****

**GLOSSARY**

**ISR–**Instute for Social Research under the Cabinet of Ministers of the Republic of Uzbekistan

**United Nations Population Fund –**the fund aims to ensure universal access to sexual and reproductive healthcare (including family planning), promote reproductive rights, reduction of maternal mortality.

**World Health Organization** (**WHO)** is the leading organization in coordinating health care activities within the United Nations Organization with a leading role in resolving global health issues.

**Cluster** is the group of several homogenous elements, which may be considered as an independent unit with intrinsic properties.

**Mahalla** is a local citizen's self-governing body (a community). Mahalla in an urban area and rural citizen's convention unites people regardless of their social and ethnic background. The term “mahalla”has been adopted in our country to ensure uniform reference to a neighborhood. A mahalla is not part of government administration agencies.

**Household** is a group of people (or one person) living in the same premises and sharing all their income and material assets (or their part) and jointly incurring expenses on consumption of goods and services, mainly, the accommodation and food. The members of the household do not necessarily have to be related through kinship or otherwise.

**Family** is an association of people based on marriage related through common daily lives and mutual responsibility.

**Wellbeing** means availability to the populationof material and social wealth, including cultural goods, i.e., goods, services and conditions that satisfy certain human needs.

**Adolescent** is a boy or girl at the age of transition from childhood to youth.

**Healthy lifestyle** is a lifestyle of a human being aimed at prevention of diseases and strengthening health with main components such as:

* development of healthy habits and skills from early childhood;
* environment: safe and supportive living environment, knowledge about the impact of adverse environmental factors on health;
* smoking cessation, avoidance of drug and alcohol abuse;
* healthy nutrition: moderate nutrition in line with physiological properties of an individual and awareness about the quality of foods to be consumed;
* physical activity: a physically active life including special physical exercises adapted for specific age and individual physiological characteristics;
* personal and public hygiene: a set of rules of hygiene, compliance and the implementation of which contributes to the preservation and promotion of healthand includes knowledge of first aid.

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# INTRODUCTION

The Republic of Uzbekistan places a significant emphasis on building healthy families and bringing up a harmoniously developed and healthy generation. During the years of independence, the country has been undertaking large scale and highly important efforts in order to achieve this long-cherished goal.

Nationwide activities include activities dedicated to improvement of health and achievement of the primary goal – “Healthy Mother – Healthy Child.”

The broad idea “Healthy Mother – Healthy Child” is implemented in partnership with state and public organizations andhealthcare and educational institutions through programs aimed at improvement the health of women of fertile age and adolescents. Young people are explained the importance of healthy lifestyles, reproductive health as well as health hazards of smoking, drug abuse and other harmful habits, principle of achieving spiritual and physical perfection.

Harmonious development is one of the most important child and adolescent health indicators. Harmonious development is promoted through properly organized physical education and sports for children and young people.

Adoption of the Presidential Decree of the Republic of Uzbekistan dated 24 October 2002, the Resolution of the Cabinet of Ministers of the Republic of Uzbekistan “On Organizing the Activities of the Fund for Childhood Sports Development”dated 31 October 2002, and Presidential Decree of the Republic of Uzbekistan “On Measures to Improve the Activities of the Fund for Childhood Sports Development”dated 29 August 2004 enabled fully-fledged implementation of measures dedicated to shaping and strengthening the health of the younger generation in the country

The country has been creating all necessary conditions for physical education and sports activities in each mahalla and every family. Sports movement among school children and young people has made strides in the development. The state program “The Year of a Healthy Child” (2014) ensures further improvement of the legislative framework, strengthening of family relationships, enhancing the role and responsibility of the health system, education and sports, as well as state and public structures to form healthy and harmoniously developed generation –our children and young people.

In this regard, it is of immediate interest to monitor the formation of reliable and high-quality information about the health of the population, first of all, that of the younger generation through conducting specialized sociological research. In particular, identifying the knowledge of children and young people about their health, family values, significance of sport for health through the subjective evaluation is of specific practical interest.

It is common knowledge that statistics does not allow for complete assessment of quality of delivered health care, especially, the subjective perception of its quality by the population. These facts as well as information about women including women from socially vulnerable populations, who for various reasons fail to undergo regular health checkups, can be gathered only with the help of specialized random sample surveys. Regular household surveys are the optimal and prompt way of gathering information on a broad range of questions about health care including maternal health, which is crucial in identifying needs of families and services they require.

It is still relevant to improve access to quality information about the health of the population, primarily, the access of the young generation to such information as without knowing their attitude to own health, family values, their subjective assessment, quality and access to physical education and sports, implementing the successful policy of protecting public health becomes challenging. This is especially important for further mainstreaming of sports among adolescent girls to boost their health, harmonious development and to prepare them to start their adult and family lives.

When it comes to nurturing a healthy generation, it is appropriate to remember the statement, which is well recognized by the people and has become a noble call to action: “A healthy child is, as a rule, born to a healthy and close-knit family”. Sports are the best way to build such families, - said the President of Uzbekistan, Islam Karimov. – Boys and girls, who go in for sports, are noted for their robust health and common sense. In the future, they will raise their children in the same spirit. The more such families, the stronger is the healthy atmosphere in the society”.

“Bringing up a healthy generation is creating a foundation for a glorious state and the frameworks of a successful life”. The President, Islam Karimov, made these statements in the early years of independence and they determined the main goal of the country and priorities of the national policy for the future. This being said, Uzbekistan set a fundamental and noble goal during the first days of independence to guide efforts in the long run: our children should be smarter, stronger, wiser, and, indeed, happier than us.

**The goal of this project is to develop specific proposals to develop** reproductive health attitudes, healthy lifestyles as well as commitment and need to exercise and go in for sports of adolescent boys and girls.

The stated goal determined the following *objectives* of the project:

- to hold a sample survey of households in the city of Tashkent, the Republic of Karakalpakstan, Surkhandarya, Namangan and Syrdarya provinces to assess the attitudes and practices of adolescents in relation to maintaining a healthy lifestyle including the importance of health and a healthy lifestyle in the value system of parents;

- to identify attitudes and practices of parents in relation to how well their children maintain a healthy lifestyle and their access to information on reproductive health, prevention of STIs and HIV;

- to ascertain the nature of children’sdaily consumption of foods that ensure their physical, mental and psychological development;

- to determine families’ demand for exercise and sports;

- to assess current conditions for doing sports near place of residence and study;

- to prepare evidence-based proposals about improving effectiveness of currently implemented measures to protect the health of children and their mothers;

- to develop a set of measures to advocate and promote healthy lifestyles, medical awareness of the population based on findings of qualitative assessment by experts (leaders of mahalla committees, school managers and teachers, health workers) of the extent of adolescent involvement in exercise and sports; existing objective and subjective issues and challenges that impede the maintenance of healthy lifestyles including involvement of adolescents into exercise and sports.

The findings of household surveys in selected regions of the country served as the informational background for this research.

# Section 1. SURVEY METHODOLOGY AND SAMPLE DESCRIPTION

The sociological survey consisted of several stages:

**Stage 1.** *Exploring methodological basis of foreign and national experience in holding surveys of shaping healthy lifestyles among adolescents*.

The works of the Center for Reproductive Health, the Republican Scientific and Practical Center “Oila” (“Family”), “Ijtimoiy Fikr” Center for the Survey of Public Opinion, and publications of researchers in periodical scientific journals of “Ijtimoiy Fikr”, “Sog’lom Avlod Uchun” and others were scrutinized. In addition, reports and memoranda of international organizations including those of the UN Population Fund were reviewed.

Modern approaches and dimensions in exploring various components and factors that influence the shaping of healthy lifestyles in adolescents, sources of national and international statistics, findings of sociological surveys in other countries and opportunities for their implementation in the context of Uzbekistan were considered.

**Stage 2.** *Conducting the sociological survey.* The sample included families with children aged 10-19 years in urban and rural areas, where first choice of the respondent choice was a mother of children aged 10-19 years, while the second choice of the respondent in the absence of the mother was a father, a caregiver or another person who takes care of their upbringing. The respondents were surveyed **individually** observing the anonymity of the respondent’s personality and confidentiality of the interview content.

Taking the available information basis into consideration, samples at the level of specific territories (districts, towns, mahallas) were organized in line with the following sequence:

– the first step involved selection of districts (towns) according to an established methodology, i.e., selection of at least 25% from their total quantity considering demographic and geographic specifics and concentration of families;

– the second step entailed sampling unit identification among urban and rural mahallas or rural citizen’s conventions (RCC) (clusters), which are part of selected administrative district;

– the third step – selection of household – was based on random sampling of 10 households within a mahalla (stepwise sampling).

Sampling parameters, which comply with aforementioned technique, are shown in Table 1.

**Table 1.1.Sample size identification**

| Regions | Resident Population Size as of  1 January 2013, thousand people | Number of Households, thousand HH | Number of Districts and Towns with *Hokimiyats*(district/town hall) – K | Sample of Districts and Towns (at least, 25% of K) | Number of Clusters  (Nv/20) | HH Sample Size Taking the Number of HH in the Region (Nv) |
| --- | --- | --- | --- | --- | --- | --- |
| Republic of Karakalpakstan | 1736,2 | 370,5 | 16 | 3 | 9 | 180 |
| Namangan Province | 2805,2 | 710,1 | 16 | 3 | 12 | 240 |
| Surkhandarya Province | 2863,4 | 609,7 | 14 | 3 | 12 | 240 |
| Syrdarya Province | 763,7 | 188,9 | 11 | 3 | 9 | 180 |
| Tashkent City | 2351,8 | 691,4 | 12 | 3 | 12 | 240 |
| **Total** |  |  |  | **15** | **54** | **1080** |

The project implementers conducted the survey using the Questionnaire developed with due consideration of goals and objectives of the survey (Annex 1). The main questionnaire includes five sections with open and closed questions:

(1) demographic characteristics of surveyed households;

(2) lifestyle and nutrition;

(3) health;

(4) education, physical culture / sports;

(5) reproductive attitudes and harmful habits;

as well as annexed individual questionnaire “Reproductive Health and Reproductive Attitudes” for men or women aged under 49 years (Annex 2).

Table 1.2. **Distribution of qualitative properties of the survey**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Visit Outcome** | | | **Respondent’s Gender** | |
| **Total for the Survey** | **Completed the Main Questionnaire and the Annex** | **Only Completed the Main Questionnaire** | **Male** | **Female** |
| Total for the Survey | 1080 | 966 | 114 | 83 | 997 |
| Urban | 538 | 492 | 46 | 37 | 501 |
| Rural | 542 | 474 | 68 | 46 | 496 |
| Republic of Karakalpakstan | 180 | 157 | 23 | 29 | 151 |
| Namangan Province | 240 | 219 | 21 | 8 | 232 |
| Surkhandarya Province | 240 | 226 | 14 | 29 | 211 |
| Syrdarya Province | 180 | 145 | 35 | 14 | 166 |
| Tashkent City | 240 | 219 | 21 | 3 | 237 |

The survey indicators for the visits are shown in Table 1.2. There were a total of 1080 visits: 538 – in urban area and 542 – in rural area. Women prevailed among the respondents (92.3%) both in urban (93.1%) and in rural (91.5%) areas. The visit outcomes included completion of the questionnaire for all respondents and the annex for 90% (966) of the respondents.In terms of regions, there were 240 visits each in Tashkent city, Namangan and Surkhandarya provinces and 180 visits each in the Republic of Karakalpakstan and Syrdarya province.

Table 1.3. **Characteristics of surveyed HH members, by gender, persons**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Gender** | | | **Adolescents** |
| **Total for the Survey** | **Male** | **Female** |
| Total for the Survey | 5828 | 2898 | 2930 | 1976 |
| urban | 2886 | 1382 | 1504 | 966 |
| rural | 2942 | 1516 | 1426 | 1010 |
| Republic of Karakalpakstan | 956 | 489 | 467 | 328 |
| Namangan Province | 1454 | 730 | 724 | 420 |
| Surkhandarya Province | 1274 | 630 | 644 | 495 |
| Syrdarya Province | 897 | 456 | 441 | 305 |
| Tashkent City | 1247 | 593 | 654 | 428 |

As shown in Table 1.3, a total of 5828 HH members were surveyed: 2898 men (49.7%) and 2930 women (50.3%). Adolescents made up 33.9% of the surveyed. Women prevailed among the surveyed urban respondents (52.1%) and men prevailed among surveyed rural respondents (51.5%). Adolescents amounted to 33.5% in urban and 34.3% in rural areas. Across regions, men and women were equally surveyed with the exception of Tashkent City, where more women were surveyed (52.5%). As for adolescents, fewer were surveyed in the Namangan Province (28.95) and more in the Surkhandarya Province (38.9%).

Analysis of the education level showed respondents with secondary education prevailed among the survey subjects, whose percentage amounted to 41.7%, while 31.1% of the surveyed had no education (given the fact that one of the household selection criteria was the choice of families with adolescent children, there was a large number of respondents without any education or preschoolers and schoolchildren), 16.9% of the respondents had secondary (school) education, and 10.3% had higher (Table 1.4)

Table 1.4. **Educational attainment of the surveyed HH members, %**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Education** | | | |
| **None** | **Secondary (School)** | **Secondary Special** | **Higher** |
| Total for the Survey | 31,1 | 16,9 | 41,7 | 10,3 |
| urban | 31,5 | 17,0 | 37,5 | 13,9 |
| rural | 30,6 | 16,8 | 45,6 | 6,9 |
| Republic of Karakalpakstan | 31,8 | 12,9 | 43,3 | 12,0 |
| Namangan Province | 33,8 | 24,7 | 38,6 | 2,9 |
| Surkhandarya Province | 32,9 | 12,9 | 44,0 | 10,2 |
| Syrdarya Province | 24,7 | 19,3 | 48,0 | 8,0 |
| Tashkent City | 29,7 | 12,8 | 37,3 | 20,2 |

The place of residence determined the significant difference among respondents with higher education. Thus, there were 13.9% respondents with higher education in urban areas and whose number is more than two times greater than among similar respondents, who live in rural areas (6.9%). There were more respondents with specialized secondary education in rural areas (45.6%) than in urban areas (37.5%).

The analysis of the respondents’ employment status showed that 5.7% were preschoolers, 26.0% - schoolchildren, 11.0% - students of vocational colleges and academic lyceums, 1.3% - university students (twice more in urban settings), 16.6% - work by hire, 4.2% - entrepreneurs (more that twice as many in urban settings), 5.6% - pensioners (more that twice as many in urban settings) and the others (Figure 1.1).

**Figure 1.1. Description of the surveyed HH members’ employment, %**

Across regions, there were more students in the Republic of Karakalpakstan and Tashkent City, morepersons working by hire in Tashkent City (22.4%) and fewer in the Namangan Province (6.0%). There were more farmersin the Republic of Karakalpakstan, more people employed at dehkan farms in the Namangan Province (6.2%), and people working abroad in the Namangan (3.4%) and Surkhandarya (2.7%) Provinces. There were more homemakers in the Namangan Province (14.3%) and fewer the Surkhandarya Province (6.0%), while the Surkhandarya Province (3.3%) had the largest number of person who neither study nor work and the Syrdarya Province had the highest number of the unemployed (3.0%). The Namangan Province and Tashkent City had the most pensioners (8.2% and 8.1%, respectively).

# Section 2. MATERNAL AND CHILD HEALTHCARE POLICY AND ACHIEVEMENTS IN THE REPUBLIC

Legal, economic and social protection of motherhood and childhood just as creating conditions for improving the wellbeing of families, their social and financial status as well as ensuring the harmonious development and wellbeing of the younger generation are priority areas of Uzbekistan’s national policy.

Currently, the aim of ongoing healthcare reforms is to ensure wellbeing of the population and to promote and maintain healthy lifestyles. Nurturing the harmoniously developed generation and creating the modern healthcare system that complies with international standards is the key impetus for the healthcare reforms. Healthcare reforms in Uzbekistan are gradually implemented considering high relevance of the sector for the socioeconomic life of society.

The legal and regulatory framework for the sector was the first and foremost foundation for the sector-specific reforms. Over the years of independence, 14 laws, 20 edicts and decrees of the President of the Republic of Uzbekistan and more than 100 Resolutions of the Government were adopted, among which instruments aimed at respecting the rights of women and children, taking care of the younger generation, protecting their health, preventing infectious diseases, improving primary health care, and efficient functioning of the specialized high-tech care have special importance.

It is noteworthy that the Convention on the Rights of the Child was one of the first international treaties acceded by Uzbekistan and ratified by the Parliament on 9 December1992, while the first national order of merit of the independent state approved in 1993, became the “Sog’lom Avlod Uchun” (“For Healthy Generation”).

The country is implementing a number of targetednationalprograms in the area of mother and child healthcare and nurturing a healthy generation; further consolidation and improvement of efforts to strengthen reproductive health, give birth to a healthy child, shape a physically and spiritually developed generation.

At present, Uzbekistan has a well-established countrywide network of maternity hospitals and child healthcare facilities equipped with state-of-the-art medical and diagnostic equipment both in urban and in rural areas. Over 99% of births take place with the participation of skilled health workers.

The country has put in place a uniform system of specialized healthcare delivery for children consisting of the Republican Specialized Scientific and Practical Medical Center for Pediatrics and 13 provincial children’s multi-profile medical centers. The Government pays great attention to the development and strengthening of these centers. The national investment program provides for construction of new and rehabilitation of existing healthcare facilities. Modern diagnostic and therapeutic equipment is procured using the proceeds of foreign loans and grants, in particular, those from the German Government.

The Republican Specialized Scientific and Practical Medical Center for Obstetrics and Gynecology and its four regional branches, the republican and ten perinatal centers deliver specialized high-tech health care to mothers and newborns. The Republican Specialized Scientific and Practical Medical Center for Obstetrics and Gynecology was equipped with advanced medical equipment within the frameworks of a join project with the Government of Japan. Highly skilled human resources of the Center ensure provision of the entire range of diagnostic and treatment services in line with world standards. The republic is implementing an effective method of providing care to mothers and children following the principle of regionalization, i.e., patients should receive healthcare services depending on their condition and the extent of his/her ailments and diseases in a relevant healthcare facility (on primary, secondary or tertiary levels).

With the view of building healthy families and reducing the number of possible hereditary diseases, the country has introduced a system of mandatory prenuptial medical clearance in relation to a number of illnesses such as HIV infection, tuberculosis, mental, substance-abuse related and venereal diseases, congenital and hereditary diseases for persons intending to enter a marriage to prevent birth of children with disabilities. To this end, the National Program “Mother and Child Screening” has been implemented since 1998 upon the initiative of the President of the Republic of Uzbekistan.

All regions of the country have set up modern screening centers equipped with necessary laboratory equipment, diagnostic analyzers, and staffed skilled human resources for prevention of congenital and hereditary illnesses.

Thirty percent of all pregnant women and almost 100% of women in risk groups are annually covered with prenatal screening enabling prevention of birth of 2,000 children with congenital and hereditary illnesses per year.

With the view of building healthy families and reducing the number of possible hereditary diseases, the country has introduced a system of mandatory prenuptial medical clearance in relation to a number of illnesses such as HIV infection, tuberculosis, mental, substance-abuse related and venereal diseases, congenital and hereditary diseases for persons intending to enter a marriage to prevent birth of children with disabilities. Thus, in line with the Resolution of the Cabinet of Ministers dated 25 August 2003 “The Procedure for Mandatory Health Checkup of Young People Intending to Enter a Marriage” was enforced on 1 January 2004.

