Exposure of children to early childhood development programs and subsequent school entry and grade progression within broader contexts of the home environment in Uganda.

by

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In the School of Child and Youth Care

Supervisory Committee

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Abstract

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Children's entry into school at appropriate ages and their successful progression through the primary grades are strong predictors of later life opportunities and successes. This retrospective study focuses on factors that can influence age appropriate school entry and grade progression with children who were eight at the time of the study and who live in a peri-urban community in Uganda. Children in this resource constrained community face risks of educational exclusion and longer term underachievement that arise from social, health and economic disadvantages, inequalities and inadequate services. The most disadvantaged children, those who live in households with life stress events such as the absence of one or more parents or the impact of diseases such as HIV and AIDS, are at risk of not enrolling in school at an appropriate age or not advancing successfully. Such risks may be mediated through family composition and family demographic variables and may be ameliorated through the presence of community programs designed for young children. This study examined the influence of family variables, home environment life stress events, and exposure to early childhood development (ECD) services on the educational transitions of young children. The study determined that children living with biological parents, and parents with higher educational levels, had more opportunities of exposure to community-based ECD

programs, had higher success in enrolling in school at an age-appropriate time, and more successfully progressed through the grade levels. For the purposes of this study, data were collected from 535 children and their 535 caregivers in the peri-urban community of Kyanja in Kampala, the capital city of Uganda. The findings provide a backdrop for a discussion regarding the relationship between home environment life stress events, community ECD services for young children, and the current educational status of children aged eight years. A major focus lies on whether enrolment in ECD can help close the gap created by events in and the structure of the home environment.

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My deepest gratitude to my family especially my husband, George, for his un-wavering love, financial and moral support and sacrifice. He has had to pay the price for my long periods of absence. Thanks to my children, Kenneth and his wife Jackie, Samuel, Lois and Eunice for shaping, inspiring and praying for me. I am indebted to the Stokes, my Canadian host family and the friends and volunteers at Jolly Nyeko Foundation Canada for all the support they have provided. Thanks to God for granting me this opportunity for His purpose.

Dedication

I dedicate this dissertation to the Almighty God and the children of Uganda, both known and unknown, past, present and future. They live their lives with hopeful expectation of a better and brighter future, heaven-bent and joyful in all things unseen. Thank you for giving me the opportunity to represent you as a voice and ambassador for your well-being through this thesis.

Abbreviations

AFC	Action For Children
AIC	AIDS Information centre
AIDS	Acquired Immuno Deficiency Syndrome
BvLF	Bernard van Leer Foundation
CG	Consultative Group on ECCD
ECE	Early Childhood Education
ECCE	Early Childhood Care and Education
ECCD	Early Childhood Care and Development
EFA	Education for all
ECD	Early Childhood Development
ECDVU	Early Childhood Development Virtual University
HIV	Human Immuno Deficiency
HOME	Home Observation for Measurement of the Environment
HSQ	Home Screening Questionnaire
HDI	Human Development Index
JLICA	Joint Learning Initiative on Children and HIV/AIDS
KCC	Kampala City Council
LC	Local Council
MDG	Millennium Development Goals
MoGLSD	Ministry of Gender, Labor, and Social Development
MoES	Ministry of Education and Sports
MoH	Ministry of Health

NCC	National Council for Children
OVC	Orphans and other vulnerable children
SCF	Save the Children Fund
SSA	Sub-Saharan Africa
SPSS	Statistics Package for Social Scientists
TASO	The AIDS Support Organization
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UNESCO	United Nations Education Scientific and Cultural Organization
UNHS	Uganda National Health Survey
UNICEF	United Nations Children and Education Fund
UNDP	United Nations Development Program
UPE	Universal Primary Education
USA	United States of America

Glossary

Caregivers: Persons responsible for the care of children

Child: A person below the age of 18 years.

Child development: Consists of several interdependent domains of sensori-motor, cognitive-language and social-emotional functions.

Class: Alternative term for a grade level in a school

Class progression: Also grade progression refers to the advancement of a child from one level to another.

Early childhood: A period of a child's life from birth to eight years

ECD exposure: Enrollment into an ECD program

Formal ECD: Preschool initiatives focusing on preparing children for school, commonly called 'school readiness.' In Uganda, these initiatives are often operated by profit making agencies.

Non-formal ECD: Programs for children under the age of eight years old focusing on providing custodial care for children while caregivers work outside the home. In Uganda, typically these involve less academic work than formal ECD except for basic numeracy and language. Often there is a focus on social skills, health, nutrition and parenting programs. In Uganda, these initiatives are often operated by not-for-profit organizations.

Orphan: Person below the age of 18 years who has lost one or both parents.

Primary caregivers: Heads of households responsible for the care of children

Pre-school: Learning opportunities often for children from age three to five, before school.

Pre-primary: A period before a child enters primary school.

School: Typically refers to an institution for educating children. A common reference for school is primary school referring to an educational opportunity for children between the ages of six and thirteen years, normally referred to as school age.

Transition: The progression in the educational ladder of children from home to ECD and on to school.

SECTION 1 INTRODUCTION

Overview

Children's entry into school at appropriate ages and their successful progression through the primary grades are strong predictors of later life opportunities and successes (Aidoo, 2008, Chapter 2; Nsamenang, 2008, Chapter 7; Richter, Foster & Sherr, 2006; Njenga & Kabiru, 2001; Walker, Wachs, Gardner, Lozoff, Wasserman, Pollitt, Carter, et al. 2007; Arnold, Bartlett, Gowan & Merali, 2006; Grantham-McGregor, Cheung, Cueto, Glewwe, Richter & Strupp, 2007). This retrospective study focuses on factors that can influence age appropriate school entry and grade progression with children who were eight at the time of the study and who live in a peri-urban community in Uganda. Children in this resource constrained community face risks of educational exclusion and longer term underachievement that arise from social, health and economic disadvantages, inequalities and inadequate services. The most disadvantaged children, those who live in households with life stress events such as the absence of one or more parents or the impact of diseases such as HIV and AIDS, are at risk of not enrolling in school at an appropriate age or not advancing successfully. Such risks may be mediated through family composition and family demographic variables and may be ameliorated through the presence of community programs designed for young children. This study examined the influence of family variables, home environment life stress events, and exposure to early childhood development (ECD) services on the educational transitions of young children. The study determined that children living with biological parents, and parents with higher educational levels, had more opportunities of exposure to community-based ECD programs, had higher success in enrolling in school at an age-appropriate time, and more successfully progressed through the grade levels. For the purposes of this study, data were collected from 535 children and their 535 caregivers in

the peri-urban community of Kyanja in Kampala, the capital city of Uganda. The findings provide a backdrop for a discussion regarding the relationship between home environment life stress events, community based ECD services for young children, and the current educational status of children aged eight years. A major focus lies on whether enrolment in ECD can help close the gap created by events in and the structure of the home environment. Section one outlines the focus and setting of the study, section two details the study design, section three explains the method used, section four discusses the results of the study, and section five discusses the findings and conclusions arising from the study.

1.1 The study focus

Children in resource constrained communities in Africa are growing up with limited opportunities for education and other basic necessities like health and nutrition (Aidoo, 2008, Chapter 2; Grantham-McGregor, et al. 2007; Joint Learning Initiative on Children and AIDS, 2009). The education of these children is highly dependent on the caregiver and is greatly influenced by community factors, such as social, spiritual and material supports available to them. Young children from birth to eight years old, the period often referred to as early childhood (Arnold, 2008), are likely to be the most vulnerable children impacted by home environment influences (Richter, 2010). The home environment influences considered in this study include effects of HIV and AIDS, family migrations, break-ups, job losses, and deaths from various causes. The provision of services for young children in peri-urban centers in Uganda is marked by inaccessibilities and inadequacies. Researchers, including the Joint Learning Initiative on Children and AIDS (JLICA) support that well designed ECD interventions can result in higher educational attainment and counteract home factors that predict poor outcomes (JLICA, 2009; Arnold, 2008; Myers, 1992). There is a need for studies to better

understand how young children in Sub-Saharan Africa (SSA) and Uganda manoeuvre their way through education amidst such home and environmental life stressors. There is also a need to better understand the possible benefits of ECD programs in assisting children to successfully transition from home to primary school. In this study, the following terms have been used.

1.1. 1 Definition of terms.

In this study, ECD contextually refers to programs for children from birth through to eight years old (The Consultative Group on Early Childhood Care and Development, 2010; Garcia, Pence & Evans, 2008). The underpinning concept is that ECD begins at home and the environment in which children are born and grow impacts their development (Boakye, Etse, Adamu-Issah, Moti, Matjila, & Shikwambi, 2008, Chapter 9). ECD involves the survival, growth, development and care of children (Pence & Nsamenang, 2008; Myers, 1992). In specific terms, integrated ECD involves health, nutrition, water and sanitation, basic care, stimulation, learning, social protection, emotional care and family empowerment (Aidoo, 2008, Chapter 2), and non integrated ECD relates to educational activities oriented to school readiness. One of the arguments for early childhood programs is that they bridge gaps between home and school, leading to better adjustment to primary school and higher achievement levels (Njenga & Kabiru, 2001). The ECD programs in this study refer to integrated and non-integrated activities of education. Other closely related terminologies to ECD are Early Childhood Care and Education (ECCE) and Early Childhood Education (ECE) both of which refer to learning in terms of more ‘formal’ educational programs (Engle, Black, Behrman, Cabral de Mello, Gertler, Kapiriri, et al., 2007).

ECD services are understood to give a good start in life involving nurturing, care and a safe environment for children who are commonly said to be the future of any society and nation

(Nsamenang, 2008, Chapter 7). Other authors note that child development consists of several interdependent domains of sensori-motor, cognitive-language and social-emotional functions (Grantham-McGregor, et al. 2007). There is rapid brain development which can be modified by the quality of the environment, effects of poverty, social-cultural contexts that expose children to risks that affect their brain. Child development programs are designed to improve the survival, growth, and development of young children and reduce risks, while ameliorating the negative effects of those risks (Engle, et al. 2007). The ECD programs for 0-3 year old children focus mainly on parental education where health and nutrition of the children are important components. Parents and the community leaders are the main audience and key child care providers. The programs for children aged 4-5 years old tend to be center-based and focus more on pre-school activities of group learning and socialization and fostering cognitive development (Aidoo, 2008, Chapter 2; Hayden, 2006), while programs for the 6-8 year old children are basically school focused. There is evidence that good nutrition, good health care, and competent parenting during the crucial early childhood period can build a sturdy foundation for physical growth, cognitive development, and later economic success (JLICA, 2009).

At the 1990 World Conference on Education for All (EFA) held in Jomtien, Thailand, a conscious inclusion of the rights of the young child became evident, incorporating statements like learning begins at birth (UNESCO, 2000). An EFA follow up conference in Dakar, Senegal in 2000, strengthened the ECD component making it the first of six key goals: "expanding and improving early childhood care and education, especially for the most vulnerable and disadvantaged children" (UNESCO, 2000, p.3).

In this study, ECD exposure refers to enrolment in an ECD program in relation to the following key variables: enrolled or not enrolled regardless of length of stay in ECD; age at

enrolment, that is, earlier than four, which is considered early age of enrolment, as four years old considered to be the standard age of enrolment in Uganda, and at five years old, considered to be late enrolment. The study also identifies if the children are enrolled in formal centers operated by private-for-profit or in non-formal ECD centers such as the Action For Children (AFC) community centers.

Formal ECD centers in this study refer to pre-school or pre-primary initiatives that often focus on school readiness for children aged three to five (Prochner & Kabiru, 2008, Chapter 6). The non-formal ECD initiatives include learning opportunities for children under the age of eight years old focusing on providing custodial care for children while caregivers work outside the home. The service involves less academic work except basic numeracy and language, and more of social skills, health, nutrition and parenting programs. These initiatives are often operated by not-for-profit organizations. The non-formal ECD centers, such as, centers in Kyanja parish operated by Action For Children (AFC), encompass principles of community-based initiatives such as joint efforts between the community members and any external support provided often by non government agencies, mutual assistance through peer group support, social responsibility by making contributions to the management of the centers and community reliance (Prochner & Kabiru, 2008, chapter 6; Bernard van Leer Foundation, 1994). In Uganda, the formal pre-schools are preferred by the privileged elites in the urban and semi-urban areas, while the non-formal community-based models are the choice of the marginalized mostly semi-urban and rural dwellers (NCC, 2010).

In this paper the term ‘school’ will refer to primary school as defined by the Uganda Ministry of Education (2006) relating to learning opportunities for children of age six to thirteen. And in this study the broad reference is to children aged six to eight years old, with a particular

focus on eight years old. Some children would have enrolled in school younger or older than the government recommended age of six years.

Transition is the progression in the educational ladder from home to ECD, and then on to primary school (Njenga & Kabiru, 2001).

The home environment in this study refers to socio-demographic variables that are likely to be associated with the education and development of young children in the home, such as: relationship of the caregiver to the children, age of caregiver, gender of caregiver, education of the caregiver, total number of children in the home, number of orphans, number of children aged eight in the home, number of children in the home that are enrolled in ECD, number of children in primary school, presence of HIV and AIDS in the household, divorce or separation of parents, family migration, loss of employment, death of parent(s), illness of parent(s) and lack of school fees.

The term caregivers will refer to biological and non-biological caretakers of children within the nuclear and extended family system that is connected with the child through blood relationship (Hayden, 2006). These caregivers will include parents, grandparents, siblings and any other heads of households responsible for child caring (Myers, 1992). Caregivers considered in this study are the 'primary' caregivers, referring to those that take the position of 'heads' of households.

In this study, the parents will mean two-parent nuclear families and single parent families. On the other hand, any caring adult can provide parenting (Evans, Matola, & Nyeko, 2008, Chapter 14) if they are responsible for providing food, clothing and help when the child is sick or tired. In Uganda, and most of SSA, most caregivers for young children are females (Prochner & Kabiru, 2008, chapter 6) including mothers, aunties, grandmothers and girl child

siblings. Fathers do not traditionally participate actively in the care of young children although they are expected to provide family resources and security. Often, however, fathers and male siblings can be seen to play and tell stories to young children (Prochner & Kabiru, 2008, chapter 6).

In order to understand the context of the study, the following sub-section provides an overview of the situation of children in Uganda.

1.1.2 Children birth to eight years in a Ugandan context—an overview.

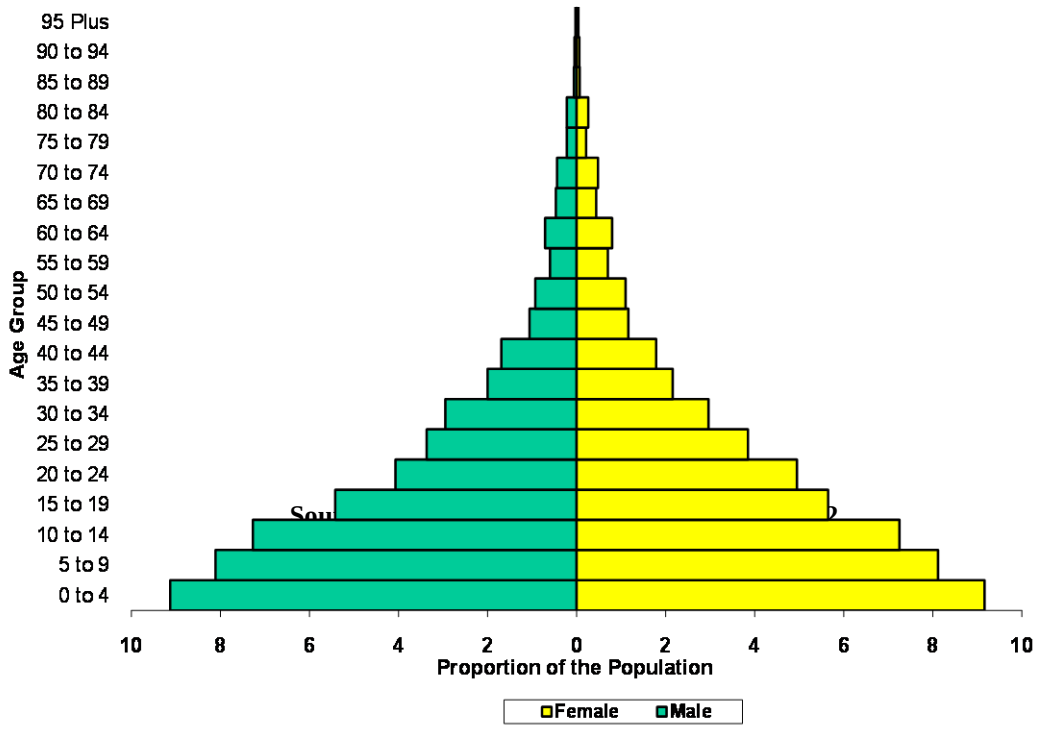
Civil wars and poverty conditions in Uganda have resulted in limited access to social services, poor environmental conditions, inadequate household material supplies, and social instability for many children in the country. When these conditions combine with the poor health services' infrastructure and HIV/AIDS in communities, the end result is overworked and demoralized child caregivers (Ministry of Gender, Labor and Social Development, 2011)

Such challenges in turn negatively affect children's growth, education and development. The demographic and socio economic data of Uganda place the country either at the highest or the lowest end compared with the rest of the world. In the United Nations Development Program (UNDP) ranking of the Human Development Index (HDI) in 2009, Uganda's position is 143 out of 169 countries with an index of 0.422. This index places Uganda slightly above the regional HDI average for SSA of 0.389 (Uganda Bureau of Statistics, 2010).

Uganda covers a total area of 92,525 square miles or 241,000 square kilometers, and it is located across the equator in East Africa. The country is divided into 154 districts, subdivided into counties, sub-counties, parishes and villages (sometimes referred to as zones). The temperatures in Uganda range between 22 to 30 degrees centigrade with an average of about 25 degrees centigrade. It is usually a wet or dry equatorial climate all year round.

The Uganda Bureau of Statistics (UBOS) projected that Uganda's population in 2006 would be 29 million, while the last comprehensive population census in 2001 had placed the population at 25.7 million (UBOS, 2006). In the year 2008, the bureau projected the population grew to 30.7 million people, with a density of 123 persons per kilometer (UBOS, 2010). The population growth rate in 2006 was 3.2 % per annum (in 2006). Within the population, 56% are persons below the age of 18 years (NCC, 2007). Females comprise 51% of the entire population. The National census of 2002 estimates the sex ratio at 95 males for every 100 females (UBOS, 2006) quoting the 2001 Uganda population and housing census, main report). The Uganda population is largely composed of young dependent people below the age of 15 years (51%) as shown in Figure 1.

Figure 1: Uganda population pyramid



The pyramid shows a lean population from the middle age group to the top and a large, dependent youth population at the bottom. The statistical projections indicate that the structure has not changed over the last ten years (UBOS, 2010).

A national household survey conducted in 2009/2010 by the Uganda Bureau of Statistics (UBOS), a body mandated by the Uganda government to regularly collect statistics in the country, found that for every 100 persons in the working age range of 15 to 64 years, there were 117 dependent persons (UBOS, 2010). This dependency ratio is exacerbated by a low life expectancy rate of 54.1 years, one of the lowest in the world. Between the years 2002 and 2009, UBOS (2010) reports that the elderly persons, above 60 years, decreased from 6% to 5% of the total population. Uganda's fertility rate of 6.7 children per individual woman and a population growth rate of 3.2% are also among the highest rates in the world (UNDP, 2009; United Nations Population Fund, 2010). Out of the entire population of Uganda, children aged birth to five are 22.6%, while the children aged six to twelve total 22.9% (UBOS, 2010). This is important for the ECD sector because the national budgetary allocations would need to be commensurate with the population structure, the heaviest population being in the early ages. The Bernard van Leer Foundation (BvLF) recommends that ECD should be seen as the basic underpinning for society's future and the foundation of a healthy, prosperous and creative nation (BvLF, 1994), yet Uganda's position is the opposite. ECD is not a major national concern. ECD is not a mere provision of pre-school places for children before they enter formal school system, but also involves the health and nutrition of the child, the quality of the child's learning environment, the relationships children have with their caregivers and the surrounding environment and promotion of a child-friendly environment.

There are three major ethnic groups in Uganda, the Bantu, the Nilotics, and Nilo-Hamites (Rwabukwali, 1997). The Bantu is the largest ethnic group and is found in southern, central and western Uganda. Among the Bantu, the Baganda form the largest tribe with 16.7%, followed by Basoga with 8%. The other ethnic groups, the Nilotics and Nilo-Hamites are found in the north and east of Uganda. The Luo form the largest group (15%) in this category. Within the three ethnic groups are over 40 tribal groupings spread throughout the country (Ministry of Finance, Planning and Economic Development, 2009)

Uganda's overall literacy rate, defined as the ability to write meaningfully and read with understanding in any language, is 69% among persons aged 10 years and above with more males (76%) found at this level than females (63%) (UBOS, 2006). The literacy rates are higher for urban dwellers (86%) than their rural counter parts (66%).

The percentage of the population living below the poverty line went down from 39% in 2002/3 to 31% in 2005/6 and is claimed to be the result of humanitarian and other government interventions such as the Northern Uganda Social Action Fund (UBOS, 2010).

