

**SEX EDUCATION, CONTRACEPTIVE USE AND PRE-MARITAL SEXUAL
BEHAVIOUR AMONG IN-SCHOOL ADOLESCENTS IN NAMAYINGO DISTRICT,**

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DECLARATION

I **Okello Mercy Letaru** declare that this dissertation titled “Sex Education, Contraceptive Use and Premarital Sexual Behaviour among In-school Adolescents in Namayingo” is my original work, and has never been presented for a degree at any other university.

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APPROVAL

This thesis, written by Okello Mercy Letaru, was done under our supervision and has been submitted with our approval as the university supervisors.

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SIGNATURE DATE

DR. ALI BAGUWEMU

DEDICATION

I dedicate this dissertation to my dear husband, Mr Dickson Okello, my mother, Trephean Asianzu my children Abigail Okello, Jethro Okello and Mr Isaac Aguku, whose unwavering support, love, care encouragement and selflessness have changed me. I am exceedingly humbled and pray that the Lord blesses and reward them abundantly.

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LIST OF ABBREVIATIONS AND ACRONYMS

CDOs Community Development Officers

SLT Social Learning Theory

SRH Sexual and Reproductive Health

ABSTRACT

The study examined the connection between sex education, contraceptive use and premarital sexual behaviour in a stratified random sample of 375 In-School Adolescents in Namayingo district. Using a correlational survey design, data was collected with the help of a structured questionnaire and analysed using descriptive statistics, Pearson correlation and regression analysis. It was found that sex education helps adolescents delay sexual intercourse by enhancing their resolve to refrain from premarital sex. Furthermore, it was discovered that there was a substantial association between sex education and contraceptive use ($\beta = -.41$, $p < 0.05$), sex education and premarital sexual behavior ($\beta = -.30$, $p < 0.05$) and contraceptive use and premarital sexual behavior ($\beta = .15$, $p < 0.05$). Both sex education and contraceptive use explained 9% ($r^2 = 0.89$) of the variation in premarital sex behaviour with contraceptive use having a very small contribution of only 1%. Therefore, Sex education helps adolescents realize that it is chaste and virtuous not to be sexually active and resist temptations to engage in sexual conduct.

Contrary to public opinion, sex education can increase the moral cleanness of adolescents and so learning about sex and sexuality can be promoted as a morally clean act at school,

The researcher recommends that further research needs to investigate the appropriate age and methods that can be used to educate adolescents on how to manage sexual issues effectively. In addition, parents should not leave sexual education to schools. They should also be able to supplement what their children learn from school and endeavour to answer the questions that their children present to them about sexual education.

Key words: Sex education, Contraceptive use, Premarital sexual behaviour

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter contains the background to the study, statement of the problem study purpose, objectives, research questions, scope, significance, hypotheses and conceptual frame work.

1.2 Background

In many cultures, it is customary to withhold information about sexual topics from young people since it is deemed improper to talk about them (Reiss, 2019). Traditionally, a child's parents were responsible for providing any information on sexual issues, and this was frequently delayed until the youngster was about to get married (Nabugoomu et al., 2020). The progressive education movement of the late nineteenth century on the other hand, was responsible for the spread of school-based sex education and the inclusion of "social hygiene" in North American school curricula (Mathew, 2017). While sex education is being implemented in Uganda, in both school and home settings, there is still a scarcity of data regarding whether it was meeting the needs of adolescents, especially in the delay of sexual behavior, creating a need for this study.

Historical Perspective

Before the 19th century Pre-Marital Sexual behaviour was a cultural and morally issue that was not supposed to be discussed in the public domain (Muthengi et al., 2016). According to Muthengi 2014 study on global morality, premarital sexual

behaviour was judged to be immoral in predominantly Muslim nations such as Malaysia, Indonesia, Jordan, Pakistan, and Egypt, with each receiving more than 90% condemnation. Western Europeans were the most welcoming, with less than 10% rejection in Spain, Germany, and France. Premarital sex is considered a sin by the Roman Catholic Church and must be atoned for by confession in Christianity.

Premarital sexual behaviour was frowned upon in many Sub-Saharan African civilizations, and children were only taught about it when they were ready to get married (Mathew, 2017). , studies on Pre-Marital Sexual Behaviour, especially among adolescents were weak up to the 1970s due to the fact that sexuality issues were still overshadowed by the social cleanliness and moral purity campaigns that were intended at eliminating prostitution, STIs, and pre-marital sexual behaviour (Mathew, 2017). For some time, during the 1990s, Pre-Marital Sexual Behaviour among adolescents was still in the closet due to the mistaken assumption that offering accurate, comprehensive sexuality information to young people would encourage risk-taking behaviours and Pre-Marital Sex (Zimmerman, 2015). However, from the mid-19th century, debates on Pre-Marital Sexual Behaviour started creeping into the domain of sexual health and sex education (McGranahan et al., 2021). Pre-Marital Sexual Behaviour is now an accepted topic of discussion in the field of adolescent sexual and reproductive health (Zimmerman, 2015).

Studies on comprehensive sex education that taught teenagers about sexual health, including contraception and abstinence-till marriage, have become vibrant in the United States since the 1980s (Muthengi, et al., 2014). Sex education research was then founded on the idea that educating young people with comprehensive, medically correct sexual health information will reduce their inclination to take risk

Currently, sex education is perceived as a key strategy for promoting sexual health of adolescents by lowering risky sexual behaviour (Kantor et al, 2020). Pre-Marital Sexual Behaviour is now an accepted topic of discussion among adolescent sexual and reproductive health (Zimmerman, 2015).

However, an increasing number of adolescents experience early sexual maturation while in primary and secondary school and are faced with vulnerabilities and challenges of engaging in risky, unprotected sex and exploitation. Therefore, they need information and empowerment about their rights and responsibilities in order to manage sexual urges, resist exploitation and abuse (Reiss, 2019).

Theoretical Perspective

This study was based on the Social Learning Theory (SLT) proposed by Bandura (1977). The SLT emphasizes the importance of observational learning, imitation and modelling in understanding human behaviour. Bandura's (Bandura, 1993) theory combines cognitive, behavioural, and environmental influences to explain how people learn and how that learning translates into behaviour. The core concepts of SLT include observational learning, self-efficacy, self-regulation and reciprocal determinism, which is the dynamic interaction between the person, their behaviour and the environment (Deci and Ryan, 2002). In the context of premarital sexual behaviour among in school adolescents, the SLT provides a useful framework for understanding how Sex education received by adolescents can affect their resolve to delay sex or use contraception in case they find themselves in a compromising situation (Kemigisha et al., 2018). Applying the SLT to this context involved examining how in school adolescents learn and adapt their sexual behaviours in response to their environment, social interactions, and internal beliefs.

Conceptual Perspective

The study focused on the association between Sex Education, Contraceptive Use and Pre-Marital Sexual Behaviour among in-school adolescents.

Sex education

Sex education was the first independent variable of this study. It referred to the learning experiences designed to help individuals attain skills of managing sex life effectively (Reiss, 2019). The Uganda national sexuality education framework (2018) defines sex education as a lifelong process of acquiring information, skills, forming attitudes and values about sexuality and interpersonal relations issues as well as gender roles. According to McGranahan et al. (2021), sexual education in Uganda, targets young people in primary and secondary schools by providing them accurate information and developing appropriate skills and values about sexuality and gender roles in line with the laws and policies of Uganda (Batwala, 2021). Sex education in Uganda is based on the premise that positive education promotes health behaviours by fighting moral corruption and placing a firewall to protect the thoughts of adolescent (McGranahan et al., 2021). In this study, sex education was perceived as school and home-based instruction on human sexuality, which includes emotional relationships and responsibilities, consent, reproductive health, reproductive rights, safe sex, birth control and sexual abstinence.

Contraceptive Use

The use of Contraceptives by adolescents was the second independent variable of the study. Modern Contraceptive methods include condoms, pills, Depo Implants, intrauterine devices (IUD), the Lactation Amenorrhea Method (LAM), Traditional ones include the rhyme technique (periodic abstinence) and withdrawal (Kemigisha et al., 2019). Although the WHO (write in full first and then abbreviate) believes that all of these procedures are safe for everyone, the effectiveness of the traditional ones is being called into question. UNICEF (2020) also notes that contraceptive prevalence in Uganda was 27.2% in 2018. In most adolescents the use of condoms has become a common contraceptive method due to their ease of access, and efficiency in protecting against STIs and pregnancies (Search Institute (2020)). Hence in this study contraceptive use was perceived as adolescents having positive attitude and skills to access, acquire and use condoms during sexual activity.

Pre-Marital Sexual Behaviour

Pre-Marital Sexual Behaviour is the dependent variable which is often perceived as the sexual relations before getting married (Rahmani et al. 2014). Premarital sex was initially taken as a moral issue by many cultures and condemned by many religions. From the 1960s, particularly in Western nations, premarital sex started gaining more acceptance and was perceived as one having sex at an early age (Norris, et al., 2006). Premarital sexual behaviour still has negative connotations due to the fact that it increases one's risk of contracting sexually transmitted infections and experiencing unintended pregnancies (Salvagni and Wagner, 2006). It also includes, having multiple sexual partners, having sex while under the influence of alcohol or drugs, and unprotected sexual behaviours. Hence, when we figure in the

intention of preventing young adolescents from adverse outcomes of premarital sexual behaviours, premarital sexual behaviour and be perceived as failure to abstain from sex (Mathew, 2017). In this study, Premarital sex behaviour referred to conditions, beliefs and norms that encourage in-school adolescents to engage in sexual activity at an early age.

Contextual Perspective

There are compelling reasons the world over to solidify initiatives to control premarital sex behaviour among adolescents (Guttmacher Institute., 2017). Currently, Young people aged 15 to 24 account for 41% of early pregnancies (Mathew, 2017). Worldwide, about 18 % of HIV-positive persons are in their adolescence (Ketting, et al., 2016). Hence, Sex education is critical for proper sexuality and life skills development of adolescents. Experts concur that adolescents with accurate information on sexual issues have been found to develop attitudes and behaviours that permit them to realize sexual health as well as self-efficacy to avoid sexual abuse and risky premarital sex (Marshall et al., 2020). Considering this problem, Uganda has put in place several initiatives such as PIACY, the national sexuality education framework (2018) to provide Curriculum-based sexuality education to adolescents, to improve their communication skills, self-esteem and decision-making capacity so as to shield them from early sex, STIs, HIV and unwanted pregnancies (Kemigisha et al., 2018). The Uganda government introduced compound messages to create awareness about sexuality and the consequences of risky sexual behavior as a quality standard measure for primary schools in Uganda (Kemigisha et al., 2018). Also, formal, culturally grounded children's camp commonly known as Ekisakate have been allowed to provide sexuality knowledge and skills to children.