One of the main areas to achieve the goal of “Healthy Mother - Healthy Child” is to improve nutrition and prevent micronutrient deficiency. In order to address the issues of nutrition, namely, to improve the nutrition and prevent micronutrient deficiency in mothers and children, Uzbekistan employed an integrated approach aimed at achieving short-term goals (maximizing coverage of children under 6 months of age with exclusive breastfeeding, micronutrient (vitamin A, iron) supplementation, midterm objectives (flour fortification and salt iodization) and long-term goals (nutrition behavior change aimed at promoting healthy and balanced diets).

This approach has been introduced through the implementation of the:

- National Flour Fortification Program (Presidential Decree of the Republic of Uzbekistan “On Measures to Implement the Project ‘National Flour Fortification Program’ ” dated 11 August 2005 (2005-2009);

- Law “On Prevention of Iodine Deficiency Conditions” (2007);

- Policies aimed at Improving Nutrition of the Population of the Republic of Uzbekistan (2009-2011);

- The Law “On Prevention of Micronutrient Deficiency in the Population” (2010г.);

- Resolution of the Cabinet of Ministers of the Republic of Uzbekistan “On Additional Measures to Strengthen Reproductive Health of Women and Children in Rural Regions of the Republic”(2010);

- Resolution of the Cabinet of Ministers of the Republic of Uzbekistan “On Measures to Implement the Law ‘On Prevention of Micronutrient Deficiency of the Population’ ” (2010).

There is special focus on implementing international standards of WHO/UNICEF in the area of maternal and child healthcare. WHO/UNICEF techniques such as safe motherhood, breastfeeding and healthy nutrition, child growth and development monitoring, extended vaccination program, supplementation with vital micronutrients for children and women of reproductive age, and integrated management of childhood illnesses are successfully implemented in the country.

The International Symposium “National Model of Maternal and Childhood Health: ‘Healthy Mother – Healthy Child’ ” held on November 25-26, 2011 upon the initiative of the President of Uzbekistan, Islam Abduganievich Karimov, was a landmark event for the country and international medical community.

The proceedings of the Tashkent Symposium have become the official UN document. At the 66th session of the UN General Assembly, the materials of the forum were distributed as official recommendations.

One of recommendations of the Tashkent International Symposium was further enforcement of legal and regulatory instruments and implementation of programs aimed at improving nutrition and preventing micronutrient deficiency, especially, among women of childbearing age and children, ensuring breastfeeding and healthy complementary foods for all children. Additional measures to strengthen reproductive health of mothers in rural regions of the country include provision of pregnant women with free multivitamins that contain a necessary spectrum of vital micronutrients. A special national program was adopted to ensure annual allocation of budgetary funds to procure multivitamins and invigorate the health of more than 400,000 pregnant women.

The Government is taking major efforts to improve nutrition of the population and successfully implementing programs to fortify flour and iodize salt. The Republic of Karakalpakstan is implementing a joint project with UNICEF to use sprinkles (multivitamin powder) to enrich the meals of children aged 6-12 months.

Taken actions have significantly improved availability of iodized salt for the population. The percentage of the population consuming iodized salt increased from 8.0% in 2002 to 64% by 2012 (in the future, this indicator should be higher than 90%).

Two programmatic documents were passed in order to sustain the effectiveness of nationwide actions to boost reproductive health, develop and strengthen the obstetrics system, maternal and childhood healthcare, and shape the physically and spiritually developed generation.

**Pursuant to the first document, a Presidential Edict of the Republic of Uzbekistan as of 13 April 2009:**

• a Government Commission was organized under chairmanship of the Prime Minister to ensure coordination of activities of all stakeholder ministries, agencies, and region-specific administrative bodies, relevant obstetrics departments, centers for women’s reproductive health, perinatal and screening centers;

• a Program of Measures was approved in order for healthcare facilities and academic institutions, citizens’ self-governing bodies and women’s committees, mass media to organize large-scale public advocacy and information campaigns, especially, for young people, on issues pertaining to building a healthy family and maternal and childhood healthcare and implement the target “Healthy Mother – Healthy Child”.

**The second document, Presidential Edict of the Republic of Uzbekistan dated 1 July 2009, approved the Program of Measures for Further Strengthening and Increasing the Effectiveness of Efforts Aimed at Improving Reproductive Health of the Population, Giving Birth to a Healthy Children, and Shaping a Physically and Spiritually Developed Generation for 2009 - 2013**, aimed at:

• improvement of reproductive health of the population, creating the necessary conditions for the birth of a healthy child;

• further infrastructural improvement of obstetrics, maternal and childhood and primary healthcare facilities to provide medical care for mothers and children;

• intensification of public awareness raising about the birth and upbringing of healthy children, instilling desire in young people for building healthy and happy families and maintaining healthy lifestyle;

• ensuring the necessary conditions for the fully-fledged physical and harmonious development of children and adolescents and shaping a physically healthy and spiritually developed younger generation;

• training health personnel working in the field of maternal and child health and improving the quality of care for mothers and children.

Key activities of all structures within the health care system of the Republic of Uzbekistan involved in maternal and childhood health are based on the implementation of activities outlined in these national programs.

In their turn, all programs and projects in the area of maternal and childhood health implemented in partnership with international financial institutions and organizations such as WHO, UNICEF, UNFPA, WB, ADB, JICA and others are aimed at improving, assuring and controlling quality of care at all levels of service delivery to achieve MDGs on reducing maternal and childhood mortality; ensuring accessible reproductive healthcare services; developing and practical application of primary healthcare, childhood and obstetrics facilities as well as clinical guidelines, standards and protocols.

The implemented National Program for 2009-2013 played a key role in sustaining outcomes of previous initiatives through significant improvement of cross-sector collaboration, coordinated efforts of national and international partners, financial support from the government, human resources, infrastructure and public relations. The current program placed special emphasis on improving maternal and childhood health through a clear-cut action plan with earmarked budget and implementation timelines.

Following the outcomes of the implemented national programs for maternal and childhood healthcare:

* anemia rate among women of childbearing age has decreased by 2.5 times during the recent 10 years;
* as compared to 1991 indicators, maternal mortality rate has decreased by more than 3.4 times;
* children’s growth and development has improved;
* under-five mortality has decreased 4 times and infant mortality reduced by 3.6 times.

In order to achieve sustainability of achievements and to further improve maternal and childhood healthcare, a new National Program was approved in a Presidential Edict of the Republic of Uzbekistan dated 1 August 2014, “On the National Program for Further Improvement of Reproductive Health of the Population, Mothers, Children and Adolescents in Uzbekistan for 2014-2018.”

# Section 3. KNOWLEDGE, ATTITUDES AND PRACTICES OF ADOLESCENTS’ PARENTS IN SHAPING HEALTHY LIFESTYLES OF THE YOUNGER GENERATION

The extent of a family’s success in its health-forming functions is determined by how well a family including adolescents and young people build their health behavior. Along with financial status, family structure, educational attainment of the parents, emotional relationships between parents and children and intra-familial microclimate are, indeed, highly important.

Carefully planned and continuously followed daily routine is a mandatory law in a child’s life. Hygienically optimal daily routine provides for adequate time for all necessary elements of life activity and high working capacity throughout the waking hours.

Well-organized daily routine creates a smooth and cheerful mood, interest towards academic and creative activities, games, and promotes adequate child development. The concept of “24-hour regimen” includes activities, organization and distribution of all activities, rest, and meals throughout a 24-hour period. Carefully planned and organized daily routine is an important factor that ensures timely and harmonious physical and mental development of children and adolescents, optimal working capacity and prevents development of fatigue and boosts overall resilience of a human body.In this regard, awareness of parents about their child’s lifestyle is of specific practical interest (Table 3.1).

**Table 3.1. Distribution of responses about awareness of parents (caregivers) about their child’s lifestyle, % of surveyed parents of adolescents**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Total for the Survey** | | **Urban** | | **Rural** | |
| **10-14 years** | **15-19 years** | **10-14 years** | **15-19 years** | **10-14 years** | **15-19 years** |
| How many hours should a child sleep at night at the age of…? | 7 and more hours | 9,2 | 9,2 | 4,6 | 7,8 | 13,7 | 10,5 |
| 8-9 hours | 56,7 | 77,8 | 58,4 | 77,9 | 55,0 | 77,7 |
| 10 and more hours | 34,2 | 13,1 | 37,0 | 14,3 | 31,4 | 11,8 |
| How many times a day should have meals at the age of …? | 2 and fewer times | 0,8 | 1,1 | 0,9 | 1,3 | 0,7 | 0,9 |
| 3-4 times | 81,2 | 89,4 | 80,1 | 88,7 | 82,3 | 90,0 |
| 5 and more times | 18,0 | 9,5 | 19,0 | 10,0 | 17,0 | 9,0 |
| How many times a day should a child receive a hot meal at the age of …? | fewer than 2 times | 0,2 | 0,9 | 0,2 | 0,6 | 0,2 | 1,3 |
| 2 times | 81,9 | 85,6 | 82,9 | 85,7 | 81,0 | 85,6 |
| 3 and more times | 17,9 | 13,4 | 16,9 | 13,8 | 18,8 | 13,1 |
| How many hours a day may a child watch television at the age of …? | 2 and fewer hours | 64,0 | 39,6 | 67,3 | 39,8 | 60,7 | 39,5 |
| 3 hours | 26,0 | 35,3 | 24,9 | 40,7 | 27,1 | 29,9 |
| 4 and more hours | 10,0 | 25,1 | 7,8 | 19,5 | 12,2 | 30,6 |

In the current context, a risk for child’s health is partly due to increased academic workload. It lies at the basis of inadequate duration of nighttime sleep and outdoor time for adolescents and senior school students. At the same time, a number of factors relating to the life of a child is related to the influence of his/her family.

Findings of the survey of parents’ (caregivers’) awareness about specifics of their child’s lifestyle depending on age showed parents were aware of duration of sleep that was close to the physiological standard of nighttime sleep in children aged 10-14 years (at this age it is recommended that they sleep between 9 and 9.5-10 hours): 56.7% believed that at this age children need to sleep 8-9 hours and 34.2% require sleep for more than 10 hours. 77.8% of parents responded that sleep duration of adolescents aged 15-19 years should be 8-9 hours, which corresponds to the physiological standard. Significant difference between the places of residence was not observed. It should be noted that 13.7% of children aged 10-14 years and 10.5% of children aged 15-19 years in rural areas lacked sleep and failed to meet their physiological requirement for sleep.

According to obtained answers, the awareness of parents (caregivers) about frequency of meals is as follows: 81.2% of parents respondents replied that children aged 10-14 years should have 3-4 meals (in rural area, the percentage was higher 82.3%, which is higher than in the city), 18% of parents believed that frequency of meals should be 4-5 and more times (urban – 19.0%, rural – 17.0%).It is recommended that children and adolescnets have 4-5 meals a day including 2-3 hot meals (breakfast, lunch, and dinner) for adequate growth and development. In terms of frequency of hot meals, most responses (81.9% (urban – 82.9%, rural – 81.0%)) were about two times. The same applies to awareness about frequency of meals for adolescents aged 15-19 years. The findings show that most parents were close to proper information about frequency of meals for children and adolescents. Better awareness about frequency of meals depending on the region of residence was noted in the Surkhandarya Province (Table 3.2).

Presently, children and adolescents spend their leisure time watching television, working or playing computer games. It is important to remember that television viewing and computer use create a significant load on the visual sensory system. Total television and computer time should not exceed 1.5 hours for junior school students and 2 hours for secondary school students.

**Table 3.2. Distribution of parents’ (caregivers’) responses about practices and lifestyle of their child, % of surveyed parents of adolescents**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Total for the Survey** | | | **Urban** | | | **Rural** | | |
| **Average for All Adolescents** | **10-14 years** | **15-19 years** | **Average for All Adolescents** | **10-14 years** | **15-19 years** | **Average for All Adolescents** | **10-14 years** | **15-19 years** |
| What time does your child get up on weekdays? | 6 a.m. and earlier | 43,0 | 34,8 | 49,9 | 29,9 | 24,4 | 35,1 | 55,9 | 46,4 | 63,2 |
| 7-8a.m. | 55,8 | 63,4 | 49,4 | 68,8 | 74,0 | 63,8 | 43,0 | 51,5 | 36,5 |
| 9a.m. and earlier | 1,2 | 1,8 | 0,7 | 1,3 | 1,5 | 1,1 | 1,1 | 2,1 | 0,3 |
| What time does your child get up at the weekend? | 6 a.m. and earlier | 17,1 | 13,9 | 19,9 | 8,6 | 8,0 | 9,1 | 25,6 | 20,4 | 29,6 |
| 7-8 a.m. | 62,8 | 65,8 | 60,2 | 59,1 | 63,4 | 55,1 | 66,4 | 68,5 | 64,8 |
| 9 a.m. and earlier | 20,1 | 20,3 | 19,9 | 32,3 | 28,6 | 35,9 | 7,9 | 11,1 | 5,5 |
| What time does your child go to sleep on weekdays? | earlier than9 p.m. | 6,9 | 7,2 | 6,5 | 3,0 | 3,1 | 2,9 | 10,7 | 11,9 | 9,8 |
| from9 to 11 p.m. | 80,1 | 84,5 | 76,3 | 83,5 | 87,4 | 79,7 | 76,8 | 81,3 | 73,3 |
| 11 p.m. and later | 13,1 | 8,2 | 17,2 | 13,6 | 9,5 | 17,4 | 12,5 | 6,8 | 16,9 |
| What time does your child go to sleep at the weekend? | earlier than9 p.m. | 4,1 | 4,6 | 3,6 | 2,0 | 2,3 | 1,8 | 6,1 | 7,2 | 5,2 |
| from9 to 11 p.m. | 60,2 | 64,6 | 56,4 | 61,0 | 66,8 | 55,4 | 59,4 | 62,1 | 57,3 |
| 11 p.m. and later | 35,7 | 30,8 | 40,0 | 37,0 | 30,9 | 42,8 | 34,5 | 30,6 | 37,5 |
| How many meals does your child have? | 2 meals | 2,7 | 3,2 | 2,2 | 2,4 | 2,3 | 2,5 | 3,0 | 4,3 | 2,0 |
| 3 meals | 33,1 | 25,8 | 39,5 | 33,5 | 22,9 | 43,5 | 32,8 | 28,9 | 35,8 |
| 4 meals | 53,5 | 58,1 | 49,6 | 52,6 | 59,5 | 46,0 | 54,4 | 56,6 | 52,8 |
| 5 and more meals | 10,6 | 12,9 | 8,7 | 11,5 | 15,3 | 8,0 | 9,8 | 10,2 | 9,4 |

Responses show that 64.0% of parents believe that television viewing in daily routine of a child aged 10-14 years should last two hours or less (urban – 67.3%, rural – 60.3%) and 26% of parents think that television screen time may be three, four and more hours (10%).Awareness of parents about recommended television viewing time for adolescents aged 15-19 years is lower: 39.6% of the respondents believe it should be two hours and less (equally so in urban and rural areas), 35.3%of respondents think that this time should be three hours (urban – 40.7%, rural – 29.9%), 25.1% responded that this time should be four hours and more (urban – 19.5%, rural– 30.6 %). Respondents from Tashkent City and the Namangan Province are better aware about recommended television viewing time.

Thus, parents are, in general, informed about the necessity of following a daily routine with adequate duration of nighttime sleep and frequency of meals, but there is a need to strengthen awareness raising campaigns on healthy nutrition and recommended television viewing time. The analysis of findings from the survey of parents about how well their children follow their daily routine showed that most children of all ages get up (6-7 a.m.) and go to sleep (from 9 to 11 p.m.) at recommended time of the day. This being said, rural children get up earlier (6 a.m. and earlier – 55.9%) than urban children (29.9%).Nutrition turned out to be a behavioral factor of an adolescent that is most dependent on the family’s practices. The survey findings showed that frequency of meals for children of all ages (10-14 and 15-19 years) was as follows percentagewise: two meals – 2.7% (here, parents’ awareness about two and fewer meals comprised 0.8% in relation to children aged 10-14 years and 1.1 % for children aged 15-19 years, i.e., in reality, this is inadequate nutrition – undernourishment by more than two times than awareness); three meals – 33.1%, four meals – 53.5 %, five and more meals – 10.6%.

The analysis of parents’ responses showed that foods that are useful and valuable for children’s and adolescents’ development prevail in diets of adolescents (Table 3.3).

**Table 3.3. Distribution of parents’ (caregivers’) responses about weekly food consumption, % of surveyed parents of adolescents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Daily, frequently** | | | **Rarely** | | | **Hardly ever / Never** | | |
| **Average** | **10-14 years** | **15-19 years** | **Average** | **10-14 years** | **15-19 years** | **Average** | **10-14 years** | **15-19 years** |
| Fresh fruit during the season | 93,6 | 94,6 | 92,8 | 5,8 | 4,8 | 6,7 | 0,6 | 0,6 | 0,5 |
| Fresh fruit out of the season | 41,7 | 45,1 | 38,8 | 47,6 | 44,3 | 50,4 | 10,7 | 10,7 | 10,8 |
| Fresh vegetables (uncooked) | 75,5 | 81,7 | 70,2 | 20,8 | 16,3 | 24,7 | 3,7 | 2,0 | 5,1 |
| Sweets (candy and chocolate) | 42,6 | 42,7 | 42,5 | 44,2 | 45,1 | 43,4 | 13,2 | 12,3 | 14,1 |
| Coca Cola and etc. | 10,1 | 8,9 | 11,1 | 40,7 | 38,0 | 43,1 | 49,2 | 53,1 | 45,8 |
| Milk | 62,0 | 64,2 | 60,2 | 22,9 | 23,5 | 22,3 | 15,1 | 12,3 | 17,5 |
| Cheese | 13,9 | 14,7 | 13,2 | 33,0 | 34,0 | 32,1 | 53,1 | 51,3 | 54,7 |
| Other dairy products (yoghurt, cottage cheese, and etc.) | 70,4 | 70,2 | 70,5 | 23,9 | 24,3 | 23,5 | 5,7 | 5,4 | 6,0 |
| Flakes from grain crops (corn flakes, dry breakfast cereal, and etc.) | 13,9 | 13,9 | 13,9 | 45,6 | 48,1 | 43,6 | 40,5 | 38,0 | 42,5 |
| Fish | 3,1 | 2,2 | 3,8 | 33,1 | 33,8 | 32,6 | 63,8 | 64,0 | 63,6 |
| Eggs | 70,0 | 69,2 | 70,7 | 25,7 | 27,2 | 24,5 | 4,3 | 3,6 | 4,8 |
| Sausage products | 19,6 | 18,9 | 20,2 | 49,4 | 50,9 | 48,0 | 31,0 | 30,2 | 31,7 |
| Patty cakes | 20,6 | 17,7 | 23,2 | 57,4 | 61,8 | 53,7 | 21,9 | 20,5 | 23,2 |
| Cakes, ice cream | 47,2 | 49,7 | 45,1 | 43,4 | 42,5 | 44,3 | 9,4 | 7,8 | 10,6 |

Thus, virtually all adolescents (93.6%) consume fresh fruit in season daily and less than half of them (41.7%) and rarely 47.6% eat fresh fruit out of season. Three-quarters of adolescents consume fresh uncooked vegetables daily and 20.8% of them do so rarely. Milk is consumed daily by 62.0% and rarely –by 22.9%, very rarely –by15.1% of adolescents; other dairy products - 70.4%, 23.9% and 5.7%, respectively. Eggs are present in daily diets of 70.4% of adolescents and a quarter of them eat eggs rarely.