Kampala district, which is also the capital city of Uganda, is on the intersection between the southern and central areas of the country, lying in the Lake Victoria basin. Being on a high altitude of 1,000 meters above sea level, and in the lake basin, raises the humidity of the city to a high level of 75%. The population of Kampala is said to be three million by day and two million at night because over one million people dwell just outside Kampala in the cities of Jinja, Entebbe and Mukono but work in Kampala during the day. Kampala is divided into 5 administrative divisions of Nakawa, Rubaga, Kawempe, and Makindye. The fifth division is Makerere and Kyambogo universities that were graded as an administrative division due to the large population of students that is above 20,000 in total. Nakawa division is on the eastern part

of Kampala district and is sub-divided into 28 administrative parishes including Kyanja parish, the site of this study. The parish is representative of other similar, semi-urban communities (Kampala City Council, 2009). In the Uganda administrative system, each village has a Local Council (LC) and committees that range from LC1 at village level to LC5 at district level. All adult residents in the village at LC1 are eligible to vote and to elect their leaders. They participate in the village social and economic affairs.

The government allocates 15% of the annual national budget towards public education (UNICEF, 2010; National Council for Children, 2010). The education sector has registered steady growth in enrolment into primary education since the introduction of Universal Primary Education (UPE): 1996, N= 3.3million, in 2000, N=6.6 million, in 2004, N=7.3 million, in 2010, N= 8.9 million. However, the budget excludes program activities for ECD, except supporting a department within the Ministry of Education and Sports (MoES) responsible for the supervision and monitoring of early childhood services. The department, called the pre-primary and primary directorate, developed an education sectoral policy and a thematic curriculum for ECD in 2007 (MoES, 2008) to guide the development and provision of educational services for children birth to eight years. According to this policy, the MoES is the lead agency in the implementation of the ECD programs, yet it does not clearly indicate how networks and collaborations can be strengthened through the coordination of ECD activities by various stakeholders to avoid overlap and duplication of efforts. The policy seems to lean more heavily towards early childhood education (ECE) than early childhood development (Ministry of Gender, Labor and Social Development, 2011). ECE is a sectoral component of ECD that focuses more on the education of children while ECD incorporates an integrated approach including health, nutrition, and social protection (UNICEF, 2008).

All these policy issues impact on the development of ECD programs in Uganda. The Government is sectorally organized and no one sector is responsible for early childhood development, probably due to what Engle, et al. (2007) call the invisibility of the problem, not investing in ECD, resulting in government's failure to respond to the long term effects of failing to make ECD investments.

In 2000, the National Council for Children (NCC) embarked on developing a national ECD policy that is yet to be finalized. The reason for non-completion may be because ECD funding and implementation still lies in the hands of the private sector rather than government. The NCC, which is located within the Ministry of Gender, Labor and Social Development (MGLSD), is the key government body charged with coordinating all children's programs in Uganda (NCC, 2007). A problem that arises in the Ugandan government's approach to young children is that despite ECD cutting across ministries, there exists no designated ministry to coordinate all ECD activities; instead, ECD appears as a small unit amidst the various activities coordinated by the National Council for Children, making connections with other ministries a challenge given the little funding allocated for NCC programs. ECD needs to be seen in relation to the whole child (BvLF, 1994), the community, and family rather than just preparation for education. With a holistic approach, other relevant multisectoral sectors like health, nutrition, and psycho-social care will be included. Health systems of primary health care can be boosted by strategies for improving psychosocial care and developmental counseling, so that the integrated or comprehensive ECD would be a composition of health, nutrition, education and social protection services (Engle, et al. 2007).

Uganda's Ministry of Health (MoH) supervises regional and district hospitals as well as health centres in rural areas that provide antenatal services (NCC, 2007). A range of ECD health

related services such as: immunizations, growth monitoring, provision of vitamin A supplements, nutritional guidance, counseling to parents, treatment of childhood diseases and antigens to women of child bearing age to protect their unborn children are offered (Ministry of Health, 2010). In addition, the MoH developed general program standards for ECD services for children birth to three and a public sector program for parent education that serves children birth to eight years (NCC, 2007). A national system for pre-natal education exists at antenatal clinics throughout the country (Vargas-Baron, Subrahmanian & Dickerson, 2009). The percentage of births with skilled attendants is only 42% which may explain the high maternal mortality rate of 550 per 100,000 and quite high infant mortality rate of 78 per 1,000, placing Uganda among the countries still far from achieving the Millennium Development Goals (UBOS, 2010). These figures are an indicator of a stressed health sector. In this context, it is relevant to note that the Ministry of Health budget allocation for the year 2010 was only 2% of the total national budget (UNICEF, 2010). This low allocation of funds leaves the ministry dependant on external funding. The Uganda Nutrition and ECD Project, supported by the World Bank from 1995 to 2000, did not directly target child development but involved communities in terms of defining interventions and establishing control. The result was improvement in breast feeding practices, growth rates and parental attitudes towards ECD, but very limited effects on child development outcomes (Engle, et al, 2007).

There is no comprehensive national system for giving nutritional supplements for malnourished children, but caregivers for children in ECD and lower primary, are encouraged to pack a snack for the children to eat at break time. As well, the schools make lunch arrangements for children who stay at school longer than the morning session. The provision, however, varies in quality in relation to the status of homes where children came from. While in some urban

centers the meal is prepared at the venue, in rural areas the common practice is for children to carry along with them packed lunches. For severely malnourished children, there exists a treatment facility called the Mwanamugimu Nutritional Clinic located at Mulago National Referral Hospital in Kampala. This facility, which also serves as a training unit for the Makerere University Medical School, is accessed by only a few parents and children who can afford to travel to the city. The clinic admits an average of 75 children each month (MoH, 2009). Caregivers living in rural and semi rural areas and those living miles away from Kampala city, whose children might be malnourished due to social economic home environment stressors that result in a lack of proper nutrition, are equally unlikely to access information about the nutritive services and cannot afford to travel to the clinic. In Uganda, 14% of the children birth to five years have low birth weight (2.5 kilograms) and 44.8% are stunted, while 19% are underweight (Vargas-Baron, et al. 2009). The situation of children is further complicated by HIV and AIDS whereby 130,000 children are reported to have AIDS and 7.7% of children birth to five years die due to HIV and AIDS related illnesses each year.

1.1.3 An overview of children and HIV/AIDS in Uganda.

For nearly three decades HIV and AIDS have devastated families with the tragedy of death and medical, financial and social burdens (UNICEF, 2010). Children affected by AIDS form a major concern in HIV and AIDS aspects (Hayden, 2006; UNICEF, 2010; Ntozi, 1997), although they are to some extent overshadowed by the intensity of the overall epidemic (Hunter & Williamson, 1994). However, UNICEF, the United Nations agency mandated to handle children's issues globally, reported that improved evidence and accelerated action is rewriting the story of AIDS impact on children by including children's issues in interventions designed to avert HIV and AIDS consequences (UNICEF, 2010). Before 2005, in many sub-Saharan African

countries, children who had lost both parents to AIDS were much less likely to be in school than children whose parents were alive, and were less likely to get adequate support for proper nutrition, immunizations, stimulations required for a healthy living (Hunter & Williamson,1994). Today, in most places they are almost equally likely to be in school (UNICEF, 2010), and the humanitarian and development community are increasingly aware of the depth of the problem for the young children (Fonseca, O'Gara, Sussman and Williamson, 2008, Chapter 5).

Uganda was one of the first countries to openly acknowledge the presence of HIV and AIDS, and then also one of the first to address it (Okware, 1987). There was a rapid rise in the number of cases from two in 1980, to seventeen by the end of 1983, then surging to 48,000 in 1995 with a prevalence rate of 25% among the adult population (Rwabukwali, 1997). In 1992, the government established a multi-sectoral AIDS control program and coordination entity, the Uganda AIDS Commission (UAC). In addition, there were a number of private agencies established to join the fight against the epidemic, including The AIDS Support Organization (TASO), the Philly Lutaya Initiative, and the AIDS Information centre (AIC); these were the first agencies to fight against the spread of HIV/AIDS and to provide care for patients (Uganda AIDS Commission, 2007). These 'first' agencies became models in SSA (Allen, 2006). With these strategies and other programs in place, combined with the President's mass awareness campaigns (UAC, 2006) the epidemic started to decline by the end of 1995. However, the prevalence rates that had been declining, then began to plateau at 7.1 percent, and have been static at 6.4% since 2006 (UAC, 2007; UNICEF/UNAIDS, 2010). The impact of HIV and AIDS is still visible in the communities and in many families resulting in orphaned children.

UNAIDS/WHO (2005) define an orphan as a child under 18 years who has lost one or both parents. There are reportedly 13 million children in SSA that have been orphaned by HIV

and AIDS (UNICEF, 2008) and out of these more than two million are in Uganda (UBOS, 2006). During the Uganda National Health Survey (UNHS), which is a major social economic national survey conducted in Uganda every two years, an orphan was defined as any child with one or both parents deceased (UBOS, 2006). However, O'Hare, Venables, Nalubega, Nakaketo, Kibirige & Southall (2005) broaden the definition to include a child whose mother or father has left the family home, which introduces a category of children the Uganda ministry responsible for youth and children, the Ministry of Gender, Labor, and Social Development (MGLSD), terms as orphans and other vulnerable children (MGLSD, 2004).

The UNHS defined a child as vulnerable if he or she had a parent who had been chronically ill for three of the preceding 12 months, who lived in a household with a chronically ill adult, or who lived in a household where an adult died in the previous 12 months period (UBOS, 2006). This definition meant that a child with one or both parents deceased was not necessarily considered vulnerable, which supports the view that orphanhood alone did not mean vulnerability (UNICEF, 2010). Some orphans have able caregivers while others suffer serious consequences and challenges of stressed home environments regardless of their location, but children living in rural and the semi-rural contexts are especially at risk due to limited resources available to them.

In SSA, communities and families have become important players in the fight against HIV and AIDS, especially in caring for the affected persons (UNICEF, 2009). Commonly, these caregivers are also socio-economically vulnerable. Grainger, Webb, and Elliot (2001) point out that children who lose mothers will have different consequences from those who lose fathers. Children without mothers tend to migrate to other homes, and are usually taken care of by maternal aunties or maternal grandparents, while children whose fathers have died tend to remain

with their mother, stay in the households and continue in school. However, whatever the circumstances, children in low income communities are faced with a wide variety of challenges as noted below.

1.1.4 Challenges facing children in peri-urban contexts in Uganda.

In Uganda, more than 80 percent of all children live in rural and semi-rural areas (NCC, 2007). Migrant patterns are visible where men especially move to urban and peri-urban centers to find work (BvLF, 1994). It is common in Uganda for a father to migrate to town leaving his children, wife and aged parents behind in the rural village (UBOS, 2010) for labor in what Streuli, Vennam and Woodhead (2011) called 'seasonal migration' (p. 54). In an economy where the majority of the population (88%) lives in rural areas, it might be expected that provision of social services would target the rural and semi-rural areas. However, the average distance to a government hospital is 25 kilometers (UBOS, 2006). This is reached by walking as the main mode of transport. In the urban and peri-urban centres, it is estimated that the nearest government hospital is eight kilometers away. The doctor- patient ratio in Uganda overall is 1 to 2,000 persons. As a result, it is unimaginable for a caregiver with children in a remote location to have the services of a doctor when needed. Caregivers report overwhelming daily challenges associated with providing psychological, social and economic care to their children in situations of limited resources, in settings where formal health care is virtually absent unaffordable or unknown (Kipp, Tindyebwa, Rubaale, Karamagi, and Bajenja, 2007). In the peri-urban areas, work schedules and patterns reflect less hours spent at home as caregivers are engaged in economic outdoor activities to raise the needed funds to take care of the children. This impacts the children as some are known to stay home and miss school to provide additional help at home (Kipp, et al. 2007).

Furthermore, nutritional deficiencies and failures in appropriate stimulation during a critical period of early childhood are likely to disrupt the healthy formation of the brain, as Arnold's study in Nepal confirms (2000). Such disruptions often signify a reduction in the child's learning ability, with negative consequences for later school performance (Young & Mustard, 2008, chapter 4; Myers, 1992; JLICA, 2009).

1.1.5 Ugandan families under stress–HIV/AIDS and other home environment stresses.

Families with primary caregivers, that is caregivers who are heads of households, provide a context in which children develop, learn, and thrive (UNICEF, 2010; Richter, Foster & Sherr, 2006). Conversely, some families lack home nurturing relationships and this can impact children's possibilities for development. The Joint Learning Initiative on AIDS studies (JLICA, 2009) have concluded that, overall, the effects of HIV and AIDS on African family structures have not yet been irreversibly destructive. The conclusion is derived from an observation that since the 1970s, households in Southern Africa have, on average, increased rather than decreased in size. It remains to be clarified whether the increase in household size is an indicator for less disrupted family structures. Likewise, the rare occurrence of children and grandparent headed households does not mean the family structure is untouched. Comparatively, the proponents of disrupted family structure systems (Kipp, et al, 2007) are saying, in as much as such cases have become rare, they are visible unlike the period before HIV and AIDS.

The HIV/AIDS epidemic has instigated changes in family roles and has resulted in situations that have challenged traditional family structures and eroded predictable patterns of behavior (Garcia, Pence, & Evans, 2008; Evans, Matola, & Nyeko, 2008, Chapter 14). This has added even more anxiety and stress for the caregiving families (Kipp, et al., 2007).

As HIV/AIDS affects mainly the sexually active age groups in their economic prime time, the cumulative effect of deaths of these younger adults in the families, who often are the breadwinners, pose specific social and economic challenges and can be overwhelming for the affected families (Minujin, Delamona, Davidzink & Gonzales, 2006). The death of a male family head may cause a drastic short term decline in household income. Some households take longer to recover from this crippling income-generation capacity. As Woodhead and Moss (2007) point out, families already affected by poverty and illiteracy are less able to promote children's best interests resulting in migration and transfers of children to other relatives, sometimes from one poverty stricken relative to another (Hayden, 2006). In their recent publication, Streuli, Vennam and Woodhead (2011) state that poverty levels and location determine whether children attend pre-school and school. Poverty in the developing world goes beyond accessibility to income but also in terms of severe deprivation of basic necessities of food, safe drinking water, health, shelter and education (Garcia, Viranta & Dunkelberg, 2008, Chapter 1).

Across Uganda, there are overwhelming issues that affect the ability of families and communities to care for their children, especially after the death of one or both parents. In the vast majority of cases, an orphan or any other vulnerable child (OVC) will have a surviving relative who may be willing to offer support and care. Surviving parents are often limited by resources in economically depressed areas due in part to the AIDS pandemic and other life stressors. Although grandparent households account for a small percentage of adult-headed households, they remain a significant contributor in OVC care. However, because of their age and lack of economic vitality, due in part to the death of their children, they face obvious challenges in addressing the needs of children (Lewis, 2006).

1.1.6 Services for young children and families in peri-urban areas – ECD and other programs.

The provision of services for young children in peri-urban centers in Uganda is marked by inaccessibilities and inadequacies, yet research supports that well designed ECD interventions can result in higher educational attainment and counteract home factors that predict poor outcomes (JLICA, 2009; Arnold, 2008; Myers, 1992; Grantham-McGregor, et al. 2007).

If families are functional and supportive, children are more likely to go to school and to perform well, and the provision of early childhood services also enhances the likelihood of children attending school. The government standard on enrolment in primary school requires that children enrol in primary school at age six, therefore, six year old children should be in primary one, seven year old children in primary two, and eight year old children in primary three (NCC, 2007). However, this is not always the case, as established by the Uganda Demographic and Household Survey (UDHS) of 2009 (Ministry of Finance, Planning and Economic Development, 2009). The survey found that although primary education enrolment has been increasing from 6.6 million pupils in 2000, to 7.3 million in 2004, and on to 8.3 million in 2009 (UBOS, 2010), 68% of the enrolled pupils in primary one were below or above the age of 6 years. This is largely the result of the government's UPE policy of encouraging mass enrolment without restrictions on the upper age of enrolment and a lack of enforcement of lower age limits. In some cases, 60 and 70 year olds have enrolled in primary schools sitting in class with children fit to be their grandchildren (New Vision Newspaper, Uganda, 24th May 2011). Because adult education is not free, and functional adult literacy classes are inadequate, the elderly have resorted to UPE that is principally free, though with some hidden costs of scholastic materials. Such occurrences highlight the need to further develop adult education to meet the needs of the adult population

that would like to return to school. Nevertheless, the introduction of UPE could be the reason for an increase in the literacy rates in Uganda. The average literacy rate among persons 10 years and above is 73%, with male literacy (79%) being higher than that for females (66%). This rate is an increase by 4% from 69% in 2006 when the male literacy rate was 77% and female rate was 63% (UBOS, 2010). Furthermore, the current literacy rate shows that urban household members were more likely to be more literate (88%) than the rural household members (69%), with Kampala city having the highest literacy rate of 92% compared to other regions (UBOS, 2010). Despite the increase in literacy rates and enrollment, the education sector faces challenges, notably in terms of infrastructure. The NCC (2007) reported that in 2005, there were only 520 classrooms, 185,344 chairs, and 10, 608 tables to accommodate 7.3 million pupils. In 2010, the UBOS survey put the ratio of pupils to teachers and pupils to class rooms as 49 and 68 respectively. This type of educational infrastructure accounts for the low retention of pupils in school where only 21% of females and 24% of the males that enrol in primary school complete seven years of primary education (NCC, 2007). In order for children to achieve high quality education, there are three important pillars to consider, that is, access, progression in grades and retention in school. Pre-primary education is an important aspect in enrolment.

In Uganda, pre-primary education has various names including: Preschool, Nursery School, Kindergarten, Infant Schools, Day Care, and Early Childhood Development (Nankunda, 2003). Regardless of name, the services are provided by the private sector, which includes private-not-for-profit ECD education and private-for- profit agencies normally operated by enterprising business women in urban and peri-urban centers. A few profit based centers are emerging in rural areas (NCC, 2007, NCC, 2010). The Ministry of Education developed an ECD policy with a purpose of contributing towards access to quality education for children. However,

government activities are limited to licensing, registration, curriculum development and training for teachers. The rest of the implementation is left to the private sector.

Many urban residents are able to enrol their children in private-for-profit centers whose charges vary from Uganda shillings 600,000/= to 2,400,000/= (Can $ 300 to $800) per year. The families that cannot afford the cost seek the services of the private-not-for-profit organizations, such as Action For Children. The most disadvantaged children are least likely to have access to quality services, except where innovative programmes specifically target these groups (Woodhead & Moss, 2007). The peri-urban families have a choice of the centers depending on the household's abilities to pay for services. Free child care services would increase the use of quality ECD facilities especially by the disadvantaged children (Lokshin, Glinskaya & Garcia, 2008, chapter 19).

In addition to slow but steady increases in the provision of primary education for young children, infant immunisations against six preventable childhood illnesses namely: Measles, Polio, Diphtheria, Tuberculosis, Whooping Cough and Tetanus, have successfully led to a reduction of the Infant Mortality Rate from 100 deaths out of 1,000 in 1995 to 76 deaths out of 1,000 (UBOS, 2010). However, the immunization services are more prevalent in the urban and peri-urban areas than in rural areas, and among the educated and wealthier mothers who are keen at immunising their children than among the less educated and disadvantaged mothers (UBOS, 2010).

The child health divisions of the MOH provide health care for children from birth to five years. The range of services include treatment for childhood illnesses paying particular attention to malaria prevention and treatment; raising awareness for safe water and sanitation; implementing vaccination programs; promoting child and mother nutrition including

breastfeeding for the first six months; raising awareness for HIV and AIDS prevention and providing voluntary counseling (NCC, 2010).

1.1.7 Challenges of school enrolment and grade progression.

Athanasiou (2006) clarifies that although young children face numerous transitions in their lives, perhaps two of the most significant are the transitions from home to ECE and ECD programs and into school. Children impacted by home environment life stressors are likely to have fewer opportunities of accessing early childhood education (Njenga & Kabiru, 2001; Richter, 2010). Enrolment in school depends more on the availability of physical and social supporting resources such as nutrition, scholastic materials and infrastructure such as classrooms, chairs and desks.

Howes (1988) asserts that children who are in poor quality ECD settings may fail to receive sufficient attention to facilitate their progress in school. The settings may be a result of the ratio of children to adults, the sheer numbers of children in the class, or caregivers who lack knowledge of child development issues. UBOS (2010) reports that the ratio of pupils per teacher in Uganda is 49 to 1. These numbers are likely to affect the provision of adequate infrastructure like space for child seats. In the peri-urban areas one in every three pupils enrolled in primary does not have adequate sitting and writing space (UDHS, 2010). Such inadequacies in the infrastructure in turn affect grade progression. The job and labor sector in Kyanja does not seem to support the demands of the children. The majority of the caregivers are employed in low-skilled labor as domestic servants, petty traders, and small scale retail traders. The more literate and skilled employees work in sales, clerical work, teaching and health services (Lokshin, et al, 2008). Poverty and underemployment contribute to stressed home environments, a situation found in Kyanja parish of Kampala city.

1.2. Kyanja specific

1.2.1 Children in Kyanja parish.

Data regarding children in Kyanja parish are largely non-existent, although records from Kampala City Council (2007) and Action For Children (2009) administrative records show that there are over 1,900 children eight years and below in pre-primary and primary schools in the parish. In an evaluation study of AFC programs in the parish, Roby and Shaw (2008) found that out of the study sample composed of adults and children, the highest number, 32%, were children in the five to seven age range with a gender distribution of 49.5% females and 50.5% males. The national population gender composition tends to be the reverse. Generally, female numbers are higher than male numbers (UBOS, 2010). Further research would examine whether the Roby and Shaw findings were only unique to Kyanja AFC program or represent a general trend in the parish.