However, Kemigisha et al.,(2018) show that about 26% of the girls and 23% of boys start sexual activities in lower primary school which negatively affects their school life. Namayingo district, ranks high among areas in Uganda where children are confused about sexual issues and are vulnerable to child pregnancies, HIV and school dropout (Nabugoomu, et al.,2020). Schools that endeavor to provide some sexual educations are doing it haphazardly with each perusing its own agenda and others have been found using wrong and vulgar language on this sensitive issue (UNICEF, 2020). Subsequently adolescents in this region have received less sexual education, predisposing them to risky early sexual behaviour (McGranahan et al.,2021).

1.3 Statement of the problem

Adolescents with accurate information on sexuality issues develop attitudes and skills that enable them to avoid sexual abuse and risky premarital sex (UNICEF, 2020; Search Institute,2020). In view of this fact, the Uganda government put in place initiatives such as PIACY and the national sexuality education framework (2018) to provide Curriculum-based sexuality education to adolescents, so as to shield them from early sex, STIs, HIV and unwanted pregnancies (Batwala, 2021).

Despite government efforts, Namayingo district was found to have close to 39.2% adolescent pregnancies leading to a high school dropout rate (Nabugoomu, et al.,2020). Despite this urgent and recurring need, In regard to this problem, there is still little understanding of the status of sex education received by adolescents , its appropriateness in equipping adolescents with knowledge, skills and values to delay sexual intercourse (Kemigisha,et al.,2019). Failure to urgently address this problem, would leave a large proportion of children in Namayingo district with misconceptions

about sexual behaviour, making it difficult for them to make appropriate sexual decisions which in turn would lead to poor health. Therefore, to address this problem, this study examined, the connection between sex education, contraceptive use and premarital sexual behaviour among school-going adolescents in Namayingo district.

1.4 Purpose

The study examined the connection between sex education, contraceptive use and premarital sexual behaviour, among school-going adolescents in Namayingo district.

1.5 Objectives

The study was guided by the following objectives: -

1. To analyze the relationship between sex education and adolescents' use of contraception.
2. To find out the relationship between sex education and premarital sexual behaviour among adolescents in Namayingo.
3. To examine the relationship between contraceptive use and premarital sexual behaviour among adolescents in Namayingo.
4. To determine the predictive potential of sex education and contraceptive use

1.6 Hypothesis

The study adopted the following hypothesis: -

1. Sex education is related to contraceptive use.
2. Sex education is related to premarital sexual behaviour.
3. Contraceptive use and premarital sexual behaviour are related.
4. Sex education and contraceptive use significantly predict premarital sexual behaviour.

1.7 Scope

1.7.1 Geographical scope

The research was carried out in Namayingo District, among school-going adolescents. . Despite Uganda government initiatives such as PIACY and the national sexuality education framework (2018) to provide Curriculum-based sexuality education to adolescents in the country, Namayingo district is reported to have many cases of early sex, STIs, HIV and unwanted pregnancies among adolescents (Batwala,2021). The district has one of the highest (39.2%) adolescent pregnancies leading to a high school dropout rate (Nabugoomu, et al.,2020). Hence the area was a fitting study site, since it would provide adequate and credible sample.

1.7.2 Content scope

The research focused on the connection between sex education, contraceptive use and premarital sexual behaviour among adolescents. This was thought to be of help in equipping the school going adolescents with the knowledge, skills attitudes and values

that would help them to develop respectful sexual relationships, make responsible choices, understand their rights and protect their health.

1.7.3 Time scope

The research was confined to be conducted from the month of January 2022 to July 2023. The selection of this period was guided by the availability of the respondents that this study was interested in.

1.8 Significance

The information collected will aid in the development of National and Namayingo district policies that will guide and help to review the teaching of sex education in schools.

Teachers, parents and school officials will use the study findings to deepen their understanding of sex education, contraceptive use and premarital sexual behaviour. Particularly, school counsellors will be provided with information which will enable them to design more focused appropriate interventions.

It is also hoped that school going adolescents will benefit from learning more about how sex education, contraceptive use affects their premarital behaviour, in that they know what is required to do and will hopefully avoid any pitfalls.

The findings will also be used as a basis for ascertaining whether it is appropriate to mainstream sex education and encourage adolescents to use contraceptives.

1.9 Conceptual Framework

The Conceptual Framework relating Sex education, contraceptive use and premarital sexual behaviour among in- school adolescents is described in figure 1.1.

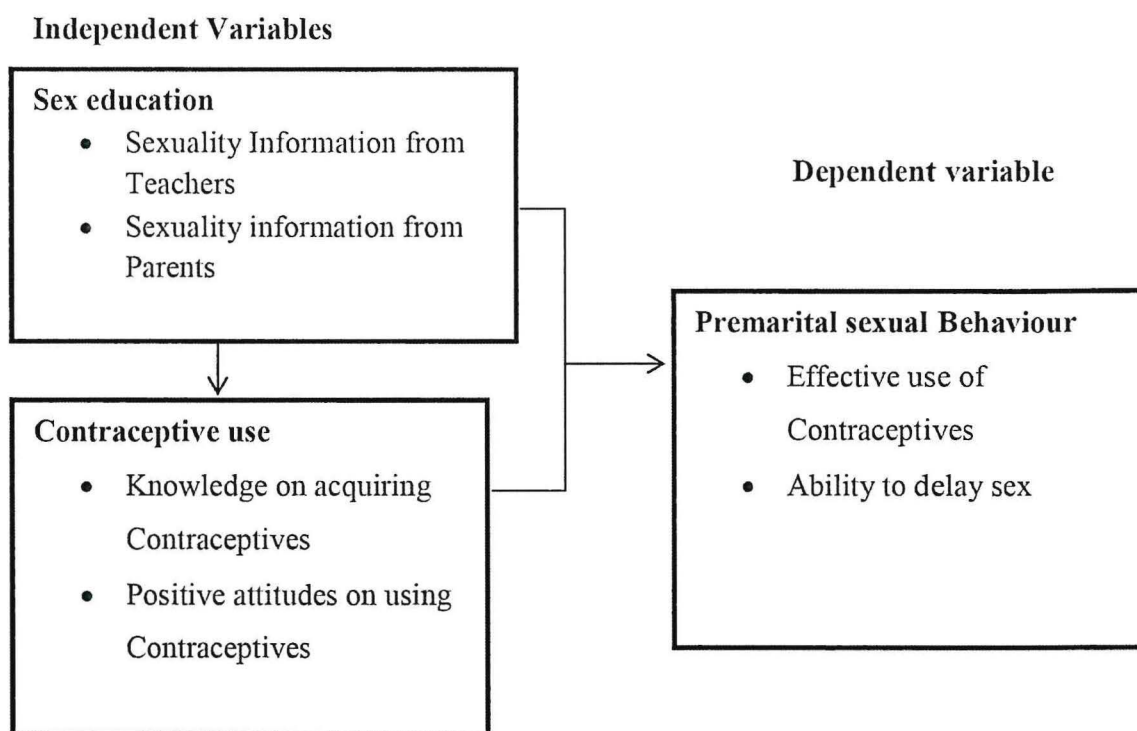


Figure 1.1: *Relationship between premarital sex education, contraceptive use and sexual behaviour among in- school adolescents*

Source: based on Bandura (1993), Rahmani et al., (2014) and McGranahan et al., (2021).

The conceptual framework in Figure 1.1 shows that Sex education and contraceptive use are related to pre-marital sexual behaviours of in-school adolescents. Sex education from teachers and parents provides in-school adolescents with accurate information about sex and contraception. This information empowers adolescents to make informed decisions regarding Contraceptive Use and Premarital Sexual Behaviour. When in a situation where they are pressured or enticed to have sex, they may tactfully refrain or decide to use contraception so as to prevent STIs and unwanted pregnancies.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter examines the theory underlying the study as well as the literature pertinent to the research objectives.

2.1 Theoretical Review

The study was based on Bandura's (1977) Social Learning Theory. The theory presupposes the role of observational learning in which Adolescents can learn from observing others who are successfully managing their lives (Bandura, 1977). This includes engaging in healthy behaviours, abstaining from sex and accurately using protection (Bandura, 1993). Observational learning can foster a sense of community and decrease feelings of isolation, thereby enhancing feelings of empowerment among adolescents (Titiloye and Ajuwon, 2017). Besides, the theory argues that self-efficacy is an individual's belief to execute behaviours necessary to produce specific performance attainments. It can also contribute to the ability to cope with peer pressure, to engage in pre-marital sex or enable adolescents effectively utilise protection (Search Institute, 2020). In the context of Pre-marital sexual behaviour, high self-efficacy can empower individuals to engage in behaviours that promote their sexual health (Reiss, ,2019). This belief in their ability to manage their health can lead to better sexual behaviour and overall wellbeing.

In addition, the theory argues that self-regulation is very important because it involves controlling one's behaviour, emotions, and thoughts in the pursuit of long-term goals (McGranahan et al.,2021). Effective self-regulation can help Adolescents

adhere to their healthy lifestyle choices which are critical for positive sexual behaviour. The theory also anchors its assumption on the principle of reciprocal determinism in which Bandura proposed that a person's behaviour, personal factors (such as cognitive skills and attitudes) and environmental factors (such as social support and education) interact in a reciprocal manner. For in school adolescents, sex education and along with a supportive environment can encourage positive health behaviours such as Pre-marital sexual Behaviour.

The Social Learning Theory thus provides a comprehensive framework for understanding how sex education, contraceptive use and Pre-marital sexual behaviour among in-school adolescents are connected. Interventions to promote positive sexual behaviour among in-school adolescents should focus on enhancing self-efficacy, providing opportunities for observational learning through peer support groups, teaching self-regulation strategies and creating environments that promote positive reciprocal interactions (Kemigisha et al.,2019). Through these mechanisms, the Social Learning Theory (SLT) offers valuable insights into designing effective strategies for supporting Adolescents in their journey towards sexual health and wellbeing.

2.3 Relationship between sex education and contraceptive use

In many cultures, it was customary to withhold information about sexual issues from adolescents since it was deemed improper to talk about them. Traditionally, a child's parents were responsible for providing any teaching and this was frequently delayed until the youngster was about to get married. The growth of school-based sex education, as well as the inclusion of "social hygiene" in North American school curriculum were both outcomes of the late-nineteenth-century progressive education movement (Kemigisha et al., 2019).