Equal numbers of adolescents consume sweets (candy and chocolate) daily and rarely (42.6% and 44.2%, respectively) as well as cakes and ice cream – 47.2% and 43.4%.This data is insufficient to identify how healthy this is because we do not know about the quantity of consumed sweets of all types. Unfortunately, adolescents’ diets rarely have foods such as fish (daily – 3.1%, hardly ever 63.8%), cheese and cereals from grain crops.

There was no significant difference in food consumption depending on the place of residence. However, most urban adolescents consumed fresh fruit out of season, cheese and sausage products (Table 3.4).

Table 3.4. **Distribution of adolescents according to weekly food consumption**

**in urban and rural areas,%**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Weekly, often** | | **Rarely** | | **Hardly ever/ Never** | |
| **Urban** | **Rural** | **Urban** | **Rural** | **Urban** | **Rural** |
| Fresh fruit in season | 92,0 | 95,2 | 7,1 | 4,6 | 0,9 | 0,2 |
| Fresh fruit out of season | 48,1 | 35,2 | 42,0 | 53,1 | 9,9 | 11,6 |
| Fresh vegetables (uncooked) | 72,5 | 78,4 | 23,8 | 17,9 | 3,7 | 3,7 |
| Sweets (including candy and chocolate) | 37,0 | 48,2 | 47,8 | 40,6 | 15,2 | 11,3 |
| Soft drinks (including Coca Cola and etc.) | 9,1 | 11,1 | 40,3 | 41,1 | 50,6 | 47,8 |
| Milk | 58,0 | 66,1 | 24,9 | 20,8 | 17,1 | 13,1 |
| Cheese | 19,5 | 8,3 | 41,8 | 24,2 | 38,7 | 67,5 |
| Other dairy products (yoghurt, cottage cheese and etc.) | 70,3 | 70,5 | 24,7 | 23,1 | 5,0 | 6,5 |
| Flakes from grain crops (corn flakes, dry breakfast cereal, and etc.) | 12,3 | 15,5 | 53,3 | 38,0 | 34,4 | 46,5 |
| Fish | 2,4 | 3,7 | 34,2 | 32,1 | 63,4 | 64,2 |
| Eggs | 67,7 | 72,3 | 26,8 | 24,7 | 5,6 | 3,0 |
| Sausage products | 24,3 | 14,9 | 49,6 | 49,1 | 26,0 | 36,0 |
| Patty cakes | 18,0 | 23,2 | 57,1 | 57,7 | 24,9 | 19,0 |
| Cakes, ice cream | 40,7 | 53,7 | 50,6 | 36,3 | 8,7 | 10,0 |

The percentage of the daily intake of food with the exception of fresh vegetables, fruit (consumed in a large percentage of low-income families), while consumption of cakes and ice cream (these products are no longer consumed in middle-income households) was higher in families with high income (Table 3.5).

Table 3.5. **Distribution of responses to the question “How many times a week are listed products consumed?” depending on the wellbeing of a family, %**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Daily, often | | | Rarely | | | Hardly ever / Never | | |
| high-income families | middle-income families | low-income families | high-income families | middle-income families | low-income families | high-income families | middle-income families | low-income families |
| Fresh fruit during the season | 98,2 | 94,7 | 79,2 | 1,3 | 4,9 | 19,2 | 0,4 | 0,4 | 1,7 |
| Fresh fruit out of the season | 59,5 | 37,5 | 33,3 | 35,7 | 51,2 | 48,3 | 4,8 | 11,2 | 18,3 |
| Fresh vegetables (uncooked) | 64,8 | 80,1 | 67,5 | 32,2 | 17,0 | 22,5 | 3,1 | 2,9 | 10,0 |
| Sweets (candy and chocolate) | 44,1 | 43,6 | 33,3 | 48,9 | 43,2 | 41,7 | 7,0 | 13,3 | 25,0 |
| Coca Cola and etc. | 17,2 | 8,5 | 5,8 | 45,8 | 40,3 | 35,0 | 37,0 | 51,2 | 59,2 |
| Milk | 72,7 | 60,7 | 50,0 | 19,4 | 23,0 | 28,3 | 7,9 | 16,3 | 21,7 |
| Cheese | 24,2 | 11,4 | 10,0 | 48,9 | 28,2 | 31,7 | 26,9 | 60,4 | 58,3 |
| Other dairy products (yoghurt, cottage cheese, and etc.) | 78,4 | 69,9 | 58,3 | 18,1 | 23,8 | 35,0 | 3,5 | 6,3 | 6,7 |
| Flakes from grain crops (corn flakes, dry breakfast cereal, and etc.) | 16,3 | 12,7 | 15,0 | 62,1 | 43,0 | 31,7 | 21,6 | 44,2 | 53,3 |
| Fish | 7,0 | 1,9 | 0,8 | 51,5 | 27,7 | 32,5 | 41,4 | 70,4 | 66,7 |
| Eggs | 76,2 | 70,8 | 53,3 | 20,7 | 25,2 | 39,2 | 3,1 | 4,0 | 7,5 |
| Sausage products | 33,5 | 16,6 | 11,7 | 49,8 | 47,7 | 59,2 | 16,7 | 35,8 | 29,2 |
| Patty cakes | 14,5 | 23,3 | 15,0 | 69,2 | 53,8 | 57,5 | 16,3 | 22,9 | 27,5 |
| Cakes, ice cream | 41,0 | 50,7 | 38,3 | 52,0 | 40,7 | 43,3 | 7,0 | 8,6 | 18,3 |

Personal hygiene is an indispensable component of a daily routine and a factor of shaping a health of a child at any age. Responses of parents showed that practically all surveyed parents know how frequently their children brush or do not brush their teeth. A positive development is that 58.8% (urban – 66.0%, rural – 51.7%) of children brush their teeth more than once daily and 36.6% brush teethonce daily (urban – 29.9%, rural – 43.2%). These indicators are higher among girls (Tables 3.6 and 3.7).

Table 3.6.**Distribution of parents’ (caregivers’) responses about brushing teeth,**

**% of the surveyed parents of adolescents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **10-14 years** | | | **15-19 years** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| More often than once daily | 58,8 | 50,9 | 67,8 | 54,3 | 48,7 | 61,1 | 62,6 | 52,8 | 73,2 |
| One daily | 36,6 | 42,0 | 30,4 | 40,0 | 43,2 | 36,3 | 33,6 | 40,9 | 25,7 |
| Not every day, but at least once weekly | 3,6 | 5,4 | 1,6 | 4,6 | 6,3 | 2,7 | 2,7 | 4,6 | 0,7 |
| Several times a month | 0,5 | 0,9 | 0 | 0,8 | 1,5 | 0 | 0,2 | 0,3 | 0 |
| Never | 0,1 | 0,2 | 0 | 0 | 0 | 0 | 0,2 | 0,3 | 0 |

Table 3.7. **How often does the adolescent brush his/her teeth in urban and rural areas? %**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Urban** | | | **Rural** | | |
| **Total** | **10-14 years** | **15-19 years** | **Total** | **10-14 years** | **15-19 years** |
| Всего | More often than once daily | 66,0 | 64,1 | 67,8 | 51,7 | 43,4 | 58,0 |
| One daily | 29,9 | 31,7 | 28,3 | 43,2 | 49,4 | 38,4 |
| Not every day, but at least once weekly | 3,3 | 3,8 | 2,9 | 3,9 | 5,5 | 2,6 |
| Several times a month | 0,0 | 0,0 | 0,0 | 0,9 | 1,7 | 0,3 |
| Never | 0,2 | 0,0 | 0,4 | 0,0 | 0,0 | 0,0 |
| мальчики | More often than once daily | 56,6 | 56,2 | 56,9 | 45,9 | 41,8 | 49,4 |
| One daily | 37,1 | 38,5 | 35,8 | 46,3 | 47,5 | 45,2 |
| Not every day, but at least once weekly | 5,2 | 4,6 | 5,8 | 5,5 | 7,8 | 3,6 |
| Several times a month | 0,0 | 0,0 | 0,0 | 1,6 | 2,8 | 0,6 |
| Never | 0,4 | 0,0 | 0,7 | 0,0 | 0,0 | 0,0 |
| девочки | More often than once daily | 75,3 | 72,0 | 78,4 | 59,1 | 45,7 | 68,1 |
| One daily | 22,9 | 25,0 | 20,9 | 39,1 | 52,1 | 30,5 |
| Not every day, but at least once weekly | 1,5 | 3,0 | 0,0 | 1,7 | 2,1 | 1,4 |
| Several times a month | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 |
| Never | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 |

Clean hands prevent many infectious diseases, so the questionnaire included a question about washing hands before meals.The parents’ responses show that, in general, 47.9% of children and adolescents wash their hands every time before a meal: 44.3% of children aged 10-14 years and 50.9% of children aged 15-19 years. 35.3% frequently wash their hands and 10.6% of adolescents wash their hands rarely (12.1% - children aged 10-14 years). 3.4% of children have to be made to wash hands before a meal, especially, boys aged 10-14 years (8.1%). 1.8% of parents did not know or found it difficult to answer whether their children wash hands before a meal (Tables 3.8 and 3.9).

Table 3.8. **Distribution of parents’ (caregivers’) responses about hand washing before a meal** (% of surveyed parents of adolescents)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **10-14 years** | | | **15-19 years** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Every time | 47,9 | 43,9 | 52,4 | 44,3 | 41,0 | 48,2 | 50,9 | 46,5 | 55,7 |
| Often | 35,3 | 35,0 | 35,6 | 33,4 | 33,9 | 32,7 | 36,9 | 36,0 | 37,9 |
| Sometimes / rarely | 10,6 | 12,2 | 8,9 | 12,1 | 11,1 | 13,3 | 9,4 | 13,2 | 5,4 |
| When hands are very soiled | 1,0 | 1,9 | 0,0 | 1,8 | 3,3 | 0,0 | 0,3 | 0,7 | 0,0 |
| When made to wash | 3,4 | 4,5 | 2,2 | 6,2 | 8,1 | 4,0 | 1,0 | 1,3 | 0,7 |
| Never | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 |

Cleaning hands is a well-established practice among urban children, so 53.7% of children wash their hands before every meal (48.9% - children aged 10-14 years, 58.3% - adolescents aged 15-19 years). In rural settings, 42.1% of children wash hands before every meal (39.1% of children aged 10-14 years and 44.3% of adolescents aged 15-19 years). Awareness of parents about their children’s hand washing skills is higher in an urban setting (1.3%of parents did not know or found it difficult to answer) than in rural areas (2.2% of parents did not know whether their children wash their hands before a meal). Comparatively, more girls wash hands before every meal than boys (Table 3.9).

Table 3.9. **How often does an adolescent wash his/her hands with soap before a meal in urban and rural settings?** (%of surveyed parents of adolescents)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Urban** | | | **Rural** | | |
| **Total** | **10-14 years** | **15-19 years** | **Total** | **10-14 years** | **15-19 years** |
| every time | 53,7 | 48,9 | 58,3 | 42,1 | 39,1 | 44,3 |
| often | 26,4 | 25,2 | 27,5 | 44,1 | 42,6 | 45,3 |
| sometimes/ rarely | 11,5 | 13,7 | 9,4 | 9,8 | 10,2 | 9,4 |
| when hands are very soiled | 0,9 | 1,5 | 0,4 | 1,1 | 2,1 | 0,3 |
| when made to wash | 5,2 | 8,4 | 2,2 | 1,7 | 3,8 | 0,0 |
| Never | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 | 0,0 |

Thus, most children of all ages, especially, girls follow rules of personal hygiene. In this regard, the situation is better in urban families. The percentage of adolescents who observe hygiene increases as children become older from 14to 19 years.

Organization of leisure time and include games and activities at own choice (reading, music, drawing and other creative activities, sports) are an important component in the development and shaping the health of children and adolescents.

Outdoor activities (going for walks) are the most effective type of recreation resulting in increased blood oxygenation and supplementation of ultraviolet deficiency allowing for body conditioning and increased motor activity. Overall duration of outdoor recreation activities varies in the age groups: junior schoolchildren – 3-3.5 hours, secondary schoolchildren – 2.5-3 hours, and senior schoolchildren - 2-2.5 hours.

Playtime and leisure activities of own choice help children to form positive emotions, develop individual inclinations and creativity. A child ought to have time for leisure activities of own choice (reading, music classes, drawing, sports, and community involvement).

The analysis of parents’ responses about how their children and adolescents of all ages shows that most responses were about helping parents around the house(54.9%) and television viewing and working at the computer (54.8%). In the first case, girls prevailed (66.6%), while there were more boys in the second case (58.0%)(Tables 3.10 and 3.11).

These responses are followed in rank by sports (total –35.6%: boys – 48.6%, girls – 20.9%), reading books, music and dance classes (34.1%). This being said, it is necessary to point out that with age, the percentage of children who go in for sports, especially, of girls decreases. Thus, the percentage of children aged 10-14 years who go in for sports is 39.2% (boys – 48.3%, girls – 28.3%), while at the age from 15 to 19 years, their percentage amounts to 32.6% (boys –48.8%, girls – 15.0%). A reverse trend is observed in relation to group of children who read books, have music and dancing classes in their free time: girls prevail in each age group (42.5% - aged 10-14 years, 45.0% - aged 15-19 years) as compared to boys (27.3% - aged 10-14 years, 23.8% - aged 15-19 years). According to findings, the percentage of girls, who read books and have music classes in their free time, increases with age.

Adolescents aged 15-19 years prefer to attend cultural events with friends (24.8%) and fewer, especially boys, do so with their parents/grandparents (14.6%). In age group of 10-14 year, 32.0% of children play in the yard (boys – 30.6%, girls – 33.6%) and as children grow older, age group of 15-19 years, there are fewer children (6.2%) spend their free time in the yard (boys – 5.6%, girls – 6,8%).

In their free time, 4.9% of children earn money (1.0% - at the age of 10-14 years, 8.2% - at the age of 15-19 years). As children grow older, from age 14 to 15 years, the percentage of girls, who earn money, increased from 0.9% to 4.3% and of boys – from 1.1% to 11.9% (Tables 3.10 and 3.11).

Table 3.10. **Distribution of parents’ (caregivers’) responses about how their adolescent children spend their leisure time, % of surveyed parents of adolescents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **10-14 years** | | | **15-19 years** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Attends cultural and other events together with parents (grandparents) | 16,5 | 12,9 | 20,6 | 18,7 | 14,4 | 23,9 | 14,6 | 11,6 | 17,9 |
| Attends cultural events with friends | 21,0 | 21,8 | 20,2 | 18,3 | 18,5 | 18,1 | 23,3 | 24,8 | 21,8 |
| Plays in the yard | 18,1 | 17,4 | 18,8 | 32,0 | 30,6 | 33,6 | 6,2 | 5,6 | 6,8 |
| Watches television, spends time in front of a computer | 54,8 | 58,0 | 51,2 | 59,2 | 62,4 | 55,3 | 51,1 | 54,1 | 47,9 |
| Reads books, has music and dancing classes | 34,1 | 25,4 | 43,9 | 34,2 | 27,3 | 42,5 | 34,0 | 23,8 | 45,0 |
| Does sports | 35,6 | 48,6 | 20,9 | 39,2 | 48,3 | 28,3 | 32,6 | 48,8 | 15,0 |
| Helps parents around the house | 54,9 | 44,6 | 66,6 | 52,9 | 43,5 | 64,2 | 56,6 | 45,5 | 68,6 |
| Earns money | 4,9 | 6,8 | 2,8 | 1,0 | 1,1 | 0,9 | 8,2 | 11,9 | 4,3 |
| Other | 4,8 | 2,6 | 7,3 | 4,8 | 2,6 | 7,5 | 4,8 | 2,6 | 7,1 |

Depending on place of residence, leisure activities had their specific features. In rural areas, 55.5% (boys – 54.5%, girls – 56.4%) and in the urban settings, 54.3% (boys – 51.5%, girls – 56.9 %) of children and adolescents in all age groups help their parents around the house.

Table 3.11. **How do adolescents spend their leisure time after school in urban and rural areas, % of the surveyed**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Urban** | | | **Rural** | | |
| **Total** | **10-14 years** | **15-19 years** | **Total** | **10-14 years** | **15-19 years** |
| Attends cultural and other events together with parents (grandparents) | 23,4 | 24,4 | 22,5 | 9,6 | 12,3 | 7,5 |
| Attends cultural events with friends | 27,7 | 24,4 | 30,8 | 14,4 | 11,5 | 16,6 |
| Plays in the yard | 19,9 | 33,2 | 7,2 | 16,2 | 30,6 | 5,2 |
| Watches television, spends time in front of a computer | 62,5 | 61,5 | 63,4 | 47,2 | 56,6 | 40,1 |
| Reads books, has music and dancing classes | 36,6 | 37,0 | 36,2 | 31,5 | 31,1 | 31,9 |
| Does sports | 36,4 | 38,2 | 34,8 | 34,9 | 40,4 | 30,6 |
| Helps parents around the house | 54,3 | 51,5 | 56,9 | 55,5 | 54,5 | 56,4 |
| Earns money | 5,9 | 1,5 | 10,1 | 3,9 | 0,4 | 6,5 |
| Other | 5,4 | 5,0 | 5,8 | 4,2 | 4,7 | 3,9 |

As many as 62.5% of urban children (boys - 66.7%, girls - 58.3%)and 47.2% of rural children (boys - 50.5%, girls – 43.0%) of all ages watch television and sit in front of a computer. By reaching the age of 15-19 years, the percentageof both boys and girls, who spend their spare time watching television and using a computerin urban areas increased and reduced in rural areas (Table 3.12).

Table 3.12. **Distribution of Parents’ (Caregivers’) Responses about How their Adolescent Children Spend their Free Time, % of the Surveyed Parents of Adolescents**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | **Average for All Adolescents** | **10-14 years** | **15-19 years** |
| Watches television on weekdays | 2 hours or less | 70,7 | 68,8 | 72,4 |
| 3 hours | 21,2 | 20,7 | 21,6 |
| 4 hours and more | 8,1 | 10,5 | 6,0 |
| Watches television at the weekend | 2 hours or less | 46,2 | 44,7 | 47,5 |
| 3 hours | 27,4 | 26,6 | 28,1 |
| 4 hours and more | 26,4 | 28,8 | 24,4 |
| Spends time in front of the computer on weekdays | Does not use electronic devices | 43,1 | 46,9 | 39,8 |
| 1 hour | 29,6 | 31,2 | 28,3 |
| 2 hour | 17,7 | 15,9 | 19,2 |
| 3 hours or more | 9,6 | 6,0 | 12,7 |
| Spends time in front of the computer at the weekend | Does not use electronic devices | 45,6 | 48,9 | 42,9 |
| 1 hour | 20,5 | 22,7 | 18,5 |
| 2 hour | 17,9 | 17,3 | 18,4 |
| 3 hours or more | 16,0 | 11,1 | 20,2 |

As many as36.4% of urban and 34.9% of rural children and adolescents engage in sports as their main pastime activity, but among children aged 10-14 years in rural areas more children and adolescents (40.4%) than in urban areas (38.2%) engage in sports. A reverse pattern is observed among adolescents aged 15-19 years: in urban settings, the percentage of children (34.8%), who engage in sports, exceeds their percentage in rural area (30.6%). In terms of sex: in towns, 50.6% of boys (46.2% of children aged 10-14 years and 54.7% of children aged 15-19 years) and 22.5% of girls (30.3% of children aged 10-14 years and 15.1% of children aged 15-19 years); in rural areas,46.9% of boys (50.4% of children aged 10-14 years and 44.0% of children aged 15-19 years) and 19.1% of girls (25.5% of children aged 10-14 years and 14.9% of children aged 15-19 years).