The exact number of children 0 to 18 years and the number of schools in Kyanja parish are unknown. Nevertheless, the children respondents in this study were registered in over 70 pre primary and 45 primary schools. It is unclear whether all those schools were located in the parish, but it is likely some children were enrolled in schools outside the parish, and would be taken to school each day by the caregivers with affordable transport means, otherwise, they would walk long distances, 5 kilometers or more, to school. The latter would likely be children from stressed households. Roby and Shaw (2008) found that within the families in the AFC program, only 42% of the children lived in nuclear families with one or both parents, while 43% lived with grandparents.

Secondly, the study showed that some children living in such substitute care had a living parent who was unwilling or simply unable to support the children. Unfortunately, the study

revealed that for such children whose parents were alive but had migrated, 27% reported they had no contact with any of their parents or any other relative since joining the new home.[1]

In Kyanja parish, more than 80% of the children below eight years of age have been immunised against killer diseases (Kampala City Council, 2007). However, data from Nakawa division, which is an administrative level composed of 26 parishes including Kyanja, the children live in very difficult circumstances with high incidences of morbidity, and mortality rates of 88/1,000 for Infant Mortality and 97/1000 for Under 5 Mortality (Kampala City Council, 2007). There are still a few older people, 60 years and above, that have the caregiving responsibility, although it can be overwhelming given their often deteriorating health conditions (Kakooza and Kimuna, 2006; Ssengonzi, 2007).

1.2.2 Family structures under stress in Kyanja.

Being a semi-urban community, Kyanja parish has both urban and rural features. The urban nature is exemplified by the residents living in small rented rooms with inadequate, often unhygienic sleeping space for members of the household (Roby & Shaw, 2008). Poor storage containers for water and food are visible in the households (AFC, 2002). The family occupations involve casual, out of home labor with many caregivers working full time and each day of the week in markets and small kiosks. This work style leaves less time for child caring except when the children accompany their caregivers to the work place, a situation that could be hazardous since there are hardly any day care facilities in such areas. The parish is also characterized by a subsistence farming culture of growing some food crops in small backyard gardens around the household. The backyard gardening often allows the children to keep in close

[1]Kyanja parish being a peri-urban community with a migrant population, families are likely to have fewer contacts with extended family members outside the city.

range for caregiver observation. However, realizing the need for more time in the garden, and a place where children would be kept safe while the caregivers ran their errands, AFC was requested by the families to open ECD centers in the parish.

1.2.3 Services for young children in Kyanja.

In Kyanja community, home environmental impacts are visible. In 1999 as AFC was initiating activities in Kyanja parish, nine out of ten households were caring for an orphaned child under the age of eight years old (AFC, 2002), and 60% of the school age children were out of school. However, by 2008 the numbers of children out of school had reduced to less than 20% and fewer households, also about 20%, were caring for orphans. In 1999, there were ten pre-primary and three primary schools all operated by profit making agencies. However, since 2000, and with the entry of AFC in the community, there has been a stimulus at establishing more educational centers and enrolling children in ECD and in school. Roby and Shaw (2008) found more than 70 pre-primary and more than 45 primary schools in the parish. AFC alone operates nine ECD not-for-profit centers in the parish, namely: Jolly Angels, Little Angels, Flowers of Joy, Children of Hope, Love and Joy, Children of Love, Noah's Ark, Victory and Faith, and Angels of Mercy. The next two paragraphs will briefly describe the two different types of ECD programs considered in this study. The first type will describe the private, not-for-profit centers used in this study (referred to as non-formal) and the second type will describe the profit making centers (referred to as formal programs).

The non-formal ECD centers serve as a hub for comprehensive activities including medical care, immunizations, growth monitoring, vitamin and nutritional supplementation, psychosocial stimulation and emotional therapies, hygiene and habit education (AFC, 2010). Services such as medical care, counseling, HIV and AIDS testing, income generation activities

and others are arranged and extended to the caregivers of the young children by AFC staff. The ECD centers operate five days a week, Monday to Friday, from 8:00am to 12:00. The caregivers bring the children in the morning and pick them at twelve o'clock. Children as young as 2-3 years old but also 4-8 years old benefit from the center services. While at the center, the children participate in stimulating physical exercises while learning individual and group play. They learn to make their own age-appropriate play materials from locally available materials. They are taught age-appropriate songs, dance and drama, riddles, poems and listen to stories usually told by elders that visit the centers on a regular basis. The children receive habit training such as greeting, culturally appropriate sitting positions, especially when sitting on the floor mat, praying before meals, hand washing and toilet use. They learn about the environment, through nature walks, observing and exploring the world around them. They learn to differentiate between plants for food like potatoes from non-edible plants, identify useful seeds, rocks and stones, different domestic animals and identify names of different insects, and other living beings in their surroundings. The children also experience minimal school readiness activities such as numerals and literacy by talking, reciting alphabets, written symbols and pictures and counting wooden blocks. They undergo weighing, height monitoring and nutrition support. Child counseling is provided when needed and the children take rest naps in a rest place provided at the center (AFC, 2009). AFC adopted a model of community-based ECD promoted by BvLF (1994) in East Africa that incorporates establishment of management committees. The committees mobilize the caregivers to acquire facilities where they can operate the ECD centers, contribute materials, labor, money, identify caretakers (in formal systems, called teachers), agree on payment for the caretaker, supervise the caretakers and generally monitor the operations of the center, all done within their limited resources and often on voluntary basis.

The other main form of ECD provided in Kyanja is the private, for-profit programs (referred to as formal ECD programs). These programs are much greater in number, 61compared to 9 for non-formal centers, and a larger number of children in the parish use them; for example, in this study, there were 454 children registered in formal centers compared to 60 in non-formal centers. These programs focus mainly on preparing children for school. They emphasize rote learning of reading, writing and numeracy (Prochner & Kabiru, 2008, Chapter 6). They tend to be large, efficient and economical in order to maximize their profits. Their main expense is paying teachers' salaries, and may not have extensive interaction with parents except when it relates to the children's learning details.

In addition to the ECD programs, there is one health centre operated by the local government and two health units operated by private agencies offer health care services (Kampala City Council, 2007). The private health care centers offer services on a cost sharing basis; but the clinic managed by AFC is free for the children registered in the program.

1.2.4 Challenges of school enrolment and grade progression for children in Kyanja.

Schools in Kyanja parish have some urban features, such as availability of electricity, fairly good physical structures, and qualified teachers (MoES, 2006). However, similar to the rural and semi-rural settings, Kyanja schools lack scholastic materials such as text books, libraries, resource centers, computers, sports grounds, sports uniforms and equipment, all for educational purposes. The Roby and Shaw (2008) study found that the family income in Kyanja ranged from $0 to $2,000 USD per year, with a mean income of Uganda shillings 785,000/= per year, or approximately $350 (Cdn.) based on July 2011 conversion rates. The main common source of income is selling food, including produce from small gardens, or other items at a small shop or roadside stall. The revenues from these sources can hardly cover tuition fees for all the

children in the households. The result is that some children remain in ECD, which charge no tuition fees, for more than the two year stipulated period and have not progressed into primary school where tuition fees are required (AFC, 2008). In order to better understand the interaction of individual, family, community, and service factors as they impact on children's enrolment in and progress through primary schools, this study was undertaken in Kyanja parish in 2010.

1.3 Study location and justification for selection

Kyanja parish was selected because being a project site for Action For Children, it has experienced ECD programing targeting households impacted by home life stressors especially HIV and AIDS (AFC, 2003). The parish has children of the age group the study was interested in, and their caregivers were easily accessible to the researchers and the principal researcher in terms of travel arrangements. The parish is only 10 kilometers from the city center and takes 11 minutes to reach by road. Furthermore, being a semi-urban community, the parish reflects both the rural and urban features representative of many other communities in Uganda. For example, despite Kyanja's proximity to the city, only eleven kilometers out of the city center, its physical, economic and social infrastructure resemble rural features. The population is composed of land owners and also squatter residents who don't own the land they live on. Kyanja is a community at a crossroads. Close to the city centre, but still semi-rural in nature, it is on the verge of bursting into an urban community. The affluent have bought plots of land from the formerly absentee land owners, and constructed mansions for the upper class dwellers. However, sandwiched between the large mansions are the less privileged homesteads with populations struggling for survival. The nearest health center is approximately 15 kilometers away in an adjacent parish called Kasangati.

Kyanja Parish is located to the north east of Nakawa division with a population of 8,584 (Uganda Population and Housing Census, 2002) including 1,900 children under the age of 8 (Kampala City Council, 2007). Over 20% of these children are orphaned and living in households headed by the elderly. The parish is a peri-urban community composed of nine villages. The villages are referred to as zones in the Ugandan context. The nine villages are: Walufumbe, Kisasi, Katumba, Kyanja Central, Kisasi, Kulambiro, Kasana, Kondogolo and Ttuba. In the 9 villages, there are 4,359 males, and 4,225 females living in 1,970 households (Kampala City Council, 2007).

The ethnic grouping in this community is mainly composed of Baganda, the largest group in the central region of Uganda. However, being a semi-urban community, there are also some other ethnic tribes like Banyarwanda (who came from Rwanda in the 1940-50s), Banyankole (from southern areas), and other Ugandan tribes from different regions. Most of the population speaks Luganda, the local language of the people in central Uganda.

The economic activities in the parish include mainly small scale retail trading, tiny backyard gardening, and service provision that includes hair dressing and casual non- skilled labor. The majority of the residents are tenants who rent one-room houses amidst big mansions owned by absentee landlords that rent out to the affluent working class tenants. The upper and middle class residents work in the metropolitan part of the city, while the lower class subsists on their labor from within the community. The latter form the largest part of the clientele for Action For Children, although all the households in the parish with children under age eight participated in the study (AFC, 2008; Roby & Shaw, 2008).

It is this parish, Kyanja that was selected for a retrospective study on the association between home environment factors, early childhood services and child outcomes versus educational participation. The next section describes the study design and the variables studied.

SECTION 2 STUDY DESIGN

2.1 Rationale of the study

A body of contemporary research suggests that family characteristics interact with child-care variables to influence child outcomes (Le Roux, 2002; Arnold, Bartlett, Gowani & Merali, 2006; Jaramillo & Mingat, 2008, Chapter 3; Streuli, Vennam, & Woodhead, 2011), and that children who enrol in ECD are more likely to continue on to school and progress in grades. In general, children are more likely to go to school and perform well if their parents are educated and supportive (Jaramillo and Mingat, 2008, chapter 3).

Arnold, et al. (2006) further assert that children enrolled in early intervention child-care programs were generally more successful in school than those who did not enrol and that ECD enhances enrolment and reduces drop outs (Grantham-McGregor, et al, 2007). Proponents of ECD further attribute ECD as a safety net for disadvantaged children claiming that ECD interventions can help compensate for a lack of a supportive home environment but are most effective when integrated with family support, health, nutrition and educational services (Engle, et al. 2007; Kabiru & Hyde, 2003).

Families undergoing stress are more likely to enrol their children in poor quality child-care settings and to receive poor quality learning opportunities thereby perpetuating the poverty cycle (Jaramillo & Mingat, 2008, chapter 3). Caregivers, especially women, face negative life stressing events associated with poverty, lack of support, stigma and loss due to HIV and AIDS (Engle, et al. 2007).

Equally, caregivers who are less well-educated are less prepared to select and pay for high quality education services and children are at risk of poor school progression (Arnold, et al. 2006).

2.2 Retrospective study design

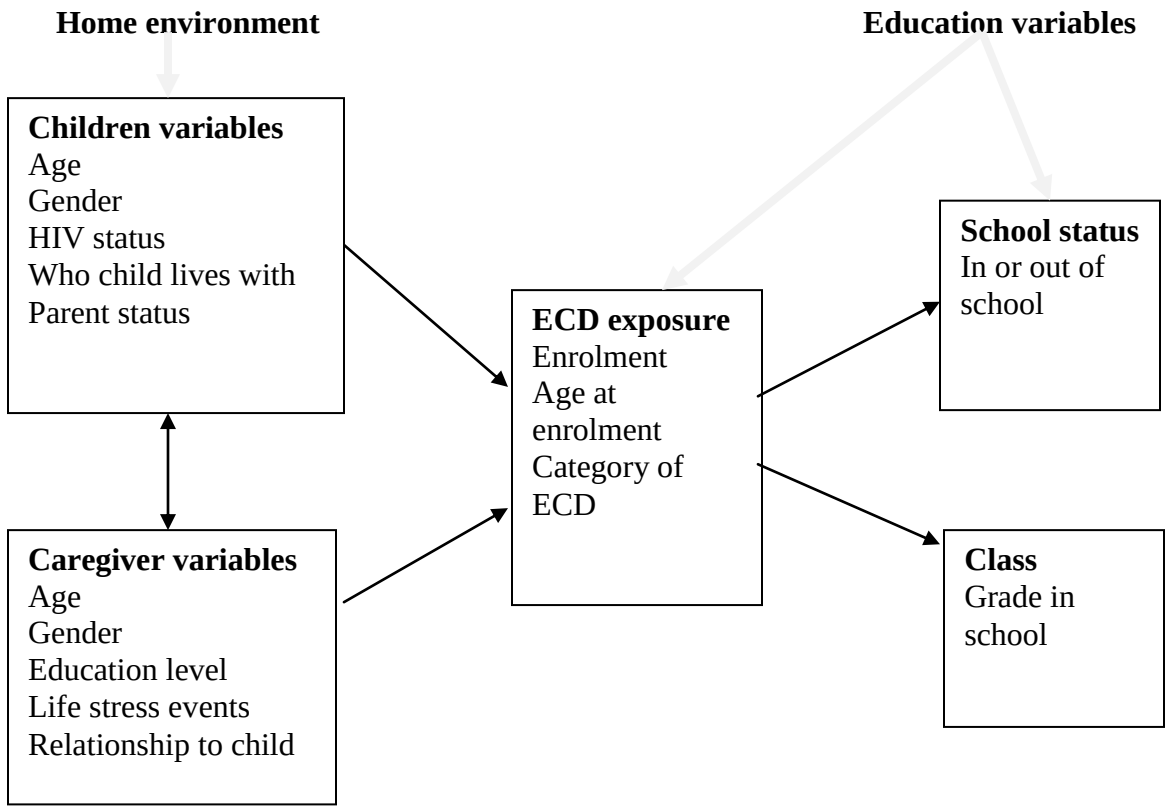
This study uses a retrospective design. A retrospective study design is one that involves analyzing past events to generate new knowledge and identify future trends (Gilger, 1992). A quantitative, retrospective approach was selected to investigate social and demographic variables' influences on children's education placements. Children and primary caregivers' demographics were among the independent variables. Child characteristics of interest included age, gender, HIV and AIDS status, and orphan status. The primary caregiver characteristics of interest included the caregivers' socio-demographic data on age, gender, and education level. In addition, home environment variables of: relationship to the children, numbers of children in the home, children aged between birth and eight, children in ECD, children in primary school, life stress events in households, and number of children impacted by HIV and AIDS, were also included.

A second set of independent variables related to ECD exposure which included enrolment into ECD, age at enrolment, and category of ECD the children were enrolled in—that is, formal or non-formal ECD centers. The study was interested in establishing the association between the ECD exposure variables, as well as child and caregiver variables, and the educational outcomes of school entry and grade.

Dependent variables included school status and class. The indicator was whether the children were in or out of primary school and current grade or class level at the age of eight years. In order to investigate the impact of the home environment on the transition of children in education, the study considered the association between enrolment of children in school, their class, and the presence of life stressing events in the household. The indicators for the life stressing events were parent's death, migration, job losses, divorce or separation, and lack of

school fees. Figure 1 is a summary pictorial presentation of the association between the independent and dependent variables.

Figure 2: Socio-demographics, ECD exposure and school outcomes



2.3 Rationale for selecting the study design

Three quantitative research designs were considered before selecting the retrospective approach for this study. The designs considered were: cross sectional surveys, longitudinal panel surveys, and a retrospective design. These designs have varying advantages and disadvantages with reference to understanding child transition in Kyanja parish. The retrospective design was found to be a useful, practical and appropriate design for this study. The retrospective design is easily verifiable since the data refer to what has taken place.

The design has maximum efficiency, for example the children are of the same age, and therefore all have same chance of being studied. The design can address a large cohort, and it is easy to combine samples of children and caregivers.

The variables are easy to verify, for example, going to school or not, enrolled in school or not. The reliable records are easy to recall, such as, did the child get into ECD or not? Is the parent alive? When did the child come to live in home? Lastly, the respondents in the study are competent to recall the facts, they are parents and other heads of households that closely interface with the children.

2.3.1. Considering a cross section design.

A cross section design uses only a cross section of the population that is sufficiently diverse to provide reliable results. Had this study chosen to use a cross sectional design, the following steps would be applied: a section of the population, children, determined by age, would be selected, all children within the age range of four to eight would be sampled. The children would be categorized into three cohorts of: four and five year olds as an ECD group; 2) six year olds as a group entering primary school; and 3) seven and eight years old children expected to be in primary two and three. For each of these groups, the expected outcomes would differ in terms of the results of exposure or no exposure to ECD and life stress environment factors in their households. Being a cross sectional design, one of its basic distinguishing features from other designs is that it assesses the prevailing circumstances of the respondents ‘as is’ at the time of the study. The feature of ‘as is’ weakens the efficacy of the cross-section design because it does not measure change, whether increasing or decreasing. In addition, the design cannot confirm that the first variable is a cause and the second variable is its effect. The design can at best point to a relationship between variables. This may not be very helpful in the social sciences

and humanities where practical solutions are sought to improve the well being of society. Cross-section research takes a section of its target group and bases its overall finding on the views or behaviors of those targeted, assuming them to be typical of the whole group. This type of methodology can jeopardize representativeness and generalizability of the study.

2.3.2 Considering a longitudinal design.

A longitudinal study design involves the repeated use of the same items/measures over long periods of time with the purpose of establishing cause and effect relationships (Goodwin & Goodwin, 1996). Choosing a longitudinal design methodology, the study would select children of a certain age, for example, four and five years, and follow them systematically for a certain period, e.g. four years. The advantage with this design is that it provides an opportunity to obtain fairly accurate cause and effect factors rendering itself as a scientific method that is objective, systematic and devised to permit accumulation of reliable knowledge (Cherry, 2000). The four year period would allow the study to follow children aged four and five years from ECD through to primary two and three. In the first year, both the four and five years old would be expected to be in ECD, in second year, the five year olds would still be in ECD, while the six year olds would have enrolled for primary school. In third year, the same cohort would be expected to be in primary one and two, while in the fourth year, primary two and three. The study would assess the cause and effect of progressing or not progressing within the four year period.

The advantage over other designs is that longitudinal studies track the same people over a period of time, and therefore the differences identified are less likely to be the result of cultural differences across generations and time, which makes longitudinal studies relatively accurate. Longitudinal panel surveys have the potential to measure individual change in the components under study and yet also the summation of a variable across time (Creel, 2007). Panel surveys are

useful as ongoing sources of up-to-date information, and any new data can be examined as they become available and supplementary questions added. This is an advantage that panel surveys have over other designs where a complete new survey would need to be conducted if there are emerging issues. However, the design suffers a number of inherent limitations.

Longitudinal surveys normally require a long period of time to obtain the required data. Researchers face challenges arising from keeping the same subjects over a long time. In the process, some subjects may drop out of the study resulting in high attrition rates (Creel, 2007; Evans & Miguel, 2005). There can be potential losses through non response, and if new elements are introduced to the population, it can increase costs, for example, of reinterviewing. One of the most critical limitations of longitudinal designs is the high cost of the study in terms of time and money. Often larger sample sizes are required and studied over a long period. It was therefore crucial to think through other designs that have a shorter life span, for example, the retrospective design that was appropriate for this study.

2.3.3 Deciding on a retrospective design.

A retrospective study design involves analyzing past events to generate new knowledge and identify future trends (Gilger, 1992). The method has diverse possibilities, including rigorous tracking of historical data in literature reviews and in standard references, archival studies (Wright, 1998; Mossman, 2006), oral histories and testimonies, eye witness accounts of written or oral events (Stein, Fonagy, Ferguson, & Wisman, 2000), and a wide variety of other historically situated data (Goodwin & Goodwin, 1996).

Retrospective study designs have been used before to obtain information on students' home environments in relation to their academic performance (Kurdek & Sinclair, 1998). In a USA retrospective study of eighth graders and their family structure, Kurdek and Sinclair (1998)

studied 219 students with a mean age of 13.84 years (SD = 0.58) regarding their school performance. The study obtained information on students' end of year grades, in relation to their home environment. The study found that students from two parent nuclear families had higher end-of-the-year grades than students in either mother-custody or stepfather families. Whereas Kurdek and Sinclair (1998) were interested in the performance of the children in terms of end-of-year grades, the current study interest is the progression of children in relation to enrolment, repetition, and grade promotion.

In an archival study, Gilger (1992) used a parent self-report survey to assess past and present academic achievements of adults and children. The study assessed reports of 559 males and 559 females, including children. The age ranged from children of mean age 5.74 to adults of 90 years. In this U.S. study, the researcher used tests to compare survey responses with actual test scores. In the analysis, the historical data on school achievement was found valid and the accuracy of both parent and self-report data improved for children as the age range increased, that is, the older the child, the more accurate the data. Notwithstanding the difference in the retrospective time period of study (22 years), the study findings provide a foundation for a historical study in grade progressions for younger children birth to eight. The combination of self report and parent report provides a synergetic relationship to counteract the shortcomings of any unreliable or missing data from young children.

