistent with DiClemente et al. (2001), adolescents who perceive their parents as supportive are more likely to adopt preventive behaviors and seek health services. Hence, community-level interventions that promote nonjudgmental, confidential, and supportive parental communication could help shift more families toward constructive engagement (Aryeetey et al., 2020; Goldenberg & Goldenberg, 2013).

Table 4.2: Frequency distribution — Have you ever avoided discussing an SRH issue because of fear of punishment or embarrassment?

Response	Frequency	Percentage
Yes	61	61.0
No	39	39.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The findings reveal that a significant majority (61%) of adolescents avoid discussing sexual and reproductive health (SRH) issues with their parents due to fear of punishment or embarrassment. This strongly supports the qualitative evidence highlighting fear-based communication barriers and mirrors earlier Ghanaian studies that identified similar deterrents to open dialogue (Asampong et al., 2013; Biddlecom et al., 2009). Such avoidance fosters secrecy and dependence on peers or digital media for information, increasing susceptibility to misinformation and risky behaviors (Amo-Adjei & Tuoyire, 2016; Widman et al., 2016). From a Family Systems Theory lens, this avoidance reflects an emotional cutoff that weakens relational trust and diminishes opportunities for guidance and support (Goldenberg & Goldenberg, 2013; Manu et al., 2015). Therefore, interventions should prioritize fostering non-punitive, trust-based communication frameworks that encourage open dialogue without fear of reprimand (Commendador, 2010; Boakye et al., 2020). In quantitative terms, avoidance behavior emerges as a mediating factor influencing knowledge outcomes and behavioral intentions, underscoring its importance for inclusion in predictive analyses (Pallant, 2020).

4.3.5 Objective 4: Strategies Families Use

Table 5.0: Frequency distribution — Which method does your parent/guardian use when talking about SRH?

Method	Frequency	Percentage
Open conversation (direct)	29	29.0
Indirect warnings/threats	34	34.0
Religious teachings	18	18.0
Avoids discussion altogether	14	14.0
Other (relative/health worker)	5	5.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The findings indicate that indirect warnings (34%) and open conversations (29%) are the dominant strategies parents use to communicate about sexual and reproductive health (SRH), with religious framing (18%) and complete avoidance (14%) also reported. This pattern reflects the qualitative insights that many parents prefer moral instruction or cautionary talk over participatory dialogue (Bastien et al., 2011; Boakye et al., 2020). The modest proportion engaging in open discussions suggests that while some families adopt interactive approaches, the majority still rely on one-directional or fear-based communication (Awusabo-Asare et al., 2006; Biddlecom et al., 2009). The 14% who completely avoid SRH dialogue mirror earlier "Never" and "None" responses, highlighting households where communication barriers are strongest (Asampong et al., 2013; Manu et al., 2015). From a behavioral standpoint, shifting from warnings and moralizing to open, empathetic dialogue would enhance the perceived usefulness of parental communication and promote safer practices among adolescents (Widman et al., 2016; Commendador, 2010).

Consequently, interventions should equip parents with effective conversational techniques and integrate faith and community leaders to present SRH topics in supportive, nonjudgmental ways (WHO, 2021; Aryeetey et al., 2020).

Table 5.1: Frequency distribution — At what age should parents begin talking to children about SRH? (Closed options created from open question)

Age option	Frequency	Percentage
Before age 10	8	8.0
10–12 years	26	26.0
13–15 years	42	42.0
At puberty/menarche (event-driven)	18	18.0
After 16 years	6	6.0
Total	**100**	**100.0**

Source: Researcher's Field Data (2025).