Despite early attempts at school-based sex education, most information on sexual issues was still learned informally from friends and the media in the mid-twentieth century and much of it was either incomplete or of dubious value, particularly in the years immediately following puberty, when interest in sexual issues was at its peak (Banerji et al., 2008). The increase in adolescent pregnancies following the 1960s, particularly in Western countries, exacerbated the scarcity. Sex education programs were created as part of each country's efforts to reduce pregnancies, despite substantial opposition from parent and religious groups (Tupper and Kenneth, 2013). As such, young people are rarely equipped in many nations with the knowledge, abilities, and resources necessary to make a smooth transition into adulthood. They frequently struggle to communicate successfully with parents, instructors and medical experts about their sexual and reproductive lives (Mcauley and Salter, 1995). As such, teenagers are at the risk of misinformation from peers and the media as a result of inadequate programs and a lack of sex education (Raj and Boehmer 2013).

Young adults' sexual and reproductive behaviours and health knowledge have significant effects on the long-term health and well-being of a population. According to estimates, one-third of all new sexually transmitted illnesses and nearly half of new HIV infections worldwide affect people under the age of 25 (Raj and Boehmer 2013). Unwanted pregnancy can have a devastating impact on a young girl's life since it keeps her from pursuing her education and training, and it also has detrimental implications on her health due to sexual and reproductive decisions (Chandra-Mouli et al., 2014; Greene and Merrick, 2015). In most nations, societies typically regard young women rather than young men, accountable for the consequences of unprotected intercourse (Greene et al., 2002; UNAIDS, 1999).

In many countries, unintended adolescent pregnancies are another factor that leads to early marriage. This is evidenced by the percentage of adolescents who have their first child less than eight months after marrying (UNICEF, 2005).

In South America and Africa, the rate of post-conception marriage reported in this manner among women aged 20 to 24 giving birth before the age of 20 ranges from 10% to 40%. (UN, 2013). Early couplings are more likely to lead to forced marriage, a gender-based health and human rights violation (WHO 2011) which does exacerbate gender inequality.

Unsafe abortion practices are a major contributing factor to the detrimental health effects of adolescent pregnancy (Hindin et al., 2016; Morris and Rushwan 2015; WHO 2007; Senanayake, Nott and Faulkner, 2001). The prevalence of abortion is caused by a lack of access to safe and affordable pregnancy termination services, contraceptive failure, as well as illegal methods used in termination attempts which emphasizes the significance of continuous contraceptive provision (Gipson and Hindin, 2008; Polis et al., 2016).

As a result, the 2012 London Summit on Family Planning underlined the importance of providing modern contraception to women and girls as well as family planning as a potent weapon for bringing about societal change (Family Planning, 2020). Despite their relevance, adolescents frequently lack access to contraception and face numerous challenges to obtaining and appropriately utilizing it properly (Chandra-Mouli et al., 2014).

Nevertheless, it is not just a lack of access to contraceptives that causes concern. Many children do not have access to sex education. As such, they are unaware of the consequences of having an early sexual debut (Titiloye and Ajuwon,

2017). These findings show that, access to health services, sex education as well as using of a contraceptive methods, are frequently essential for effective prevention of adolescent pregnancy (Guttmacher Institute, 2017).

2.4 Relationship between contraceptive use and premarital sexual behaviour

The global use of modern contraceptives has recently grown, rising from 54% in 1990 to 57% in 2012 (WHO, 2012). Africa's predictions remain startlingly low at 23% and 24%, respectively (Blanc et al., 2009). Sub-Saharan African statistics are substantially lower than those displayed above. This has been connected among other things to shortcomings in transportation and health-care infrastructure (Cleland et al., 2006; UNFPA, 2012). These studies also demonstrate that long-term family planning alternatives such as intrauterine devices, injectables and implants are preferred by women.

Also, global monitoring of contraceptive access focuses on married women. (UN 2016; UNFPA 2010). As a result, vulnerable groups like sexually active, unmarried young women are routinely overlooked. Unmarried adolescent girls have greater unmet contraception need than married women (MacQuarrie, 2014; UN 2014). Despite the fact that the consequences of unexpected pregnancy are more severe for them, unintended pregnancy, unsafe abortion, maternal and infant death, school dropout, lost economic potential, and worse educational attainment for both current and future generations (Hindin et al. 2016; Neelofur-Khan and WHO 2007; UN 2013; WHO 2010), many do not use contraception due to a lack of access (Chandra-Mouli et al., 2014; Greene and Merrick, 2015).

Nearly half of high school students have had sexual intercourse at least once in their lives and 34% are sexually active (have sex once in three months) [CDC,

2014]. However, only over 60% of sexually active teenagers are reported to use a condom during their previous intercourse and roughly 14% are reported to use no prophylactic measure at all (CDC, 2016). Widman et al., (2014) went on to say that first-time condom use is a strong predictor of future consistent condom use. Despite the fact that adolescents in poor countries participate in considerable quantities of sexual activity and utilize contraception, the former has a quicker growth tendency than the latter (Ali and Cleland, 2005). According to Ali and Cleland's (2005) study of 27 Sub-Saharan nations, although the prevalence of premarital sex before the age of 18 grew significantly in 19 countries, there was no general tendency toward early (before the age of 18) sexual initiation between 1994 and 2004 (Mensch et al., 2006). According to the reproductive and contraceptive histories of single women aged 15 to 24 in eight Latin American countries, it is indicated that condom use is increasing more faster than dependence on any other technique (Ali and Cleland, 2005).

According to Blanc and Way (1998), long-term contraceptive use is not guaranteed and termination occurs due to failure, method characteristics such as side effects or ease of use and a change in necessity. While some women convert to a new method immediately, others experience a month-long or longer gap. Teenagers and young women are particularly vulnerable to cessation because they have less access to family planning awareness than older individuals. As such, they engage in more unpredictable and irregular sexual behaviour and yet less aware of how to use contraceptive methods efficiently (Blanc and Way, 1998). Ali and Cleland (2004) found that women under the age of 25 in underdeveloped nations were more likely than in developed countries to discontinue their method of contraception after a 24 months period.

Even with the greatest of intentions, teenage pregnancies still occur and adolescent pregnancy prevention initiatives still do not work as well as they should. 13–15 The success of adolescents in preventing pregnancy frequently depends on their access to contraceptive knowledge, practices and services (Santhya and Jejeebhoy, 2015). Approximately 25% of married women between the age of 15 and 19 in the developing world and the former Soviet Union do not utilize any type of contraception despite trying to avoid or delay pregnancy (Ross and Winfrey, 2002).

2.5 Relationship between sex education and premarital sexual behaviour

According to the UNICEF (2001) poll, more than two-thirds of young people in ten of the twelve developed nations where data are available, receive sex education. In Denmark, Finland, Germany, Iceland, Norway, the United Kingdom and the United States, the percentage reaches 80%. In Australia, the United Kingdom and the United States, approximately 25% of 15-year-olds and 50% of 17-year-olds have had sex. A 2005 Kaiser Family Foundation poll of teenagers in the United States found that 29% felt compelled to engage in sexual activity, 33% were in a relationship where things were moving too fast sexually and 24% had "done something sexual they did not really want to do. Some polls have identified peer pressure as a factor that pushes both boys and girls to have sex (Allen, 2003).

According to research done by the CDC (2016), 34% of high school students are sexually active (have sex in every three months), and nearly half receive sexual education at least once in their life (CDC, 2014). The study indicated that around 60% of sexually active teenagers used a condom during their most recent encounter, and about 14% claimed they did not use any kind of contraception. Furthermore, studies show that using a condom for the first time during intercourse is a reliable predictor of

subsequent, frequent condom use (Shafii et al, 2004). Unprotected intercourse among teenagers raises the risk of unexpected pregnancy and sexually transmitted infections, therefore consistent contraceptive usage is critical. If a person engages in risky sexual conduct such as having several sexual partners, using contraception seldom or inconsistently, he or she is more likely to get a Sexually Transmitted Infection (STI) (Crosby et al., 2001). According to Smith and Snell, religion influences the sexual attitudes and actions of American teenagers (2009). While most of the research found religion to be protective, resulting in later sexual initiation and fewer lifetime partners, some studies found religion to be associated with contraceptive non-use or inconsistent use as well as higher-risk sexual encounters (Brewster, Cooksey, Guilkey and Rindfuss, 1998). A number of studies, (Aparicio, Pecukonis, and Zhou, 2014; Kramer, Barrett, DaVanzo, Ellison, and Grammich, 2014; Hill, Siwatu and Robinson, 2014; O'Brien et al., 2013; Aparicio, Pecukonis and Zhou, 2014), have looked into the impact of religion on adolescents' use of contraceptives and sexual attitudes and behaviour. The majority of studies O'Brien et al., 2013; Kramer et al., 2007; Barrett et al., 2014; Regnerus, 2005; Manlove et al., 2008; Rostosky et al., 2003; Nonnemaker et al., 2003; Lammers et al., 2000; Meier, 2003) found no link between higher religious attendance and using contraceptives.

Parental education is a protective factor for beginning sexual activity and using contraception (Cubbin, et al., 2005; Glei, 1999; Gold et al., 2010; Manlove, Terry-Humen, Ikramullah and Moore, 2006; Manlove et al., 2008). Additionally, research has indicated that adolescent sexual habits can be protected by attending school (Brewster et al., 1998; Darroch, Landry and Oslak, 1999; Manlove, 1998; Kirby, 2002). Teenagers with more educated parents, particularly women, are more

likely to use contraception during their first and most recent sex than adolescents with less educated parents (Cubbin et al., 2005).

More so, studies revealed that adolescents who regularly attended religious services and/or saw religion as essential in their lives had less sexual experience and more restricted attitudes toward premarital sex than those who did not (Leonard and Scott-Jones, 2010). Bearman (2001) discovered that youths who took "virginity promises," which are common in many religions to encourage postponing sex until marriage, were less likely to participate in sexual activity. Yet, other studies found that religious affiliation was substantially related to youth not using contraception (Raine et al., 2003). A lack of parent-child discussion about sex and contraception use is one factor for the low incidence of contraceptive use (Malcolm et al., 2013; Moore, Berkley-Patton, Bohn, Hawes and Bowe-Thompson, 2015). Widman et al., (2014) found that more than one-third of adolescents did not discuss sexual issues with their parents.

DiClemente et al., (2001), found that improved communication between couples and parents led to more regular and consistent use of contraception while decreasing communication raised the likelihood of not using contraception (Widman et al., 2014; Halpern-Felsher et al., 2004; Malcolm et al., 2013; Moore et al., 2015).

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter presents a detailed description of the methodology that was employed in this study. This includes the research design, target population, sampling strategy, tools, data collection procedure, data administration and analysis, and ethical considerations.