Researchers Yancura and Aldwin (2009) emphasize that well designed retrospective assessments can generate very valuable data about childhood experiences and therefore should not be overlooked. However, the researchers caution about reports being influenced by individual characteristics such as age, gender, and physical health status. In their study, they found that older adults have been shown to remember more factual and event-related details than

young adults, while females tend to recall more details than men. Home environmental factors such as deaths and divorce or separation could also be related to poor mood influence, therefore eliciting negative memories that might clog clear reporting. This discussion is very important in considering the current study that includes an assessment of life stress events in the home and their influence on the education of the children. Some items become highly emotionally salient and more easily recalled than others. The use of this design requires a clear understanding of the items being measured and how to measure them. Using the home screening questionnaire (HSQ), the subjects investigated in this study were identified, that is, children that had attained eight years of age and their caregivers, while retrospectively analyzing their past life histories to understand and describe causation factors that pointed to their current life situations.

The advantages of the retrospective design include establishing links between variables across time, and identifying antecedents for particular circumstances that occurred in the past. The data provides guidance for interpreting or predicting future events. Legal and policy research of historical events, court rulings and policy proclamations provide considerable guidance in legal and policy making processes (Goodwin & Goodwin, 1996). A study of government historical documents on ECD would undoubtedly influence decisions on policy formulations for the future. The searching and tracking of historical data can be extensive and vigorous, but the process unveils precise data that may not have been captured in other ordinary literature review. This makes the methodology advantageous for clarifications and explanations of events answering questions of where, when, what and who (Goodwin & Goodwin, 1996). In the research on the young children, the outcome of the study is historical trajectories of children that could easily be overlooked by other designs that are less vigorous and intensive as the retrospective design. However, the design has limitations as well.

A study by Bill, Terrie, Avashlom, Langley and Phil (1994) recommended that reliance on retrospective reports, for example, about psychosocial variables, should be approached with caution as it cannot be precise in estimating event frequencies or event dates. Respondents may not recall what happened, or if they do, there is a risk of what Forth (2008) calls telescoping data, misrecalling the date, placing it later or earlier.

Despite Yancura and Aldwin's (2008) assertion that older adults have been shown to remember more factual and event-related details than young adults, very elderly caregivers, such as grandparents in rural or semi rural communities like Kyanja, may not recall events in a child's life, or may not know the events because the child was not living in the household at the time. But these can be overcome by admitting data from other family members like older siblings in the household (Gilger, 1992).

After reviewing advantages and disadvantages of the various methods, the retrospective design was found more practical in examining the school outcomes. The design allowed getting a large sample of children in a short period of time. Therefore in consideration of this design, the study determined to maximize the suitability of the retrospective design by focusing on things that could be recalled, not relying on one recorder, but getting multiple reports from caregiver and children.

SECTION 3 METHOD

Using a retrospective design, the study identified children who had attained eight years of age and retrospectively analyzed their past life histories to understand and describe causation factors that relate to current life situations. Oral information related to what and why events happened in the child's home environment were collected. Certain limitations of the retrospective design were overcome by using multiple reporters and focusing the questions on concrete issues that could be reliably recalled and verified by the respondents.

3.1 Procedure

3.1.1 Training of interviewers.

The study recruited four Ugandan interviewers, two females and two males, who were experienced in working with children and community development. They were interviewed to satisfy the requirement of exhibiting good communication skills, conversant with the local language, culturally sensitive to the people in the community, and comfortable to speak about HIV and AIDS issues. Additionally, the research team was further trained on how to conduct research and also in the following areas: 1) purpose of the study; 2) relevance of the study for the target population; 3) informed assent[2] and consent procedures; 4) interview techniques; 5) confidentiality issues; and 6) addressing questions or concerns.

3.1.2 Pretest.

A pre-test survey was conducted to refine the tools and orient the researchers for the study. The pilot interviews were held in Kiwatule parish which is adjacent to Kyanja and has

[2] Children assent while caregivers give consent.

similar socioeconomic contexts. Choosing another parish was done to avoid contaminating the research respondents in Kyanja but still being able to properly assess the instruments. Twenty children and twenty caregivers were interviewed in a period of two days. The results were used to re-fine the questionnaires and at the same time check how feasible it was to obtain the children and caregivers' consent. Furthermore, the pre-test revealed the possibility of children responding to the questions and determining which questions needed redesigning or deleting. Data from the pre-test were not included in the analyzed data set.

3.1.3 Data collection procedure.

The study had four research assistants, with the writer as the principal researcher rotating among research assistants daily to ensure standardized interview protocol. The four researchers split into two pairs and each pair moved together to a household, separating at the point of interviews, one interviewed the child while another interviewed the caregiver simultaneously in a private setting. Each person conducted five interviews each day, making a total of twenty interviews, ten of children and ten of caregivers.

The forms were filled out by the interviewer and written in English regardless of whether the respondent chose to use the local dialect or not. At the end of each interview, the respondents were verbally thanked while the children received biscuits in appreciation of their time. The data collection process extended from April 2010 through late September 2010. In each village, the researchers started from one location, the home of the village council chairman and followed the village path from door to door, interviewing all the children aged eight years old and their primary caregivers in the households. If an appointment was missed at a household or center, another date was fixed with the person present, or the parish chairman returned to make a new appointment with the potential respondent.

During the study period, the researchers met at the end of each day with the principal researcher for process group meetings. They discussed issues that arose during the day, ensured adherence to procedures and protocol and planned for the next day. The meetings were held at an agreed location in the community, usually at a shop of a community person that freely accepted host the team for approximately one hour each day. There was no financial compensation for respondents, though some cookies were given to the children after the interview.

3.1.4 Recruitment of participants.

Selection of respondents was in two phases, selection of site and selection of respondents. In order to obtain an overall picture as it was at the time of the study, Kyanja Parish was purposively selected as it is a project location of Action For Children. The survey process proceeded with selecting zones in the parish. The nine zones namely; Central, Kasana, Katumba, Kisasi, Kondogolo, Kulambiro, Nazareth, Tuuba, and Walufumbe were given codes A, B, C, D, E, F, G, H, I, and J for confidentiality purposes. The zones differ in geographical and population sizes. The smallest zone, Kondogolo, has a total population of 700 in 149 households and the largest zone, Central, has a population of 1,200 in 300 households. All nine zones in the parish were studied. In order to obtain the number of households, all the households in the parish were selected. Phase two involved selecting the respondents by selecting all households with children and then households with children of eight years of age, either in or out of ECD and school. In every selected household, there were two categories of respondents: children in category one and caregivers in category two.

3.1.4.1 Children.

All households with children were selected out of all households in the parish. This was followed by selecting all the children aged eight years old in the household. The children were from different backgrounds, some were found living with parents, grandparents, and others with various relatives. Some children were living in households that were of affluent status depicted by the type, size and ambiance around the homestead, while others lived in low income settings with crowded, small households, sometimes a family with more than four children in a one-roomed house. The children, both girls and boys, were in different grades and educational status making a variety that provided a rich experience of home environmental factors for the children. The study targeted children of eight years old regardless of whether in or out of ECD, and whether in or out of primary school. Children who were unable to respond to the questions due to illness were excluded. One child with a hearing and speech difficulty was removed by the caregiver from the community to an unidentified location even after consenting to the interview. The opportunity to interact with her was missed.

3.1.4.2 Caregivers.

The primary caregivers, who were self identified as the heads of households, were selected regardless of the relationship to the children. The caregivers included parents, grandparents, aunts, uncles, older siblings and any other biological or non-biological primary caregivers found in the household. Both females and males were selected for interviews regardless of their educational backgrounds. The only adult respondents in the study were heads of households, who had the responsibility of caregiving for children aged eight living in Kyanja parish at the time of the study. All respondents were residents in the study area. Participants, especially grandparents and other caregivers who were unable to communicate due to health

reasons – frail, very sick or very senile and therefore having memory impairment, were excluded. Before embarking on the data collection, it was necessary to obtain approvals from the University of Victoria and the Uganda research agencies mandated to approve researches.

3.1.5 Ethics.

The study obtained institutional review board approvals from the University of Victoria's Ethics Research Board, but also in Uganda, from the Uganda National Council of Science and Technology (UNCST) and the Mildmay Hospital's Ethics Research Committee that provided a peer review. The peer review was a requirement by the UNCST because the nature of the study involved sensitive subjects as minors and HIV and AIDS affected persons. The Mildmay Hospital in Uganda cares for children living with AIDS, and therefore was an appropriate agency to review this study protocol. After a series of discussions with the Hospital's ethics committee, the Mildmay Hospital recommended the study for the final approval by the UNCST who approved the research protocol.

At the community level, an introductory letter was written to the parish chairman who in turn introduced the research to the individual village leaders. The research team obtained permission from every village chairperson before entering the households.

To maintain the research ethics at household level, an assurance was made regarding total confidentiality by assigning codes to each family to track the family's data in the study but not necessarily tracking personal information. The villages were equally coded rather than using usual area names. The participants were informed of any potential inconvenience, such as emotional feelings, that would arise in the study especially relating to recalling some stressful events that could have occurred in the home such as death through HIV and AIDS related

illnesses. To prevent these risks, the research arranged counseling services free of charge at the Kyanja social centre. Fortunately, no case needed any specialised counselling.

The study was cognisant of the fact that the principal researcher is at the same time the founder of Action For Children (AFC) that has programs supporting over 1000 families in Kampala district, 80 of which are found in Kyanja Parish. In order to avoid a conflict of interest and prevent a situation of some families feeling obligated to participate in the study in order to please or gain favour from the organization, it was explained from the start of the study that the research did not belong to AFC. The principal researcher participated in the study as a student of the University of Victoria and not as founder of AFC. The research assistants did not act on behalf of AFC. The parish leader who assisted in identifying households for interviews acted in his capacity as an elected village leader. Finally, the criterion for selection of families to participate in the study was only with regards to the children's ages and not their participation in the organization's programs.

The consent process began with a letter addressed and delivered to the parish chairman soliciting his participation in introducing the research to the community. As the elected head of the village, the chairman solicited participation of the caregivers by word-of–mouth. Once prospective participants were identified, they were screened to determine whether they met eligibility requirements. Respondents were asked for their availability on the day of the interview, agreeing on the date, time and venue. This was followed with an appointment form indicating the name of the caregiver, names of child or children aged eight years in the household, and the village where a particular household is located. This mapping resulted in a list indicating locations and numbers of the respondents. The appointment form contained a section that was signed by all prospective respondents. In case of child respondents, both

children and caregivers signed the assent and consent forms respectively, signifying willingness and permission for the children to participate in the study (see Appendix 3, Form 1 and 2, and Appendix 4). An identification number was assigned to the village and the family to track the family's data in the study but not necessarily tracking personal information. An assurance was made in regards to total confidentiality. Where a respondent was unable to sign or write her or his name, a thumb print was valid.

3.2 Measures

3.2.1 Measurement scale.

This study used an adapted version of the Home Screening Questionnaire (Richter & Grieve, 1991; Brockington, Oates, George, Turner, Vostanis, & Sullivan, 2001) derived from the Home Observation for Measurement of the Environment (HOME) scale (Bayley, 1969 quoted in Richter, & Grieve, 1991; Elardo & Bradley, 1981); it is a tool that has been used in South Africa by Linda Richter and her colleague (Richter & Grieve, 1991). For the South African study, the Home Screening Questionnaire (HSQ) was translated from English into the local languages, Sizulu, Setswana and back to English for cross checking. The interviewers had to be language flexible in the face of a multilingual South African community.

While Richter and Grieve (1991) used the scale on infants, the HSQ was translated in local languages giving an example of a translation into a local African language. The scale was adjusted to suit children of eight as Totsika and Sylva (2004) adjusted the HOME to suit ages 3-6 years in their study on the early childhood home environment. In Kyanja Parish, the common language of the community is Luganda, the native language spoken in the central region of Uganda. And since the HSQ has been translated before into an African language, this study

questionnaire was suitably translated into Luganda, and adjusted to suit eight year olds, which is close to the six year olds in the Totsika and Sylva study (see Appendix 2).

The questionnaire was translated by an expert translator into Luganda, the language the respondents easily followed. A repeat translation back to English, and finally, into Luganda ensured that the original text content was left intact and correct. However, Kyanja being a semi-urban community, some questionnaire forms in English were available for respondents that would choose to respond in the English language.

3.2.2 Research instruments.

The data collection process used a structured questionnaire to gather historical data on children and their caregivers. The interviews included details on the events that took place in the children's lives from birth to eight years. Each questionnaire consisted of close-ended questions using a Likert scale, ranking, and Yes/No formats. The first page of the questionnaire contained instructions for the interviewer and for the respondents. The instructions were reminders extracted from the training for the researchers that was held three weeks before the survey. They included such items as being observant in case the respondent felt uncomfortable and wanted to stop the interview and in case there were questions the child felt uneasy to answer. The questionnaires sought data on the situation of the children using Form 1, and the caregivers using Form 2, as contained in Appendix 1 and 2 respectively.

3.2.2.1 Children's questionnaire.

The questionnaire contained 22 questions seeking information on who the child lived with, gender, age when they came to live in the home, school status, class, enrollment in ECD,

year and age at enrolment into ECD, class and performance in class. There was no question for age of the child because the age of eight was the sole criteria for inclusion in the study.

3.2.2.2. Caregivers' questionnaire.

The questionnaire's first page contains the instructions for the interviewer and the respondent. The rest of the pages sought information about the respondent's age, gender, education level and number of children in the home. The questionnaire then focused on the particular child aged eight in the home. If there were more than one, the caregiver answered questions for each child on a separate form. The questions addressed the education history of the child, parent status and life stress events in the household. Additional information included questions on HIV and AIDS in the household.

The respondents selected from the range of answers provided on the scale and if no answers were available, the respondents had an option of choosing 'other' and explained what that other option was.

3.3. Interviews

The data were collected by interviewing respondents in person. The children interviews lasted approximately 30 minutes while the caregiver interviews lasted approximately one hour, or more if there were additional children cared for by the same caregiver in the household. In each village, approximately 59 households were interviewed and a total of 1070 responses, from children and from caregivers, were obtained. Three households withdrew from the study after signing the consent form, and two children had left the communities before they could be interviewed. No particular reasons were given. The rest of the children respondents participated in the research with enthusiasm. They answered questions eloquently and whenever they needed

help, especially with numbers, the interviewer cross checked with the caregiver. The collected data were cleaned, removing incomplete questionnaires, correcting mistakes and sorting the questionnaires to match the caregiver and the child while preparing the data for computer entry and analysis.

3.4 Analysis process and variables

On completion of data collection and cleaning, the data were coded and entered in a computer using the Statistics Package for Social Sciences (SPSS). This process was followed with data merging. During the merger, each household was given a code that linked the caregiver and child in the same household. Data analyses were then conducted.

The study analysis is at three levels namely: descriptive, bivariate and multivariate. In the descriptive analysis, frequencies and the background characteristics of respondents are described. The variables considered at this level of analysis are the demographics of children and their caregivers. These are gender, ECD exposure, school status and class for children, and age, gender, and education level for the caregivers. The life stress variables for the caregivers are HIV and AIDS status. Other main variables included parents and others. This category was composed of single parents, or two-nuclear parent household. The second category was the grandparents and others. This category included children living with grandparents and any other caregiver besides parents. Other variables were number of children in household, number of children in ECD and school, and number of children impacted by HIV and AIDS.

The next level of analyses involved conducting bivariate analyses, such as Pearson correlations. Bivariate analyses were conducted to determine if relationships existed between the child and caregiver variables, ECD history, and school status, that is, entry into school, class in school, as dependent variables. In the multivariate logistic regression analysis, all significant

child and caregiver variables that predicted ECD exposure in the bivariate analyses were included. The independent variables included socio-demographic factors and home environment life stressors. ECD exposure was analysed at two levels: 0 = no ECD exposure, 1 = ECD exposure, the categories of ECD included: formal education operated by profit making organizations, and non-formal ECD implemented by a not-for-profit organization. All significant child and caregiver variables that predicted school entry in the bivariate analyses were entered in the model and analysed. All those who made it to school, were analysed at various levels: all significant child and home environment variables that predicted class and ECD exposure variables were assessed, and the age of enrolment, that also predicted class, was analysed. This led to predicting the variables with the strongest negative and positive effects on child entry in school, and child progression in class or grade. The next section provides the results of the study.

SECTION 4 RESULTS

4.1 Descriptions of results

4.1.1 Sample demographics.

A simple descriptive analysis was run on children and caregiver demographic variables. There were 455 households with children aged eight years old, but because there were some households with more than one child, the number of answered questionnaires was 535 for caregivers and 535 questionnaires for children. Therefore, the analysis procedure uses the number 535 for each set of respondents. The sample was composed of N= 449 (83.9%) female caregivers, N= 86 (16.1%) male caregivers, N= 265 (49.5%) female and, N= 270 (50.5%) male children. There were 1070 responses as shown in Table 1:

Table 1: Demographics of children and caregivers responses

	N=1070	
Category	**N**	**%**
Children		
Male	270	50.5
Female	265	49.5
Total	**535**	**100.0**
Caregivers		
Male	86	16.1
Female	449	83.9
Total	**535**	**100.0**

Out of the 535 caregiver responses received, 54 were taking care of two (2) children each aged eight years, 11 were caring for three (3) children aged eight, and one (1) respondent had five (5) children aged eight years old. The rest of the respondents, N= 389 (73%), had one child aged eight. Seventy two percent of the caregivers were aged below forty years, with only 3% of the

caregivers above 60 years old.

4.1.2 ECD exposure.

According to child reports, the children that ever enrolled in ECD were, N= 476 (89.1%) compared to N= 58 (10.9%) who had never enrolled in ECD, while the caregiver report put the number at N= 512 (95.7%) as enrolled in ECD compared to N= 23 (4.3%) who had not enrolled. Children reports indicated that the number of children that were enrolled in the formal ECD centres were, N= 454 (88.3%) compared to, N= 60 (11.7%) enrolled in the non formal ECD centers operated by AFC. The caregiver reports put the number as, N=455 (88.7%) in the formal compared to N = 58 (11.3%) in the non formal centers.

From the children report[3], the majority of the children, N= 254 (47.5) stayed in ECD for 1-2 years, but there is a substantial number, N= 112 (20.9%) who stayed for less than a year and another, N= 142 (26.5%) who stayed longer than two years. The majority of the children, N= 184 (35.9%) enrolled in ECD in 2007, followed by N=120 (23.4%) who registered in 2006, and N= 200 (39.2%) enrolled at age 5 years, followed by 4 years old, N= 141 (27.6%). When the children were asked what enabled them to stay in school an overwhelming majority reported they loved school, N=378 (72.8%), and a number of the children, N= 222 (42.7%) claimed that their performance in primary school was top, while others said it was middle, N= 198 (38.1%). There were also answers of lower performance, N= 86 (16.5%). And the reasons for good performance were given as having learnt reading and writing in ECD, N= 216 (48.5%), while others, N=138 (31%) said they learnt most of the work in ECD.

[3] The results reported in this paragraph are useful in highlighting characteristics of the children in the study. However, they were found insignificant in predicting education outcomes, therefore were omitted from the final model.

For the children who did not enrol in ECD, when asked why they did not enrol in ECD, the majority of the children responded they had no tuition fees, N= 13 (76.5%), but a majority of those without fees, N= 11 (68.8%), expressed they had a desire to enrol.

4.1.3 School status and class.

The majority of the children, N= 516 (96.4%), are in school, with the highest percentage enrolments in Primary two, N= 162 (31.4%), followed by Primary three, N=121 (23.4%). The rest of the children were enrolled in primary one, N=109 (21.1%), primary four, N= 65 (12.6%) and others were still in ECD, N= 43 (8.3%). The school grade results show that 60.9% of the children are below the expected standard grade of primary three, while 12.6% are above the grade, either in primary four or above.

4.1.4 Life stress events.

Caregiver data indicated that N= 369 (69.8%) reported no known major life stress events in the household, while N= 160 (30.2%) reported having a life stress event in the household. This question was only asked to the caregivers. The type of life stress events ranged from death of parents, N=55 (10.3%) to family migration N= 47 (8.8%). Others were divorce or separation, N = 14 (2.6%) and loss of job, N = 3 (0.3%).

Reports on the status of parents of children in the households revealed that N= 456 (86%) had both parents alive, while N = 18 (3.4%) had both parents dead. Others, N = 56 (10.6%), had one parent alive. The majority of the children lived with parents, N= 386 (72.3%), while others, N= 79 (14.8%) lived with grandparents. Some children, N = 69 (12.9%), live with other relatives such as aunts, uncles, stepmothers, and siblings. In regards to cause of death, HIV and AIDS

accounts for the highest number of deaths, N = 18 (25%), followed by death due to accidents, N= 17 (23.6%), and deaths due to Malaria, N = 15 (20.8%).