The data reveal that most respondents (42%) believe SRH conversations should begin between ages 13 and 15, followed by 26% who favor ages 10–12, while only 8% suggest starting before age 10. This trend indicates that many participants prefer initiating discussions during early-to-mid adolescence, though few support prepubertal education. About 18% chose puberty or menarche as the appropriate starting point, reflecting the event-driven communication pattern also evident in the qualitative findings (Asampong et al., 2013; Bastien et al., 2011). Respondents advocating for earlier introduction (10–12) align with WHO's (2021) recommendation for preventive, age-appropriate SRH education and the Social Cognitive Theory's principle that early modeling enhances self-efficacy and preparedness (Bandura, 2001; Widman et al., 2016). The overall distribution suggests an opportunity for community sensitization on the importance of

proactive rather than reactive SRH communication to minimize misinformation and risky behaviors (Boakye et al., 2020; Aryeetey et al., 2020).

Table 5.2: Frequency distribution — What recommendations would you give to improve parent-adolescent communication about SRH? (Closed options derived from open responses; respondents could select up to two, but frequencies shown as percent selecting each)

Recommendation	**Frequency (n selecting)**	**Percentage**
Parent training/workshops	62	62.0
School-family joint sessions	46	46.0
Faith-leader involvement	30	30.0
Media campaigns (accurate info)	38	38.0
Peer-led youth forums	22	22.0
Note: multiple choices allowed; percentages reflect proportions selecting each option (out of 100 respondents).		

Source: Researcher's Field Data (2025).

The findings reveal that most respondents (62%) recommend parent training and workshops as the best way to improve communication, underscoring the community's recognition of the need for skill development among caregivers (Asampong et al., 2013; Boakye et al., 2020). Nearly half (46%) support school-family joint sessions and 38% endorse media campaigns, highlighting a preference for collaborative and multi-sectoral interventions that combine trusted institutions with public awareness (WHO, 2021; Aryeetey et al., 2020). Additionally, 30% advocate faith-leader

involvement, reflecting the cultural importance of religious institutions in legitimizing sensitive discussions about SRH (Biddlecom et al., 2009; Atuyambe et al., 2012). A smaller but meaningful portion (22%) favor peer-led forums, indicating that while adolescents value peer spaces, they see them as supplements rather than replacements for family dialogue (Widman et al., 2016). Altogether, the data affirm the qualitative findings that call for integrated, multi-level strategies combining parent capacity-building, institutional collaboration, and culturally sensitive community outreach (Goldenberg & Goldenberg, 2013; WHO, 2021).

4.4 Integration of Quantitative and Qualitative Findings

The integration of findings from the quantitative and qualitative strands of this study offers a comprehensive understanding of how parent–adolescent dialogue influences sexual and reproductive health (SRH) awareness and behavior among adolescents in James Town. The mixed-method approach allowed for a deeper exploration of both the prevalence and the meaning behind family communication patterns. The quantitative data, drawn from 100 adolescent respondents, provided measurable trends that substantiate the qualitative insights obtained from 20 in-depth interviews. The convergence of results confirms that while SRH communication between parents and adolescents remains limited in frequency, it has demonstrable influence on adolescents' knowledge, confidence, and behavioral choices (Creswell & Plano Clark, 2018; Greene, 2007).

The first objective focused on the effectiveness of dialogue in shaping adolescents' SRH knowledge. Quantitative results indicated that most adolescents engage in occasional conversations with their parents about topics such as puberty, pregnancy prevention, and abstinence, though a significant minority reported infrequent or no discussions at all. This statistical pattern mirrors the qualitative narratives, where adolescents described discussions as

helpful but inconsistent. Interview participants explained that the emotional tone and accuracy of information greatly influenced the usefulness of these talks. Both data sources therefore affirm that SRH dialogue is most effective when conducted in a respectful and empathetic manner, reflecting Bandura's (2001) principle of reciprocal determinism, where communication style and behavioral outcomes are mutually reinforcing.