3.1 Research design

According to Pandey and Pandey (2021)., a study design is a general strategy for how you want to obtain answers to your questions. The research used a qualitative correlational study design. When using a qualitative correlational design, a researcher analyses the relationships between variables, comprehends and evaluates their statistical relationship without the interference of any other variables (Cook and Cook, 2008).I thou

3.2 The target population

The target population involved 375 adolescents between the ages of 13 and 20 who attended four primary and three secondary schools supported by compassion international Uganda in Namayingo District. The primary schools were Busiro, Buwondo, Siabona and Busiula while secondary schools were Busiro SS, Lwagoswa and Suswale. All the 375 adolescents were targeted because they were all supported by compassion international Uganda in various aspects of child and life development issues including sexuality education.

3.3 Sample size and sampling techniques

Census method was used to determine the sample size. So, every member of the population was taken into consideration. This approach was used to reduce sampling errors and attain accurate and reliable information about the study unit. A total of 375 learners from 7 schools of which the researcher selected 53 from Busiro 57 from Buwondo 48 from Siabona, 38 from Busiula, 57 from Busiro SS, 58 from Lwangoswa 48 and 64 from Buswale 64 using stratified random sampling. This served as the sample that was used as the representative of the population under study based on gender, age and class.

3.4 Data Collection Methods

A questionnaire was utilized to collect data. This approach allowed the researcher to collect information from a large number of randomly selected respondents (Creswell, 2013). The use of the questionnaire allowed for the collection of sufficient data encouraged on-the-spot data gathering and also increased anonymity. The researcher prevented rushed responses by training those helping in the data collection process at school and thus was able to collect more accurate data.

3.5 Measurement of variables

The questionnaire had four sections Section A captured the demographic information. Section B gathered data on whether adolescents got sex education from teachers and parents using 9 items that were adapted from Agnew (2019). Sample items read as ‘My Parents and teachers’ talk to me about the importance of abstinence’. Data on Contraceptive use was captured in section C to establish adolescents knowledge and intention to use conception to avoid STIs and unwanted pregnancies, using 13 items

adopted from Ampofo (2016). The items read as “Adolescents should seek their parents” consent to obtain contraceptive methods. Section D captured the intention of adolescents to engage in premarital sex following Sedgwick (2014). Sample items read ‘Am ready to have sex with a lover without telling my parents/guardians. Responses on items in sections B through D were measured on a five-point Likert scale where 1 represented strongly disagree to 5 representing strongly agree.

3.6 Data Quality Control

Data quality control was achieved through ensuring validity of instruments and reliability of data.

3.6.1 Validity of instruments

In order to ensure that the data collected was based on the purpose of the study, the face and content validity of the measures were assessed by the two research supervisors. This helped to provide insights for corrections and adjustments to the final instrument and to eliminate any ambiguous questions and poorly written grammar. . In terms of content validity, the researcher ensured that all the variable items adhered to the study's conceptual framework. Each item was scored on a four-point scale, with four indicating very relevant, three indicating relevant, two indicating slightly relevant and one indicating not relevant. The content validity index (CVI) was derived by dividing the total number of items by the number of things that were declared legitimate. The findings are summarized in Table 3.1.

Table 3.1: CVI of the instrument

Evaluator	Questionnaire for Adolescents
Supervisor 1	0.75
Supervisor 2	0.78
Average	0.77

Source: supervisors' ratings (2022)

The average CVI for the questionnaire was 0.77, which was higher than the minimum value of 0.7 advised by Esses et al., (2018) for research purposes. Given that the instrument's items had been adapted from earlier investigations, the construct validity of the instrument was determined once more using exploratory factor Analysis. Data from 24 pupils' pre-tests were used. Items with eigenvalues larger than one were deemed important contributors to the variables. Tables 3.2 through 3.4 present the findings.

Table 3.2: Rotated Factor Matrix for sex education

Component	1	2	3
The teacher gives you information on sex	.915	.689	.050
Your teacher frequently discusses abstinence with you	.849	.528	-.120
Every time we have SE, abstinence is always recommended	.521	.673	.147
Parents regularly hold SE-related programs at home	.707	-.088	.521
You are reminded by your parents and teachers of the value of abstinence	.563	-.151	.697
SE is not a waste of time	.725	.409	.720
The teacher always conducts programs concerning STDs at school	.744	.225	.079
Parents always talk about attraction to the opposite sex during SE	.861	-.032	-.074
SE aids pupils in making good decisions about their sexual behavior.	.513	.655	.376
Eigenvalues	4.72	1.19	1.05
% Of Variance	52.53	13.24	11.67
Cumulative Variance	52.53	65.78	77.45

The findings in table 3.2 show that the aspects of sex education that were measured, loaded strongly on 3 factors, and accounted for about 77.5 % of the variation, which was a good measure of the construct.

Table 3.3: Rotated Factor Matrix for contraceptive use

Component	1	2	3	4
I approve of the use of Contraceptives	.228	-.532	.605	.266
The use of contraception is important for an adolescent to have sex	.054	.095	.626	-.666
Contraception usage is against my religion	.516	-.536	.556	.755
It is good for students to carry condoms	.246	.651	-.109	.342
Sexual activity while a student causes crisis pregnancies	.670	-.452	-.042	.194
Adolescents should seek their parents' consent to obtain contraceptive methods	.739	-.397	.029	.289
It is easy to get contraceptives	.865	-.012	-.360	.135
Sex is not enjoyable when I use a condom	.803	-.112	-.348	-.191
I know how contraceptives work	.418	.457	.452	.470
People who insist on condom use are promiscuous	.659	.641	-.209	-.037
You play sex worried about getting pregnant/impregnating somebody	.790	.092	.259	-.271
I approve of the use of contraceptives	.274	.681	.486	.111
Sexual activity is not advised for students.	.716	.079	.695	-.605
Eigenvalues	9.81	2.11	1.619	1.14
% of Variance	51.65	11.11	8.523	6.00
Cumulative Variance	51.65	62.77	71.29	77.29

The findings in table 3 show that the aspects of contraceptive use that were measured, loaded strongly on 4 factors, and accounted for about 77.3% of variation, which was more than 50%. Therefore, the aspects were a good measure of contraceptive use.

Table 3.4: Rotated Factor Matrix for Premarital sex behaviour

Component	1	2	3	4
Am willing to have unprotected sex with multiple sex partners	.146	-.022	-.439	.775
I like to have sex before being married.	.527	-.445	.454	.424
I intend to have sex during my secondary and primary school life	.815	.305	-.352	-.145
I enjoy playing sex	.791	.304	-.366	-.068
I'm prepared to have the pregnancy terminated if it occurs accidentally.	.873	-.009	-.220	-.266
I enjoy seeing obscene pictures	.832	.041	.134	.000
I'm willing to use drugs and alcohol during sexual activity.	.769	-.220	-.313	-.152
Am willing to consume and watch pornography	.828	-.186	-.050	.164
Am willing to have sex with a high-risk partner	.464	.336	.652	.088
Am ready to have sex with a lover without getting their permission	.506	.697	.703	.066
I value coitus without love before marriage.	.560	.247	.403	-.009
I enjoy the business of prostitution.	.635	.507	.079	-.061
Even Prior to marriage, I prefer coitus with minimal affection.	.842	.408	-.029	-.142
There is nothing wrong with having sex before getting married.	.719	-.299	.091	-.347
When a boy engages in sexual activity with numerous girls, there is nothing wrong with him.	.755	.423	-.097	.077
There is nothing wrong with a girl having multiple sex relationships with boys.	.836	-.390	-.051	-.084
There is nothing wrong with thoughtful kissing before marriage	.703	-.110	-.231	.188
Sexual activity prior to marriage that is free of emotional attachment is good	.833	-.355	.137	.136
There is nothing improper about open anal sex.	.792	-.038	.261	.394
Eigenvalues	4.593	2.477	1.650	1.485
% Of Variance	35.333	19.052	12.691	11.420
Cumulative Variance	35.333	54.385	67.076	78.496

The findings in Table 3.4 show that the aspects of premarital sexual behaviour that were measured, loaded strongly on 4 factors and accounted for about 78.4 % of the variation, which was more than 50%, Hence the items were taken to be a good measure of premarital sexual behaviour. Also, a pre-test of instruments was done, and it was revealed that participants would be able to provide reliable data.

3.6.2 Reliability of data

The Cronbach's alpha coefficient was used to evaluate the questionnaire's reliability. The pre-test sample comprised of 12 secondary school students and 10 upper primary school pupils. Table 3.5 provides the findings.

Table 3.5: Reliability coefficients (Cronbach's alphas) for the questionnaire

Variable	No. of items	Alpha (α)
Sex Education	9	.83
Contraceptives use	13	.76.
Premarital sex behaviour	8	.83

Source: Pilot data from the field 2022

The findings in Table 3.5 reveal that the Alpha coefficients of the variables (sex education =.83, contraceptives = .76, premarital sex behaviour=.83.) were above 0.7, the recommended minimum value by Rubbin and Babbie (2016), for surveys.

3.6 Data collection procedure

The researcher obtained permission from the directorate of postgraduate studies which was in form of an introductory letter. The letter was distributed to the district education officers and head teachers whose offices were responsible for

schools where the data were going to be collected. The letter also served to request for permission to go on and conduct the research, which was granted. This then allowed the researcher to go on and collect data. The researcher administered questionnaires to respondents from the different schools. A note outlining the overall goal of the study was included with each questionnaire. Students responded to the group questionnaire and the researcher was available to provide the needed guidance.

3.7 Data management

After the data was collected questionnaires were first coded by being given an identity number. Using SPSS, preliminary data assessment was done to check for any potential violations of the fundamental presumptions underlying the use of univariate, bivariate and multivariate approaches. Missing data and tests for normality were done, where data characteristics were illustrated in tables and graphs.

3.8 Data processing and Data analysis

The accuracy, consistency and completeness of data were ascertained after it was gathered. Utilizing descriptive statistics, data was examined (measures of central tendency and measures of variations). The results were presented in tables. Version 20 of the Statistical Package for Social Sciences (SPSS) program was employed to aid in the analysis.

Hypothesis 1, 2 and 3 were measured using the Pearson correlation coefficient to determine the relationship between the variables, and hypothesis 4 was measured using the multiple linear regression tests to assess the predictive potential of sex education and contraceptive use on premarital sexual behaviour.

3.9 Ethical issues

Before handing out the questionnaires, the researcher provided participants with a brief description of the study's objectives and assured them of its confidentiality. Subjects had the opportunity to decline taking part in the study, which was entirely voluntary.