4.1.5 HIV and AIDS in the households.

In relation to HIV and AIDS in the household, N= 504 (95.1 %) reported no presence of HIV and AIDS in the household, while N= 26 (4.9%) reported there was a person in the household with HIV and AIDS. The person reported to be with HIV and AIDS was mainly a parent, N = 13 (39.4%), followed by other people in the household, N= 12 (36.4 %). The siblings reported to be living with HIV and AIDS were, N= 8 (24.2 %). Other people category included a nephew (N=1), granddaughter (N= 2), brother in law (N=1), aunt (N=1) to the caregiver as well as a 'none of the above' response of N=6.

On whether the children had been tested or not, the results showed that the majority, N= 474 (89.4%) had never been tested, while N=56 (10.6%) had been tested. Out of those tested, N= 48 (85.7%) were found negative, while N= 8 (14.3%) were positive. And of the children that tested positive, N= 6 (75%) were receiving anti-retroviral treatment, while N=2 (25%) did not receive the treatment.

4.2 Correlations

Correlation analyses were conducted between the predictors from the home environment life stress events to identify and eliminate non-significant variables before examining the contribution of significant predictors on the dependent variables of school status and class. Despite the presence of literature that suggests HIV and AIDS as a life stress factor on the home environment which is negatively associated with the progress of children in school (Hunter, 1994), no significant correlation was found between HIV and AIDS life stress variables and the

dependent variables of school status and class. Therefore, HIV/AIDS was omitted from the final model. However, other home environment life stress variables related or unrelated to HIV/AIDS, such as death of parent, loss of job and family migration, were found to be correlated with the dependant variables of school status and class. Caregiver variables of gender and number of children in the household were insignificant and were omitted from the model. Table 2 and Table 3 show the correlation results from the children and caregiver respectively.

4.2.1 Correlation results from the children reports.

Table 2: Correlations of demographic variables with ECD exposure and school outcomes

	1	2	3	4	5	6	7	8	9
1.ECD exposure									
2.Enrolment age	-.33**								
3.ECD category		-.12**							
4.School status	.32**	-.12**							
5.Class	.37**	-.43**	.12**						
6.Caregiver Age			-.17**						
7.Caregiver Education	.12**	-.15**	.16**	.17**	.17**				
8.Life stress	-.28**	.16**		-.14**	-.13**	.16**	-.16**		
9.Parent /other	.12**		.17**		.12**	-.38**		-.28**	

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

When correlations were done, it was found that parent status, that is, if the children lived with parents or not, was correlated with ECD exposure, that is, whether the children were enrolled in ECD or not, r = .12**, (p≤ .004). This means that children living with parents were more likely to report having been exposed to ECD than children not living with parents . Parent status was also correlated with the ECD category the children attend, that is, formal / non formal ECD, r = .17**, (p≤ .001. The children living with parents are more likely to attend the formal ECD centers.

The parent status, (that is, living in a parent headed household that is composed of either single parents or a two-nuclear parent household, as opposed to living in a grandparent headed household, which included children living with grandparents and any other caregiver besides parents), was found to be correlated with the class of the children, r = .12**, (p≤ .008). Children living with parents are more likely to progress in grades than children living with grandparents.

The educational level of caregivers was found to be correlated with the children's exposure to ECD, r = .12** (p≤ .005). The higher the education level of caregiver, the more likely the children will be exposed to ECD. Similarly, the education level of caregivers was correlated with the category of ECD the children attended, r =.16**, (p≤ .001). The higher the educational level of caregivers, the more likely the children will be in formal ECD centres. The education level of caregivers was however negatively correlated with children's age of enrolment into ECD, r =-.15**, (p≤ .001) meaning that the higher the education level of caregivers, the more likely the children will enrol in ECD at an early age, below four years.

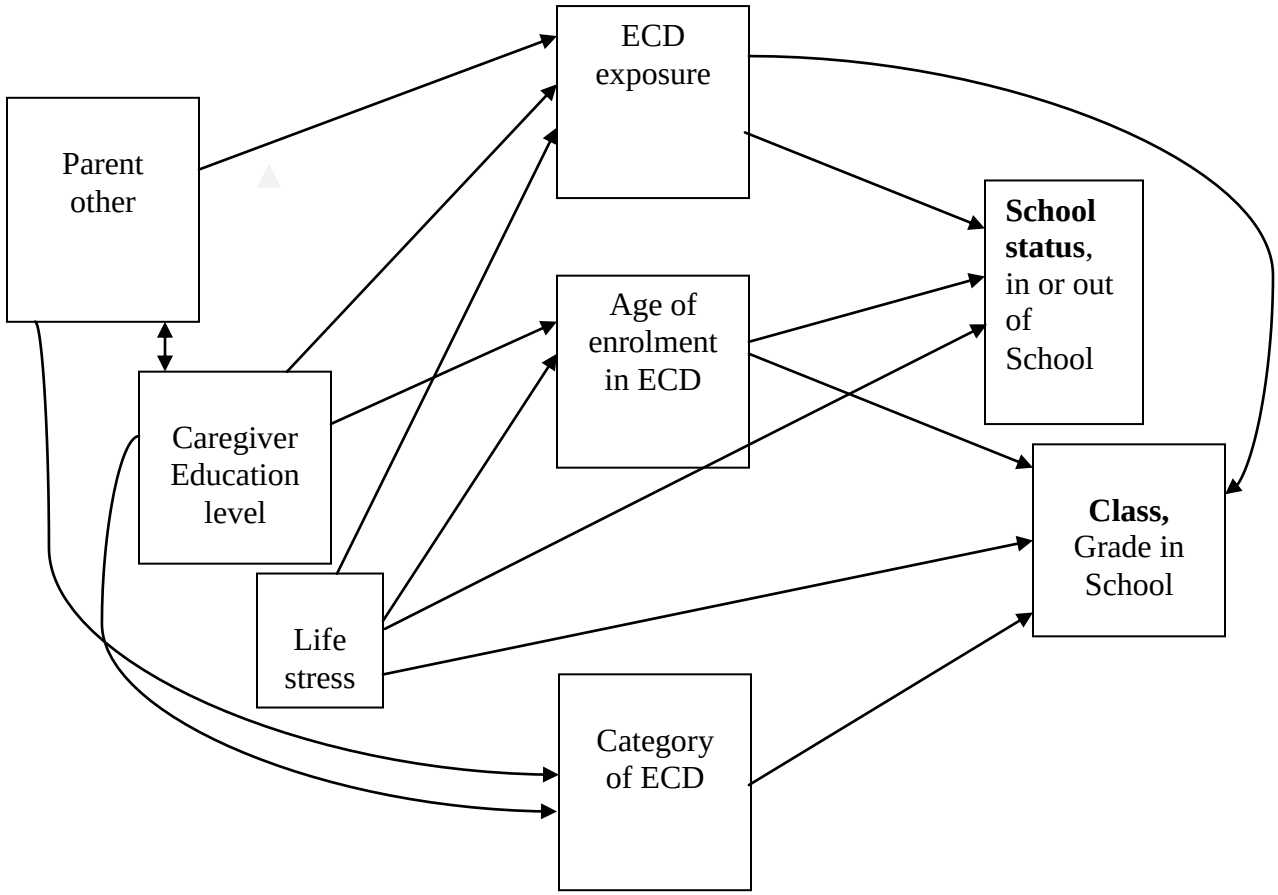
Life stress events in the household was negatively correlated with ECD exposure, r = -.28**, (p≤ .001), that is, children from households that report the presence of life stress events are more likely not to be enrolled in ECD. In addition, life stress events (i.e. one or more) in a household was negatively correlated with school status, r = -.14**, (p≤ .005); therefore, children in households with a life stress event are more likely to be out of school than children without a life stress event in the household. Similarly, life stress events in the households were also inversely correlated with class, r = -.13**, (p≤ .001), that is, children in households reporting life stress events, were more likely to be in lower grades or class levels. On the other hand, life stress events in the household was correlated with age of enrolment, r = .16**, (p≤ .001) so that

children in households that reported a life stress event were more likely to enrol in ECD at an older age.

ECD exposure, that is, if the child ever enrolled in ECD or not, and regardless of how long they stayed in ECD, was found to be correlated with school status, r =. 32** ($p \leq .001$); therefore, children exposed to ECD were more likely to be in school than children who had not been exposed to ECD and also more likely to be in higher grades since class correlated with ECD exposure, r = .37**, ($p \leq .001$). However, age of enrolment was negatively correlated with school status, r = -. 12**, ($p \leq .007$), so that children that enrolled in ECD at an early age were more likely to be in school and also be in higher grades than the policy stipulates as class is negatively correlated with age at enrolment, r = -.43**, ($p \leq .001$).

ECD category was correlated with class r = .12**, ($p \leq .006$). Children enrolled in formal centers were more likely to be in higher classes than children enrolled in non-formal centers. The revised hypothetical model in Figure 2 shows the results of the correlation analysis. It shows that all the variables, except the age of the caregiver, were significant and remained in the model.

Figure 3: Demographic variables correlated with school outcomes (child report)



4.2.2 Correlation results from the caregiver reports.

The correlation results based on the caregivers are presented in Table 3

Table 3: Correlations of demographic variables with children's education outcomes

	1	2	3	4	5	6	7	8	9
1.ECD exposure									
2.Enrolment Age									
3.ECD category									
4.School status	-.35**								
5.Class		-.30**							
6.Caregiver Age			-.18**						
7.Caregiver Education			.15**	.12**	.17**				
8.Life stress	-.18**			-.18**	-.16**	.16**	-.16**		
9.Parent /other			.15**			-.38**		-.28**	

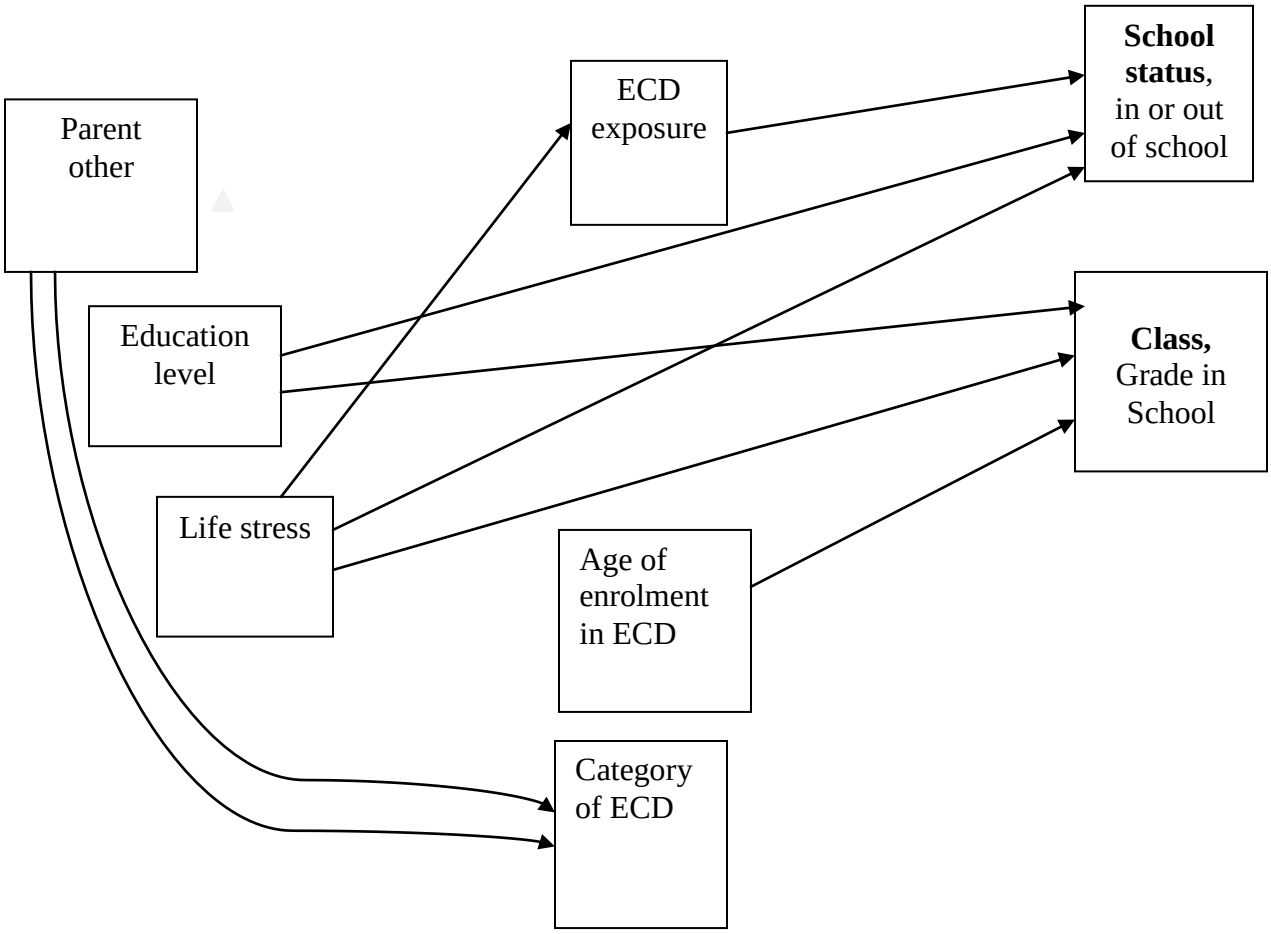
** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

In the responses provided by the caregivers, it was found that **e**xposure to ECD was correlated with school status, r = .35** ($p \leq .001$), signifying that the children exposed to ECD were more likely to be in school. In addition, the children living with parents were more likely to be in formal ECD centers than the non-formal centers. The parent variables correlated positively with category of ECD, r = .15**, ($p \leq .001$). The age of the children at enrolment in ECD was negatively correlated with class, r = -.30** ($p \leq .001$). This means that the children who enrolled in ECD at an early age were more likely to be in upper classes than those who enrolled at an older age.

The education level of the caregiver was found to be correlated with school status, r = 12** ($p \leq .005$). The higher the education level of the caregivers, the more likely the children were enrolled in school. Education level of parent was also correlated with ECD category, r = .15**, ($p \leq .001$), which meant that the higher the education level of parents, the more likely the children were enrolled in formal ECD centres, and the more likely the children were in upper grades as educational level of the caregiver also correlated with class, r = 17** ($p \leq .001$).

Life stress event was negatively correlated with school status, r = -.18** ($p \leq .001$). The households that reported the presence of a life stress event were more likely to have children out of school. Similarly, life stress events in households were negatively correlated with class, r = -16**, ($p \leq .001$). Children living in households that experienced life stress events were more likely to be in lower grades, and not to have been exposed to ECD as life stress event was negatively correlated with exposure to ECD, r = -18**, ($p \leq .001$). Based on the caregiver correlational results, a revised hypothetical model is presented in Figure 4. This model formed the basis for the regression analyses.

Figure 4: Demographic variables with children's education outcomes (caregiver report)



4.3 Regression analysis

4.3.1 Regression results from the children reports.

In the first stage of the analysis, the technique of hierarchical logistic regression analysis was used to predict the dependent variable of school status (in or out of school) with the socio-demographic predictors, that is, parent status, education level of caregiver, and life stress, entered in the first block, while ECD exposure was added in the second block. The results are shown in Table 4.

Table 4: Hierarchical logistic regression of children's home environment factors with school status (children report).

	Block 1		Block 2	
	OR	OR (95% C.I)	OR	OR (95% C.I)
Caregiver Demographics				
Parent other	0. 97	(0.36-2.67)	0.81	(0.28-2.35)
Education level	3.46**	(1.64-7.30)	4.08**	(1.71-9.73)
Life stress	0.31*	(0.12-.85)	0.69	(0.23-2.09)
ECD history				
ECD exposure			14.31***	(4.86-42.18)
Model χ^2	20.79		24.11	
Nagelkerke R^2	**.15**		**.31**	

Note: *p≤.05, **p≤.01, ***p≤.001

The final model was significant (χ^2 (4, N=528) = 44.89, p <.001) with the Nagelkerke R^2 showing that 31% of the variance was explained. In the first step of this model, the socio demographic domain predictors contributed significantly in the prediction of school status (χ^2 (3, N=528) = 20.79, p <.001) and the Nagelkerke R^2 statistic indicated that 14.5% of the variance in education status was explained. The Hosmer and Lemeshow Goodness of Fit test indicated that the model adequately fit the data (χ^2 (6, N=528) = 1.79, p <.94). Parents' education level and life stress were the two significant predictors of school status. Children having higher educated caregivers and lower life stress levels are more likely to be attending school.

In the second stage of the logistic regression analyses, the ECD exposure predictors were added. This block of predictors contributed significantly to the model (χ^2 (4, N=528) = 24.11, p <.001). The amount of variance explained was 30.6%. The Hosmer and Lemeshow Goodness of Fit test indicated that the model adequately fit the data (χ^2 (6, N=528) = 6.14, p <.41). Parent education level remained a significant predictor and the ECD exposure was also significant. Specifically, school attendance was associated with higher caregiver education and ECD exposure.

In the next stage of the data analysis, hierarchical linear regression analyses were used to test the multivariate relationships between the predictors of parent status, education level of parents, life stress, and class (grade level) of the children. This strategy allowed testing for possible mediated relationships. In this analysis, the socio demographic predictors in the model, i.e. parent status, education level of caregiver, and life stress were entered in the first block, while age at enrolment in ECD and ECD category were entered in the second block to predict class (grade level) of the children. The results are presented in Table 5.

Table 5: Linear regression of children's home environment factors with class (children report)

	Block 1 β	Block 2 β
Caregiver demographics		
Parent other	.07	.04
Education level	**.16*** **	**.11** **
Life stress	-.09	-.04
ECD exposure		
Age of enrolment		**-.39*** **
ECD category		**.05**
R^2 Change	**.05*** **	**.15*** **
R^2 Total		**.20*** **

Note: *p≤.05, **p≤.01, ***p≤.001

The overall regression model was significant (F = 7.71; df = 3, 493; p<, .001). In the first block of the regression analysis, the socio demographic predictors, parent status and life stress, explained 5% of the variance. The only significant predictor was the education level of the caregiver, β = .16*** and it explained 4.5% of the variance. In the second block, education level remains significant, β =.11**, and also age at enrolment is significant, β = -.39***.

The second block of predictors explained an additional 15% of the variance in class. The higher the educational level of caregivers, the more likely the children enrolled in ECD at an early age and the more likely the children are in higher class.

4.3.2 Regression results from the caregiver reports.

In the first regression model, the technique of hierarchical logistic regression analysis was used to predict the dependent variable of school status with the socio demographic predictors, that is, parent status, education level of caregiver and life stress were entered in the first block, while ECD exposure was added in the second block. The results of this analysis are shown in Table 6.

Table 6: Hierarchical logistic regression of children's home environment factors with school status (caregiver report)

	Block 1		Block 2	
	OR	OR (95% CI)	OR	OR (95% CI)
Caregiver Demographics				
Parent	1.30	(0.50-3.20)	1.23	(0.45-3.36)
Education level	2.06*	(1.05-4.06)	1.94*	(0.92-4.11)
Life stress	5.02**	(1.83-13.74)	3.53*	(1.21-10.31)
ECD history				
ECD exposure			.08***	(0.03-.23)
Model χ^2	20.66		38.68	
Negelkerke R^2	.14		.25	

Note: *p≤.05, **p≤.01, ***p≤.001

In the first step of this model, the socio demographic domain predictors contributed significantly in the prediction of school status (χ^2 (3, N=529) = 20.66, p <.001) and the Nagelkerke R^2 statistic indicated that 14% of the variance in education status was explained. The Hosmer and Lemeshow Goodness of Fit test indicated that the model adequately fit the data (χ^2 (6, N=529) = 3.32, p <.77).

Parents' education level and life stress were the two significant predictors of school status. Children having higher educated caregivers and lower life stress levels were more likely to be attending school.

In the second step of the logistic regression analyses, the ECD exposure predictors were added. This block of predictors contributed significantly to the model (χ^2 (4, N=529) = 18.03, p <.001), with the Nagelkerke R^2 statistic indicating that 25% of the variance was explained. The Hosmer and Lemeshow Goodness of Fit test indicated that the model adequately fit the data (χ^2 (6, N=529) = 6.82, p <.34). Parent education level remained a significant predictor and the ECD exposure was also significant. Specifically, school attendance was associated with higher caregiver education and ECD exposure. The final model was significant (χ^2 (4, N=529) = 38.68, p <.001) with the Nagelkerke R^2 showing that 25% of the variance was explained.

In the second regression model, hierarchical linear regression analyses were used to test the multivariate relationships between the predictors of parent status, education level of parents, life stress, and class according to the caregivers' reports. This strategy allowed testing for possible mediated relationships. In this stage of analysis, the significant predictors in the model, i.e. parent status, education level of caregiver, and life stress were entered in the first block, while ECD exposure and age at enrolment were entered in the second block. The results of this analysis are presented in Table 7.

Table 7: Linear regression of children home environment factors with class in school (caregiver report)

	Block 1 β	**Block 2** β
Caregiver Demographics		
Parent	.05	.03
Education level	.15***	.16***
Life stress	-.11*	-.13**
ECD exposure		
Age of enrolment		-.30***
ECD enrolment		-.01
R^2 Change	.04***	.09***
R^2 Total		.13***

Note: *p≤.05, **p≤.01, ***p≤.001

In the first block of the regression analysis, the socio demographic predictors, that is, parent status and life stress only explained 4% of the variance. The only significant predictor was the education level of the caregiver, $\beta = .15^{***}$ and it explained 4.4% of the variance. When the second block of predictors was entered, an additional 9% of the variance was explained with education level remaining significant $\beta = .16^{**}$, and age at enrolment also significant $\beta = -.30^{***}$. The higher the educational level of caregivers, the more likely the children enrolled in ECD at an early age and attained a higher class level in school. These predictors together explained 13% of the variance in class.