In urban area, more children of all ages, especially girls, tend to spend their free time reading books and having music and dancing classes. Twice as many children and young people living in the city attend cultural events with parents and friends. Similarly, more urban adolescents spend their spare time making money.

Answers of parents on how their children spend their free time showed that on weekdays, 70.7% of children and adolescents (68.8% of children aged 10-14 years and 72.4% of children aged 15-19 years) watch television for two hours and less, the rest of the children spend more time watching television than recommended (21.2% - 3 hours, 8.1% - 4 or more hours).

In urban areas, the percentage of children who spend time watching television within recommended time is greater than in rural areas, which indicates to a greater awareness of the urban population about an optimal daily routine for children.

More children and adolescents (68.2%) living in towns use electronic devices than those (45.8%) in rural areas. The majority of children spend a recommended amount of time in front of a computer (from 1 to 2 hours), but 15.1% of children (6.9% of children and adolescents aged 10-14 years and 22.8% of adolescents aged 15-19 years) in the urban settings and 4.2% children (5.1% of children and adolescents aged 10-14 years and 3.6% of adolescents aged 15-19 years) in rural areas spend more than recommended amount of time in front of a computer (3 and more hours).

Regardless of age and place of residence, television and computer screen time for children and adolescents is significantly greater during weekends than on weekdays and exceed recommended time, which is highly undesirable. It is recommended that open-air playtime be increased during holidays and days off, when active outdoor games, sports, competitions, and excursions can be organized and more time may be allocated for creative activities. It is important that parents focus on the above because according to the findings, the children tend to engage into more static activities on days off (spending time in front of a television set and computer).

The analysis of answers shows that parents take their upbringing of children seriously and responsibly. Thus, 91.5% (91.1% - urban, 91.9% - rural) of the surveyed parents believe that they should have special skills in raising adolescents. This being said, 80.7% of respondents think that they have sufficient knowledge and skills to bring up their children and adolescents, 15.3% (16.5% - urban, 14.0% - rural) believe that they do not have adequate knowledge and skills (Tables 3.13 and 3.14).

**Table 3.13. Attitude of parents to the problem of bringing up adolescents, % of surveyed parents of adolescents**

|  |  |  |
| --- | --- | --- |
|  | **yes** | **no** |
| Do you think parents should have special skills of raising adolescents? | 91.5 | 6.6 |
| Do you think you have sufficient knowledge and skills to bring up children and adolescents? | 80.7 | 15.3 |

**Table 3.14. What skills do you require?, % of respondents who think that they do not have sufficient skills to raise their children**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Fundamentals of medical knowledge | 37,0 | 32,4 | 41,7 |
| Law | 40,9 | 25,7 | 56,3 |
| Religious sources | 9,6 | 2,9 | 16,5 |
| Psychology | 51,4 | 60,0 | 42,7 |
| Survival basics | 13,0 | 8,6 | 17,5 |
| A skill to make an impression on other people | 13,9 | 11,4 | 16,5 |
| Reproductive health knowledge | 13,0 | 14,3 | 11,7 |
| Other | 4,3 | 5,7 | 2,9 |

The survey found that parents believe that they do not have sufficient information and skills to educate their children, especially, in psychology (total - 51.4%, urban - 60.0% rural - 42.7%), law (40.9% and more than in rural areas - 56.3%), and medicine (37.0%, more than in rural areas - 41.7%). Parents in rural areas place a lot more emphasis on skills such as basics of survival (17.5%), religious primary sources and the ability to make an impression on others (16.5%) than in urban areas.

The survey ascertained that parents evaluate their children’s health status as excellent in 19.3% (14.9% - urban, 23.6% - rural), good in 72.2% (76.4% - urban, 68.1% - rural), satisfactory in 8.2% (8.4 % and 8.1%, respectively), and poor in 0.3% (0.4% and 0.2%, accordingly)of cases (Tables 3.15 and 3.16).

**Table 3.15. Distribution of parents’ (caregivers’) responses about child’s health, % of surveyed parents of adolescents**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Excellent | 19,3 | 14,9 | 23,6 |
| Good | 72,2 | 76,4 | 68,1 |
| Satisfactory | 8,2 | 8,4 | 8,1 |
| Poor | 0,3 | 0,4 | 0,2 |

According to the interviewed parents, the following have an impact on children’s health: nutrition (60.3%), lifestyle (42.8%), material wealth (28.5%), environmental situation (27.1%) and sports (23.9%) (Table 3.16).

**Table 3.16. Distribution of parents’ (caregivers’)responses,   
% of surveyed parents of adolescents**

|  |  |  |  |
| --- | --- | --- | --- |
| **Which factors influence a child’s health status?** | **Total** | **Urban** | **Rural** |
| lifestyle | 42,8 | 53,3 | 32,3 |
| specifics of nutrition | 60,3 | 70,4 | 50,2 |
| heredity | 10,7 | 8,0 | 13,5 |
| harmful habits | 15,6 | 12,8 | 18,3 |
| environmental situation | 27,1 | 18,8 | 35,4 |
| family’s material wealth | 28,5 | 28,4 | 28,6 |
| engaging in sports | 23,9 | 28,6 | 19,2 |
| other | 2,4 | 2,6 | 2,2 |

Answers of urban respondents by far exceeded answers of rural respondents to questions about factors such as nutrition (70.4%), lifestyle (53.3%) and sports (28.6% and 19.2%in rural areas), and environmental situation (18.8% and 35.4%in rural areas). Financial wellbeing was observed equally in urban and rural areas. It is also notable that a higher percentage of rural parents knew about the important influence of harmful habits (18.3%) and heredity (13.5%) on shaping children’s health.

It is gratifying to point out that practically all parents (total – 97.0%, urban – 98.9%, rural – 95.2%) believe that they are responsible for their children’s health and report that they children and adolescents are also responsible for their own health (21.3%, almost equal percentage in urban and rural settings). The responsibility of health workers was reported in 20.5% of answers (urban – 20.1%, rural – 20.8%). In urban areas, academic institutions are believed to be responsible for children’s health (21.4% and 12.2% in rural areas) (Table 3.17).

**Table 3.17. Distribution of parents’ (caregivers’) responses,   
% of surveyed parents of adolescents**

|  |  |  |  |
| --- | --- | --- | --- |
| **Who should be responsible for a child’s health status?** | **Total** | **Urban** | **Rural** |
| Parents | 97,0 | 98,9 | 95,2 |
| Relatives who take care of the child | 5,8 | 5,6 | 6,1 |
| Health workers | 20,5 | 20,1 | 20,8 |
| Academic institution (school/college) | 16,8 | 21,4 | 12,2 |
| The child him/herself | 21,3 | 21,0 | 21,6 |
| Other | 0,7 | 0,9 | 0,6 |

Thus, according to findings of sociological surveys the following factors and conditions within a family, which influence the health of an adolescent, were ascertained:

- parents, regardless of their financial status and educational attainment, pay ample attention to adolescent health,

- in most cases, parents were informed:

a)about children’s health and determinants of childhood health;

b) about organizing a child’s daily routine (duration of sleep time, frequency of meals, creating sound leisure time needs in adolescents and sufficient physical activity for a child during spare time);

c) about sanitary and hygienic skills.

- parents pay considerable attention to education of adolescents focusing on the need to improve their skills in a number of areas, particularly, psychological, legal and medical dimensions.

There is a need to intensify efforts for raising parental awareness and development of necessary parental skills to ensure healthy nutrition of children, adequate physical activity and to inspire children, especially girls, to engage in sports in order to further improve organizational measures to work with families on enhancing child upbringing practices, growth and development of children and effective shaping of childhood and adolescent health.

The survey findings show that our country has created all opportunities to engage adolescents from low-income families in sports, which explains the insignificant difference as compared to high- and middle-income families, whereas more children from low-income families regularly attend sports clubs, sports schools, and professional sports facilities as compared to children from high- and middle-income families.

With the view of achieving sustainability of attained results and better organizational efforts and encouraging adolescents to engage into physical activity/sports, there is a need to:

- intensify efforts dedicated to raising awareness and developing skills of physical activity in families;

- take relevant actions for physical training and sports to become a tradition and one of key customary family activities to ensure harmonious development of adolescents;

- continue activities to provide for necessary conditions (additional equipment and outfitting sports facilities with relevant sports gear and streamline heating at sports facilities in winter time) to engage in sports; and

- reconsider and establish a uniform system of fees for adolescent sports.

# Section 4. NEEDS AND ACCESS OF THE POPULATION TO PHYSCIAL EDUCATION AND SPORTS SERVICES FOR ADOLESCENTS

Harmonious development is a crucial childhood health indicator. Soundly organized physical education and sports activities for children promote harmonious development. Scientific evidence suggests that physical activity ensures fundamental health benefits for children’s and young people’s health. This conclusion is based on the findings of observational studies have shown that higher levels of physical activity are associated with more favorable health parameters. Similarly, experimental studies have shown that preventing irregularity in physical activity is associated with improved health outcomes.

Mass sports are one of powerful tools for resolving multitude social issues associated with sound organization of leisure time for children and adults, with moral and cultural upbringing of members of society as well as increasing and sustaining their working ability. Physical training and sports are traditionally considered as crucial factors of strengthening the health of a nation.

Since 2002, Uzbekistan has been creating all conditions for integration of physical culture into every family. Sports movement among studying children and young people has gained momentum. The following sports competitions have become popular“Umid nihollari” (“Progeny of Hope”) –among students of general education schools, “Barkamol avlod” (“Harmonious Generation”) –among students of vocational colleges and academic lyceums and Universiades – among students of higher academic institutions.

Sports clubs and recreation groups set up at gyms and sports clubs set up within general education and youth sports schools, academic lyceums of the republic cover 2.2 million studying young people.

Considering the fact that millions of schoolchildren currently joining in sports activities in the republic, the role and importance of not only systematic monitoring and evaluation of organizations involved in physical education and sports and their impact on the development and health of children are increasing, but also of identifying social, economic and other determinants of ensuring sufficient physical activity, especially, effective involvement of children, adolescents, and young people in sports.

It is a well-known fact that achieving maximum coverage and involvement of children in health improvement through physical activity and sports heavily relies on commitment of families. Good results in this area will be only possible if parents and other family members are informed about the role and importance of physical activity including sports in shaping health and harmonious development of children and adolescents. In this regard, one of main objectives of this survey was identifying information messages for raising parental awareness about this issue.

The analysis of responses showed that 93.7% of parents are informed about the need for physical activity in ensuring wholesome development of children and adolescents, this percentage was higher among urban (96.1%) than rural (91.3%) parents. Only 0.9% of parents did not know or found it difficult to answer a question about significance of physical activity and there were three times of such parents in rural areas (1.5%) than in urban settings (0.4%) (Table 4.1).

**Table 4.1. Distribution of parental awareness about the necessity of physical activity for a child aged 10-14 and 15-19 years, %**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | **Total** | **Urban** | **Rural** |
| Is physical activity necessary for fully-fledged development? | Yes | 93,7 | 96,1 | 91,3 |
| No | 5,4 | 3,5 | 7,2 |
| How often should a child engage in physical activity?, % from affirmative answers to the previous question | Daily | 76,7 | 80,5 | 72,7 |
| Every other day | 11,9 | 10,3 | 13,5 |
| Once-twice a week | 11,2 | 8,9 | 13,5 |
| Once-twice a week | 0,3 | 0,4 | 0,2 |
| How many hours should a child exercise every day at the age of 10-14 years? | 1 hour and less | 64,4 | 69,2 | 59,4 |
| 2 hours | 29,1 | 26,5 | 31,7 |
| 3 and more hours | 6,5 | 4,3 | 8,9 |
| How many hours should a child exercise every day at the age of 15-19 years? | 1 hour and less | 48,2 | 53,8 | 42,4 |
| 2 hours | 36,1 | 34,8 | 37,4 |
| 3 and more hours | 15,7 | 11,4 | 20,2 |
| Who, in your opinion, has a greater influence on the development of the child’s motion activity?, % of respondents | Father | 41,1 | 30,3 | 51,8 |
| Mother | 51,0 | 59,9 | 42,3 |
| Educators/teachers | 6,6 | 7,6 | 5,5 |
| Someone else | 1,3 | 2,2 | 0,4 |

Children and adolescents aged 10-19 are normally recommended to engage in at least 60 minutes of physical activity (moderate to intensive) on a daily basis. Intensive physical activity designed to strengthen muscles and bones should be arranged three times per week. It is necessary to point out that 76.7% of parents, who gave an affirmative answer regarding the importance of physical activity, believe that children should engage in physical activity daily (urban - 80.5%, rural – 72.7%), 11.9% - every other day, 11.2% - 1-2 times a week. As for duration of daily physical activity, 64.4% (for children aged 10-14 years) to 48.2% (for children aged 15-19 years) of parents report one hour or less; 29.1% to 36.1%, accordingly, report two hours; 6.5% to 15.7%, respectively, report three and more hours.

Parents largely shape physical activity in children and adolescents (mother –in 51.0% of cases, father – in 41.1% of cases), whereas educators/teachers influence this aspect in 6.6% of cases. The survey findings suggest that there are differences depending on place of residence. Thus, in urban settings, a mother (59.9%), and in rural settings, a father (51.8%) exercises a significant influence on a child’s physical activity (Tables 4.2-4.4).

**Table 4.2. Distribution of parents’ responses,**

**“Which of parents engaged in sports?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Father | 36,9 | 40,9 | 32,8 |
| Mother | 7,0 | 7,8 | 6,3 |
| Both parents | 5,1 | 5,6 | 4,6 |
| None | 49,5 | 44,2 | 54,8 |

The survey showed that 49.5% of parents did not engage in sports, while this percentage is higher in rural areas and amounted to 54.8%. Among parents engaged in sports, fathers equaled 36.9% (urban – 40.9%, rural – 32.8%), mothers – 7.0% (urban – 7.8%, rural – 6.3%)(Table 4.2).

**Table 4.3. Distribution of parents’ responses,**

**“Is there a tradition in your family to jointly go in for sports?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| yes | 21,4 | 19,7 | 23,1 |
| No | 75,1 | 76,8 | 73,4 |

Unfortunately, sports activity is not a family tradition in three fourths of cases, while sports are more of a tradition in rural (23.1%) rather than urban (19.7%)families (Table 4.3).

**Table 4.4. Distribution of parents’ answers, “Which member of your family is currently engaged in physical activity/sports?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Father | 21,5 | 24,7 | 18,3 |
| Mother | 5,6 | 6,7 | 4,6 |
| Brothers/sisters | 43,8 | 46,3 | 41,3 |
| Someone else | 1,0 | 0,9 | 1,1 |
| No one | 40,7 | 38,1 | 43,4 |

It is noteworthy that assessment physical activity (physical training and sports) through answers of parents showed that during the survey no one in 40.7% of families engaged in physical activity/sports, brothers and sisters went in for sports in 43.8%, fathers did sports in 21.5% of families and mothers went in for sports in 5.6% of families. In the urban settings, the situation looked brighter (**Tables 4.5 and 4.6)**.

**Table 4.5. Distribution of parents’ answers,**

**“Should sports activities be encouraged?, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Yes | 88,5 | 88,5 | 88,6 |
| No | 8,3 | 11,6 | 8,1 |
| Don’t know | 3,1 | 3,0 | 3,3 |

**Table 4.6. Distribution of parents’ responses,**

**“Under what conditions would you encourage sports activities?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Adolescents engages in physical activity/sports | 17,7 | 12,9 | 22,6 |
| Proximity of sports facilities | 12,9 | 12,9 | 12,9 |
| Affordable fees | 5,6 | 6,5 | 4,8 |
| Absence of fees | 10,5 | 12,9 | 8,1 |
| Presence of skilled coaches | 6,5 | 4,8 | 8,1 |
| Under no conditions | 19,4 | 24,2 | 14,5 |
| Don’t know | 27,4 | 25,8 | 29,0 |

In both urban and rural areas, 88.5% of surveyed parents think that it is necessary to encourage children to engage in sports. This gives hope that the percentage of children and adolescents, who engage in sports, will increase. Yet, 27.4% (rural - 29.0%) of parents do not know how they will encourage their children to engage in sports; 19.4% of parents would not encourage their children to go in for sports under any conditions. Significant importance is attached to fees, especially, in urban areas: 10.5% think that sports classes should be free-of-charge (urban – 12.9%, rural - 8.1%), while 5.6% believe that fees should be affordable (urban – 6.5%, rural – 4.8%). Equal amount of answers about proximity of sports facilities were received (12.9%). One of the conditions reported by parents was that adolescents already engage in physical activity/sports (17.7%, especially, in rural areas – 22.6%).Parents also reported in 6.4% of cases that they would encourage their children to engage in sports in presence of skilled coaches and this percentage of parents was two times higher in rural area (8.1%) than in urban area (4.8%).

The survey showed that parents take interest in their children’s studies and assess their academic achievements and failures. Thus, 24.2% of parents reported that their children perform excellently, 59.5% - well, 14.6 % - passably, and 0.6% - poorly at school. Academic performance is practically the same regardless of place of residence. There is also a fact that a certain percentage of children (1.1%) did not study during last 12 months and there are twice as many such adolescents in urban (1,5%) than in rural (0.7%) areas (Tables 4.7 and 4.8**)**.

**Table 4.7. Distribution of parents’ responses,**

**“How do you assess learning performance during the last academic year?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Excellent | 24,2 | 23,6 | 24,7 |
| Well | 59,5 | 58,9 | 60,1 |
| Passable | 14,6 | 15,4 | 13,8 |
| Poor | 0,6 | 0,6 | 0,6 |
| Did not study during the last 12 months | 1,1 | 1,5 | 0,7 |

Most parents (76.7%) give attention to their children’s homework and take part in this process. The duration of such participation varies. The analysis of parents’ responses to a question “How often during the last academic year did your child do homework with father and mother?” showed that children do their homework with their parents daily in 23.7% (urban – 25.7%, rural - 21.8%) of cases, weekly in 25.2% (urban – 25.8%, rural – 24.5%) of cases, sometimes (once a month), and in 26.0% (urban – 21.2%, rural – 30.8%) of cases. Among the surveyed parents, 23.3% of the respondents (urban – 24.7%, rural – 22.0%) never did homework with their children (Table 4.8).

**Table 4.8. Distribution of parents’ responses,“How often during the last academic year did your child do homework with father (mother)?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Daily | 23,7 | 25,7 | 21,8 |
| Weekly | 25,2 | 25,8 | 24,5 |
| sometimes / once a month | 26,0 | 21,2 | 30,8 |
| Never | 23,3 | 24,7 | 22,0 |

This fact is largely negative if children’s academic performance is poor and they require psychological, other support, and additional study time together with parents or other family members (grandparents, older siblings).

The responses allow concluding that most adolescents (60.3%) take part in extramural events (Table 4.9).

**Table 4.9. Distribution of parents’ responses, “Has your child participated in any out-of-school activities such as an Olympiad (academic competition), tournaments or contests during the recent academic year?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Olympiad | 16,9 | 15,2 | 18,5 |
| Tournaments | 31,5 | 30,3 | 32,7 |
| Contests | 18,1 | 22,9 | 13,3 |
| Did not participate | 39,7 | 37,9 | 41,5 |

Almost every third child (31.5%) participated in sports tournaments (more rural children – 32.7%), 18.1% of students took part in various contests (more urban children – 22.9%), and 16.9% took part in Olympiads (more in rural areas – 18.5%).