In order to keep the privacy of the participants, the researcher restricted access to the instruments to the teachers. Before the research began, the respondents received enough information about how they would be treated during the research, how risks would be managed, and the advantages of taking part in this study. The researcher minimized coercion and undue influence by giving respondents enough time to consider the material presented.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF FINDINGS

4.0 Introduction

This chapter focuses on the presentation, analysis and interpretation of data. The study looked at the connection between sex education, contraceptive use and Premarital Sexual behaviour. This involved assessing the predictive influence of sex education and contraceptive usage on premarital sexual conduct. Based on the survey responses from 367 adolescents in school, The results on the respondents' demographic information are reported first. Then a descriptive analysis on premarital sexual behaviour, sex education and use of contraceptives is given. Lastly, an inferential analysis of the issues that were being investigated is given.

4.1 Respondents' Demographic Characteristics

Information on gender, age, whether they are enrolled in school, the class they attend, the sort of school they attend and the person they live with are all presented in this section. Analysis of variance was done for each background feature to determine how the premarital behaviours of the teenagers change with each background characteristic. Table 4.1 contains information about the respondents' background information.

Table 4.1: Socio-Demographic Information of Respondents (N=367)

Variable	Category	Percentages	
Gender		F	%
	Male	201	54.8
	Female	166	45.2
Age Category	9-11 years	84	22.9
	12-14 years	83	22.6
	15-17 years	82	22.3
	18-20 years	118	32.2
Attend school	yes	321	87.5
	P1-p5	45	12.3
Class	P6-P7	140	38.1
	S1-S3	136	37.1
	Boarding	7	1.9
Type of school	day	202	55.0
	Mixed	112	30.5
	Parent(s)	246	67.0
Person stayed with	Relative	61	16.6
	Guardian	46	12.5
	Friend	14	3.8

Source: Primary data from the field (2022)

4.1.1 Gender

Table 4.1 shows that the study comprised of both male (54.8%) and female (45.2%) participants. The respondents identified their gender. This gave the study an opportunity to get views from the different gender.

4.1.2 Age category

Table 4.1 shows that the majority (54.5%) were between the ages of 15 and 20. Therefore, most of the respondents were in the teenage age, the time when they were very inquisitive about sexual issues and wanted to try out things. We can conclude that their responses were candid.

4.1.3 Attending School

Table 4.1 shows that the majority (87.5 %) of the respondents were attending school. Among those attending school, (75.2%) of them were in upper primary and senior secondary of which (55%) attended day school (55%). This implies that respondents were in a situation where they could receive both formal and informal guidance on sexuality issues. Also attending day school meant that they had less monitored movement and so were often exposed to sexual -related information.

4.1.4 A person stayed with

Respondents were asked to indicate the person they stayed with. The results in Table 4.1 show that most of them stayed with their parents (67.0%) and 16.6% stayed with relatives. This meant that most respondents stayed with persons who were more likely to give them protective information about sexual education so as to behave responsibly.

4.2 Status of sex education, contraceptive use and premarital sexual behaviour

The sex education received by adolescents, their contraceptive use and premarital sexual behaviour were explored using descriptive statistics. The findings are presented next.

4.2.1 Sex education received by adolescents

In this study, sex education **was** the first independent variable. This was conceptualized as the acquisition of accurate sexual education and guidance from teachers and parents. The Aspects with mean response ≥ 3.5 were closer to agreeing on the Likert scale that was used to measure the variables and therefore implied that respondents agreed with the aspects. The findings are summarised in table 4.2.

Table 4.2: Mean response, SD and ratings on Sex Education received by Adolescents

Aspects	Mean	SD	Rating
Your teacher gives you information on sex	3.13	1.38	Disagree
Your teacher frequently discusses abstinence with you	3.60	1.42	Agree
Every time we have SE, abstinence is always recommended.	3.84	1.23	Agree
Parents regularly hold SE-related programs at home.	3.72	1.31	Agree
Parents and teachers talk to you about the importance of abstinence	3.78	1.30	Agree
SE is not a waste of time	3.89	1.28	Agree
The teacher always conducts programs concerning STDs at school	3.74	1.23	Agree
Parents always talk about attraction to the opposite sex during SE	2.92	1.53	Disagree
SE helps students make informed decisions about Sexual Behavior	3.17	1.52	Disagree
Overall score	3.53	1.36	Agree

Key: 1=strongly disagree (SD), 2=disagree (D), 3= not sure (NS), 4= agree(A), 5=strongly agree (SA)

Table 4.2 shows that respondents agreed to the aspects examined. In general (mean=3 .53, SD=1.36) that they received some sex education. They agreed that their teachers always talk to them about abstinence (mean=3 .60, SD=1.42). Abstinence is always encouraged every time they have sex education (mean=3 .84, SD=1.23)., Parents always carry out sex education programs at home (mean=3.72, SD=1.31) and parents and teachers discuss the importance of abstinence (mean=3.78, SD=1.30). Respondents also agreed that sex education is not a waste of time (mean=3 .78, SD=1.30) and that the teachers always conduct programs concerning STDs at school (mean=3 .74, SD=1.23).

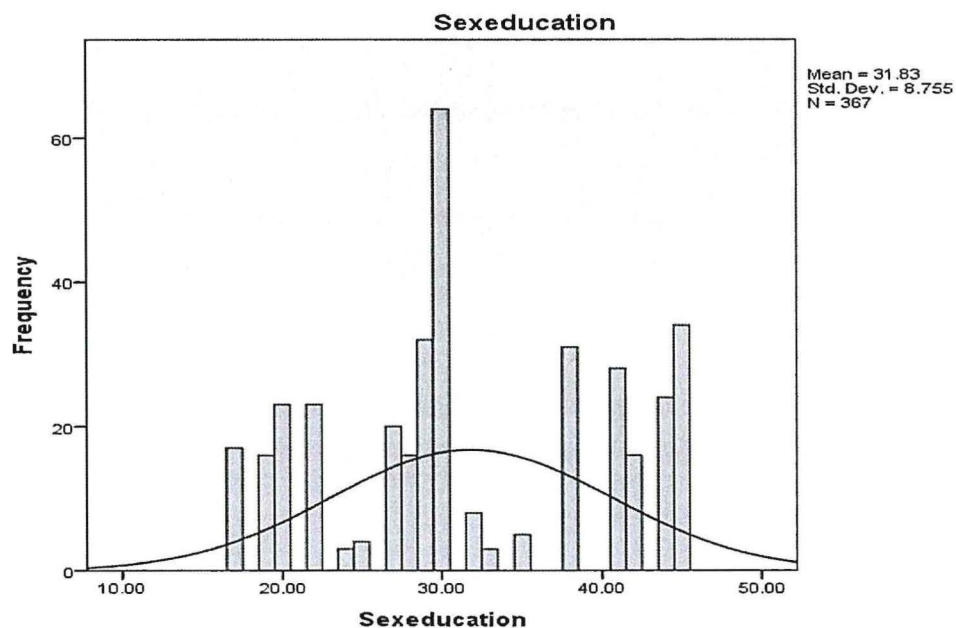
However, respondents who disagreed that teachers give them sexual education were (mean=3 .13, SD=1.38). Those that disagreed that parents always talk about the attraction of the opposite sex during sex education were (mean=2.92 .74, SD=1.53). Also, those that disagreed that sex education helps students to make informed decisions about Sexual Behavior were (mean=3.17, SD=1.52). The findings show that sex education received by adolescents may be more academic and does not effectively meet the needs of adolescents.

The researcher then examined the general distribution of results on sex education. The average index for the 9 items that measured the variable is summarised in table 4.3.

Table 4.3: Statistical summary for Sex Education

Descriptive	Statistic	Standard error
Mean	31.82	.45
Median	30.00	
Std. Deviation	8.75	
Variance	76.64	
Skewness	.044	.13
Kurtosis	-1.17	.25
Range	28.00	
Minimum	17.00	
Maximum	45.00	

Despite the higher level of response dispersion ($SD = 8.75$), the results in table 4.3 demonstrate that the mean value of 31.82 was near the median value of 30.00, indicating that the responses were normal. The curve in figure 4.1 also confirms that data on sex education was normally distributed and appropriate results could be obtained when data is subjected to linear correlation and regression.

**Figure 2: Histogram for Sex Education**

4.2.2 Status of contraceptive use among adolescents

Contraceptive was the second independent variable for this study. This was conceptualized as a student having a positive attitude and /or using contraceptives to prevent unwanted pregnancies and STIs. The aspects with mean response $\Rightarrow 3.5$ were closer to agreeing on the Likert scale that was used to measure the variables therefore implying that respondents agreed to the aspects. Table 4.4 summarises the findings.

Table 4.4: Mean response, SD, and ratings on contraceptive use

Aspects	Mean	SD	Rating
I approve of the use of contraceptives	1.61	1.25	Disagree
The use of contraception is important for an adolescent to have sex	1.76	1.03	Disagree
Contraception usage is against my religion	2.41	1.54	Disagree
It is good for students to carry condoms	1.87	1.13	Disagree
The result of having sex as a student is crisis pregnancy.	3.15	1.32	Disagree
Adolescents should seek their parents' consent to obtain contraceptive methods	3.16	1.45	Disagree
It is easy to get contraceptives	2.69	1.16	Disagree
Sex is not enjoyable when I use a condom	2.57	1.15	Disagree
I know how contraceptives work	1.99	1.01	Disagree
People who insist on condom use are promiscuous	2.20	1.22	Disagree
You play sex worried about getting pregnant/impregnating somebody	2.41	1.11	Disagree
I approve of the use of contraceptives	1.83	1.04	Disagree
Sexual activity is not advised for students.	2.34	1.33	Disagree
Overall score	2.31	1.21	Disagree

Key: 1=strongly disagree (SD), 2=disagree (D), 3= not sure (NS), 4= agree (A),

5=strongly agree (SA)

Table 4.4 shows that generally, respondents disagreed with the using of contraception rating it at (mean=2.31, SD=1.21). They disagreed to the use of contraceptives measuring it at (mean=1.61, SD=1.25). Those that disagreed at using contraception as important for an adolescent to have sex were (mean=1.76, SD=1.03). Those that disagreed that contraception usage is against their religion were (mean=2.41, SD=1.54) and that it is good for students to carry condoms were (mean=1.87, SD=1.13). They also disagreed with the idea that having sex as a student causes crisis pregnancies rating it at (mean=3.15, SD=1.34). Those that disagreed that adolescents should seek parents' consent to obtain contraceptive methods were (mean=3.16, SD=1.45). For those that disagreed that it is easy to get contraceptives were (mean=2.69, SD=1.16). Those who agreed that they knew how contraceptives work were (mean=1.99, SD=1.01) and for those that disagreed that people who insist on condom use are promiscuous were (mean=2.20, SD=1.22).