SECTION 5 DISCUSSION

The major findings from this study are: 1) Status of caregivers, that is, relationship to the child, and 2) educational level of caregivers are important variables in predicting children's transition from home to ECD and to school; 3) ECD history, that is, if the child attended ECD or not, child age at enrolment, and category of ECD is significantly related to school status, that is, if in or out of school and progress in class. 4) Life stress events in the household are significantly related to transition of children in school.

The information from this study is valuable for various individuals and groups. For example, primary caregivers will appreciate the value of enrolling their children in ECD realizing that such enrolment predicts grade progression. These results are similar to Myers' assertion (1992) that ECD attendance correlates with increased enrolment and retention in primary school. Another example is that policy makers can benefit from the knowledge generated that points to necessary policy changes and new policy formulations in ECD and in supports for home environments. One such policy issue concerns the age of enrolment in ECD. This study found that the earlier the children enrolled in ECD, even at age two to three, the better their transition into and through school.

The results of this study have revealed that 89.1% of the children were enrolled in ECD, most likely because of Kyanja's proximity to the urban area. The current situation differs from the years of 1999- 2000 during AFC's first entry into the community when ECD services were less available, with fewer than ten pre-primary centers in the entire parish (AFC, 2002). Of the children who were enrolled in ECD

during the period of the study, 84% were enrolled in the formal ECD centers. However, the formal ECD centers are deemed very expensive and unaffordable for many caregivers (NCC, 2006; AFC, 2008). In order for all families to benefit from ECD services, it is essential that ECD is affordable and accessible for all children. In Kenya, Njenga and Kabiru (2008) assert that the high cost of child care discourage caregivers from using formal care facilities, however in Kyanja parish, a high percentage of children attended formal centers. The difference may be that Kyanja community is a semi-urban community that has some features similar to urban centers, where formal pre-school charges can be affordable, except for severely disadvantaged children, specifically those living in households with non-biological caregivers and households reporting the presence of major life stress events. In such cases, less expensive non-formal care is an important option to have available.

This research has contributed to a better understanding of young children, their home environments, their association with early education, and their progress in schooling systems. The data is valuable to groups, societies, organizations that conduct educational programs because the research points out factors that these groups need to be aware of to improve the well being of the children in their care, among which is the status and education of the caregivers.

5.1 Characteristics of caregivers

The characteristics of caregivers display an important relationship with children's access to education. Children living with biological parents most likely have a higher level of enrolling in both ECD and primary school at an earlier age than children living with non biological caregivers.

A Save the Children Fund study (2006) found a correlation between adult illnesses leading to eventual death in a household and access to education of children in stressed households. The children who had lost parents went to school, although they enrolled at an earlier age, most likely due to lack of care at home but were cared for at school. In this study, most children living with non-biological caregivers were in school.

Caregiver and child gender in this study is not a significant predictor for educational transition patterns, an outcome similar to the findings of Njenga and Kabiru (2001) in Kenya and Hayden (2006) in Namibia. It could be argued that it is a result of having more than 80% of the respondent caregivers as females who have been traditionally considered child caregivers (UNESCO, 2010). In this study, the children, N=86, who were found living in households headed by male caregivers were equally in school, thus making gender an insignificant factor. Importantly, the insignificance of child gender in school attendance can be seen as a plus for the Millennium Development Goals (MDGs) 2000 whose target in education was elimination of gender disparity in school by 2015 (UNESCO, 2006).

The education level of the caregivers reflects a strong relationship with the access to and transitions within education for the children. The higher the education level of the caregivers, the more likely that the children were in school and in higher grades, while the reverse was also observed. Children in lower grades were found in households where caregivers had lower educational levels.

These findings are similar to conclusions by Birgit (2011) who analyzed whether pre-school education closes gaps in language abilities of children aged three to five with different social backgrounds. Birgit's study demonstrated that children of higher educated

parents improved their vocabulary more strongly than children with parents of lower educational level.

In a related vein, Kagitcibasi et al (2001) study of a Turkish semi-urban intervention found that compared to a control group, mothers who participated in a family enrichment and cognitive training program improved their mother-child interactions thereby enhancing the children's participation in early learning. In addition, low levels of maternal caregiver education, although a distal risk factor (Walker, et al., 2007), are likely to lead to offsprings that are exposed to inadequate dietary intake and unhygienic sanitation—risk factors as well in children's development.

In Uganda, literacy levels are as low as 57% (UBOS, 2010). This study suggests that one possible reason for low school enrolment across the country (60%) could be the low education level of parents. This supports earlier assertions (UNICEF, 2010; JLICA, 2009) emphasizing the association of the level of education of the household head with children's school enrolment and attendance. A recent study on the cognitive development of five year olds conducted in a semi-urban community of Entebbe, Uganda by Nampijja, et al. (2010) found that parents in urban parts of the country tended to send their children to school. The urban dwelling parents were found to be of a higher educational level than parents in rural areas, a possible reason for higher children enrolment's in early education programs in urban areas. Given such findings, the government policy may need to refocus awareness messages to target the education of caregivers in all parts of the country.

However, more research is needed to determine additional factors that influence school enrolment. While the education level of caregivers is one of the factors, this study found that ECD exposure can also be a part of the solution.

5.2 ECD exposure

5.2.1 Enrolment in ECD and primary school.

This study has revealed that children who attended ECD were more likely to be in school than those who never attended ECD. This result is consistent with a number of recent studies in the Majority (Developing) World (Birgit, 2011; Engle, et al. 2008; Fabian & Dunlop, 2007; Bernard van Leer Foundation, 2006; Biryetega & Brown, 2004; Njenga & Kabiru, 2001) which found that ECD promotes or encourages children to enroll in school. Proponents of ECD exposure (Woodhead & Moss, 2007; Garcia, Pence & Evans, 2008) assert that ECD bridges a gap between home and school and strongly influences children's enrolment in school. Children that were reported to have been exposed to ECD were more likely to be in school than children who were not exposed to ECD despite the presence of life stress events. It's also noted that all the predictors were mediated when ECD exposure was added to the model signifying that when children enrol in ECD, it reduces the effect of other predictors. It is this study's assertion that ECD enrolment, particularly as quality programming is advanced, is likely to be a stronger predictor in the future for school status than parent status, caregiver education level, or life stress events.

5.2.2 Category of ECD.

This research has revealed that the majority of children in the study were enrolled in formal ECD centres and these children were also in higher classes of school. This demonstrates the fact that ECD centers operated for profit had higher chances of enrolling children in primary school and maintaining progression to higher grades, than children enrolling in non formal, not-for-profit ECD centres, although family and home factors interacted with these results.

The type of ECD (formal or non formal) the children were enrolled in was correlated with the presence of life stress events in the household signifying that the category of ECD was a strong predictor of school status and class or grade level; for example, children who enrolled in formal ECD centers were more likely to reside in households less affected by life stress events such as HIV and AIDS and therefore more likely to be in school and in higher classes.

5.2.3 School Class Level.

The study revealed that class level was strongly predicted by ECD enrolment and children who had enrolled in ECD (and completed at least two years) were in higher grades than those who did not. Some children were in higher grades than the government expectations, that is, instead of Primary 3, many (12.5 %) were found in Primary 4 and some (3.1 %) in Primary 5. Despite the policies, children are still enrolled either earlier, or later, but the strongest predictor emerged as exposure to ECD (either category of ECD).

The largest group (34%) of the children were in Primary 2, a level below the expected government class level of Primary 3, and there were 21% still in Primary 1, and 7% in ECD. A total of 62% of the children in this study are below their expected class or grade level. Only 23% of the children were in the 'right' grade (Primary 3), the expected grade as per government policy. The Uganda government needs to review the current policies and assess their applicability. While the results of this study have pointed to stressed home environments, parent education, and age at enrolment as factors that predict school status and class level, further research is needed to establish more factors influencing children's grade levels such as, the influence of poverty, which was not specifically addressed in this study.

It is likely that a lack of tuition fees for primary school enrollment kept the children registered in ECD or enrolled in primary school late, after six years of age. In addition, parenting programs that include home visiting, information and skills sharing, income generation, and child-parent interaction have been found to result in higher test scores for children and therefore successful progression in class (Engle, et al. 2007). Variables such as these could be productively pursued in future research.

5.2.4 Age at enrollment.

One of the study's findings is that children who enrolled at an early age into ECD, some (35%) as early as two and three years of age, were more likely than those who did not, to be progressing in school and in higher classes. Early enrollment, even at the age of two or three years old, and staying longer, sometimes up to four years, has been found to result in more consistent and larger effects on child development. In addition, in the health sector, early stimulation at less than two years is believed to attenuate the effects

of malnutrition more than for children above two years. Food supplementation for two to three years olds, combined with community, and family programs with center-based initiatives, would produce better results than single components of either parenting programs or ECD centers, and these are also believed to improve cognitive levels more than intervention at later ages of four and above.

In the correlation analysis, age at enrollment is a negative predictor because the children are enrolling at an earlier age than prescribed by the government. This finding corresponds with the Uganda Demographic and Household Survey of 2010 (Ministry of Finance, Planning and Economic Development, 2010) that found 68% of the pupils who enrolled in primary one were below or above the age of 6 years.

There are limited studies relating to age of enrolment in Uganda, most likely due to limited availability of ECD services. The majority of ECD services in Uganda are for–profit at formal ECD centers.

5.3 Life stress events in the households

Life stress events had a negative impact on children's enrolment in both ECD and school. Thirty percent of all respondents reported a life stress event in the household ranging from death of parents (10%), migration of family (8.8%), divorce/separation of parents (2.6%), no money to pay school fees (2.6%), parent sick (2.4 %), loss of job (0.9%). It is important to recognize that the death of a parent had the highest percentage, a probable reason for the impact that life stress had on the education of the children. It is also notable that the cause of death was mainly from HIV and AIDS related causes (25%) as reflected in Table 8 below from caregiver report:

Table 8: Cause of death

Category	Frequency	Percent
HIV/AIDS	18	25.0
Accident	17	23.6
Malaria	15	20.8
Don't Know	14	19.4
Other	8	11.1
Total	**72**	**100.0**

Richter (2010), writing from a South African context that reflects some commonalities with Uganda, concludes that the lives of many young children are characterized by tenuous home environments. Walker, et al. (2007) note a belief that depressed mothers are less sensitive and more negative when interacting with infants, and maternal responsivity and sensitivity lead to higher infant cognitive ability and mothers attending programs that provide information on capabilities of their young children showed short term improvements in maternal behavior. Richter (2010), writing in a similar vein, clarifies that family and social relations, and opportunities to learn and succeed, are powerful counter forces. Even though they were not found to be statistically significant in this study, HIV and AIDS effects are nevertheless crucial to consider in undertaking child and family research in many parts of Africa.

5.4 HIV and AIDS in the households

While caregivers reported HIV and AIDS as a major cause of death in the households, HIV and AIDS presence in the households at the time of the study was low with only 5% of the households reporting its presence. In this study, HIV and AIDS had

no significant correlations with school enrolment and grade progression, but was significant in relation to HIV testing of children as reported in caregiver reports. The findings of this study are not consistent with assertions that children affected by HIV and AIDS have difficulty accessing educational services (Richter, Foster & Sherr, 2006; Hunter & Williamson, 1994), but confirms studies by UNICEF (2010) and Kasirye and Hisali (2009) who concluded that while in the past HIV and AIDS affected children may have missed school, SSA countries have made significant progress towards achieving consistent levels of school attendance. This study has found similar results that despite the presence of HIV and AIDS in the household, there was high school enrolment in the cohort and the disease did not affect school enrolment. Instead, the presence of life stressors in general, not necessarily HIV and AIDS alone, was a stronger predictor of age at school enrolment. The reasons may be due to the fact that children in households facing life stress events are more likely to be mobile, migrating from one household to another (Oleke, Blystad, Moland, Rekdal, & Heggenhougen, 2006). Therefore, those children are likely to be in lower classes arising from missed years or repetition, or that they keep enrolled in ECD, even at an older age. Engle et al. (2007) assert that interventions for young children affected by HIV and AIDS, such as, access to care, and community based child care have not been rigorously assessed. This study contributes to the knowledge base on access to ECD and its effect on the children's educational outcomes. It provides an assessment of ECD provision in life stressed households that include HIV and AIDS and the study found that ECD increases opportunities for children in school.

Although this study was not focused on how many people had died from HIV and AIDS related illnesses, a question was asked as to the cause of death if the child's parent was reported to be deceased. Finding 5% of households currently having an HIV and AIDS person in the household reinforces the veracity of reporting in the study as it is consistent with national data on HIV and AIDS. Current HIV and AIDS prevalence rate in Uganda is reported as 7.5 % for the whole country, with a range between 2.3%-8% (Uganda AIDS Commission, 2007). Secondly, the person reported to have HIV and AIDS was a parent (39%). This also compares positively with the national reports of HIV/AIDS as being higher among persons of child bearing age, likely to be the parents. According to the Uganda AIDS Commission (2007), 77% of all adult infections in males and 58% in women were among people aged 30 years and above.

This finding is important for policy implementers who target HIV and AIDS high risk populations, and are useful in regards to putting interventions in place for children affected by HIV and AIDS. Of those reported to be living with HIV and AIDS in the households, 24% were children. Walker, et al. (2007) emphasize that infected children risk delays in developmental domains especially language acquisition. This is another important aspect to consider in relation to communities similar to Kyanja, considering that the national prevalence rate is reported to be 0.7% among children (Uganda AIDS Commission, 2007). This is an opportune time to focus attention on young children with HIV and AIDS, especially intensifying PMTCT which reduces the number of babies born with AIDS so that medical resources that would be spent on AIDS-positive babies would be channelled to improving general child health. It should also be noted that six respondents gave no answer as to who had HIV and AIDS in the household. Further

research would be necessary to find out if stigma is prevalent in the community and a likely cause for non responses.

While Uganda as a nation has promoted voluntary counselling and testing (VCT) for more than ten years, this study still found that 89% of the children have never been tested for HIV and AIDS. Again this calls for more vigilance in HIV and AIDS. However, it also shows the people have the right to accept to go for testing or not and it is a positive sign that 11% have been tested. Fortunately, 86% of those tested were found negative, but 14.3% were found positive. Of the positive children, 75% were receiving anti retroviral (ARV) treatment, while (25%) did not receive treatment. This finding confirms what Engle, Dunkelberg and Issa (2008), pointed out that young children often fall through the cracks of existing HIV treatments, and further affirms UNICEF (2010) concern that children are diagnosed with HIV early in life but their test results are not collected, therefore the children are not enrolled for treatment. Further studies would be needed to determine what messages can reach the caregivers of HIV and AIDS infected children to encourage them to access paediatric ARV care, especially where the medicines are available and free.

In summary, while HIV and AIDS did not feature as a strong predictor of the transitioning of children, it is associated with life stress events that became negative predictors for children's transition in education. Secondly, the data provide a basis for researchers, policy makers and implementers to review and find suitable interventions in caring for people affected with HIV and AIDS, especially the children.

5.5 Strengths and limitations of the study

The strengths of this study are located in its retrospective, caregiver and child respondent design. It is most likely the first Ugandan study to provide such an extensive range of data on caregivers and children from the same household answering questions on similar topics. Secondly, it is a kind of a mini census where every household in Kyanja parish was reached by the research team. However, the only households where interviews were conducted were the households with children of the targeted age, eight year olds. This design and its implementation ensured that no eight year old child in Kyanja parish was left out. Such a high completion rate is due in a larger part to appointments being made at an appropriate period of time before the interviews.

Although some respondents were unavailable causing the research team to make repeated visits, almost all, except two cases where the children relocated out of the parish even after signing consent and assent forms, were available for interviews.

However, there are limitations to this study. First, the data base was comprised of participants who were found at home. The majority of the caregivers found at home were females as the males were often out to fend for the family. Despite the assertion that in HIV and AIDS impoverished communities, the females are the household heads, (Oleke et al. 2006), this study found the opposite. Households were headed by males, but the majority were not home for interviews as reported by the respondents. Increased involvement of males in caregiving and participating in research on children would have enriched the results of this study. Despite this, the males that were found at home and responded to the questionnaire (16.1%) provided good comparative data that is important to the research.

The data set did not include other possible predictor demographic variables such as income and employment, nor were other issues considered such as culture or ethnicity. The study did, however gather data on socio-demographic data that were relevant to the study such as age, gender and education level. Future research that integrates advanced multivariate inquiry would be beneficial to understanding the broader picture of caregiving, parenting, and education in an era of life stressors and socio-economic challenges such as limitations in income. Furthermore, the collection of data from schools may have provided more useful data, but such activity was outside this study's boundaries.

Limited data are available on transitioning of children over time. Further research would benefit from conducting a longitudinal study that would follow a cohort of children over time to provide a broader range of data examining relationships between home environments and educational participation. Such data could expand the discussion of the impact of home environments and life stressors on education.

The number of HIV and AIDS reported cases were fairly few. Therefore, the influence of HIV and AIDS on the transition of the children from home to ECD and on to school was not sufficient to allow for significant results but could allow for discussion of trends of HIV and AIDS in the households in comparison with the national trend.

5.6 Conclusion

The study has evaluated the relationship between home environment life stressors and found significant correlations with the education of young children. The importance of ECD services for young children has also been established. Variables significant for the enrolment and progression of children in school have been identified as caregiver

education level and parent status. This study has implications for government policies and priorities, some of which are considered below.

Family centred policies and programs that address the importance of early childhood development will improve children's well being while reinforcing the home environments' capacity to deal with life stress events. Lack of social-economic security prevents caregivers and children from reaping the benefits of interventions that could otherwise prove highly effective. Increasingly, the cumulative effects of home environment effects constrain households from providing children with needed educational opportunities.

Even when caregivers are strongly committed to sending children to school, their capacity to do so depends on social factors such as their own education level, access to local services, and the ability of biological parents to remain together to support their children. These factors become predictors of children's educational outcomes.

The government of Uganda has unmet responsibilities in supporting communities access to ECD and school. Government commitments, backed by strong new evidence on the importance of ECD and parental education levels, provide a historic opportunity to increase the effectiveness of a family centered policy. Interventions to promote ECD are cost effective investments to ensure that children are prepared for educational opportunities, thereby achieving the Millennium Development Goals of ensuring enrolment for both girls and boys (Engle, et al. 2007; UNESCO, 2000). Uganda could make a commitment for the future by investing in early childhood development.

The study provides a basis for further research in establishing the association of life stressing events in African households, events that may include HIV and AIDS. Such

studies will go a long way to improving the literature on the young child in Africa, Uganda in particular, and has the potential to improve the lives of young children, especially those living in resource constrained settings.

This study explored the related historical experiences, educational concerns of two critical groups of respondents whose voices are rarely heard: children and caregivers. In addition, merging the data strengthened the validity and reliability of the data, a strategy that has rarely been used in responding to the educational needs of children in Uganda.

Even though data were collected in only one parish, it is believed to be representative of certain other parishes in Uganda, and can be applied to other similar settings. While the study has its limitations, they have minimal adverse effects on the findings. The limitations can be utilized by other research agents to augment and expand the type of study undertaken, helping to build a larger, more diverse, and relevant literature on the young child in Africa.

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Appendices

Appendix 1 Questionnaires

Form 1: Questionnaire for children aged eight years old

Date ----------Name of interviewer----------
Village number ----------Household number----------
Child's number----------

Instructions for Interviewers

1. This is a segment of the child's interview. One form should be filled for each child aged eight years old in the home, whether biological, related, or unrelated to the primary caregiver.
2. If the child cannot recall some of the information, ask caregiver or elder sibling available.
3. Indicate the answers by circling the number representing the response provided by the child.
4. Have the supportive documents available - a copy of the consent form that was signed by the child's caregiver, the child and the parish chairman.
5. During the interview, if the child seems hesitant or uncomfortable, ask if they would like you to come back later or if they would like to stop the interview. Do not pressure them to continue the interview.
6. Read the instructions below to the children.

Instructions to Children

1. The purpose of this interview is to obtain information about your life experience at home and your progress in education. What you tell us will help us understand what children like you experience in education and therefore find ways to improve the education programs for young children in Kyanja parish.
2. I encourage you to answer all the questions because your responses are important to this study. I encourage you to be honest and tell me your true answers. If there are questions that you prefer not to answer, that is alright. If at any point during the interview you want to stop or postpone it to another time, that is also okay.
3. Your answers will be kept confidential. No one outside the research will know how you answered these questions.
4. Thank you for completing the interview.