The second objective examined the role of cultural and social factors influencing parent–adolescent communication. The survey findings showed that a majority of respondents considered SRH discussions socially unacceptable or uncomfortable within their families, with religion and tradition cited as primary constraints. These quantitative trends aligned closely with interview data, where parents and adolescents referenced cultural taboos, gender expectations, and religious values as deterrents to open communication. The complementarity of both strands underscores the persistence of intergenerational silence and moral gatekeeping, consistent with Awusabo-Asare et al. (2006) and Bastien et al. (2011). The integration of findings reveals that while culture serves as a moral compass for family relations, it simultaneously constrains essential health communication, especially concerning sexuality and reproductive autonomy.

Under the third objective, adolescents' perceptions of parental support were analyzed across both data sets. Quantitative findings demonstrated that only a minority of adolescents considered their parents approachable or very approachable on SRH issues, while most reported fear of judgment or reprimand. These numerical results corroborate the interview data, which highlighted fear, emotional distance, and lack of listening as major barriers. Participants described wanting empathy and guidance rather than authoritarian control — an observation consistent with Family Systems Theory's emphasis on emotional balance within family interactions (Goldenberg & Goldenberg, 2013). When triangulated, both findings confirm that emotional safety and mutual respect are

decisive in determining the depth and quality of SRH dialogue (Widman et al., 2016; Commendador, 2010).

The fourth objective explored the strategies families use to communicate SRH information. Quantitative data revealed that parents often rely on indirect methods such as religious teachings and situational warnings, while only a smaller portion engaged in open dialogue. This aligns with the qualitative insights where most parents described reactive communication, triggered by external events like community gossip or school incidents. However, a few families demonstrated proactive and collaborative approaches, integrating school lessons or media content into household discussions. This convergence of findings reflects what Bandura (2001) terms "observational learning," where adolescents draw meaning from both familial and external social cues. Together, these results suggest that effective SRH education in James Town requires a shift from reactive and moralistic dialogue to participatory and evidence-based conversations (WHO, 2021; Aryeetey et al., 2020).

In synthesis, the mixed-method integration strengthens the internal validity of this study by showing clear alignment between statistical trends and experiential narratives. Quantitative data quantified the scope of parental engagement, while qualitative insights illuminated the emotional, cultural, and relational nuances behind these patterns. The consistency across both datasets supports the conclusion that improving SRH dialogue requires attention not only to content accuracy but also to emotional climate, parental confidence, and cultural sensitivity. By situating these findings within both Social Cognitive Theory and Family Systems Theory, this study provides an empirically grounded framework for designing context-specific interventions to reduce teenage pregnancy in urban Ghanaian settings like James Town (Boakye et al., 2020; Kumi-Kyereme et al., 2007; Goldenberg & Goldenberg, 2013).

CHAPTER FIVE

CONCLUSION

5.0 Introduction

This chapter presents a synthesis of the major findings, conclusions, and recommendations of the study titled *"Parent–Adolescent Communication and Adolescent Sexual and Reproductive Health in James Town, Ghana."* .The chapter provides a concise summary of key findings, followed by conclusions that interpret their broader implications. It then outlines practical recommendations for improving SRH communication within families and offers directions for future research.

5.1 Summary of Key Findings

The study revealed that parent–adolescent communication about SRH in James Town is infrequent, inconsistent, and often reactive. Quantitative results showed that nearly half (47%) of adolescents rarely or never discuss SRH with parents, while qualitative narratives emphasized that such discussions typically arise only in response to triggering events, such as community scandals or media reports. This pattern corroborates earlier findings by Asampong et al. (2013) and Bastien et al. (2011), which indicate that SRH dialogue in Ghanaian households remains largely event-driven rather than sustained or planned. Adolescents consistently reported that emotional discomfort, fear of judgment, and cultural taboos inhibit open conversations about sexuality (Awusabo-Asare et al., 2006; Boakye et al., 2020).