Respondents further disagreed that they play sex worried about getting pregnant/impregnating somebody measured (mean=2.41, SD=1.11). Those that disagreed that they approve the use of contraceptives were (mean=1.83, SD=1.04) and that it is not good to have sex as a student were (mean=2.34, SD=1.33). The findings imply that, the low use of contraception by respondents did not result from having a negative attitude, or not because contraception was not against their religion, and not because they did not feel that people who use condoms are promiscuous, or because sex is not enjoyable when they use a condom. Instead, it was probably due to the feeling that they were not ready to use contraception since they were not sexually active and did not need to have knowledge about it.

The researcher then examined the general distribution of results on the use of contraception. The average index for the 13 items that measured the variable is summarised in table 4.5.

Table 4.5: Statistical summary for contraceptive use

Descriptive	Statistic	Standard error
Mean	30.04	.46
Median	29.00	
Std. Deviation	8.86	
Variance	78.55	
Skewness	-.48	.13
Kurtosis	-.42	-.42
Range	32.00	
Minimum	13.00	
Maximum	45.00	

Despite the higher level of dispersion ($SD = 8.86$) in responses, the results in table 4.5 demonstrate that the mean = 30.04 was near the median = 29.00, indicating that the responses were normal. The curve in figure 3 also confirms that data on the use of contraception was normally distributed and appropriate results could be obtained when data is subjected to linear correlation and regression.

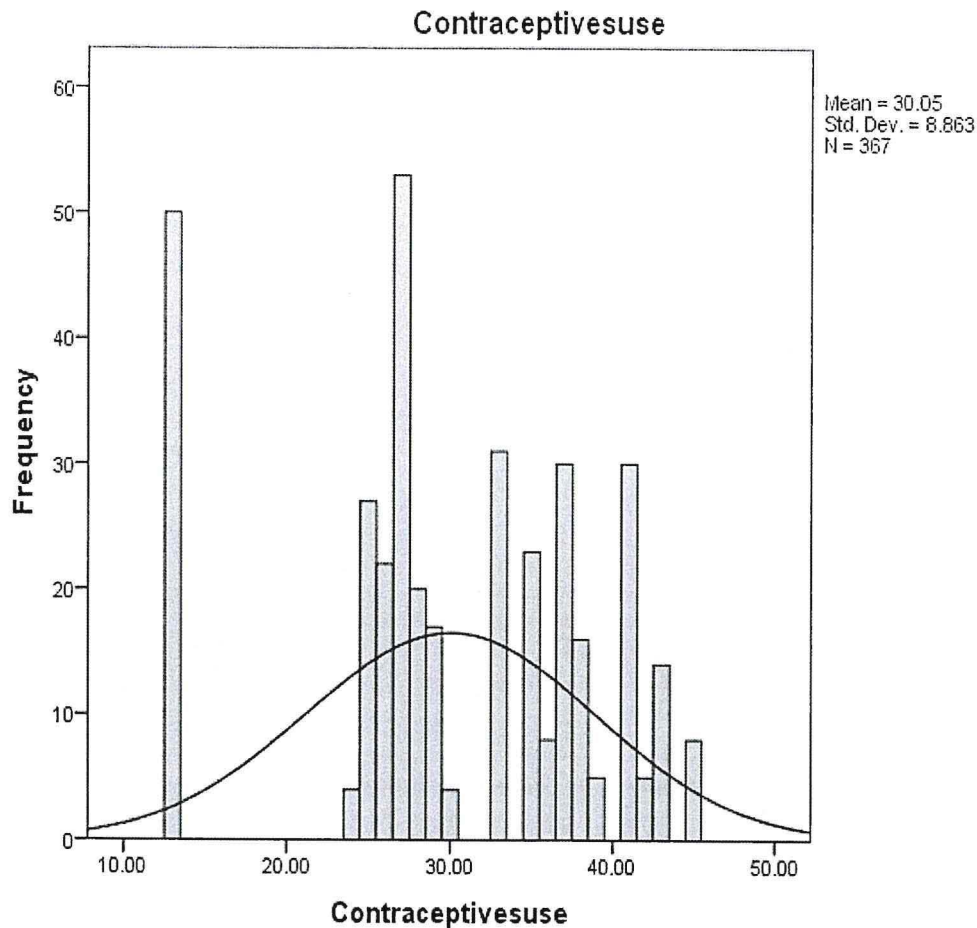


Figure 4.2: Histogram for Contraceptive use

4.2.3 Status of Premarital Sex among Adolescents

Premarital sexual behaviour was the dependent variable of the study. This variable was conceptualized as a student having strong intentions to have sex before marriage. The aspects with mean response ≥ 3.5 were closer to agreeing on the Likert scale that was used to measure the variables. Table 4.6 summarizes the findings.

Table 4.6: Mean response, SD and ratings on Premarital sexual behaviour

Aspects	Mean	SD	Rating
Am willing to have unprotected sex with multiple sex partners	1.89	1.36	Disagree
I like to have sex before being married.	1.33	.84	Disagree
I intend to have sex during my secondary and primary school life	1.70	1.07	Disagree
I enjoy playing sex	1.70	1.07	Disagree
I'm prepared to have the pregnancy terminated if it occurs accidentally.	1.61	1.04	Disagree
I enjoy seeing obscene pictures	1.59	1.00	Disagree
I'm willing to use drugs and alcohol during sexual activity.	1.84	.95	Disagree
Am willing to consume and watch pornography	1.53	.81	Disagree
Am willing to have sex with a high-risk partner	1.35	.64	Disagree
Am ready to have sex with a lover without getting their permission	1.49	.81	Disagree
I value coitus without love before marriage.	1.70	.88	Disagree
I enjoy the business of prostitution.	1.43	.74	Disagree
Even Prior to marriage, I prefer coitus with minimal affection.	1.65	.92	Disagree
There is nothing wrong with having sex before getting married.	1.74	.82	Disagree
When a boy engages in sexual activity with numerous girls, there is nothing wrong with him.	1.63	.84	Disagree
There is nothing wrong with a girl having multiple sex relationships with boys.	1.49	.68	Disagree
There is nothing wrong with thoughtful kissing before marriage	1.65	.92	Disagree
Sexual activity prior to marriage that is free of emotional attachment is good	1.50	.82	Disagree
There is nothing improper about open anal sex.	1.42	.73	Disagree
Overall score	1.59	0.89	Disagree

Key: 1=strongly disagree (SD), 2=disagree (D), 3= not sure (NS), 4= agree (A), 5=strongly agree (SA)

The results in table 4.6 show that respondents generally disagreed indicating a mean of 1.59 and SD=.89) with all the items that measured the level of premarital sex. Those that disagreed that they like to have sexual relations before marriage were (mean=1.33, SD=.84) and those that disagreed to the intention to have sex during their secondary and primary school life were (mean=1.70 and SD=1.07). Furthering the survey, those that disagreed to the willingness to have sex with a partner without his or her consent were (mean=1.49, and SD=.81). Respondents that disagreed to cherish coitus without affection before marriage were mean=1.70 and SD=.88).

Respondents who disagreed that there is nothing wrong with premarital sexual intercourse measured mean=1.74 and SD=.82). Those that disagreed that there is nothing wrong with a boy who has sexual intercourse with many girls measured mean=1.63 and SD=.84). Those that disagreed that there is nothing wrong with a girl who has sexual intercourse with many boys were mean=1.49 and SD=.68)., and that there is nothing wrong with sexual intercourse without emotional attachment before marriage measured mean=1.50 and SD=.82). The findings show that premarital sexual behaviour is very low among adolescents, possibly due to the fact that they feel they are not ready for it and therefore not appropriate at their age.

The researcher then examined the general distribution of results on premarital sex. The average index for the 21 items that measured the variable is summarised in table 4.7.

Table 4.7: Statistical summary for premarital sexual behaviour

Descriptive	Statistic	Standard error
Mean	30.35	.61
Median	24.00	
Std. Deviation	11.74	
Variance	137.88	
Skewness	.95	.13
Kurtosis	-.59	-.59
Range	39.00	
Minimum	19.00	
Maximum	58.00	

Although the degree of response dispersion ($SD = 11.74$) was large, the results in table 4.7 show that the mean value of 30.35 was very near to the median value of 24.00, indicating that the responses were normal. The curve in figure 4 also confirms that data on the involvement of adolescents in premarital sex was normally distributed and appropriate results could be obtained when data is subjected to linear correlation and regression.

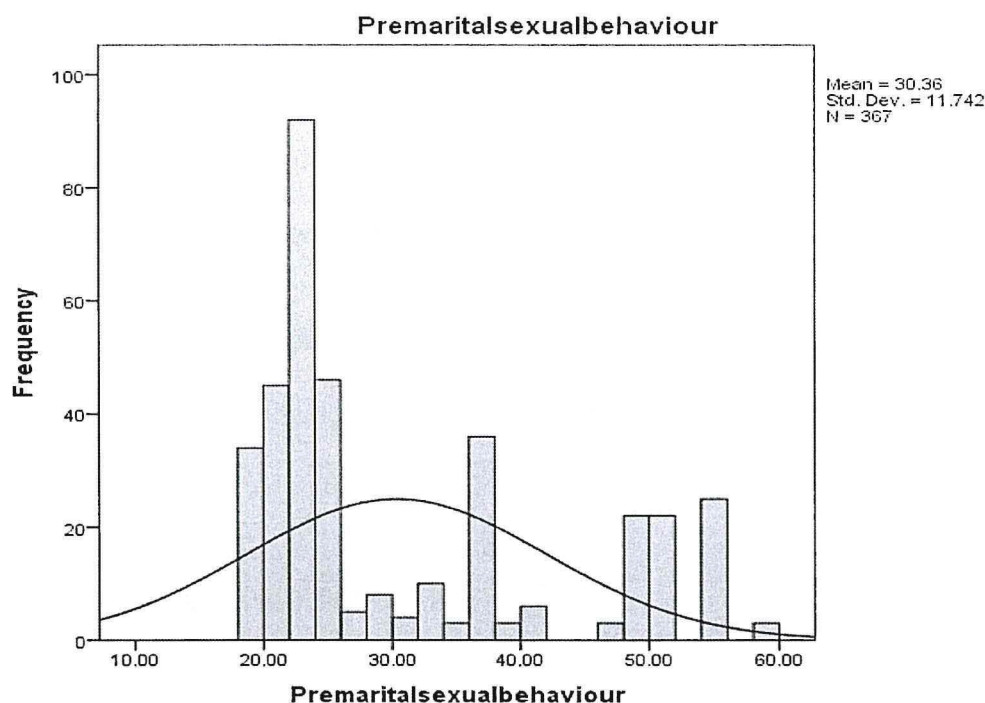


Figure 4.3: Histogram of Premarital sex behaviour

4.3 Relationship between sex education, contraceptive use and premarital sexual behaviour

The relationship among sex education, contraceptive use and premarital sexual behaviour was examined using Pearson correlation. The findings are summarized in table 4.8.