No.	Question	Valid Response	Enumerator Instruction
1	Sex of respondent	1. Female 2. Male	
2	Who do you live with?	1. Grandmother 2. Grandfather 3. Mother 4. Father 5. Other (**Specify)**----------	**If the child is living with mother or/and father, skip to Qn. 4**
3	How old were you when you came to live in this home?	1. < 1 year 2. 1 year to 3 years 3. 4 years to 6 years 4. > 7 years 5. Don't know	
4	Do you attend school?	1. Yes 2. No	**If the answer is no skip to Qn. 8**
5	What is your class?	1. ECD 2. Primary 1 3. Primary 2 4. Primary 3 5. Other (**Specify grade)**----------	
6	What is the name of your school?		**State name**
7	On average, how many days per week do you go to school?	1. 1 day 2. 2 days 3. 3 days 4. 4 days 5. 5 days	
8	**(For children not in ECD)** Did you graduate from ECD?	1. Yes 2. No	**If answer is yes, skip to Qn. 11**
9	Why are you not in **(or why didn't you attend)** ECD?	1. No ECD in area 2. No one to take me to ECD center 3. No fees 4. Don't know 5. Other reasons (**specify)**-------	
10	In future, are you expecting that you will:		
	(a) Enrol in ECD?	1. Yes	

No.	Question	Valid Response	Enumerator Instruction
		2. No	
	(b) Enrol in primary school?	1. Yes 2. No	
	(C) Graduate from primary school?	1. Yes 2. No	
	If child is not in school, skip to question 19		
	If child is not in school, skip to question 19		
11	When did you enrol in ECD?	1. 2010 2. 2009 3. 2008 4. 2007 5. Other (**Specify)**----------	
12	How old were you when you enrolled in ECD?	1. Less than 4years 2. 4 years 3. 5 years 4. 6 years 5. More than 6 years	
13	How long did you stay in ECD?	1. Less than 6 months 2. 6 months to 1 year 3. 1 year to 2 years 4. More than 2 years.	
14	What is the name of your ECD?		**Categorize as non formal (AFC) or formal for all others**
15	What has enabled you to keep in school?	1. My guardian pays school fees 2. I love school 3. There is coaching (extra guidance in studying) at school 4. Don't know 5. Others (**specify)**----------	
16	What is your last grade report position in class?	1. Top 2. Middle 3. Lower 4. Other **(specify)**----------	
17	What are the factors that	1. I learnt most material from	

No.	Question	Valid Response	Enumerator Instruction
	have helped your performance?	ECD 2. I learnt reading and writing 3. I understand the language used in class 4. Other (**Specify)**----------	
18	**(For lower performance**) What are the factors that have affected your performance?	1. I don't understand the language 2. The material used is complicated for me 3. Sickly most times 4. Others (**Specify)**----------	
	End of interview for children in school		
	If child is not in school:		
19	Why are you not in school?	1. No school fees 2. No guardian to support me 3. It was my choice 4. Don't know 5. Others (**Specify)**----------	
20	What do you do while you are not in school?	1. Work in the gardens 2. Assist my caregiver at her project 3. Do casual jobs to earn money 4. Any other **(specify)**----------	
21	Has your caregiver ever requested you to go to school?	1. Yes 2. No	
22	Would you prefer to be in school than doing what you are doing now?	1. Yes 2. No	

Form 2: Questionnaire for primary caregivers

Date ----------Name of interviewer----------
Village number ----------Household number----------
Caregiver number----------

Instructions for Interviewers

1. This is a segment of the primary caregiver's interview. One form should be filled for each primary caregiver in the home.
2. Have the supportive documents available - a copy of the consent form that was signed by the primary caregiver and the parish chairman.
3. During the interview, if the caregiver seems hesitant or uncomfortable, ask if they would like you to come back later or if they would like to stop the interview. Do not pressure them to continue the interview.
4. Indicate the correct answers by circling the responses provided by the caregiver.
5. Read the instructions below to the primary caregiver.

Instructions to primary caregivers

1. The purpose of this interview is to obtain information about your life experience as a caregiver. What you tell us will help us understand what caregivers like you experience in caring for children and therefore find ways to improve programs for the care of young children in Kyanja parish.
2. I encourage you to answer all the questions because your responses are important to this study. I encourage you to be honest and tell me your true answers. If there are questions that you prefer not to answer, that is alright. If at any point during the interview you want to stop or postpone it to another time, that is also okay.
3. Your answers will be kept confidential. No one outside the research will know how you answered these questions.
4. Thank you for completing the interview.

No.	Question	Valid Response
1	What is your highest educational level attained?	1. No education 2. Primary level 3. Secondary level 4. Post secondary level 5. Other (**Specify)**
2	What is your age?	1. < 20 yrs 2. 20 – 29 yrs 3. 30 – 39 yrs 4. 40 – 49 yrs 5. 50 – 59 yrs 6. 60 – 69 yrs 7. > 69 yrs
3	Gender	1. Female 2. Male
4	How many children below 18 years old do you take care of in this home?	1. Below 1 2. 1 – 3 3. 4 – 6 4. Above 6
5	How many children below 8 years old do you take care of in this home?	1. Below 1 2. 1 – 3 3. 4 – 6 4. Above 6
6	How many children below 18 years old in this home are in primary school?	1. Below 1 2. 1 – 3 3. 4 – 6 4. Above 6
7	How many children below 8 years old in this home are in primary school?	1. < 3 2. 3 – 6 3. 7 – 10 4. 11 – 14 5. > 15
8	How many children below 8 years old in this home are in ECD?	1. < 3 2. 3 – 6 3. 7 – 10 4. 11 – 14 5. > 15
		The next questions are about the children aged eight years old living in this home
9	Did the child ever attend ECD	1. Yes 2. No 3. Don’t know

No.	Question	Valid Response
		If no skip to Qn. 14 **If don't know skip to Qn. 14**
10	What is the name of the ECD?	**Specify** **Categorize as non formal for AFC or formal for all others**
11	Which year did the child attend ECD?	**1. 2010** **2. 2009** **3. 2008** **4. 2007** **5. Other (specify)**
12	How old was the child when enrolled in ECD?	**1. < 2year** **2. 2 years** **3. 3 years** **4. 4 years** **5. > 4 years**
13	Why was the child enrolled in ECD?	**1. Was advised by community leader** **2. To free time for other cores** **3. For child to obtain preschool education** **4. Other (specify)**
14	Is the child currently enrolled in primary school?	**1. Yes** **2. No**
		If no skip to Qn. 19
15	What class is the child currently in?	**1. P 1** **2. P 2** **3. P 3** **4. P 4** **5. P 5**
16	Which year did the child enrol in primary school?	**1. 2010** **2. 2009** **3. 2008** **4. 2007** **5. 2006**
17	How old was the child when enrolled in primary school?	**1. < 4 years** **2. 4 years** **3. 5 years** **4. 6 years** **5. 7 years**
18	Are grade reports of the child available?	**1. Yes** **2. No**
		Skip to Qn. 20
19	Why isn't the child enrolled in primary school?	**1. No school fees** **2. Child is sickly most of the**

No.	Question	Valid Response
		time **3. Parents are sick** **4. Other (specify)**
20	Is there any other stressing event you know this child's family experienced?	**1. Yes** **2. No**
		If no skip to Qn. 23
21	What is /were the life stressing event(s)?	**1. Divorce of parents** **2. Separation of parents** **3. Remarriage of parents** **4. Destruction of family residential home** **5. Migration of family** **6. Loss of job for parents** **7. Any other (specify)**
22	Which year did that/these event(s) occur? (specify)	**1. 2010** **2. 2009** **3. 2008** **4. 2007** **5. 2006** **6. 2005** **7. 2004** **8. 2003** **9. 2002**
23	What is your relationship to the child?	**1. Parent** **2. Grandparent** **3. Elder sibling** **4. Other (specify)**
24	What is the status of the child's parents?	**1. Both parents alive** **2. Both parents dead** **3. Mother alive** **4. Father alive** **5. Other (specify)**
		If both parents alive, skip to Qn. 30
25	Which year did the child come to stay with you	**1. 2010** **2. 2009** **3. 2008** **4. 2007** **5. 2006** **6. 2005** **7. 2004** **8. 2003**

No.	Question	Valid Response
		9. 2002
26	If one or both parents is dead, which year did the death occur?	
(a)	Father's year of death	**1. 2010** **2. 2009** **3. 2008** **4. 2007** **5. 2006** **6. 2005** **7. 2004** **8. 2003** **9. 2002**
(b)	Mother's year of death	**1. 2010** **2. 2009** **3. 2008** **4. 2007** **5. 2006** **6. 2005** **7. 2004** **8. 2003** **9. 2002**
27	How old was the child when the death occurred?	**1. < 1 year** **2. 1 year** **3. 2 years** **4. 3 years** **5. 4 years** **6. 5 years** **7. 6 years** **8. 7 years** **9. Eight years**
28	What was the established cause of death?	**1. Malaria** **2. HIV/AIDS** **3. Accident** **4. Other causes (specify)**
29	Was the child in school at the time of the parent's death	**1. Yes** **2. No**
30	Is there any person in this home with HIV/AIDS?	**1. Yes** **2. No**
		If no, skip to Qn. 32
31	Who is the person living with HIV/AIDS in this family?	**1. Father** **2. Mother** **3. Siblings** **4. Others (Specify)**

No.	Question	Valid Response
32	Has the child been tested for HIV/AIDS?	**1. Yes** **2. No**
		If no, end interview
33	How old was the child when s/he was tested for HIV/AIDS	**1. < 1 year** **2. 1 year** **3. 2 years** **4. 3 years** **5. 4 years** **6. 5 years** **7. 6 years** **8. 7 years** **9. Eight years**
34	Is a test record available?	1. Yes 2. No
35.	What were the results of the test?	1. Negative 2. Positive
		If the results were negative, end interview here.
36.	Is the child receiving antiretroviral treatment?	1. Yes 2. No

Appendix 2 Translated sample

Olupapula 1: Ebibuuzo by'abaana ab'emyaka omunaana egy'obukulu (Children Questionnaire)

Ennaku z'omwezi---------- Amannya g'abuuza ebibuuzo ----------
Ennamba y'ekyalo---------- Ennamba y'amaka----------
Ennamba y'omwana----------

Endagiriro y'ababuuza ebibuuzo

1. Kino ky'ekitundu eky'ebibuuzo by'abaana. Olupapula lumu lwelulina okujjuzibwa ku buli mwana ow'emyaaka omunaana egy'obukulu mu maka, kakibe nti omwana muzaliranwa oba nga alina oluganda oba talina luganda kw'oyo amulabirira.
2. Omwana bw'aba nga ebimu ku bimubuuzibwa tabijjukira, buuza amulabirira oba mugandawe omukulu aliwo.
3. Okulaga okuddamu okutuufu, wetoolooze akasittale ku nnamba y'okuddamu kw'omwana.
4. Beera n'ebiwandiiko ebyetaagisa ebiriwo – gamba nga olupapula olulaga okukkiriza okubuuza omwana ebibuuzo nga luliko omukono gw'omulabirizi w'omwana, omukono gw'omwana, n'omukono gwa ssentebe w'omuluka.
5. Wakati mukubuuzibwa ebibuuzo, omwana bw'alabika nga tayagala kuddamu oba nga alabika teyewulira bulungi, mubuuze oba yandyagadde okomewo eddako oba okomye awo okubuuza ebibuuzo. Tokaka mwana kweyongera kuddamu bibuuzo.
6. Soma endagiriro y'abaana wansi.

Endagiriro y'abaana

1. Ekigendererwa ky'ebibuuzo bino kwekufuna ebikwata ku bulamubwo obw'eka era n'ebyokusomakwo. By'onotubuulira bijja kutuyamba okutegeera abaana abalinga ggwe byebayitamu mu kusoma kwabwe era n'okufuna engeri y'okugonjoola ebikwata ku misomo gy'abaana mu muluka gw'eKyanja.
2. Nkukubiriza okuddamu ebibuuzo byonna kubanga okuddamukwo kwamugaso eri okunoonyereza kuno. Nkukubiriza okubeera omwesimbu ombuulire okuddamukwo okutuufu. Bwewabaawo ebibuuzo by'otalyagadde kuddamu, ekyo kikkirizibwa. Singa owulira nga oyagala okubuuzibwa kukomekkerezebwe oba kwongezebweyo, ekyo nakyo kikkirizibwa.
3. Okuddamukwo kujja kukuumibwa n'obwegendereza. Teli muntu yenna agya kumanya ebyo by'onooba ezzeemu.
4. Weebale okumaliriza okuddamu ebibuuzo.

Olupapula 1: Ebibuuzo eby'abaana eb'emyaaka munaana egy'obukulu

	Ekibuuzo	**Okuddamu okutuufu**
1	Ekikula ky'ooyo abuuzibwa	1. Muwala 2. Mulenzi
2	Obeera n'ani?	1. Jjajja omukyala 2. Jjajja omusajja 3. Maama 4. Taata 5. Ekirala**(Nnyonyola)**
	Omwana bw'aba abeera n'omu kubazadde be (maama oba Taata) oba nga abeera nebazaddebe bombi, genda ku kibuuzo namba 4	
3	Walina emyaaka emeka mu kiseera kye watandikira okubeera wano?	1. Wansi w'omwaka gumu 2. Wakati w'emyaka 1 – 3 3. Wakati w'emyaka 4 – 6 4. Waggulu w'emyaka 7 5. Simanyi
4	Osoma?	1. Yee 2. Nedda
	Okuddamu bwekuba nti Nedda, genda ku kibuuzo namba 8	
5	Oli mu kibiina ki?	1. Mukulizo 2. Pulayimale esooka 3. Pulayimale y'okubiri 4. Pulayimare y'okusatu 5. Ekirala**(Nnyonyola)**
6	Essomero lyo baliyita batya?	
	Elinnya liwandiike	
7	B'woba ogerageranyizza, kussomero ogendayo ennaku mmeka buli wiiki?	1. Olunaku lumu 2. Ennaku bbiri 3. Ennaku ssatu 4. Ennaku nnya 5. Ennaku taano 6. Ekirala**(Nnyonyola)**
8	Wayita okuva mu kkulizo?	1. Yee 2. Nedda
	Okuddamu bwekuba nti Yee, genda ku kibuuzo numba 11	3.
9	Lwaki toli mu kkulizo oba nursery?	1. Tewali ECD mu kitundu 2. Sirina muntu yenna kuntwaala awali kkulizo 3. Sirina sente zakusasula 4. Ensonga endala **(Nnyonyola)**

		5. Simanyi
10	Osuubira gyebugya:	
(a)	okubeera mu kkulizo?	1. Yee 2. Nedda
(b)	okubeera mu pulaimale?	1. Yee 2. Nedda
(c)	okuyita pulayimale?	1. Yee 2. Nedda
	Genda kukibuzo namba 19	
11	Wayingira ddi mukulizo?	1. 2010 2. 2009 3. 2008 4. 2007 5. Ekirala(Nnyonyola)
	Ekibuuzo	**Okuddamu okutuufu**
12	Walina emyaka emeka mukiseera kyewayingirira kkulizo?	1. Wansi w'emyaka 2 2. Emyaka 2 3. Emyaka 3 4. Emyaka 4 5. Waggulu w'emyaka 4
13	Wamala emyaka emeka mu ECD?	1. Wansi w'emyezi 6 2. Wansi w'emyaka 2 3. Emyaka 2 4. Omwaka gumu 5. Wekati w'emyezi 6 n'omwaka 1
14	Elinnya lya ECD	
	Lambulula oba elina akakwate ku AFC oba ziri endala zonna	
15	Kiki ekikuwa obusobozi okubeera mussomero?	1. Omulabirizi wange ansasulira ebisale by'essomero 2. Njagala okusoma 3. Waliyo obuyambi obw'enjawulo mukuyigiriza kussomero 4. Ekirala(Nnyonyola) 5. simanyi
16	Wayita otya okusinziira ku Lipota gyewasemba okufuna	1. Waggulu 2. Wakatikkati 3. Wansi 4. Ekirala(Nnyonyola)
17	Bintu ki ebikuyambye mukuyitakwo?	1. Ebintu ebisinga nabiyigira ku kkulizo 2. Nayiga okusoma n'okuwandiika 3. Olulimi olukozesebwa mukibiina ndutegeera 4. Ekirala(Nnyonyola)
18	Bintu ki ebitaataganya okuyitakwo?	1. Olulimi olukozesebwa sirutegeera

		2. Ebikozesebwa mukusomesa bizibu gyendi 3. Mbeera mulwaddelwadde ebiseera ebisinga 4. Ekirala(Nnyonyola) **Komawano ebibuzo**
	Omwana bwaba ngatari musomero:	
19	Lwaki tosoma mu pulayimare?	1. Sirina bisale byassomero 2. Sirina muntu yenna kunsasulira 3. Kwali kusalawo kwange 4. Ekirala(Nnyonyola) 5. Simanyi
20	Okola ki nga toli mussomero?	1. Nkola mu nnimiro 2. Nnyamba omulabirizi wange mu by'akola 3. Nkola emirimu egya lejjalejja okufuna sente 4. Ekirala(Nnyonyola)
21	Omulabiriziwo yali akusabyeko okugenda kussomero?	1. Yee 2. Nedda
22	Walyagadde obeere kussomero okusinga n'okusigala awo w'oli kati?	1. Yee 2. Nedda

Weebale nnyo

Olupapula 2: Ebibuuzo by'abalabirizi (caregiver questionnaire)

Ennaku z'omwezi---------- Amannya g'abuuza ebibuuzo ----------
Ennamba y'ekyalo---------- Ennamba y'amaka----------
Ennamba y'omulabirizi----------

Endagiriro y'ababuuza ebibuuzo

7. Kino ky'ekitundu eky'ebibuuzo by'abalabirizi. Olupapula lumu lwelulina okujjuzibwa ku buli mulabirizi mu maka, kakibe nti omwana muzaliranwa oba nga alina oluganda oba talina luganda kw'oyo amulabirira.
8. Okulaga okuddamu okutuufu, wetoolooze akasittale ku nnamba y'okuddamu. Beera n'ebiwandiiko ebyetaagisa ebiriwo – gamba nga olupapula olulaga okukkiriza okubuuza ebibuuzo nga luliko omukono gw'omulabirizi w'omwana, omukono gw'omwana,
9. Wakati mukubuuzibwa ebibuuzo, abuzibwa bw'alabika nga tayagala kuddamu oba nga alabika teyewulira bulungi, mubuuze oba yandyagadde okomewo eddako oba okomye awo okubuuza ebibuuzo. Tokaka kweyongera kuddamu bibuuzo.
10. Soma endagiriro wansi.

Endagiriro y'abalabirizi

5. Ekigendererwa ky'ebibuuzo bino kwekufuna ebikwata ku bulamubwomwana era n'ebyokusomakwe. By'onotubuulira bijja kutuyamba okutegeera abaana abalinga ye byebayitamu mu kusoma kwabwe era n'okufuna engeri y'okugonjoola ebikwata ku misomo gy'abaana mu muluka gw'eKyanja.
6. Nkukubiriza okuddamu ebibuuzo byonna kubanga okuddamukwo kwamugaso eri okunoonyereza kuno. Nkukubiriza okubeera omwesimbu ombuulire okuddamukwo okutuufu. Bwewabaawo ebibuuzo by'otalyagadde kuddamu, ekyo kikkirizibwa. Singa owulira nga oyagala okubuuzibwa kukomekkerezebwe oba kwongezebweyo, ekyo nakyo kikkirizibwa.
7. Okuddamukwo kujja kukuumibwa n'obwegendereza. Teli muntu yenna agya kumanya ebyo by'onooba ezzeemu.
8. Weebale okumaliriza okuddamu ebibuuzo.

No	Ekibuuzo	Okuddamu okutuufu
1	Wasoma kutuukawa?	1. Sasomako 2. Pulayimale 3. Siniya 4. Okusinga ku ddaala lya siniya 5. Ekirala(Nnyonyola)
2	Olina emyaaka emeka?	1. Wansi w'emyaka 20 2. Okuva ku myaka 20 – 29 3. Okuva ku myaka 30 – 39 4. Okuva ku myaka 40 – 49 5. Okuva ku myaka 50 – 59 6. Okuva ku myaka 60 – 69 7. Waggulu w'emyaka 69
3	Ekikula kyo	1. Mukazi 2. musajja
4	Abaana bameka b'olabirira abali wansi w'emyaka 18 egy'obukulu mu maka gano?	1. Tebawera bataano 2. Okuva ku 5 – 9 3. Okuva ku 10 – 14 4. Okuva ku 15 – 19 5. Waggulu w'emyaka 19
5	Abaana bameka b'olabirira abali wansi w'emyaka 8 egy'obukulu mu maka gano?	1. Tebawera bataano 2. Okuva ku 5 – 9 3. Okuva ku 10 – 14 4. Okuva ku 15 – 19 5. Waggulu w'emyaka 19
6	Abaana bameka abali wansi w'emyaka 18 egy'obukulu mu maka gano abasoma mu pulaimale?	1. Tebawera 3 2. Okuva ku 3 – 6 3. Okuva ku 7 – 10 4. Okuva ku 11 – 14 5. Waggulu wa 15
7	Abaana bameka abali wansi w'emyaka 8 egy'obukulu mu maka gano abasoma mu pulaimale?	1. Tebawera 3 2. Okuva ku 3 – 6 3. Okuva ku 7 – 10 4. Okuva ku 11 – 14 5. Waggulu wa 15
8	Abaana bameka abali wansi w'emyaka 8 egy'obukulu mu maka gano abali mu kkulizo?	1. Tebawera 3 2. Okuva ku 3 – 6 3. Okuva ku 7 – 10 4. Okuva ku 11 – 14 5. Waggulu wa 15
	Ebibuuzo ebiddako bikwata ku baana abalina emyaka munaana	6.

	egy'obukulu ababeera mu maka gano	
9	Omwana yali agenzeko mu kkulizo?	1. Yee 2. Nedda 3. Simanyi
	Okuddamu bwekuba Nedda oba Simanyi genda ku kibuuzo namba 14	
10		
	Lambulula oba elina akakwate ku AFC *(formal)* oba ziri endala zonna	

	Ekibuuzo	**Okuddamu okutuufu**
11	Mwaka ki omwana gwe yabeerako mu kkulizo?	1. 2010 2. 2009 3. 2008 4. 2007 5. Ekirala(Nnyonyola)
12	Omwana yalina emyaka emeka weyayingirila mu kkulizo?	1. Wansi w'emyaka 2 2. Emyaka 2 3. Emyaka 3 4. Emyaka 4 5. Waggulu w'emyaka 4
13	Lwaki omwana yayingizibwa mu kkulizo?	1. Abantu ab'omukitundu bebatuwa amagezi 2. Okumuwa akadde okukora kubuvunaanyizibwa obulala 3. Omwana okusobora okufuna okuyigirizibwa nga tanayingira ssomero 4. Ekirala(Nnyonyola)
14	Omwana kati ali mu pulayimale?	1. Yee 2. Nedda
15	Mwaka ki omwana gweyayingiriramu pulayimale?	1. 2010 2. 2009 3. 2008 4. 2007 5. 2006
16	Omwana yalina emyaka emeka weyayingiriramu pulayimale?	1. Wansi w'emyaka 4 2. Emyaka 4 3. Emyaka 5 4. Emyaka 6 5. Emyaka 7
17	Omwana ali mukibiina ki kati?	1. P.1

		2. P.2 3. P.3 4. P.4 5. P.5
18	Lipoota z'okuyita kw'omwana weziri?	1. Yee 2. Nedda
	Ebibuuzo ebiddako bikwata ku baana abalina emyaka munaana egy'obukulu ababeera mu maka gano	3.
19	Omwana lwaki tasoma pulayimale?	1. Tewali sente zakusasulayo 2. Omwana abeera mulwadde ebiseera ebisinga 3. Abazadde balwadde 4. Ekirala(Nnyonyola)
	Okuddamu bwekuba Nedda oba Simanyi genda ku kibuuzo namba 14	5.