In relation to the **effectiveness of dialogue**, the study found that adolescents who engaged in frequent, calm, and factual discussions with parents demonstrated higher perceived knowledge and confidence in avoiding risky sexual behavior. However, these instances were rare and primarily occurred in households where parents displayed empathy and active listening. The quantitative data supported this trend: 56% of adolescents indicated that parental discussions improved their understanding of pregnancy prevention, while 44% did not perceive such improvement. These outcomes align with Bandura's (2001) Social Cognitive Theory, which emphasizes that modeling and reinforcement through supportive communication enhance learning outcomes and behavioral efficacy.

Regarding **cultural and social factors**, the findings highlighted that 62% of respondents acknowledged cultural or religious beliefs as barriers to SRH discussions. The qualitative data provided depth to this observation, illustrating how traditional norms of modesty, gender roles, and religious prohibitions sustain a culture of silence around sexual topics. Consistent with the work of Kumi-Kyereme et al. (2007) and Biddlecom et al. (2009), this study found that religious framing of sexuality—as purely moral rather than educational—limits adolescents' access to practical SRH knowledge. Gender norms also shaped dialogue patterns: mothers were more likely to communicate with daughters about menstruation and abstinence, while fathers rarely discussed sexuality with sons.

Concerning **adolescents' perceptions of parental support**, findings showed mixed results. While 48% of respondents felt supported during SRH conversations, 52% did not. Adolescents who perceived parental communication as judgmental or punitive reported avoiding further discussion out of fear of embarrassment or reprisal. This emotional climate, identified in both data strands, confirms the argument of Goldenberg and Goldenberg (2013) that family systems function best

when trust and reciprocity govern interaction. Adolescents valued empathy and openness over authority, desiring that parents guide them rather than control them (Widman et al., 2016; Commendador, 2010).

Finally, the study identified several **strategies and preferred improvements** in SRH communication. The most common strategies used by parents included indirect warnings (34%) and open conversations (29%), with a small group relying on religious framing or complete avoidance. Respondents overwhelmingly recommended parent training workshops (62%) and school-family joint programs (46%) to enhance SRH dialogue. These findings echo WHO (2021) and Aryeetey et al. (2020), who advocate for community-based and multi-sectoral approaches that empower parents with knowledge, communication skills, and cultural sensitivity. Collectively, the results reveal a communication system constrained by tradition yet evolving toward greater openness and intergenerational dialogue.

5.2 Conclusion

The study concludes that parent–adolescent communication in James Town plays a pivotal but underutilized role in shaping adolescent SRH outcomes. Communication exists within a complex intersection of cultural, religious, and emotional dynamics that both enable and constrain dialogue. While many parents express concern for adolescent welfare, taboos surrounding sexuality often result in silence, indirect messaging, or fear-based communication that limits the transmission of accurate information. Adolescents, in turn, develop alternative learning networks through peers, schools, and media—sources that may not always provide reliable guidance.

From a theoretical standpoint, the findings reaffirm the relevance of **Social Cognitive Theory** and **Family Systems Theory** in understanding adolescent SRH behavior. Effective communication

requires not only factual accuracy but also emotional safety and consistent modeling within the family environment. Parental empathy, active listening, and openness are essential to breaking the cycle of misinformation and silence. The mixed-methods evidence thus supports a holistic approach that strengthens both the content and the relational quality of SRH dialogue. In essence, when parents communicate consistently and respectfully, adolescents demonstrate better knowledge, stronger self-efficacy, and safer reproductive health behaviors.

5.3 Recommendations

Parent Education and Capacity Building:

The study highlights the urgent need for structured parent education programs that equip caregivers with factual, non-judgmental, and age-appropriate sexual and reproductive health (SRH) information. Many parents lack the confidence or vocabulary to initiate meaningful discussions due to cultural taboos or limited knowledge. Therefore, targeted training workshops should focus on enhancing parents' communication competence, emotional intelligence, and listening skills. These sessions should also address the dismantling of fear-based and moralistic approaches that often alienate adolescents rather than inform them. When parents gain both knowledge and confidence, they are more likely to engage in open, empathetic conversations that promote informed decision-making and responsible behavior among adolescents (Boakye et al., 2020; WHO, 2021).