Parents reported factors, which deserve focus of a family and an academic institution (school, lyceum, college) in relation to shaping an adolescent’s healthy lifestyle (Table 4.10).

**Table 4.10. Distribution of Parents’ Responses, “What, in your opinion, should a family and school (lyceum, college) pay attention to, when taking care about shaping an adolescent’s healthy lifestyle?”, %**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Follow daily routine, rest and sleep | 61,4 | 67,8 | 55,0 |
| Nutritionally sound diet | 49,6 | 56,3 | 43,0 |
| Physical activity | 33,3 | 34,4 | 32,3 |
| Health/clean environment | 41,2 | 35,1 | 47,2 |
| Favorable psychological environment | 20,9 | 24,3 | 17,5 |

Most responses (61.4%) were about following the daily routine, rest and sleep, 49.6% - nutritionally sound diet, 41.2% - health and clean environment, and 20,9% - favorable psychological environment (Table 4.10). This being said, the percentage of parents who listed factors other than “health and clean environment” in urban areas exceeded similar answers in rural areas.

The survey showed that most adolescents (69.9%) engage in physical activity at home and this percentage is higher in urban (75.1%) than in rural (64.8%) areas. Both in urban and rural settings, more boys (80.9% and 77.5%, accordingly) than boys (69.4% and 48.1%, accordingly) engage in sports (Tables 4.11 and 4.12).

**Table 4.11. Distribution of parents’ responses,**

**“Does the adolescent engage in physical activity at home?”, %**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Yes | 69,9 | 79,1 | 59,5 | 75,1 | 80,9 | 69,4 | 64,8 | 77,5 | 48,1 |
| No | 29,1 | 19,9 | 39,5 | 24,3 | 18,4 | 30,3 | 33,8 | 21,2 | 50,2 |

**Table 4.12. Distribution of parents’ responses,**

**“How regularly does your child engage in physical activity at home?”,  
% of those, who answered “yes” to the previous question**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| regularly every day | 53,9 | 58,1 | 47,5 | 50,5 | 56,9 | 43,1 | 57,8 | 59,2 | 54,9 |
| every other day | 25,2 | 24,0 | 26,9 | 24,5 | 19,9 | 29,8 | 25,9 | 27,7 | 22,1 |
| 1-2 times a week | 11,9 | 10,1 | 14,6 | 11,1 | 11,1 | 11,2 | 12,8 | 9,2 | 20,4 |
| less frequently than once a week | 8,7 | 7,3 | 11,0 | 13,4 | 11,1 | 16,0 | 3,4 | 3,8 | 2,7 |

Parents, who answered “yes” to whether or not adolescents engage in physical activity at home, also reported frequency of physical activity. More than half (53.9%) of them exercise regularly every day, every fourth child – every other day, 11.9% - 1-2 times a week, 8.7 % - less frequently than once a week (Table 4.12).More rural adolescents – both boys and girls – regularly exercise (57.8%).

**Table 4.13. Distribution of parents’ responses, “Does your child engage in physical activity elsewhere?”, %of Respondents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| attends a sports school professionally | 2,5 | 3,7 | 1,2 | 2,6 | 4,1 | 1,1 | 2,4 | 3,3 | 1,3 |
| regularly attends a sports club | 22,4 | 27,5 | 16,6 | 21,4 | 27,3 | 15,5 | 23,4 | 27,7 | 17,9 |
| irregularly attends sports clubs | 6,1 | 7,5 | 4,5 | 6,3 | 7,5 | 5,2 | 5,9 | 7,5 | 3,8 |
| engages in physical training / sports in unstructured sports group | 10,5 | 14,8 | 5,5 | 10,4 | 15,7 | 5,2 | 10,5 | 14,0 | 6,0 |
| does not do sports | 58,5 | 46,5 | 72,1 | 59,3 | 45,3 | 73,1 | 57,7 | 47,6 | 71,1 |

Along with exercise at home, 41.5% of adolescents (urban – 40.7%, rural – 42.3%) engage in physical activity elsewhere. Sports clubs prevail among sports facilities, where 22.4% adolescents regularly engage in various types of sports (urban – 21.4 %, rural – 23.4%) and boys prevail in the total number of adolescents. Sports clubs are attended irregularly by 6.1% of adolescents. Almost equal percentage (10.5%) of adolescents in both urban and rural settings engage in unstructured physical activity, where there twice as many boys (three times as many in urban areas), who do so. Two and a half percent of adolescents attend sports schools and engage in sports professionally and both in urban and rural areas three times more boys engage in such physical activity (Table 4.13).

It was interesting to receive responses from parents, whose children do not engage in recreational activities (physical activity and sports) in places other than home (58.5%) (Table 4.14).

**Table 4.14. Distribution of parents’ answers, “What prevents active involvement in physical activity/sports?”,% of those, who do not engage in sports**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Health status | 7,3 | 9,0 | 6,0 | 6,9 | 9,9 | 5,1 | 7,7 | 8,2 | 7,2 |
| Lack of time / Household chores | 24,1 | 22,5 | 25,2 | 24,5 | 24,0 | 24,7 | 23,6 | 21,2 | 25,7 |
| Remoteness of sports facilities | 25,0 | 31,5 | 20,3 | 15,0 | 19,0 | 12,6 | 35,1 | 41,8 | 29,3 |
| Lack of funds | 9,0 | 13,5 | 5,8 | 11,3 | 17,4 | 7,6 | 6,7 | 10,3 | 3,6 |
| This is not a tradition in our family / We believe the child should devote his/her time to something more useful (studies, learning a language, and etc.) | 16,0 | 12,0 | 18,9 | 20,1 | 14,0 | 23,7 | 11,8 | 10,3 | 13,2 |
| Child’s reluctance | 35,6 | 31,5 | 38,6 | 37,9 | 35,5 | 39,4 | 33,2 | 28,1 | 37,7 |
| Other factors | 4,6 | 6,4 | 3,3 | 6,9 | 11,6 | 4,0 | 2,2 | 2,1 | 2,4 |

It was found that the leading cause was child’s reluctance (35.6%), more among girls than boys. Twenty-five percent of respondents reported remoteness of sports facilities, especially, in rural areas - 35.1% (more than child’s reluctance - 33.2%). According to responses, 24.1% of adolescents do not exercise elsewhere due to lack of time and household chores. In 16.0% of families, there is no tradition to exercise and they prefer the child to do something more useful (education, languages, and etc.). Another reason was lack of funds (9.0%), which was reported more frequently in urban areas and amounted to 11.3% (in rural areas - 6.7%).

In order to identify how effectively physical activity is organized for children and adolescents, a special survey of parents, whose children engage in sports elsewhere, besides physical education classes (Table 4.15).

Table 4.15**. Distribution of parents’ responses, “Does your child have an opportunity to exercise/engage in sports near a place of residence?”, %**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Yes | 91,1 | 89,6 | 94,3 | 93,2 | 92,5 | 94,5 | 89,1 | 87,0 | 94,1 |
| No | 7,6 | 8,8 | 5,0 | 5,9 | 6,8 | 4,1 | 9,2 | 10,6 | 5,9 |
| Don’t know | 1,3 | 1,6 | 0,7 | 0,9 | 0,7 | 1,4 | 1,7 | 2,5 | 0,0 |

The analysis of parents’ answers showed that 91.1% of adolescents who engage in sports have an opportunity to attend classes to engage in physical activity and sports near place of residence, especially girls (94.3%) regardless of their place of residence (Table 4.16).

*What sports are more popular among children and adolescents?* Parents’ reported that, in general, most adolescents (40.4%) engage in the following sports: soccer, volleyball, and basketball. Twice as many boys play team sports (urban – 3.5 times more, rural – 1.8 times more).

Table 4.16**. Distribution of parents’ responses,**

**“What sports does an adolescent go in for?”, %**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Swimming, water sports | 8,7 | 6,8 | 12,8 | 14,6 | 11,6 | 20,5 | 3,1 | 2,5 | 4,4 |
| Soccer, volleyball, basketball | 40,4 | 49,2 | 21,3 | 32,4 | 42,5 | 12,3 | 48,0 | 55,3 | 30,9 |
| Karate, wushu, boxing, taekwondo | 25,9 | 33,2 | 9,9 | 21,5 | 32,2 | 0,0 | 30,1 | 34,2 | 20,6 |
| Olympic, artistic gymnastics | 6,5 | 0,3 | 19,9 | 9,1 | 0,0 | 27,4 | 3,9 | 0,6 | 11,8 |
| Track and field athletics, tennis | 10,7 | 4,6 | 24,1 | 13,2 | 5,5 | 28,8 | 8,3 | 3,7 | 19,1 |
| Bicycling, types of sports using sports equipment | 1,6 | 1,6 | 1,4 | 1,4 | 2,1 | 0,0 | 1,7 | 1,2 | 2,9 |
| Others | 6,3 | 4,2 | 10,6 | 7,8 | 6,2 | 11,0 | 4,8 | 2,5 | 10,3 |

The next most popular sports include karate, wushu, boxing and taekwondo (25.9%), where more rural than urban residents engage in these sports. Children of 10.7% of the parents surveyed engage in track-and-field athletics and tennis. Girls engage in these sports almost five times more. Swimming and water sports are popular among 8.7% of adolescents, where almost twice as many girls are engaged in these sports. Almost five times more urban adolescents engage in water sports. Cycling and types of sports using sports equipment are popular among 1.6% of adolescents (urban – 1.4%, rural – 1.7%). It is an interesting fact was that urban girls do not engage in these sports, while in rural areas the percentage of girls going in for these sports is 2.9%, which is more than twice as many as boys. Olympic and artistic gymnastics are sports, which involve 27.4% of girls, which is 2.3 times more than girls living in rural areas (11.8%) (Table 4.16).

*Does a choice of sports depend on a family’s wellbeing?* As parents’ responses show, adolescents from middle-income and low-income families prefer team sports (soccer, volleyball, basketball) to a greater extent – 46.2% and 41.9%, respectively, followed by karate, wushu, boxing taekwondo –24.2% and 23.3%, respectively. Although more adolescents from high-income families tend to go into the latter sports (karate, wushu, boxing, taekwondo – 31.0% and team sports – 27.9%) (Table 4.17).

Table 4.17. **Distribution of responses “What sports do children go in for?” Depending on a Family’s Wellbeing, %**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | What sports does a child go in for? | | | | | | |
| Swimming, water sports | Soccer, volleyball, basketball | Karate, wushu, boxing, taekwondo | Olympic and artistic gymnastic | Track-and-field athletics, tennis | Bicycling, types of sports using sports equipment | Others |
| High-income families | 12,4 | 27,9 | 31,0 | 7,8 | 14,7 | 1,6 | 4,7 |
| Middle-income families | 7,7 | 46,2 | 24,2 | 6,2 | 8,1 | 1,1 | 6,6 |
| Low-income families | 2,3 | 41,9 | 23,3 | 4,7 | 16,3 | 2,3 | 9,3 |

More adolescents from high-income families or 12.4% engage in swimming and water sports, more than five times as many as adolescents from low-income families. The percentage of adolescents engaged in Olympic and artistic gymnastics is higher among those from high-income (7.8%) and middle-income (6.2%) families than from low-income (4.7%). More adolescents from low-income families engage in cycling and types of sports using sports equipment. The analysis showed no significant difference between in sports depending on a family’s wellbeing.

Adolescents mainly attend state-owned sports facilities (77.9%): 80.1% of girls and 76.9% of boys. In rural areas, there is a higher percentage of adolescents attending state-owned facilities (85.6%): 91.2% of girls and 83.2% of boys. A total of 11.4% of adolescents attend sports facilities, urban – 13.7% and rural – 9.2%, with more boys attending these facilities (Table 4.18).

Departmental sports facilities are attended by 4.7% of adolescents, while in urban settings, the percentage is 7.8%, which is 4.6 times more than in rural areas (1.7%). Six percent of respondents did not know or found it difficult to answer, i.e., they did not know about the ownership status of sports facilities, which their children attend and this percentage was higher in urban (8.7%) than rural (3.5%) area.

**Table 4.18. Distribution of parents’ responses, «What is the ownership status of a sports school/club, which the adolescent attends?”, %**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| State-owned | 77,9 | 76,9 | 80,1 | 69,9 | 69,9 | 69,9 | 85,6 | 83,2 | 91,2 |
| Departmental | 4,7 | 4,2 | 5,7 | 7,8 | 6,8 | 9,6 | 1,7 | 1,9 | 1,5 |
| Private | 11,4 | 12,7 | 8,5 | 13,7 | 14,4 | 12,3 | 9,2 | 11,2 | 4,4 |
| Don’t know | 6,0 | 6,2 | 5,7 | 8,7 | 8,9 | 8,2 | 3,5 | 3,7 | 2,9 |

Practically all parents are committed to encourage their children to engage in sports. To the question: “Do you support your child’s desire to engage in sports?”,99.3% of parents, notably, 100% of parents of girls in urban areas (Table 4.19) answered “yes”.

**Table 4.19. Distribution of Parents’ Responses,**

**“Do you support the adolescent’s desire to engage in sports?”, %**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Yes | 99,3 | 99,3 | 99,3 | 99,5 | 99,3 | 100,0 | 99,1 | 99,4 | 98,5 |
| No | 0,4 | 0,3 | 0,7 | 0,0 | 0,0 | 0,0 | 0,9 | 0,6 | 1,5 |

The survey identified that regardless of sex, adolescents engage in sports, on average, three times a week during three and more years.

Parents’ responses from Table 4.20showed that almost half of adolescents engage in sports to be strong (urban – 50.7%, rural – 39.3%). Parents offered 20.8% of adolescents to engage in sports and the authority of parents in the structure of listed factors was the leading factor among urban girls (30.5%).

**Table 4.20. Distribution of parents’ responses,**

**“Why did the adolescent decide to take up sports?”, % of those engaged in sports**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Wants to be strong | 44,9 | 51,5 | 30,5 | 50,7 | 60,3 | 31,5 | 39,3 | 43,5 | 29,4 |
| Parents offered | 20,8 | 16,3 | 30,5 | 22,8 | 15,8 | 37,0 | 18,8 | 16,8 | 23,5 |
| Friends asked to join | 19,6 | 20,2 | 18,4 | 11,0 | 11,6 | 9,6 | 27,9 | 28,0 | 27,9 |
| Coach invited | 7,8 | 6,2 | 11,3 | 6,8 | 4,8 | 11,0 | 8,7 | 7,5 | 11,8 |
| Other | 6,9 | 5,9 | 9,2 | 8,7 | 7,5 | 11,0 | 5,2 | 4,3 | 7,4 |

Adolescents’ friends played an important role. Thus, 19.6% of adolescents took up sports due to their friends’ proposal. In rural areas, proposal from friends ranks second (27.9%) both among boys (28.0%) and girls (27.9%). Adolescents take up sports because of being invited by coaches in 7.8% and almost twice as many girls (11.3%) than boys (6.2%) in this case.

A section in our questionnaire concerning parents’ assessment of sports influence on adolescents is crucial. Thus, the survey ascertained that 43.3% of parents, who report that their children fall ill less frequently (urban – 45.2%, rural – 41.5%), 44.4% - became more active, and 5.4% - became more sociable (Table 4.21).

**Table 4.21. Distribution of parents’ responses,**

**“How did sports influence the adolescents?”, % of those engaged in sports**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Falls ill less frequently | 43,3 | 43,3 | 43,3 | 45,2 | 43,8 | 47,9 | 41,5 | 42,9 | 38,2 |
| Became more active | 44,4 | 44,0 | 45,4 | 43,4 | 42,5 | 45,2 | 45,4 | 45,3 | 45,6 |
| Became more sociable | 5,4 | 5,9 | 4,3 | 4,6 | 5,5 | 2,7 | 6,1 | 6,2 | 5,9 |
| Lags behind others in his/her studies | 0,4 | 0,3 | 0,7 | 0,0 | 0,0 | 0,0 | 0,9 | 0,6 | 1,5 |
| Other | 3,8 | 3,6 | 4,3 | 5,5 | 6,2 | 4,1 | 2,2 | 1,2 | 4,4 |
| Do not know | 2,7 | 2,9 | 2,1 | 1,4 | 2,1 | 0,0 | 3,9 | 3,7 | 4,4 |

Very few responses were about deteriorated academic performance (urban – no negative answer, urban – 0.9%);2.7% of parents did not know or found it difficult to answer, especially in rural areas (3.9%), a question about the influence of sports on children.

Most adolescents (65.0%) engage in sports on a free-of-charge basis. This varies regarding the place of residence. Thus, 49.3% of urban children attend fee-based sports classes, while in rural areas only 20.5% (Figure 4.1) do so.

**Figure 4.1.Distribution of parents’ responses,**

**“Do you pay for sports classes?”, % of those engaged in sports**

Assessing parents’ responses about payments, it should be pointed out that average payments depend on place of residence and sex of an adolescent.

Thus, in general, average payment amounts to 33,887.0 Uzbek soums, particularly, in urban areas, the average payments are 37,439.4 Uzbek soums, which is 11,035.1 Uzbek soums more than in rural areas.

Figure 4.2 shows that 85,0% of parents find payment for sports classes satisfactory (urban – 84.0%, rural – 87.2%) and equal percentages of parents find the payment low and excessively high (7.5% each).

**Figure 4.2. Distribution of parents’ responses,**

**“Do you think payment is…?”, % of those engaged in sports**

The majority of parents are content with a gym (sports ground and room), where their children exercise, while4.7% of parents were dissatisfied with a gym with more such parents in rural areas (6.6%, more parents of boys – 8.1%) and 3.3% of parents did not know the answer to this question (Figure 4.3).

**Figure 4.3. Distribution of parents’ responses, “Are you satisfied with a gym (sports ground or room), where the adolescent exercises?”,**

**% of those engaged in sports**

When parents reported dissatisfaction with sports facilities, 30.6% of them did not know or found it difficult to explain reasons as to why they disliked a gym (sports ground or room) and in urban area parents of all girls did not know what they disliked about sports facilities.

Equal percentages of parents were dissatisfied with lack of sports equipment and heating in winter (27.8% each). Parents of girls (100%) living in rural areasreported dissatisfaction with space heating in winter (Figures 4.4, 4.5).

**Figure 4.4. Distribution of parents’ responses,**

**“If not, then what don’t you like?”, %**

As it is known, competency of coaches and instructors is key to effective organization of sports activities. The survey ascertained that 91.3% of parents were satisfied with competency of coaches and instructors of their children, 3.3% were dissatisfied, and 5.4% of parents found it difficult to answer this question.

**Figure 4.5. Distribution of parents’ responses,“Are you satisfied with the level of competence of coaches/instructors?”, % of those engaged in sports**

We administered a survey to understand what factors may compel a child to quit sports activities (Table 4.22).

**Table 4.22. Distribution of parents’ responses,“For what reason would compel an adolescent to quit going in for sports?”, % of those engaged in sports**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Boy** | **Girl** |
| Health status | 25,7 | 25,7 | 25,5 |
| Lack of time | 14,7 | 15,0 | 14,2 |
| Remoteness of sports facilities | 2,5 | 2,6 | 2,1 |
| Higher fees | 2,2 | 2,6 | 1,4 |
| Upon child’s desire | 47,5 | 46,9 | 48,9 |
| Other factors | 7,4 | 7,2 | 7,8 |

Parents responses resulted in the following ranking: 47.5% - child’s desire; 25.7% - health status, this factor was emphasized by parents of girls living in rural areas, (33.8%); 14.7% - lack of time (in urban areas, boys’ parents prevailed (15.8%) and in rural areas, girls’ parents prevailed (20.6%); 2,5% - remoteness of sports facilities; 2.2% - higher fees (urban – 2.7%, rural – 1.7%). Other factors were reported by 7.4% of parents (urban – 12.8%, rural – 2.2%).