No	**Ekibuuzo**	**Okuddamu okutuufu**
20	Waliyo ebintu ebirala ebitaataganya by'omanyi ebyali butuuse ku maka omwana ono gye yakulira?	1. Yee 2. Nedda
	Okuddamu bwekuba Nedda, buuka ogende ku kibuuzo namba 23	3.
21	Kiki ekyo/Biki ebyo ebyataataganya obulamu bw'abomumaka?	1. Okugattululwa kw'abazadde 2. Okwawukana kw'abazadde 3. Okugattibwa okw'omulundi ogw'okubiri okw'abazadde 4. Okusanyizibwawo kw'amaka 5. Okusenguka 6. Okugobwa kw'omuzadde kumulimu 7. Ekirala(Nnyonyola)
22	Ekintu ekyo/ebintu ebyo byatuukawo Mwakaki?	1. 2010 2. 2009 3. 2008 4. 2007 5. 2006 6. 2005 7. 2004 8. 2003 9. 2002
23	Omwana omuyita otya?	1. Muzaddewe

		2. Jjajja 3. Mugandawe omukulu 4. Ekirala(Nnyonyola)
24	Ebikwata ku bazadde b'omwana	1. Bombi balamu 2. Bombi bagenzi/baafa 3. Maama mulamu 4. Taata mulamu 5. Ekirala(Nnyonyola)
	Abazadde bombi bwebaba nga balamu, buuka ogende ku kibuuzo namba 31	6.
25	Omwana yetandika ddi okubeera naawe?	1. 2010 2. 2009 3. 2008 4. 2007 5. 2006 6. 2005 7. 2004 8. 2003 9. 2002

No	**Ekibuuzo**	**Okuddamu okutuufu**
26	Bwekiba nti omu ku bazadde oba bombi baafa, mwakaki?	
	(a)Omwaka taata gweyafiiramu	1. 2010 2. 2009 3. 2008 4. 2007 5. 2006 6. 2005 7. 2004 8. 2003 9. 2002
	(b)Omwaka maama gweyafiiramu	1. 2010 2. 2009 3. 2008 4. 2007 5. 2006 6. 2005 7. 2004 8. 2003 9. 2002
27	Omwana yalina emyaka emeka omuzadde weyafiira?	1. 2010 2. 2009 3. 2008

		4. 2007 5. 2006 6. 2005 7. 2004 8. 2003 9. 2002
28	Kiki ekyaviirako omuzadde okufa?	1. 2010 2. 2009 3. 2008 4. 2007 5. 2006 6. 2005 7. 2004 8. 2003 9. 2002
29	Omwana yali mussomero mukiseera omuzadde weyafiira?	1. Yee 2. Nedda

No	**Ekibuuzo**	**Okuddamu okutuufu**
30	Eliyo omuntu yenna mumaka gano alina akawuka akaleeta obulwadde bwa mukenenya?	1. Yee 2. Nedda
	Okuddamu bwekuba Nedda, buuka ogende ku kibuuzo namba 33	
31	Ani alina akawuka akaleeta obulwadde bwa mukenenya mu maka gano?	1. Taata 2. Maama 3. Abaana 4. Ekirala(Nnyonyola)
32	Omwana yakebezebwa?	1. Yee 2. Nedda
33	Omwana yalina emyaka emeka mu biseera bye yakeberebwamu?	1. Wansi w'omwaka 1 2. Omwaka 1 3. Emyaka 2 4. Emyaka 3 5. Emyaka 4 6. Emyaka 5 7. Emyaka 6 8. Emyaka 7 9. Emyaka 8
34	Ebyaava mukukeberebwa kw'omwana webiri?	1. Yee 2. Nedda
35	Biki ebyazuulibwa mukukeberebwa kw'omwana?	1. Alina akawuka 2. Talina kawuka

	Ebyaava mukukeberwa kw'omwana bwebiba nga byali biraga nti omwana talina kawuka kaleeta mukenenya, komya wano okubuuza ebibuuzo.	
36	Omwana afuna obujjanjabi obw'amakerenda agakendeeza ku kawuka akaleeta obulwadde?	1. Yee 2. Nedda

Weebale nnyo

Appendix 3 Consent form

Form 1: Informed consent and confidentiality agreement form (caregiver)

1.0 Topic: Impact of HIV and AIDS on young children transitioning from home to ECD and on to school in Kyanja parish, Kampala, Uganda.

2.0 Principal investigator: Jolly P. Tumuhairwe Nyeko

3.0 Introduction

Jolly Nyeko is a student in the department of Child and Youth Care at the University of Victoria, and you may contact me if you have further questions by calling 256-712-80 62 92 or 256-414-54111, or jtnyeko@uvic.ca.
As a graduate student, I am required to conduct research as part of the requirements for a PhD degree in Child and Youth Care. It is being conducted under the supervision of Prof. Alan Pence of the University of Victoria, BC, Canada.

4.0 Purpose of the study

The purpose of this research project is to assess the factors that predict the educational progress of young children aged 8 years old.

The research of this type is important because it will highlight factors that policy makers and practitioners need to consider in improving the education of the young children.

5.0 What you are being asked to do

You are being asked to participate in this study because you live in Kyanja parish and you are caring for a child of eight years old. The age of eight has been selected as an age when children are graduating from ECD and lower primary to upper primary school, and yet a very formative age in the child's development.
If you agree to voluntarily participate in this research, your participation will include agreeing on the time of the interview, signing a consent form, responding to some questions related to the education of the child. The interview will not go beyond one hour, and will be conducted preferably at your home. There are also some questions that will be answered by your child after your consent has been granted.

Participation in this study may cause some inconvenience to you, including recalling some stressful events that may have occurred in the home such as death through HIV and AIDS related illnesses. This might bring you some emotional feelings.
To prevent these risks, the research has arranged counseling services that will be available to you free of charge at the Kyanja Social centre in case of need.

6.0 Benefits

The potential benefits of your participation in this research include understanding the relevancy of ECD to your child and also understanding how your child is progressing in grades. The community will understand the importance of ECD, learn the impacts of HIV/AIDS and therefore respond to mitigate its impact.

The study will contribute to the state of knowledge and understanding of the impacts of HIV/AIDS on young children, its association with transitioning of children in school, and relevancy of ECD exposure in promoting transition of young children.

7.0 Confidentiality

Your confidentiality and the confidentiality of the data will be protected by using codes in replacement of names, storing all data in a locked cabinet accessible only to the principal researcher, and electronic data will be in a password protected computer. Data from this study will be disposed of by shredding all questionnaire answer sheets after a final report has been reviewed by the university, and all electronic data will be erased.

8.0 Voluntary participation and withdrawal

Your participation in this research is completely voluntary. You have the right to withdraw from the research at any time and without any consequence by informing Jolly Nyeko or the chairman of the village before the appointed date of the interview.

9.0 Compensation/costs

No costs will be incurred by the respondent. .

10.0 Contact persons

You are encouraged to ask any questions you may have about this study. If you have any questions later please feel free to contact Jolly Nyeko at P.O. Box 3042, Kampala, Uganda. Tel No. 256-712 8062 92, or 256 414 541111, email jtnyeko@uvic.ca

11.0 Your Consent

You will receive a copy of this consent form. Your signature below indicates that you understand the purposes and procedures of this study and that you agree to participate.

If you are Ok with participating in this study kindly sign your name on the line below.

This form has been read to me and I agree to participate in this study.

Signature of the participant ---------- date ----------

Name and Signature of the interviewer/person obtaining consent

---------- date----------

Name of witness----------Date----------

Form 2: Children's informed assent and confidentiality form

1.0 Topic: Impact of HIV and AIDS on young children transitioning from home to ECD and on to school in Kyanja parish, Kampala, Uganda.

2.0 Principal investigator: Jolly P. Tumuhairwe Nyeko

3.0 Introduction

Jolly Nyeko is a student in the department of Child and Youth Care at the University of Victoria, and you may contact me if you have further questions by calling 256-712-80 62 92 or 256-414-54111, or jtnyeko@uvic.ca.
As a graduate student, I am required to conduct research as part of the requirements for a PhD degree in Child and Youth Care. It is being conducted under the supervision of Prof. Alan Pence of the University of Victoria, BC, Canada.

4.0 Purpose of the study

The purpose of this research project is to assess the factors that predict the educational progress of young children aged 8 years old.

The research of this type is important because it will highlight factors that policy makers and practitioners need to consider in improving the education of the young children.

5.0 What you are being asked to do

You are being asked to participate in this study because you live in Kyanja parish and you are eight years old.
If you agree to participate in this research, your participation will include signing this form and responding to some questions related to your education. The interview will be about thirty minutes, and will be conducted preferably at your home. There are no risks anticipated in participating in this study.

6.0 Benefits

The potential benefits of your participation in this research include understanding the relevancy of ECD to you and also understanding how you are progressing in school grades. The community will understand the importance of ECD, learn the impacts of HIV/AIDS and therefore respond to mitigate its impact.

7.0 Confidentiality

The answers you will give will be kept confidential and the data will be protected by using numbers instead of names, and no one else will have access to the data except the main researcher.

8.0 Voluntary participation and withdrawal

Your participation in this research is purely voluntary. You have the right to withdraw from the research at any time and without any consequence by informing Jolly Nyeko before the appointed date of the interview.

9.0 Compensation/costs

No costs will be incurred.

10.0 Contact persons

You are encouraged to ask any questions you may have about this study. If you have any questions later please feel free to contact Jolly Nyeko at P.O. Box 3042, Kampala, Uganda. Tel No. 256-712 8062 92, or 256 414 541111, email jtnyeko@uvic.ca

11.0 Your acceptance

You will receive a copy of this form. Your signature below indicates that you understand the purposes and procedures of this study and that you agree to participate.
If you are Ok with participating in this study kindly sign your name on the line below.

This form has been read to me and I agree to participate in this study.

Signature of the participant ---------- date ----------
Name and Signature of the interviewer/person obtaining consent
---------- date----------

Name of witness----------Date----------

Appendix 4 Translated sample of consent form (Caregiver)

Olupapula 1: Kukukkirizakwo era n'okubikkirilwa

1.0 Omulamwa: Amakulu g'obulwadde bwa mukenenya ku baana abajjibwa okuva mu maka okudda mu kkulizo okuda ku mussomera Kyanja parish, e Kampala, mu Uganda.

2.0 Okulira okunonyereza: Jolly P. Tumuhairwe Nyeko

3.0 Ennyanjula

Ndi muyizi mu kitundu eky'ekitongole ekikwata ku by'abaana mu ttendekero lya yunivasite ya Victoria, era oyinza n'okwogerako nange bw'oba olina ebibuuzo nga okubira ku ssimu +256-712-80 62 92 oba +256-414-54111, oba ku email: jtnyeko@uvic.ca.

Nga omuyizi asoma ng'alina digiri, netaagisibwa okukola okunoonyereza nga ekimu kubisanyizo okufuna digiri ey'obwa dokita mu ndabirira y'abaana n'abavubuka. Okunoonyereza kuno kukolebwa wansi wa kakensa (Polof. Alan Pence ow'ettendekero elya yunivasite ya Victoria, BC, mu Canada. Oyinza kwogeraganyako ne kakensa wange ku ssimu (250) 721 6299.

4.0 Ekigenderelwa ky'okunonyereza kuno

Ekigendererwa ky'okunoonyereza kuno kwekugerageranya ensonga ezifumiitiriza ku by'ensoma y'abaana abato abalina emyaka 8 egy'obukulu.

Okunoonyereza okw'ekika kino kwamugaso kubanga kulaga ensonga ezo abakozi b'amateeka era n'abagateeka munkola zebetaaga okutunulamu mukulongoosa eby'ensoma y'abaana abato.

5.0 Kiki ekikusabibwa okukola

Osabibbwa okwenyigira mukunoonyereza kuno kubanga obeera mu muluka gw'ekyanja era olina emyaka munaana egy'obukulu.
Bw'oba okkiriza okwetaba mukunoonyereza kuno, kijja kukwetagisibwa okuteeka omukonogwo kulupapula olulaga nti okkirizza wansi ku bbaluwa eno, n'okuddamu ebimu kubibuuzo ebikwata ku by'emisomogyo. Okubuuzibwa kujja kutwala eddakiika nga asatu era kyandibadde kirunji okubuuzibwa kukolebwe ewakawo. Teri buzibu bwonna busuubirwa kubawo singa on'etaba mukunonyereza kuno.

6.0 Okuganyulwa / emigaso

Okuganyulwa okusuubirwa okuva mukwetabakwo mukunonyereza kuno kulimu okutegeera obukulu bwa ECD gy'oli era n'okutegeera engeri gy'okolamu kossomero. Abantu abalala bajja kutegeera omugaso gwa ECD, okuyiga ebyo ebiva mu ndwadde ya

silimu era n'olwekyo banonye engeri y'okubukwatamu mukwanukula ebyo ebibukwatako.

7.0 Okubikkirilwa mukyama

Okuddamu kwo kujja kukuumibwa nga kwakyama era nebyonaddamu bijja kukuumibwa nga byakyaama nga tukozesa ennamba mukifo ky'amanyago, era teli muntu mulala yenna ajja kusobola kubituukako ngogyeko okulira okunonyereza kuno.

8.0 Eddembelyo mukwetaba n'okukomya okubuuzibwa

Okwetabakwo mukunoonyereza kuno kiva mukusalawokwo. Oliwaddembe okukomya okwetabakwo mukunonyereza kuno mukiseera kyonna era newatabaawo buzibu bwonna nga otegeezezako Jolly Nyeko nga ekiseera ky'okubuuzibwa tekinnatuuka.
Okusasulwa

9.0 Okusasulwa

Tewali

10. Abantu b'oyinza okutuukirila

Okubirizibwa okubuuza ebibuuzo byonna by'oyinza okubanabyo ebikwata ku kunonyereza kuno. Singa on'oba olina ebibuuzo eddako, oliwa ddembe okutuukirila Jolly Nyeko ku P.O. Box 3042, Kampala, Uganda. Tel No. 256-712 8062 92, oba 256 414 541111, email jtnyeko@uvic.ca

11. Okukkirizakwo

Ojja kuweebwa olupapula olulaga okukkirizakwo okwetaba mukunonyereza kuno. Omukonogwo wansi kulupapula luno gulaga nti otegedde ensonga era n'emitendera gy'okunonyereza kuno era nti okkirizza okukwetabamu.
Bwoba oli mweteefutefu okwetaba mukunonyereza kuno, mwattu teeka omukonogwo ku kasittale ako wammanga.
Ebiri kulupapula luno binsomeddwa era nzikirizza okwetaba mukunonyereza kuno.

Omukonogw'oyo aneetaba---------- ennaku z'omwezi----------

Amannya n'omukono gw'oyo abuuza / afuna okukkirizakwo----------

Olupapula 2: kukukkirizakwo era n'okubikkirilwa (Translation for children assent form)

1.0 Omulamwa: Amakulu g'obulwadde bwa mukenenya ku baana abajjibwa okuva mu maka okudda mu kkulizo okuda ku mussomera Kyanja parish, eKampala, mu Uganda.

2.0 Okulira okunonyereza: Jolly P. Tumuhairwe Nyeko

3.0 Ennyanjula

Ndi muyizi mu kitundu eky'ekitongole ekikwata ku by'abaana mu ttendekero lya yunivasite ya Victoria, era oyinza n'okwogerako nange bw'oba olina ebibuuzo nga okubira ku ssimu +256-712-80 62 92 oba +256-414-54111, oba ku email: jtnyeko@uvic.ca.

Nga omuyizi asoma ng'alina digiri, netaagisibwa okukola okunoonyereza nga ekimu kubisanyizo okufuna digiri ey'obwa dokita mu ndabirira y'abaana n'abavubuka. Okunoonyereza kuno kukolebwa wansi wa kakensa (Polof. Alan Pence ow'ettendekero elya yunivasite ya Victoria, BC, mu Canada. Oyinza kwogeraganyako ne kakensa wange ku ssimu (250) 721 6299.

4.0 Ekigenderelwa ky'okunonyereza kuno

Ekigendererwa ky'okunoonyereza kuno kwekugerageranya ensonga ezifumiitiriza ku by'ensoma y'abaana abato abalina emyaka 8 egy'obukulu.

Okunoonyereza okw'ekika kino kwamugaso kubanga kulaga ensonga ezo abakozi b'amateeka era n'abagateeka munkola zebetaaga okutunulamu mukulongoosa eby'ensoma y'abaana abato.

5.0 Kiki ekikusabibwa okukola

Osabibbwa okwenyigira mukunoonyereza kuno kubanga obeera mu muluka gw'ekyanja era olina emyaka munaana egy'obukulu.

Bw'oba okkiriza okwetaba mukunoonyereza kuno, kijja kukwetagisibwa okuteeka omukonogwo kulupapula olulaga nti okkirizza wansi ku bbaluwa eno, n'okuddamu ebimu kubibuuzo ebikwata ku by'emisomogyo. Okubuuzibwa kujja kutwala eddakiika nga asatu era kyandibadde kirunji okubuuzibwa kukolebwe ewakawo. Teri buzibu bwonna busuubirwa kubawo singa on'etaba mukunonyereza kuno.

6.0 Okuganyulwa / emigaso

Okuganyulwa okusuubirwa okuva mukwetabakwo mukunonyereza kuno kulimu okutegeera obukulu bwa ECD gy'oli era n'okutegeera engeri gy'okolamu kossomero. Abantu abalala bajja kutegeera omugaso gwa ECD, okuyiga ebyo ebiva mu ndwadde ya silimu era n'olwekyo banonye engeri y'okubukwatamu mukwanukula ebyo ebibukwatako.

7.0 Okubikkirilwa mukyama

Okuddamu kwo kujja kukuumibwa nga kwakyama era nebyonaddamu bijja kukuumibwa nga byakyaama nga tukozesa ennamba mukifo ky'amanyago, era teli muntu mulala yenna ajja kusobola kubituukako ngogyeko okulira okunonyereza kuno.

8.0 Eddembelyo mukwetaba n'okukomya okubuuzibwa

Okwetabakwo mukunoonyereza kuno kiva mukusalawokwo. Oliwaddembe okukomya okwetabakwo mukunonyereza kuno mukiseera kyonna era newatabaawo buzibu bwonna nga otegeezezako Jolly Nyeko nga ekiseera ky'okubuuzibwa tekinnatuuka.

9.0 Okusasulwa

Tewali

10.0 Abantu b'oyinza okutuukirila

Okubirizibwa okubuuza ebibuuzo byonna by'oyinza okubanabyo ebikwata ku kunonyereza kuno. Singa on'oba olina ebibuuzo eddako, oliwa ddembe okutuukirila Jolly Nyeko ku P.O. Box 3042, Kampala, Uganda. Tel No. 256-712 8062 92, oba 256 414 541111, email jtnyeko@uvic.ca

11.0 Okukkirizakwo

Ojja kuweebwa olupapula olulaga okukkirizakwo okwetaba mukunonyereza kuno. Omukonogwo wansi kulupapula luno gulaga nti otegedde ensonga era n'emitendera gy'okunonyereza kuno era nti okkirizza okukwetabamu.
Bwoba oli mweteefutefu okwetaba mukunonyereza kuno, mwattu teeka omukonogwo ku kasittale ako wammanga.

Ebiri kulupapula luno binsomeddwa era nzikirizza okwetaba mukunonyereza kuno.

Omukonogw'oyo aneetaba---------- ennaku z'omwezi----------

Amannya n'omukono gw'oyo abuuza / afuna okukkirizakwo

---------- olunaku----------