Table 4.8: Correlations between variables of the study

Variables	Stats	1	2	3
1-Premarital sexual behavior	r	1		
	P			
2-Sex education	r	-.296**	1	
	P	0.000		
-Contraceptives use	r	.150**	-.413**	1
	P	0.004	0.000	

Key; $p < .01^{**}$, $p < .05^{*}$

According to table 4.8, there was a negative correlation between sex education and premarital sexual behaviour i.e. ($r=-.296$, $p<0.01$). It was found that between sex education and contraceptive use was ($r=-.413$, $p<0.01$) and between contraceptive use and premarital sexual behaviour was ($r=.15$, $p<0.01$).

Simple regression analysis was done to establish whether sex education and contraceptive use influenced the premarital sexual behaviour of adolescents. The results are summarised in table 4.9.

Table 4.9: Simple regression results

Variables		R^2	F	b	B	P-value
Predictor	Dependent					
Sex education	contraceptives use	.171	75.198	-.418	-.413	0.000*
Sex education	Premarital sex behaviour	.088	35.101	-.397	-.296	0.000*
Contraceptives use	Premarital sex behaviour	.022	8.383	.199	.150	0.004*

Key; $p<.01^{**}$, $p<.05^*$

4.4 Sex education and contraceptive use

The first objective of the study was to determine the connection between sex education and the use of contraception. The findings revealed a strong correlation between sex education and contraceptive use. The findings in table 4.8 showed that a moderate negative and significant relationship of $r(365) = -.413$, $P<0.01$ existed between sex education and contraceptive use. The simple regression results in table

4.9 showed that sex education ($\beta = -0.413$, $p = 0.000 < 0.05$) had a negative and significant influence on contraceptive use and accounted for 17.1 % variation in the variable. Therefore, when students receive appropriate sex education on the dangers of early sex relationship such as unwanted pregnancies, STI and HIV, they are less likely to be involved in premarital sex and hence would not need to use contraception. So, sex education reduces the likelihood of adolescents being involved in sexual activity leading to no need for contraception.

4.5 The relationship between sex education and premarital sexual behavior

The second objective was to assess the relationship between sex education and premarital sexual behaviour among teenagers. The study indicated a strong relationship between sex education and premarital sexual behaviour.. The findings in table 4.8 revealed that a moderate negative and significant relationship $r(365) = -.296$, $P < 0.01$ existed between sex education and premarital sexual behavior. The simple regression results in table 4.9 showed that sex education indicating ($\beta = -.296$, $p = 0.000 < 0.05$) had a negative and significant influence on contraceptive use accounting for 8.8% variation in the variable. This means that adolescents getting appropriate sex education reduced their likelihood of being involved in pre-marital sexual behaviour. Therefore, sex education does reduce the intention of adolescents to have premarital sex.

4.6 The relationship between contraceptive use and premarital sexual behavior

The third objective was to analyse the relationship between contraceptive use and premarital sexual behavior. The researcher anticipated a large link between premarital sexual activity and contraception use. The findings in table 4.8 show that a very small positive and significant relationship r of $(365) = .150$, $P < 0.01$, existed between

contraceptive use and premarital sexual behavior. The simple regression results in table 4.9 show that sex education ($\beta = .15$, $p = 0.004 < 0.05$) had a positive and significant influence on contraceptive use accounting for a 2.2 % variation in the variable. This implies that using contraceptives increases premarital sexual behavior to some extent. The relationship was small probably due to the fact that respondents did not feel they were old enough to have sex and therefore did not see the need to know about the use of contraception. Therefore, in line with the findings of the first two objectives, adolescents had a low rate of contraceptive use and premarital sexual behaviour.

4.7 The predictive potential of sex education and contraceptive use on premarital sexual behavior

The fourth objective sought to determine the predictive influence of sex education and contraceptive use on premarital sexual behaviour. The study expected that sex education and contraception use would positively influence premarital sexual behaviour among adolescents. Hierarchical regression analysis was done, and the findings are presented in table 4.10.

Table 4.10: Hierarchical Regression results of predictors on premarital sex

Model	Effects	R ²	ΔR^2	B	P-value
Model I	Sex education	.088	.088	-.28	.000*
Model II	Sex education*contraceptive use	.089	.01	.03	.548*

Key; $p < .01^{**}$, $p < .05^*$

Dependent Variable: Premarital sexual behavior

According to table 4.10, sex education ($\beta=-28$, $p< 0.05$) had a negative and significant influence on the premarital sexual behaviour of adolescents. When contraceptive use was entered as a moderator to investigate the relationship between sex education and premarital sex behaviour, it was revealed that the interaction effect was about 1% ($\Delta R^2=0.01$) and was not significant ($\beta =0.03$, $p> 0.05$). Therefore, the influence of contraceptive use on the relationship between sex education and premarital sexual behaviour was negligible. This means that appropriate sex education highlights the dangers of early sex relationship and shows reasonableness of abstinence until one is ready for committed sexual relationships. Hence commitment to abstinence reduces the need to use contraception.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents a discussion of the findings from the analysis. This is followed by the conclusions and then ends with recommendations. The analysis focused on sex education and contraceptive use to establish their influence on premarital sexual behaviour. The discussion of the findings are provided in the first section

5.1 Discussion

5.1.1 Sex education and contraceptive use

In the first objective of the study was to assess the relationship between sex education and contraceptive use.. The results confirmed the hypothesis that a significant relationship of $r = -.413$ and $P < 0.01$ exists between sex education and contraceptive use. The relationship was negative implying that appropriate sex education, actually empowers adolescents to delay sexual behavior and subsequently use contraceptives. This finding was contrary to the common belief indicated by Mathew (2017) that sex education incites children to start thinking about sex and therefore practice it. The results affirmed the commendable goal of sexual education of giving children important life-information about sex from people they trust such as parents and teachers.

The findings imply that, getting sexual education from qualified persons helps adolescents to remain morally clean. This is through decreasing their sexual desires leading to affairs, visits to prostitutes or practicing self-abuse. According to Raj and

Boehmer (2013), sexual education serves as a protection from programs that leave adolescents to the whims of the media and peer misinformation.

5.1.2 The relationship between sex education and premarital sexual behavior

The relationship between sex education and premarital sexual behavior among adolescents was further examined. The findings confirmed the hypothesis that a significant relationship of $r = -.296$ and $P < 0.01$ exists between sex education and premarital sexual behavior. The relationship was negative meaning that children having accurate information on sex are not necessarily motivated to have premarital sex. Therefore, sex education does reduce the intention of adolescents to have premarital sex, thus lowering their likelihood of engaging in premarital sexual behavior. This finding agrees with Titiloye, and Ajuwon (2017), who found that even when sex education is sold like any other product and children are told by peers and media that if they are not consuming their share, there is something wrong with them. It is likely that premarital sex was low due to the fact that children perceived abstinence and virginity as a value. This is in line with Santhya and Jejeebhoy (2015) who found that Sex Education helps to portray abstinence and virginity as good and normal in the eyes of adolescents and many decide to choose it.

Therefore, sex education appeals to the hearts of adolescents instead of their eyes and they resolve to maintaining a high standard of moral cleanness instead of bowing to constant pressure to lose their innocence. While adolescence is a period where children are constantly fighting with the "bloom of youth," when sexual urges are strong, sex education can be a protective factor.

5.1.3 The relationship between contraceptive use and premarital sexual behavior

In the third objective, the relationship between contraceptive use and premarital sexual behavior was assessed. The hypothesis that a significant relationship of $r = .150$ and $P < 0.01$ existed between contraceptive use and premarital sexual behavior was confirmed. However, the relationship was so small. This meant that using contraceptives increased premarital sexual behavior only to a limited extent. The small relationship was probably due to the fact that respondents do not feel they are old enough to have sex. As such, they do not see a need to know about and use contraception. Therefore, in line with the findings of the first two objectives, adolescents had a low rate of contraceptive use and premarital sex.

Therefore, it is likely that sex education helps children understand the painful emotional experience of unwanted pregnancy and ruinous venereal diseases. This finding agrees with Reiss (2019) who said that appropriate sex education helps adolescents understand and choose a wiser course of exercising self-control in relation to sex. This also conforms the earlier finding of Search Institute (2020), indicating that adolescents are able to understand that premarital sex does not only bring happiness, but also frustrations and disappointments.

5.1.4 The predictive potential of sex education and contraceptive use on premarital sexual behavior

In the fourth objective of the study, the predictive potential of sex education and contraceptive use on premarital sexual behavior was ascertained. The hypothesis was that sex education and contraceptive use were positively confirmed among adolescents. Sex Education and contraceptive use combined explained close to 9 % ($R^2 = .089$) of the variation in premarital sexual behaviour of adolescents. However, it

was only sex education that had a negative and significant ($\beta = -283$, $p < 0.05$) influence on the premarital sexual behaviour of adolescents. The influence of contraceptive use was not significant. Though the interaction effect of contraceptive use in the relationship between sex education and premarital sexual behaviour was about 0.1%, it was not significant ($\beta = 0.03$, $p > 0.05$). This means that adolescents were not using contraception due to their low rate of premarital sexual behaviour.

This finding implies that adolescents had decided to deaden their bodies with regard to sexual appetite as a result of sex education, they had acquired the risks of premarital sex or due to the fact that they were not thinking about sex because they were still young. In accordance with Ketting et al., (2016), it is likely that sex education helps adolescents to be determined to remain morally clean and avoid the dangers of premarital sex. As indicated by Rose (2021) it is also likely that adolescents learn to suppress or control enticement to get involved in premarital sex. Also due to their understanding of the dangers of premarital sex, adolescents acquire mature reasoning and self-discipline by avoiding things that stimulate them into having sex.

5.2 Limitations of the study

Although this study offered useful contributions, it incurred some limitations. First, the self-report nature of the data used indicated some self-report bias. This could have increased the correlations between the study variables. As a result, future research may employ qualitative data to assess the variables examined in this study.

First, the study sample consisted of adolescents from a single rural district of Namayingo. This means that, the findings are less likely to be applicable to all

adolescents in Uganda. Future studies may attempt to duplicate this study among different groups of adolescents throughout the country.

5.3 Conclusions

The findings supported the perspective that instead of promoting promiscuousness, sex education helps adolescents to refrain from premarital sexual behaviour. Sex education also strengthens the mind and heart of adolescents to delay sexual intercourse. Sex education also helps adolescents realize that it is chaste and virtuous not to be sexually active. They are thus motivated to pursue a course of righteousness. It was also revealed that sexually active adolescents who received Sex Education resolve to use of birth control during their first intercourse and have fewer unwanted pregnancies than those who did not receive this information.