Interesting findings were received in relation to factors that prevent involvement into sports activities depending on the wellbeing of a family (Table 4.23).

Table 4.23. **Distribution of answers to the question “What prevents children from going in for sports?” depending on a family’s wellbeing, %**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Health status | Lack of time/ Household chores | Remoteness of sports facilities | Lack of funds | This is not a tradition in our family / We believe the child should devote his/her time to something more useful (studies, learning a language, and etc.) | Child’s reluctance |
| High-income families | 2,0 | 29,6 | 18,4 | 3,1 | 28,6 | 34,7 |
| Middle-income families | 6,8 | 23,0 | 28,0 | 7,7 | 14,0 | 38,9 |
| Low-income families | 16,9 | 23,4 | 15,6 | 24,7 | 11,7 | 16,9 |

The leading factor preventing involvement into sports activities in high-income families are child’s desire– 34.7% followed by: lack of time/household chores – 29.6%, not a tradition in our family/we believe the child should devote his/her time to something more useful (studies, learning a language, and etc.) – 28.6%, remoteness of sports facilities – 18.4%, lack of funds – 3.1% and health status – 2.0%.

In middle-income families, child’s desire has a leading position as well – 38.9%, remoteness of sports facilities is also very important (28.0%) and lack of time/household chores (23.0%), not a tradition in our family/we believe the child should devote his/her time to something more useful (14.0%) followed by lack of funds (7.7%) and health status (6.8%).

In low-income families, the first factor that prevents sports activity is lack of funds (24.7%) followed by lack of time and household chores (23.4%),equal percentages for health status and child’s reluctance (16.9% each), remoteness of sports facilities (15.6%). As compared to families with high- and middle-income families, fewer low-income families (11.7%) think that sports is not a tradition in their family/believe the child should devote his/her time to something more useful (studies, learning a language, and etc.).

Parents’ sports activity in the past also determines physical activity and sports (Table 4.24).

Table 4.24. **Distribution of answers “Physical activity and sports” depending parents’ sports activity in the past, %**

|  |  |  |
| --- | --- | --- |
| Has any family member engaged in sports? | Does he/she engage in physical activity? | |
| Yes | No |
| Father | 77,6 | 21,9 |
| Mother | 84,2 | 15,8 |
| Both parents | 81,8 | 18,2 |
| None | 60,7 | 37,8 |

Answers found that 81.8% of adolescents, whose both parents engaged in sports in the past, exercise at home, 84.2% - if the mother went in for sports, 77.6% - if the father participated in sports in the past. The lowest percentage of adolescents engaged in physical activity at home has been in families in which neither parent was involved in sports.

Physical exercise, to some extent, depends on wellbeing of a family (Tables 4.25 and 4.26).

**Table 4.25. Distribution of answers to the question “Physical exercise and sports” depending of a family’s wellbeing, %**

|  |  |  |
| --- | --- | --- |
| Does he/she exercise at home? | Yes | No |
| high-income families | 82,8 | 16,7 |
| middle-income families | 66,7 | 32,1 |
| low-income families | 65,0 | 34,2 |

Thus, 82.8% of adolescents from high-income families engage in physical exercise at home. The situation is analogous in middle-income and low-income families: physical exercise at home 66,7 % и 65,0%.

**Table 4.26.Distribution of answers to the question “Is he/she engaged in other physical activity?” depending on a family’s wellbeing, %**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | attends a sports school professionally | regularly attends a sports club | irregularly attends a sports club | engages in unstructured physical activity/sport | does not do sports |
| high-income families | 1,5 | 19,6 | 6,2 | 10,1 | 62,6 |
| middle-income families | 1,7 | 20,8 | 4,2 | 9,2 | 64,2 |
| low-income families | 6,2 | 32,6 | 5,7 | 12,3 | 43,2 |

Wellbeing of a family is one of the factors that determine accessibility to sports activities in respective sports facilities. According to the responses received, sports facilities are not attend by: 62.6% of adolescents from high-income families; 64.2% of adolescents from middle-income families, and 43.2% of adolescents from low-income families. It should be noted that the percentage of adolescents from low-income families who regularly attend sports clubs (32.6%), enrolled in sports schools and engage in professional sports (6.2%), and engage in physical activity and sports in unstructured groups (12.3%) is higher than the percentage of adolescents from families with high and middle income.

In general, it should be emphasized once again that Uzbekistan has been taking nationwide efforts to shape a harmiously developed generation, whereby one of important areas is ensuring necessary conditions to involve as many children, adolescents, and young people into sports. The evidence is the high level of public awareness about the role and importance of physical activity – recreation and sports activities – for shaping the health and harminous development.

Commitment of parents to sports activities of their children is also crucial. The survey evaluated conditions, which were created at sports facilities, and competencies of coaches and instructors. In this regard, respondents reported negative issues such as absence of appropriate sports equipment at a number of sports facilities and absence of heating, especially, in rural sports facilities.

Evaluation of financial expenses of families on sports activities helped identify a significant difference in payments depending on where children and adolescents live. Special attention should be paid to the fact that payment for sports activities for urban girls by far exceeds payments for sports activities of rural boys and girls.

# Section 5. KNOWLEDGE, ATTITUDES, AND PRACTICES OF THE POPULATION CONCERNING REPRODUCTIVE HEALTH AND HARMFUL HABITS OF THE YOUNGER GENERATION

“Reproductive health is the state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and systems”. Reproductive health implies not only processes related to reproduction of human beings, but also those, which ensure it.

Currently, awareness-raising efforts among adolescents and young people on the principles of reproductive health and protection are very important. It is also important from whom and what information adolescents receive. The results of the survey of parents showed that most adolescents learn about reproductive health from parents and relatives (43.1%); this percentage is higher in the city (47.2%) than in rural areas (39.1%), and more girls are informed (Table 5.1).

**Table 5.1. Distribution of parents’ responses, “From what source does an adolescent receive information about reproductive health?”,**

**% of respondents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Urban** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Parents, relatives | 43,1 | 36,4 | 50,8 | 47,2 | 43,1 | 51,3 | 39,1 | 30,6 | 50,2 |
| Friends, peers | 6,6 | 9,2 | 3,6 | 3,9 | 5,6 | 2,2 | 9,2 | 12,4 | 5,1 |
| Healthworkers | 8,9 | 9,6 | 8,1 | 5,6 | 4,9 | 6,3 | 12,2 | 13,7 | 10,2 |
| Teacher | 27,9 | 27,7 | 28,1 | 32,3 | 32,6 | 32,1 | 23,4 | 23,5 | 23,4 |
| Newspaper, magazine, special books | 6,1 | 7,3 | 4,7 | 4,5 | 5,2 | 3,7 | 7,7 | 9,1 | 6,0 |
| Radio, TV, the Internet | 5,9 | 8,5 | 3,0 | 4,8 | 7,5 | 2,2 | 7,0 | 9,4 | 3,8 |
| Other | 1,5 | 1,2 | 1,8 | 1,7 | 1,1 | 2,2 | 1,3 | 1,3 | 1,3 |

Next in rank are teachers (27.9%),this source is reported more frequently by urban parents. Health workers rank third (8.9%) in rural areas they are more active and more frequently (12.2%) than in urban areas hold awareness-raising activities among adolescents (5.6%).12.2% of rural and 3.9% of urban adolescents receive information and knowledge from friends, with this source being a prevalent one among boys. A total of 6.1% of adolescents – 4.5% urban and 7.7% rural – receive information from a newspaper, magazing or special books, especially;boys more frequently use this source. Radio, television, and the Internet were reported as information sources in 5.9% cases and again this source was reported more frequently among rural residents (7.0%) and boys regardless of place of residence.

When asked a question “Which aspects of reproductive health have you discussed with your adolescent child?” to parents, 31.7% of them have never talked with parents on this issue (urban– 33.6%, rural – 29.7%) (Table 5.2).

**Table 5.2. Distribution of parents’ responses,**

**“What aspects of reproductive health have you talked about with your adolescent child?”, % of respondents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| ability to reproduce | 6,8 | 8,7 | 4,5 | 7,1 | 9,0 | 5,2 | 6,5 | 8,5 | 3,8 |
| questions related to preparation for family life | 36,2 | 34,3 | 38,3 | 34,4 | 33,0 | 35,8 | 38,0 | 35,5 | 41,3 |
| sexual life hygiene | 36,6 | 13,1 | 63,2 | 40,0 | 17,6 | 62,0 | 33,2 | 9,1 | 64,7 |
| how pregnancy occurs | 1,6 | 0,3 | 3,0 | 1,5 | 0,4 | 2,6 | 1,7 | 0,3 | 3,4 |
| Birth control methods | 0,6 | 0,7 | 0,6 | 0,6 | 0,4 | 0,7 | 0,7 | 1,0 | 0,4 |
| HIV / AIDS | 22,8 | 25,6 | 19,6 | 17,5 | 19,1 | 15,9 | 28,0 | 31,3 | 23,8 |
| venereal diseases | 11,3 | 12,5 | 9,9 | 10,0 | 12,0 | 8,1 | 12,5 | 13,0 | 11,9 |
| never talked | 31,7 | 44,1 | 17,6 | 33,6 | 46,8 | 20,7 | 29,7 | 41,7 | 14,0 |
| other | 2,9 | 3,5 | 2,2 | 3,0 | 4,1 | 1,8 | 2,8 | 2,9 | 2,6 |

The main questions of talks with parents were: sexual life hygiene – 36.6% (urban – 40.0%, rural – 33.2%), preparation for family life – 36.2% (urban–34.4%, rural – 38.0%), HIV/AIDS – 22.8% (urban – 17.5%, rural – 28.0%, i.e., HIV/AIDS prevention receives more attention in rural areas). 11.3% of parents pay attention to venereal diseases (again, more in rural areas – 12.5%). Less attention is paid to issues such as reproduction – 6.8% (urban – 7.1%, rural – 6.5%), how pregnancy occurs – 1.6% (this information and knowledge was provided to girls 10 times more), about methods of contraception – 0.6% (Table 5.2).

Received answer, unfortunately, suggest that not all adolescents receive information about current problems such as STI and HIV/AIDS. Only 36.3% of surveyed parents spoke to their children on this topic (Tables 5.3 and 5.4).

**Table 5.3. Distribution of parents’ responses, “Have you ever spoken to your adolescent child about STIs including HIV, AIDS?”, % if respondents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Yes | 36,3 | 32,6 | 40,5 | 35,9 | 32,6 | 39,1 | 37,8 | 33,6 | 43,4 |
| No | 62,4 | 66,2 | 58,1 | 62,6 | 65,9 | 59,4 | 62,2 | 66,4 | 56,6 |

Most parents(35.5%) think that adolescents should receive information about STIs, HIV/AIDS, from teachers and this opinion is supported by 42.2% of urban parents and 28.8% of rural paretns. Parents identified themselves as a source next in rank (21.5%).

**Table 5.4. Distribution of parents’ responses,**

**“What main source of information about STIs, HIV, AIDS is the most important for an adolescent?”, % of respondents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Total** | | | **Urban** | | | **Rural** | | |
| **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** | **Total** | **Boy** | **Girl** |
| Parents, relatives | 21,5 | 19,5 | 23,7 | 21,4 | 19,1 | 23,6 | 21,6 | 19,9 | 23,8 |
| Friends, peers | 6,1 | 6,1 | 6,1 | 4,3 | 4,9 | 3,7 | 7,9 | 7,2 | 8,9 |
| Healthworkers | 14,3 | 12,7 | 16,0 | 13,6 | 10,5 | 16,6 | 14,9 | 14,7 | 15,3 |
| Teacher | 35,5 | 34,3 | 36,8 | 42,2 | 41,9 | 42,4 | 28,8 | 27,7 | 30,2 |
| Newspaper, journal, special books | 8,6 | 9,4 | 7,7 | 4,6 | 4,9 | 4,4 | 12,5 | 13,4 | 11,5 |
| Radio, TV, the Internet интернет | 12,7 | 17,1 | 7,7 | 12,6 | 18,4 | 7,0 | 12,7 | 16,0 | 8,5 |
| Other | 1,4 | 0,9 | 2,0 | 1,3 | 0,4 | 2,2 | 1,5 | 1,3 | 1,7 |

Health workers were reported by 14.3% of surveyed paretns, with practically equal distribution in urban and rural areas. An important source were radio, television, and the Internet (12.7%), especially for boys (urban 17.1 %, rural – 16.0%). Friends and relatives were preferred by 6.1 % (urban – 4.3%, rural – 7,9%), newspapers, journals and special books – 8.6 % of respondents (in rural areas, this percentage was higher than urban areas and amounted to 12.5%)(Table 5.4).

The survey identified that 28.1% of family members have a harmful habit of smoking with higher percentage in urban area (30.3%) and much larger in rural areas (25.8%) (Figure 5.1, Tables 5.5 and 5.6)

**Figure 5.1. Distribution of parents’ responses,**

**“Does any of your family members smoke?”, % of respondents**

Analysis of responses from parents who have smokers in the family, shows that most of the smokers are parents themselves (91.7%), rural areas, this indicator amounted to 97.1%, which is 10% more than in urban areas. Among smoking relatives, there were 4.3% of grandparents (4.3%),this indicator was higher in urban areas (6.1%). In 3.7% of urban families, smokers included siblings; while in rural areas these family members were not reported (Table 5.6).

**Table 5.5. Distribution of parents’ responses,**

**“Which of your family members smokes?”, % of families with smokers**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Father / mother | 91,7 | 87,1 | 97,1 |
| Brothers / sisters | 2,0 | 3,7 | 0,0 |
| Grandfather / grandmother | 4,3 | 6,1 | 2,1 |
| Someone else | 1,0 | 1,8 | 0,0 |
| No one | 0,7 | 1,2 | 0,0 |

To the question “What do you think makes people smoke?”, 36.4% of parents indicated curiosity, 26.4% - the influence of others (in the city - 21.0% in rural areas - 31.7%), 23, 1% - the loneliness or life hardships (in rural areas, this percentage was lower than in the city (27.3%) and amounted to 18.8%). Nine percent of parents did not know and found it difficult to answer this question (Table 5.7).

**Table 5.6. Distribution of parents’ responses,**

**“What do you think makes people smoke?”, % of respondents**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Total** | **Urban** | **Rural** |
| Loneliness / Life hardships | 23,1 | 27,3 | 18,8 |
| Curiosity | 36,4 | 36,8 | 36,0 |
| Influence of others | 26,4 | 21,0 | 31,7 |
| Others | 5,2 | 5,2 | 5,2 |
| Do not know | 9,0 | 9,7 | 8,3 |

With reference to the foregoing, we conclude that parents pay enough attention to their children’s awareness on reproductive health issues, especially, about reproduction, early pregnancy and relevant complications, but they insufficiently involve health professionals into the process.

In order to improve efforts to shape and strengthen reproductive health of adolescents, there is a need to intensify cooperation with health care workers, teachers to raise awareness among parents and adolescents on reproductive health, healthy lifestyles and prevention of addictions, STIs and HIV/AIDS, early pregnancy and childbirth (particularly, among students in grades 8-9, colleges and high schools as well as their parents).

# Section 6. FACTORS AND CONDITIONS THAT INFLUENCE THE SHAPING OF ADOLESCENTS’ HEALTHY LIFESTYLES

Along with household surveys, in-depth interviews with representatives of mahalla citizens’ conventions and educators and health professionals in surveyed mahallas facilitated analysis of development and promotion of healthy lifestyles, physical exercise and sports. A designed questionnaire (Annex 3) was used for in-depth interviews.

All the three categories of respondents were asked a general question: “Mark factors according to their importance, which influence healthy lifestyles of adolescents.” The findings show that despite different level of awareness about healthy lifestyles, responses emphasize significant influence of nutritionally sound diets, sports, and personal hygiene on shaping healthy lifestyles among adolescents. (Figure 6.1.)

Figure 6.1. Rating of factors according to their importance, which influence healthy lifestyles

During the survey, groups of people responsible for shaping healthy lifestyles among adolescents were identified (Figure 6.2.).

Figure 6.2. Rating of people responsible for shaping healthy lifestyles among adolescents

According to respondents, parents have the highest rating (Rank I) followed by managers of academic institutions (Rank II) and mahalla representatives (Rank III) in shaping healthy lifestyles among adolescents.

General public express vivid interest and love for sports, especially, soccer. The next popular sports in Uzbekistan include dynasties of wrestlers, *palwans* (strongmen) and tennis players (Figure 6.3.)

**Figure 6.3. Presence of families with sports traditions in a mahalla**

As mentioned above, Uzbekistan is implementing a national model of reproductive health care of motherhood and childhood and targeted program for development of children’s sports aimed at improving child and adolescent health and achieving compliance with international standards of shaping healthy lifestyles.

Under completed and ongoing target-oriented national programs, many mahallas throughout the country have seen new construction and rehabilitation of existing sports grounds/gyms (Figure 6.4). With sponsorship from various foundations, entrepreneurs and other funds, these facilities are outfitted with sufficient sports equipment (Figure 6.5.) depending on popularity of sports.

**Figure 6.4. Availability sports grounds/gyms within the mahalla**

According to the survey findings, in more than half of mahallas have functioning sports grounds (gyms), there is active construction of new sports facilities. Soccer fields (net) have gained most popularity. There high availability of soccer and volley balls (83.9%), volleyball and basketball courts (74.2%), race tracks (67.7%), pull-up bars (64.5%) and tennis tables (61.3%).

**Figure 6.5. Availability of sports grounds/gyms within a mahalla**

Mahalla citizens’ conventions with active support from local government authorities regularly hold various activities aimed at promotion of healthy lifestyles and nurturing these concepts and principles among young people as well as material incentives to take sports and physical activity (Figure 6.6)

**Figure 6.6. Activities held in mahallas to promote healthy lifestyles among adolescents**

Incentives for engagement in sports worthy of mention include sending children to summer camps (46.4%), provision of sports garments (30.4%), issuance of vouchers to attend sports clubs and to use exercise equipment (25.0%).

Reported problems and barriers in the activities of the “Commission on issues of minors, young people and sports” within mahalla citizens’ convention unanimously included lack of funds for broader scale activities and incentives for adolescents to engage in sports and physical activity. Many chairpersons of mahalla citizens’ conventions proposes holding various tournaments, competitions not only among adolescents and young people, but also other age groups of citizens in order to develop sports traditions in the community.

The survey of academic institutions within surveyed mahallas showed that in the recent five years, the government has been paying significant attention to development of children’s sports in the country. On an annual basis, new sports grounds and gyms are established or necessary equipment is provided (Figure 6.7) and large-scale promotion activities, sports competitions and events are held for the population (Figure 6.8).

**Figure 6.7. Availability of sports equipment at academic institutions**

**Figure 6.8. Availability of sports clubs at academic institutions**

Almost all surveyed academic institutions reported a high level of availability of sports equipment. Primarily, soccer, volleyball, basketball and tennis are most developed.

In partnership with local health care facilities health status of children and adolescents and prevention of acute and chronic diseases are constantly monitored. Students undergo complete clinical checkups twice a year. With support from mahalla citizens’ conventions, events and roundtables involving experts are organized for general public.