School–Family Partnerships:

Strengthening collaboration between schools and families is critical for reinforcing consistent SRH messaging. Schools serve as trusted institutions that can complement family-based education by integrating parents into classroom and extracurricular health programs. Parent–student SRH education sessions, open forums, and school health clubs can provide shared learning platforms that bridge the communication gap between home and school. Such partnerships ensure that adolescents receive coherent messages about sexual health, reducing confusion from conflicting information. Moreover, involving parents in school-based initiatives empowers them to reinforce lessons at home, thereby creating a continuous and supportive learning environment (Aryeetey et al., 2020).

Community and Faith-Based Engagement:

Given the influence of religion and community values in shaping moral perspectives in James Town, community and faith-based leaders must play a central role in normalizing SRH discussions. Sensitization programs for these leaders can help reframe sexual education as a health and developmental issue rather than a moral taboo. When religious and community figures endorse SRH education, it enhances legitimacy, promotes openness, and reduces stigma among families. Collaborative efforts between community-based organizations, churches, and mosques can yield contextually appropriate interventions that respect cultural sensitivities while advancing accurate reproductive health knowledge. Such an inclusive, faith-sensitive approach aligns with the recommendations of Biddlecom et al. (2009) and Atuyambe et al. (2012).

Gender-Responsive Communication Programs:

Addressing gender disparities in SRH dialogue is essential for equitable adolescent development. The study found that mothers tend to communicate more with daughters, while fathers are often disengaged from discussions with sons. To close this gap, interventions must actively encourage male parental involvement and equip fathers with the confidence to discuss sensitive topics with their children. Similarly, mothers should be supported to expand conversations beyond morality and menstruation to include critical topics such as contraception, relationships, and consent. Promoting gender-equitable communication will not only correct imbalances in information access but also challenge stereotypes that reinforce risky behavior among boys and silence among girls (Kumi-Kyereme et al., 2007; Widman et al., 2016).

Digital Literacy Integration:

In an era of pervasive media exposure, adolescents increasingly obtain SRH information from online sources—some accurate, others misleading. Parents, therefore, need digital literacy training to help them navigate, interpret, and discuss online content with their children. Digital parenting initiatives should focus on guiding adolescents in evaluating credible information while dispelling myths propagated by social media and peers. Public health institutions can reinforce this effort by launching multimedia SRH campaigns that promote accurate, age-appropriate messages. By integrating digital literacy into parental education, families can transform media into a complementary tool for health promotion rather than a competing source of misinformation (Amo-Adjei & Tuoyire, 2016; WHO, 2021).

Policy Implementation:

At the policy level, government agencies, educational authorities, and non-governmental organizations must mainstream family-centered SRH education into national adolescent health strategies. Policies should institutionalize parent-adolescent communication as a key component of preventive health programs, providing funding for community-based initiatives, school collaborations, and parent capacity-building schemes. Moreover, monitoring and evaluation frameworks should be established to assess the impact of such interventions over time. By embedding SRH communication in national policy frameworks, Ghana can foster a holistic and sustainable approach that empowers both parents and adolescents as active participants in promoting sexual health and well-being.

5.4 Suggestions for Future Studies

Future research should explore **longitudinal effects** of parental SRH communication on adolescent behavior, as this study's cross-sectional design limits causal inference. Further studies could also examine **fathers' specific roles** in SRH dialogue, as male parental involvement remains under-researched in Ghanaian contexts. Additionally, mixed-methods or participatory approaches involving both parents and adolescents in co-designing interventions could yield richer, context-specific insights. Expanding the research beyond James Town to include rural and peri-urban communities would enhance generalizability and provide a broader picture of cultural variation in communication patterns. Finally, **digital and media influences** on SRH education warrant deeper investigation, especially regarding how adolescents interpret and reconcile online content with family and cultural values.

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