The research also discovered a link between contraceptive use and pre-marital sexual behaviour among Namayingo adolescents. Unprotected intercourse is becoming more prevalent among teenagers resulting to undesired pregnancies. This is primarily due to youth abandoning proven means of preventing undesired births such as condom use in favour of more unproven practices such as interruptus coitus, which do not completely protect against pregnancy and HIV transmission.

The study also discovered a negative relationship between sex education and premarital sexual behaviour among Namayingo teenagers. These findings emphasize the necessity of expanding efforts to teach and educate adolescents about responsible and healthy sexual attitudes, postponing sexual activity initiation and lowering harmful sexual practices. Teenagers should be given appropriate knowledge when they are still relatively young, such as in primary school. Similarly, efforts should be expanded to encourage sexually active adolescents to have access to and use

contraception, particularly condoms so as to avoid STIs, HIV/AIDS and unwanted pregnancy. Finally, the study discovered that sex education and contraceptive use only predicted the prevalence of premarital sexual behavior among Namayingo adolescents, implying that many other factors, such as living conditions, poverty, lack of school fees, and so on, lead and influenced adolescents to premarital sexual activity.

5.4 Recommendations

Studies have shown that adolescents have trouble in accessing information regarding sex and birth control which leads them to explore and learn from untrusted sources like the internet, peers and pornography which exposes them to false information, putting them in danger of undesired pregnancies and sexually transmitted diseases. The government of Uganda should therefore implement a comprehensive curriculum that can incorporate sex education in the classroom to make information about sexual education readily available.

Also, parents should not leave the role of teaching sexual education to their child solely to teachers in schools. They should be able to supplement what their children learn from school and be able to answer questions that their children present to them regarding sexual education.

Children should be permitted to discuss issues concerning their sexuality with their peers in class with the grown-ups available to ensure that the myths associated with having sex are clarified. For example, having sex while standing up does not lead to pregnancy or interrupting coitus is one of the recommended methods of contraception.

Through regular home and school-based sexual education, adolescents sexual behaviour can be promoted as a morally clean act. In this, premarital sexual behaviour can be delayed until one is mature and responsible enough to manage its outcomes.

There is a need to promote the belief of ability to behave responsibly by avoiding behaviour that is harmful to their lives. It is important to educate adolescents on how to remain mentally clean by avoiding feeding their minds on pornography and avoiding books, TV programs, or movies that portray or condone sexual immorality. It is critical to educate parents on how to give age-appropriate sexual education to their children, as many do not feel comfortable doing so.

Adolescents also need to be empowered to be careful about what they listen to with their ears and shun songs that contain sexually explicit lyrics that may stimulate inappropriate sexual desires.

At ministry level, there is need for policy reforms and for comprehensive integration of sex education into primary and secondary school curriculum aimed at strengthening relationships, premarital sex and contraception use management.

There is a need for increased private spaces/offices where sexual reproductive health issues can be addressed from. In addition, more Health workers and CDOs are needed to support sex education communication and child protection. Increased human resources, should be accompanied by increased sensitization programs, plus involvement and collaboration of all key stakeholders, especially parents and religious institutions.

Schools should be used more fully as a hub for children empowerment on sexuality issues by turning their knowledge in Effective SRH skills. School are more appropriate for SRHR promotion given that they are traditionally organized to provide skills training to children in large and small groups and have some needed infrastructure such as classrooms, SRH materials for enabling effective SRH training.

There is need for more and better collaboration in SRH programs. A sexuality education program for young adolescents that involves all stakeholders, doing different things of the program, from whenever, they are to benefit children from one point, most probably the school should be designed and implemented.

There is need for open, clear and constructive partnership among concerned stakeholder, especially parents on SRH interventions for in school adolescents. This will provide a framework for the best ways to communicate and motivate parents to actively participate.

5.5 Recommendations for Further Research

The study's findings point to the need for additional research in the following areas:

1. A study is required to determine the role of social and cultural values in the maintenance of appropriate sexual behaviour among adolescents.
2. The study used a quantitative approach which limited the scope of the study parameters. A study with a qualitative approach can be done to explore the study variables further.

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APPENDICES

Appendix 1: Questionnaire for In-school adolescents

Introduction

I am **Okello Mercy Letaru** a student of Kyambogo University, pursuing a Master of Counselling Psychology. I am conducting a study on **“Sex Education, Contraceptive Use and Pre-Marital Sexual Behaviour among In-School Adolescents in Namayingo District”**. I request that you participate in this study by responding to the questions that follow. The study is intended for academic purposes and your participation will not cause any harm to you and confidentially will be observed. Thank you.

Section A: Biographic information

(For the following questions, kindly tick the option that best describes you)

1. Gender	Male
	Female
2. Age Category	9-11 years
	12-14 years
	15-17 years
	18-19 years
3. Class	P1-p5
	P6-P7
	S1-S3
4. Type of school	Boarding
	day
	Mixed
5. Person staying you are with	Parent(s)
	Relative
	Guardian
	Friend

Section B: Sex Education

Instructions: *For the following questions, please rank your opinions on a scale of 5=strongly agree (SA), 4= agree (A), 3= Undecided (U), 2=disagree (D), and 1= strongly disagree (SD) on whether receive information from your teacher and parents on how to manage sex-related issues in your life.*

SE	Sex Education	SD	D	U	A	SA
SE ₁	My Teacher often gives me information on sex	1	2	3	4	5
SE ₂	My teacher frequently discusses abstinence with me	1	2	3	4	5
SE ₃	Every time we have sex education in school, abstinence is always recommended.	1	2	3	4	5
SE ₄	My Parents regularly hold Sex education-related discussions at home.	1	2	3	4	5
SE ₅	My Parents and Teachers talk to me about the importance of abstinence	1	2	3	4	5
SE ₆	Sex Education is not a waste of time	1	2	3	4	5
SE ₇	My teacher always conducts discussions concerning STDs at school	1	2	3	4	5
SE ₈	My Parents always talk about how to manage attraction to the opposite sex during sex education	1	2	3	4	5
SE ₉	Sex education helps students make informed decisions about Sexual Behavior	1	2	3	4	5

Section C: Contraceptive use

Instructions: *For the following questions, please rank your opinions on a scale of 5=strongly agree (SA), 4= agree (A), 3= Undecided (U), 2=disagree (D), and strongly disagree (SD) on whether you have knowledge and skills and your attitude on using contraceptives such as condoms, pills, etc.*

CU	Conceptive Use	SD	D	U	A	SA
CU ₁	I approve of the use of Contraceptives	1	2	3	4	5
CU ₂	The use of contraception is important for an adolescent to have sex	1	2	3	4	5
CU ₃	Contraception usage is against my religion	1	2	3	4	5
CU ₄	It is good for students to carry condoms	1	2	3	4	5
CU ₅	The result of having sex as a student is crisis pregnancy.	1	2	3	4	5
CU ₆	Adolescents should seek their parents' consent to obtain contraceptive methods	1	2	3	4	5
CU ₇	It is easy to get contraceptives	1	2	3	4	5
CU ₈	Sex is not enjoyable when I use a condom	1	2	3	4	5
CU ₉	I know how contraceptives work	1	2	3	4	5
CU ₁₀	People who insist on condom use are promiscuous	1	2	3	4	5
CU ₁₁	You play sex worried about getting pregnant/impregnating somebody	1	2	3	4	5
CU ₁₂	I approve of the use of contraceptives	1	2	3	4	5
CU ₁₃	Sexual activity is not advised for students.	1	2	3	4	5

Section D: Premarital Sexual Behavior

Instructions: For the following questions, please rank your opinions on the scale of 5=strongly agree (SA), 4= agree (A), 3= Undecided (U), 2=disagree (D), and 1= strongly disagree (SD) on attitudes and involvement in sexual activities before marriage.

PSB	Premarital sexual behaviour	SD	D	U	A	SA
psb ₁	Am willing to have unprotected sex with multiple sex partners	1	2	3	4	5
psb ₂	I like to have sex before being married.	1	2	3	4	5
psb ₃	I intend to have sex during my secondary and primary school life	1	2	3	4	5
psb ₄	I enjoy playing sex	1	2	3	4	5
psb ₅	I'm prepared to have the pregnancy terminated if it occurs accidentally.	1	2	3	4	5
Psb ₆	I enjoy seeing obscene pictures	1	2	3	4	5
psb ₇	I'm willing to use drugs and alcohol during sexual activity.	1	2	3	4	5
Psb ₈	Am willing to consume and watch pornography	1	2	3	4	5
Psb ₉	Am willing to have sex with a high-risk partner	1	2	3	4	5
Psb ₁₀	Am ready to have sex with a lover without getting my parents permission	1	2	3	4	5
Psb ₁₁	I value coitus without love before marriage.	1	2	3	4	5
Psb ₁₂	I enjoy the business of prostitution.					

		1	2	3	4	5
Psb ₁₃	Even Prior to marriage, I prefer coitus with minimal affection.	1	2	3	4	5
Psb ₁₄	There is nothing wrong with having sex before getting married.	1	2	3	4	5
Psb ₁₅	When a boy engages in sexual activity with numerous girls, there is nothing wrong with him.	1	2	3	4	5
Psb ₁₆	There is nothing wrong with a girl having multiple sex relationships with boys.	1	2	3	4	5
Psb ₁₇	There is nothing wrong with thoughtful kissing before marriage	1	2	3	4	5
Psb ₁₈	Sexual activity prior to marriage that is free of emotional attachment is good	1	2	3	4	5
Psb ₁₉	There is nothing improper about open anal sex.	1	2	3	4	5

APPENDIX II: Table For Determining Sample Size

Table for Determining Sample Size for a Given Population

N	S	N	S	N	S	N	S	N	S
10	10	100	80	280	162	800	260	2800	338
15	14	110	86	290	165	850	265	3000	341
20	19	120	92	300	169	900	269	3500	246
25	24	130	97	320	175	950	274	4000	351
30	28	140	103	340	181	1000	278	4500	351
35	32	150	108	360	186	1100	285	5000	357
40	36	160	113	380	191	1200	291	6000	361
45	40	180	118	400	196	1300	297	7000	364
50	44	190	123	420	201	1400	302	8000	367
55	48	200	127	440	205	1500	306	9000	368
60	52	210	132	460	210	1600	310	10000	373
65	56	220	136	480	214	1700	313	15000	375
70	59	230	140	500	217	1800	317	20000	377
75	63	240	144	550	225	1900	320	30000	379
80	66	250	148	600	234	2000	322	40000	380
85	70	260	152	650	242	2200	327	50000	381
90	73	270	155	700	248	2400	331	75000	382
95	76	270	159	750	256	2600	335	100000	384

Note: "N" is population size
"S" is sample size.

Source: Krejcie & Morgan, 1970