**Figure 6.9. Working with girls to engage them in sports at academic institutions**

Ongoing broad-scale countrywide efforts to engage girls in sports play an important role in creating conditions that shape healthy lifestyles in younger generation. This area has become a national priority in Uzbekistan. It should be pointed out that according to the survey findings, responses mainly related to holding various competitions among girls (87.0%).

Representatives of academic institutions reported passivity of the population in relation to their attention towards enthusiasm of children and adolescents in sports as barriers for further development of sports resulting from living conditions of the population.

The survey of health care facilities showed that they organize regular health examinations of both the entire population and children and adolescents through visits of places of residence and academic institutions. When serious diseases are detected, necessary health checks are performed and these persons are referred to sanatoria for timely treatment. As a rule, 1-2% of adolescents in each mahalla require serious treatment and referrals for inpatient treatment (Figures 6.10 and 6.11).

|  |  |
| --- | --- |
|  |  |
| **Activities health by health workers during the last 12 months in order to develop healthy lifestyle skills** | |
| **Figure 6.10.in nearby mahallas** | **Figure 6.11.at schools, colleges and lyceums** |

Key measures that health facilities take in mahallas and academic institutions include talks about health hazards and prevention of smoking, alcohol abuse, drug abuse, HIV (AIDS) (92.0%), measures against various infectious diseases (87.8%), ongoing monitoring of hygiene in the population (78.0%).

In general, key factors and conditions that influence health of adolescents in a family, according to the survey findings, include the following:

- nutritionally sound and healthy diets;

- physical activity and sports;

- following rules of personal and common hygiene;

- absence of harmful habits (smoking, alcohol abuse, drug abuse and others);

- financial status and wellbeing of a family;

- dominating role and responsibility of parents in shaping healthy lifestyles;

- influence of a close-knit and strong family, family traditions and legacy.

# Section 7. TENDENCIES INREPRODUCTIVE HEALTH AND REPRODUCTIVE BEHAVIORS OF THE POPULATION

Exploring the level of awareness about reproductive health and reproductive behavior represents one of major aspects of the survey. The survey findings in the area of reproductive health and reproductive behavior largely depended on characteristics of respondents. The advantage of this survey is that it allows for comparison of findings with findings of a survey held by the Institute in partnership with experts from the Ministry of Health “Reproductive Health and a Healthy Family in Uzbekistan”.

*A respondent’s portrait.* As previously mentioned, one of important household selection criteria was presence of adolescents in a family determining changes in the structure and portrait of respondents who were asked to answer an individual questionnaire. About 91% of respondents are in a stable marriage. In particular, 5.6% of respondents have one child, 20.7% - two children, 42% - three children, 31.7% - four and more children, and 0.1% of respondents do not have children. Most respondents entered a marriage at the age of 19-25 years (70.4%).

According to findings, 21% of families recognized themselves as high-income households, 67.9% - middle-income households, and 11.1% - below middle-income households. There were no significant differences in wellbeing status across regions, while difference between provinces and the city of Tashkent appeared to be noticeable (Figure 7.1).

**Figure 7.1.Wellbeing self-assessment, % of the surveyed**

Birth control use is recognized as the most effective way to preserve overall health, strengthen reproductive health, and counteract negative factors for health. Information about contraception (effectiveness and health impact) plays an important role in building relations and making birth control use decision both for a woman and her partner/spouse.

*Public awareness and practice of contraception.* Surveys showed that the population is informed about almost all types of contraception. Respondents are better informed about birth control methods such as an intrauterine device (98% of respondents gave a positive answer to this question), contraceptive pills (94%), condoms (88%), and tubal ligation (82%).

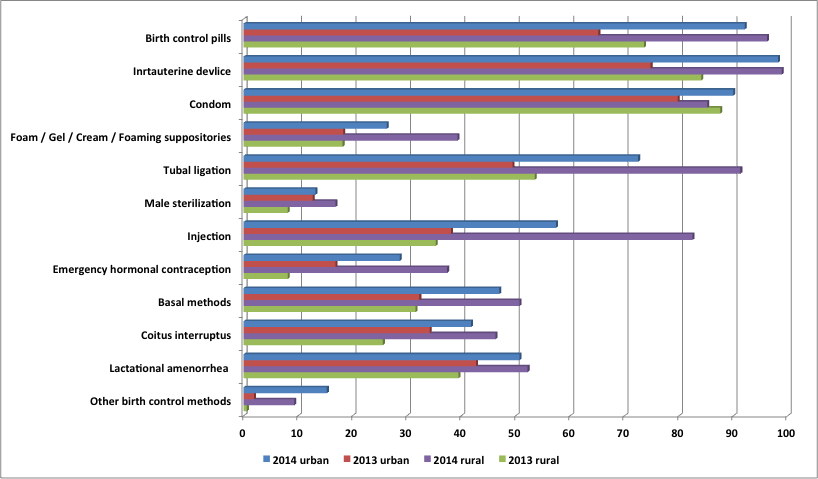
IUDs are the most widely promoted and frequently prescribed method of preventing pregnancy. Condoms are more famous owing to their double function – both contraception and protection from sexually transmitted infections. Other methods are not so well known: foam / gel / cream / foaming tables are know to 33% and male sterilization is known to 15% of respondents.

**Figure 7.2.Public awareness about birth control methods,**

**% of respondents**

A relatively high level of public awareness (about 85% of respondents) primarily resulted from intensive health reproductive promotion health workers. However, it is important that not only knowledge about contraception use, but also skills of choosing an individual method of contraception taking into account medical criteria of acceptability are crucial in practicing birth control. In developed countries, hormonal contraception (tablet and inject able forms) are in high demand since in addition to a high contraceptive effect, they also have a therapeutic effect on a female body. This section of the survey allows for a conclusion that in the future, health workers should place more emphasis on raising public awareness about hormonal contraception.

One of important areas of the national reproductive healthcare policy is maximum approximation of healthcare to the population as well as awareness of the population in rural and urban areas. The surveys showed that awareness about types of contraception is equal in urban and rural areas. Rural residents appear to be even more aware than urban residents about number of contraceptive methods such as: tubal ligation (VSC), IUDs, contraceptive pills, and condoms. This fact is the evidence of more active awareness-raising activities in rural areas and a need for improving awareness among rural residents.



**Figure 7.3.Public awareness about types of contraception in urban and rural areas, % of respondents**

Difference in the level of awareness about these issues of women and men identified during the survey is alarming, since in most families, it is a man who helps a woman to make a choice of a specific birth control method. Men are well informed about the least effective methods such as coitus interrupts and condoms. Men know much less than women about other more effective methods.

**Figure 7.4.Awareness of men and women about birth control methods,**

**% of respondents**

In the future, it is recommended to intensify awareness-raising efforts for men and young people under 30 years of age in order to achieve overall increase in general public awareness. Unfortunately, men only know about an intrauterine device (100%), condom (97.3%), coitus interruptus (59.5%) and contraceptive pills (54.1%).

With relatively high level of awareness about all types of contraception, respondents predominantly use only intrauterine devices (85.5%), lactational amenorrhea (50.8%), coitus interruptus (48.3%), birth control pills (44.7%), basal method (39.9%) and condoms (34.4%).

**Figure7.5. Contraceptive awareness and use, % of respondents**

In this regard, awareness of men about contraception methods increased and the most preferred methods include coitus interruptus (90.9%), lactational amenorrhea (83.3%), intrauterine device (59.5%) and condom (58.3%).

**Table 7.1.Contraceptive awareness and use among men and women, % of respondents**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contraceptive methods** | **Know how to use** | | **Used methods of contraception** | | **Know where to get** | |
| **men** | **women** | **men** | **women** | **men** | **women** |
| Birth control pills | 50,0 | 88,3 | 5,0 | 45,5 | 50,0 | 90,2 |
| Intrauterine device | 73,0 | 96,8 | 59,5 | 86,5 | 64,9 | 96,5 |
| Condom | 94,4 | 85,5 | 58,3 | 33,4 | 77,8 | 88,0 |
| Foam / gel / cream / foaming suppositories | 0,0 | 70,1 | 0,0 | 18,5 | 0,0 | 75,2 |
| Tubal ligation | 91,7 | 82,9 | 41,7 | 16,4 | 75,0 | 83,6 |
| Male sterilization | 0,0 | 49,3 | 0,0 | 3,5 | 100,0 | 48,6 |
| Injections | 83,3 | 79,7 | 33,3 | 21,5 | 83,3 | 83,0 |
| Emergency hormonal contraception | 50,0 | 68,7 | 0,0 | 17,1 | 50,0 | 73,1 |
| Basal method | 100,0 | 80,0 | 50,0 | 39,9 | 0,0 | 0,0 |
| Coitus interruptus | 100,0 | 83,8 | 90,9 | 46,0 | 0,0 | 0,0 |
| Lactational amenorrhea | 100,0 | 88,4 | 83,3 | 50,4 | 0,0 | 0,0 |

Levels of awareness and practical use of various birth control methods in urban and rural areas are very similar. Thus intrauterine devices are used among 88.2% of rural and 82.8% of urban residents, condoms – 24.3% and 43.7%, lactational amenorrhea – 48.6% and 53%, coitus interruptus – 45.2% and 51.7%, basal method – 25.4% and 55%, birth control pills – 45.1% and 44.2%, tubal ligation – 20.4% and 12.4%, injections –25.4% and 16.3%. Methods such as emergency hormonal contraception, male sterilization, foam, gel, cream, foaming suppositories are only gaining awareness in the population.

Even if a woman is aware of a method and its proper use, in order to avoid unplanned pregnancy, she should find out where to obtain the method. Women received information about contraception from different sources depending on a method. In case medical assistance is required, the most important source is a health worker. Information about condoms and traditional methods, mainly, come from husband/partner and mass media.

**Table 7.2.Contraceptive awareness and use in urban and rural areas, % of respondents**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Contraceptive methods** | **Know how to use** | | **Used methods of contraception** | | **Know where to get** | |
| **urban** | **rural** | **urban** | **rural** | **urban** | **rural** |
| Birth control pills | 89,6 | 85,3 | 44,2 | 45,1 | 91,2 | 87,5 |
| Intrauterine device | 95,6 | 96,2 | 82,8 | 88,2 | 94,6 | 95,9 |
| Condom | 90 | 81,4 | 43,7 | 24,3 | 90,3 | 84,6 |
| Foam / gel / cream / foaming suppositories | 77,5 | 64,5 | 17,8 | 18,8 | 79,8 | 71,5 |
| Tubal ligation | 86,8 | 79,9 | 12,4 | 20,4 | 86 | 81,5 |
| Male sterilization | 63,1 | 37,5 | 4,6 | 2,5 | 60 | 40 |
| Injections | 84,4 | 76,4 | 16,3 | 25,4 | 89 | 78,7 |
| Emergency hormonal contraception | 71,6 | 66,1 | 16,3 | 17,5 | 78 | 68,9 |
| Basal method | 87,9 | 72,5 | 55 | 25,4 | 0 | 0 |
| Coitus interruptus | 92,7 | 77,2 | 51,7 | 45,2 | 0 | 0 |
| Lactational amenorrhea | 93,6 | 83,4 | 53 | 48,6 | 0 | 0 |

Most respondents in urban and rural areas know where to get or receive contraception methods. In terms of condoms, 84.6% of rural and 90.3% urban population know where to get them, birth control pills – 87.5% and 91.2%, intrauterine device – 95.9% and 94.6%, injections – 78.7% and 89.0% and undergo tubal ligation – 81.5% and 86.0%.

However, predominantly women tend to be aware about where to get or receive methods of contraception (except for condoms). Thus, 96.5% of women know where to get/have inserted an intrauterine device (and only 64.9% of men), 90.2% - receive birth control pills (50%), 88% - obtain condoms (77.8%), 83.6% - undergo tubal ligation (75%), 83% - receive an injection (83%).

Obstetrician-gynecologists are the main source of information about possibilities of receiving various methods of contraception. Only about the method of coitus interruptus, respondents mainly learned from a partners (45.8%) and condom use – from friends and relatives (24.7%).

As for accessibility of birth control means, an important role of health care facilities in procuring the population with contraception is worthy of mention. This is probably due to the fact that most knowledge about contraception is gained during consultation after childbirth and abortion, which are equally accessible to urban and rural residents.

Respondents pointed out that they received birth control methods, primarily, at family polyclinics (26.1%), rural outpatient clinics (24.8%), urban (9.1%) and district (10.9%) hospitals and bought at pharmacies (1.7%). In urban areas, respondents chiefly received or obtained birth control methods from family polyclinics (48.7%) and city hospitals (9.6%), in rural areas – rural outpatient clinics (49%) and district hospitals (17.5%).

**Figure 7.6. Sources to get contraception, % to those who use contraceptives**

70.6% of surveyed women using contraception pointed out that they use intrauterine devices, first of all, upon recommendation of an obstetrician-gynecologist (62%), due to effectiveness (12.5%) and safety (7.6%). Rarely used methods, according to the respondents, include birth control pills and injections (Depo-Provera) (5.8% of respondents reported their use), female sterilization (16.2%), while foam, gel, cream, vaginal film, emergency hormonal contraception, injections (Depo-Provera), calendar method are practically not used in urban or rural areas.

According to respondents, these contraceptive methods tend to be unpopular because of fear of side effects and, in some cases, - the need for surgical intervention, absence of doctor’s prescription, and high price of a method.

Uzbekistan has high contraceptive use rate as testified by a large share of women who use birth control methods during the survey (72.7%).Data from the State Statistics Committee and the Ministry of Health suggest that from 2008 to 2012, there was a decrease in the number of abortions as a birth control and family planning method. Thus, the number of abortions per 1,000 women of female in childbearing age was 5.4% in 2008, by 2012, this figure decreased to 4.4%.

Similar dynamics is observed when abortions are estimated per number of 1,000 live births (from 67.1% to 61.5%). In this case, there is an increasing number of women using contraceptive methods. In 2008, their number amounted to 4,333.2 thousand people, by the end of 2012 increased up to 4,823.6 thousand people (Table 2).

**Table7.3. Dynamics of abortions\*, contraceptive use rate and total fertility rate**

**\*\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Indicators** | **Unit of Measure** | **2008** | **2009** | **2010** | **2011** | **2012** |
| Number of abortions | thousand people | 41,8 | 46,0 | 40,7 | 38,8 | 37,6 |
| Number of abortions | per 1,000 live births | 67,1 | 71,9 | 65,4 | 63,5 | 61,5 |
| Number of abortions | per 1,000 of women  (15-49 years) | 5,4 | 5,8 | 5,0 | 4,6 | 4,4 |
|  |  |  |  |  |  |  |
| Number of women using contraceptive methods by year-end | thousand people | 4333,2 | 4318,8 | 4206,4 | 4694,7 | 4823,6 |
| Number of women in fertile age, by year-end | thousand people | 7817,3 | 7945,4 | 8300,2 | 8409,1 | 8504,1 |
| Contraceptive use rate | in % | 55,4 | 54,4 | 50,7 | 55,8 | 56,7 |
|  |  |  |  |  |  |  |
| Total fertility rate, child | child | 2,50 | 2,53 | 2,34 | 2,24 | 2,19 |

\* - Data from the State Statistics Committee of the Republic of Uzbekistan

\*\* - Data from the State Statistics Committee of the Republic of Uzbekistan

The examples provided are interrelated, since the more women in childbearing age use birth control method, the fewer unplanned pregnancies and, consequently, fewer abortions. Contraceptive use rate in the recent five years increased from 55.4% to 56.7%. This fact has an impact on demographic indicators such as total fertility rate, which amounted to 21.5% in 2008 and decreased down to 2.19% in 2012.

The data provided suggest an increase in demand for contraceptive methods and greater opportunities to obtain these family planning methods, which has a positive effect on the demographic situation in the country.

**Reproductive attitudes, number of children, and cases of unplanned pregnancy.** On average, according to the survey findings, there are two and more children per family. In particular, 5.6% of respondents have one child, 20.7% - two children, 42% - three children, 24,5% - four children, 5.5% - five children, and 1.7% - six and more children.

**Figure7.7. Number of children in a family, % of respondents**

In response to a question “What should a woman do in case of unwanted pregnancy?”, 51.9% of respondents answered that they should give birth to the child and 43.8% - reported expediency of abortion. The opinions are almost equal across regions, sexes, and age groups.

**Figure7.8. A right of a woman to make a decision about her pregnancy,**

**% of respondents**

Does a woman have a right to make a decision about her pregnancy including abortions? 39.7% of respondents believe that a woman always have a right to make a decision about her pregnancy including a right to abortion, in the remaining cases, the decision is made by her husband (97.4% of respondents) and his relatives, particularly, a mother-in-law (33.2%).

37.8% of men this that a woman always has a right to make a decision about her pregnancy including a right to abortion, 100% of male respondents think a husband should make a decision about giving birth to a child and 60.9% believe that his parents should make this choice.

**Needs and access of the population to reproductive and maternal healthcare services.**Several factors such as public awareness of reproductive health as well as affordability and a wide range of services explain relatively high level of uptake in the medical institutions.

The main users of reproductive health services are women - 97.2% of the women surveyed indicated that they sought medical care.

**Figure 7.9. Frequency of visits to health facilities,**

**% of respondents**

Distance to a health facility is an important determinant of the population’s access to health services (Figure 7.10).

**Figure7.10. Distance to a health facility from a household to seek urgent reproductive care, % of respondents**

People seek reproductive healthcare services most frequently at family polyclinics (82.9%) and rural outpatient clinics (82.8%).

**Figure7.11. Most preferred health facilities for reproductive health services in urban and rural areas, % of respondents**

**Figure 7.12. Distribution of respondents’ answers to question “What medical assistance did you receive during the last 12 months”, % of respondents**

In general, the entire sample population is satisfied with the reproductive health services (70.5% of respondents), while the rest are satisfied partially or dissatisfied.

**Figure 7.13. Distribution of respondents’ answers**

**“To what extent are you satisfied with reproductive health services?”, % of respondents**

According to findings, there a growing number of people from year to year who value family planning as a necessary and positive measure, which gives an opportunity to have healthy and desired children, provide for them financially and ensure their good education.

The results of the study in 2014 in terms of reproductive health and reproductive behavior confirmed the findings of previous studies and allow forthe following **conclusions**to be made:

* Increased public awareness and more common the practice of contraceptive use. The survey showed that the population informed on almost all types of contraception. Most respondents are informed about these types of contraception such as condoms, intrauterine device (IUD), birth control pills, tubal ligation, and lactational amenorrhea. The level of awareness about the kinds of contraception is approximately the same in urban and rural population.
* The vast majority of respondents believe that their need for contraception is completely satisfied that, first of all, due to their availability, including affordability (free procurement on the part of the state).
* There are growing needs and thus the population’s access to reproductive and maternal health. The high level of awareness among women of reproductive health, as well as affordability (free) and a wide range of services determined the frequency of uptake of respondents in health facilities. During the year, half of respondents in households sought medical assistance both in urban and in rural areas.

Most often the respondents seek reproductive health careat family polyclinics and rural outpatient clinics (SVPs), city and district hospitals, and emergency care centers. Rural residents mainly turn to SVPs (82%) and district hospitals (44%). Provincial Perinatal Centers and the Republican Medical Center of Obstetrics and Gynecology are only available to a small number of rural and urban residents.

* Public awareness aboutsexually transmitted infections enables most men and women to retain their reproductive functions and reduce the risk of contracting HIV/AIDS. The main reasons for the spread of HIV in Uzbekistan are probably risky behavior as well as lack of knowledge about HIV. Overall, respondents in the surveyed regions are aware of the symptoms of HIV/AIDS and the possibility of infection with this virus. According to the responses, the main source of information about the possible ways of transmissions and reduction of the risk of infection with HIV/AIDS is the mass media - television, the Internet, newspapers, magazines, teachers in schools and other educational institutions and health care workers - a gynecologist, a nurse / midwife, family doctor.

# CONCLUSION

In Uzbekistan, maternal and childhood health and sports among adolescents were among the ranks of high-priority areas of the government policy. Gradual implementation of healthcare reforms has resulted in the establishment of the required legal and regulatory framework and mechanisms for economic incentives. As a result of implementing an entire package of national targeted programs in the area of maternal and childhood health over the years of independence, maternal mortality decreased by 3.4 times and under-five mortality decreased by 4.0 times, and growth and development of children have improved appreciably.

According to the findings of the survey, parents play a crucial role in shaping healthy lifestyles of adolescents. Thus, parents, regardless of financial wellbeing and educational attainment, pay sufficient attention to the health of their children with most of them informed about determinants of adolescents’ health and organization of a child’s daily routine.

The overwhelming majority of parents (94.0%) are informed about the importance of physical activity and sports for children. Around 76% of urban adolescents and 65.0% of rural adolescents engage in physical activity at home, 54.0% of adolescents regularly go in for sports, and 25.0% of adolescents exercise every other day.

In terms of the impact of sports on adolescents, parents reported that children fell ill less frequently (43.3%), became more active (44.4%) and more decisive (5.4%).

It should be noted that more adolescents from low-income families regularly attend sports clubs (32.6%) than adolescents from middle-income families (20.8%) and high-income families (19.6%).

The findings about parents’ attitude to reproductive and child health are also important. Talks with parents with their adolescent children regarding question about preparation for family life (36.2%), about HIV (AIDS) (22.8%), sexual life hygiene (36.6%), venereal diseases (11.3%) played an important role. At the same time, there were many parents who did not talk with their children about reproductive health.

Overall rating of factors and conditions that influence the health of adolescents according to survey findings are as follows:

1. Adequate and healthy nutrition;
2. Physical activity and sports;
3. Following rules of personal and common hygiene;
4. Absence of harmful habits;
5. Financial status and wellbeing of families.

Assessment of tendencies in public awareness and practice of using birth control methods as an important determinant of reproductive health showed that during the two recent years, there is a positive tendency towards using basic birth control methods. In particular, public awareness about birth control methods increased from 69.2% to 94.1% and about injectable contraceptives – from 36.5% to 59.7%.

The survey findings once again corroborated the effectiveness of ongoing healthcare reforms and children’s sports development in Uzbekistan

During the survey, a number of challenges were identified, which were related to further increase in the effectiveness of actions taken in the area of reproductive health, access to physical education services and sports for adolescents. This underlies the need for strengthening measures to broaden access of rural adolescents to sports services, to bring sports sites and facilities closer to rural areas, considering the specifics of settling rural residents in rural settlements, raising awareness of rural parents and adolescents about personal hygiene, optimal organization of leisure time and etc. There are facts of television viewing and computer playtime among children, which exceed recommended norms. There is a need to place stronger emphasis on ensuring parents’ awareness about adolescents’, especially, girls’ physical activity. Barriers to sports include child’s reluctance, remoteness of sports facilities, lack of funds and absence of skilled coaches and relevant sports equipment, and others.

Further improvement of organizational arrangements and measures to involve children and adolescents into sports, **it is recommended to**:

- increased awareness among parents, primarily,about nutrition of children and adolescents, socialrisks and child health risks and consequences of smoking and alcohol consumption, prevention of communicable and non-communicable diseases, physical activity and sports.

- expedientorganization of nutrition of children and adolescents by scaling up the consumption of vitamins, minerals, fruits and vegetables, creation of new industries based on local raw materials, baby food, taking into account the actual shaping demand, conduct ongoing monitoring of food consumption by children and adolescents, improved coverage hot power in secondary schools, vocational colleges, high schools, etc.

- awareness of parents is directly connected with targeted training programs about reproductive health, sports, relationships of parents and children, strengthen parents and children, strengthen family relationships and so on. These programs can be implemented with the participation of international organizations and institutions in the form of grants and technical assistance;

- in order to involve children and adolescents in physical activity and sports, along with the expansion of the construction of new and reconstruction of existing sports facilities and outfitting them with necessary equipment, there is also a need for design, construction, and planning of cities and rural districts for the convenience and accessibility, attractiveness of physical activity and sports services, design of residential apartments and complexes to create an enabling environment for physical activity, the development of infrastructure and transport taking into account outdoor activities and sports, strengthening of interaction of various structures (local authorities, heads of educational institutions, mahalla) in the organization of sports services for children and adolescents;

- improving the quality and accessibility of services provided by sports for adolescents and expansion of the range of services taking into account the new information technologies;

- take additional measures to reduce the negative impact on children and adolescents watching television and computers all established standards by their involvement in a wide variety of sporting and cultural events, to optimize the use of their free time;

- continue to monitor the trends and dynamics of reproductive health of children and adolescents and the scale of their involvement in sport and the effectiveness of measures taken.

In relation to reproductive health and reproductive behavior of the population, the following proposals are **recommended**:

* pay priority attention to ensuring universal access to quality services in the area of reproductive health and healthy family through consultations. There is a need to continuously improve skills of health workers who provide reproductive health services on counseling patients;
* given the importance of reproductive health, there is a need to mainstream intersectoral and multidisciplinary approach to the problem and involve government agencies and NGOs into resolving these problems. In this regard, it is important to support and facilitate the organization of educational activities in the field of reproductive health and behavior of the population aimed at improving their health, especially, among vulnerable groups. The expansion of social awareness in the communities, educational institutions, enterprises and organizations aimed at promoting a healthy lifestyle and healthy family, prevention of the most common infectious diseases. Religious leaders are advised to raise awareness among the male population of the republic on changing behavior in matters of care for pregnant women and children, the birth of a healthy baby, breastfeeding, save interval between births and the negative effects of early marriage and marriages between close relatives;
* there is a need to raise awareness and expand the practice of individual selection of contraceptive methods taking into account the medical criteria, their relevance and effectiveness. Particular attention should be paid to raising awareness among the population of hormonal contraceptive methods (tablets and injectable form), which are the most modern and efficient;
* given that one in five respondents indicated that in the recent five years had an unplanned pregnancy most often by the husband and his family, it is necessary to raise awareness among men and older people on early marriage, to follow inter-genetic three-year interval between births using modern and safe contraceptive methods;
* there is a need to eliminatea family planning practice such as abortion, which adversely affect reproductive health by improving access to the use of modern and effective methods of contraception;
* it is important to ensure the implementation of more effective integration of programs on sexual and reproductive health and programs for prevention of HIV / AIDS as well as access for people living with HIV/AIDS services in the field of voluntary family planning. It is necessary to integrate prevention Sexually transmitted disease, including HIV/AIDS in reproductive health services, widely introducing and promoting methods of “dual contraception”for people with risky behavior along with one of the contraceptive methods (IUDs, pills, injections) recommended mandatory use of condoms;
* it is advisable to conduct multiple sociological surveys every two years in order to identify the dynamics of results that contribute to the identification of a number of details that are not revealed by conventional statistical studies.

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# ANNEXES

***Annex 1***

**Institute for Social Research**

**under the Cabinet of Ministers of the Republic of Uzbekistan**

**QUESTIONNAIRE**

**“ASSESSMENT OF FACTORS INFLUENCING THE SHAPING OF HEALTHY LIFESTYLES AMONG ADOLESCENTS AND YOUNG PEOPLE IN UZBEKISTAN”**

*This survey is held within the frameworks of implementing the National Program “The Year of Healthy Child”. The aim of the survey is to identify factors, which influence the development of school children and young people.*

*Strict confidentiality of findings and their use is ensured. The findings will be used to obtain aggregate data for the Republic of Uzbekistan as a whole and the surveyed provinces.*

|  |  |
| --- | --- |
| HOUSEHOLD PASSPORT XP | |
| XP1. Community (cluster) name and code: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_|\_\_\_|\_\_\_| |
| XP2. Household number: | |\_\_\_|\_\_\_| |
| XP3. Supervisor's name and code: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_\_|\_\_\_| |
| XP4. Region: | Republic of Karakalpakstan …...……………………………1  Namangan Province …….…………………………………..2  Surkhandarya Province……...................................................3  Syrdarya Province ……...……...............................................4  Tashkent City……………………………….……………….5 |
| XP5. District or town name and code: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_\_|\_\_\_|\_\_\_| |
| XP6. Locale | Urban………………………………………………..............1  Rural………………………………………………………...2 |
| XP7. Interview day / month / year: | |\_\_\_|\_\_\_| / |\_\_|\_\_| / | 2 | 0 | 1 | 4 | |
| XP8. Interviewer's name and code: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_\_|\_\_\_| |
| XP9. Respondent's name and code: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_\_|\_\_\_| |
| XP10. Number of HH members: | |\_\_\_|\_\_\_| |
| XP11. Data input operator's name and code: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_\_|\_\_\_| |

**CODES OF VISIT RESULTS**

|  |  |
| --- | --- |
| 1 – the main questionnaire and annex completed | 6 – The household/selected respondent refused to give an interview |
| 2 – only the main questionnaire completed | 7 – The selected respondent is unable to give information |
| 3 – There is no adolescent of appropriate age in the household | 8 – Nonresidential home |
| 4 – There was no one at home | 9 – Incomplete interview |
| 5 – The selected respondent was away from home | 10 – Other reasons \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**TASHKENT 2014**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| INFORMATION ABOUT HOUSEHOLD MEMBERS HL | | | | | | | | | |
| HL1 | HL2 | HL3 | | HL4 | HL6 | HL7 | HL8 | HL9 | |
| HH Member Code | Names of All HH Members | Kinship with the Head of the HH | | Gender  1-Male  2-Female | Age  (in full years, if older than 95 years – record – 95) | **Adolescents**  Adolescent, male or female, aged 10-19 years?  0 - no  1 - yes | **Education**  **1**-no education  **2**-secondary (school)  **3**-secondary special education  **4**-higher  **99**-Don’t know | **Main Occupation** | |
| 1 – preschooler  2 – school student  3 – college/lyceum student  4 – university student  5 – employed in an enterprise (organization)  6 – employed in business  7 – farmer  8 – employed in a dehkan farm  9 – employed as large cattle herder  10 – works from home  11 – employed as artisan  12 – works abroad | 13 – pensioner  14 – cares for a child under 3 years of age  15 – homemaker  16 – renders services (repair of appliances, tailor, private taxi services, hair styling, trade, education, and so on)  17 – renders temporary services (common worker)  18 – does not work or study  19 – unemployed  20 – other |
| **1**–Head  **2**–Wife/Husband  **3**–Son/Daughter  **4**–Son-in-Law/Daughter-in-Law  **5**–Grandson/ Granddaughter  6–Father/Mother | 7–Brother/Sister  **8**–Father-in-Law/Mother-in-Law  **9**–Other Relative  **10**–Unrelated  **99**– Don’t know |
| 01 | Head of HH  \_\_\_\_\_\_\_\_\_\_\_\_ | 1 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 02 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 03 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 04 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 05 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 06 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 07 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 08 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 09 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 10 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 11 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 12 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 13 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 14 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 15 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |
| 16 |  | 2345678910 99 | | 1 2 | |\_\_|\_\_| | 0 1 | 1 2 3 4 99 | 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Selection of an adolescent K**  *to receive more detailed information about factors that influence the health of the younger generation* | | | | |
| **Interviewer, now you have to choose an adolescent using a Kish selection method (teen boy or girl aged 10-19 years) in a household who will be asked questions. This requires filling in Table K. From Table HL***,* **HH members, whose number in Column HL7 is circled, are transferred into Table K and these HH members are ordered in descending order by age. Household members’ codes from Column HL1, names from Column HL2, gender from Column HL4 and age from Column HL6 are transferred into this table.** | | | | |
| **K1.** | **K2.** | **K3.** | **K4.** | **K5.** |
|  | **Transfer codes from Column HL7 for all adolescents aged 10-19 years** | **Name of Household Member** | **Gender (HL4)**  1-male  2-female | **Age (HL6)**  (in full years) |
| 1. |  |  | 12 |  |
| 2. |  |  | 12 |  |
| 3. |  |  | 12 |  |
| 4. |  |  | 12 |  |
| 5. |  |  | 12 |  |
| 6. |  |  | 12 |  |
| **THE NUMBER OF ADOLESCENTS IS IDENTIFIED ACCORDING TO THE TABLE** | | | | |
| **К6.** \_\_\_\_ **(number) of adolescents(teen boys and girls)** | | | | |

|  |
| --- |
| **IF THERE ARE NO ADOLESCENTS IN A GIVEN HOUSEHOLD (TEEN BOY OR GIRL AGED 10-19 YEARS), FINISH THE INTERVIEW.**  **IF THERE IS ONLY ONE ADOLESCENT, THE SURVEY SHOULD BE ADMINISTERED TO HIM/HER**  **IF THERE IS MORE THAN ONE ADOLESCENT IN THE HOUSEHOLD, CHOOSE ONE USING THE RANDOM NUMBERS TABLE GIVEN BELOW** |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SELECTING A RESPONDENT USING THE RANDOM SELECTION TABLE:** | | | | | | | | | | |
| **Number of adolescents (teen boys or girls) living in the household** (see K6) | **The last digit in the questionnaire number** | | | | | | | | | |
| **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** |
| **1** | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| **2** | 2 | 1 | 2 | 1 | 2 | 1 | 2 | 1 | 2 | 1 |
| **3** | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 |
| **4** | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 |
| **5** | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 | 1 | 2 |
| **6** | 6 | 1 | 2 | 3 | 4 | 5 | 6 | 1 | 2 | 3 |
| **INTERVIEWER, RECORD THE ORDINAL NUMBER AND THE NAME OF THE SELECTED ADOLESCENT**  **K7.** \_\_\_\_ **ordinal number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_adolescent’s name** | | | | | | | | | | |

|  |
| --- |
| **INTERVIEWER, PLEASE CHECK IF THE RESPONDENT IS A MOTHER (FATHER, CAREGIVER) OF THE SELECTED ADOLESCENT. IF NOT, THEN SUBSTITUTE THE RESPONDENT WITH THE MOTHER (FATHER, CAREGIVER, CARETAKER) OF THE ADOLESCENT**  **ХР12.** Respondent’s name and code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_\_|\_\_\_| |

***With your permission, we will now talk in more detail about health, lifestyle, interests, habits and other aspects of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of the selected adolescent)***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **LIFESTYLE AND NUTRITION A** | | | | | | | | |
| **А1. How many hours should a child sleep at night at the age of** | | | | **А) 10-14 years \_\_\_\_\_\_\_ hours**  **В) 15-19 years \_\_\_\_\_\_ hours** | | | | |
| **А2. How many times a day should have meals at the age of** | | | | **А) 10-14 years \_\_\_\_\_\_\_ times**  **В) 15-19 years \_\_\_\_\_\_ times** | | | | |
| **А3. How many times a day should a child receive a hot meal (explain what a “hot meal” means) at the age of** | | | | **А) 10-14 years \_\_\_\_\_\_\_ times**  **В) 15-19 years \_\_\_\_\_\_ times** | | | | |
| **А4. How many hours a day may a child watch television at the age of** | | | | **А) 10-14 years \_\_\_\_\_\_ hours**  **В) 15-19 years \_\_\_\_\_\_ hours** | | | | |
| **А5. How many times a day should a child brush his/her teeth?** | | | | \_\_\_\_ times | | | | |
| **А6. What time does \_\_\_\_\_\_\_ (name) usually get up in the mornings?** (for example, 07:00, *if no definite time is reported or the time is reported as haphazardly, record - 99)* | | | | 1. On week days, \_\_:\_\_  2. On week end, \_\_:\_\_ | | | | |
| **А7. What time does \_\_\_\_\_\_\_ (name) usually go to bed?** | | | | 1. On week days, \_\_:\_\_  2. On week end, \_\_:\_\_ | | | | |
| **А8. How many meals a day does \_\_\_\_\_\_ (name) have?** | | | | \_\_\_\_ time(s) | | | | |
| **А9. How many times a day does \_\_\_\_\_\_ (name) have hot meals?** | | | | \_\_\_\_ time(s) | | | | |
| **А10. How many times a week does \_\_\_\_\_\_ (name) usually eat the foods listed below?** *Please mark one answer in each line!* | | | | | | | | |
|  | ***Once daily*** | | ***More than once daily*** | | ***5-6 times a week*** | ***2-4 timesа a week*** | ***Once weekly*** | ***Hardly ever/ Never*** |
| 1. Fresh fruit during the season | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 2. Fresh fruit off season | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 3. Fresh fruit (uncooked) | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 4. Sweets (candy and chocolate) | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 5. Coca Cola and other sweet carbonated/fizzy drinks | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 6. Milk | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 7. Cheese | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 8. Other dairy products (yoghurt, cottage cheese, kefir, sour cream, and others) | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 9. Flakes from grain crops (corn flakes, dry breakfast cereal, and etc.) | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 10. Fish | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 11. Eggs | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 12. Sausage products | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 13. Patty cakes | 1 | | 2 | | 3 | 4 | 5 | 6 |
| 14. Other **\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | 1 | | 2 | | 3 | 4 | 5 | 6 |
| **А11. How often does \_\_\_\_\_\_\_(name) brush his/her teeth?** | | 1 – More than once a day  2 – Once daily  3 – Not every day, but at least once weekly  4 - Several times a month  5 - Never  99 – Don’t know | | | | | | |
| **A12. How often does \_\_\_\_\_\_\_(name) wash his/her hands with soap before meals?** | | 1 – every time  2 – often  3 - sometimes/rarely  4 – when hands are soiled  5 – when made to wash  6 – never  99 – don’t know | | | | | | |
| **А13. How does\_\_\_\_\_\_\_(name) spend his/her free time outside school?** | | А – Together with parents (grandfather and grandmother), visits cultural events and etc.  B – Visits cultural events with friends  C – Plays in the yard  D – Watches television, sits at the computer  E – Reads books, has music, dance classes  F – Goes in for sports  G – Helps parents around the house (takes care of younger children in the family, does chores)  H – Earns money for own needs (to support the family financially)  I - Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **А14. How many hours a day does \_\_\_\_\_\_ (name) usually watch television, video?** | | 1 - On week days, \_\_\_\_ hours a day  2 - On week end, \_\_\_\_ hours a day | | | | | | |
| **А15. How many hours a day does \_\_\_\_\_\_\_(name) usually spend with electronic appliances such as a personal computer or a tablet?** | | 1 - On week days \_\_\_\_ hours a day  2 - On week end \_\_\_\_ hours a day | | | | | | |
| **А16. Do you think parents should have special skills to raise adolescents?** | | 1 - Yes  2 - No  99 – Don’t know | | | | | | |
| **А17. Do you think you have enough knowledge and skills to raise children and adolescents?** | | 1 - Yes 🡺**in Section В**  2 - No  99 – Don’t know | | | | | | |
| **А18. If not, what skills do you require?** *(Specify)* | | A – Basics of medical knowledge  B – Law  C – Religious primary sources  D – Psychology  Е – Survival fundamentals  F – A skill to be able to impress other people  G – Reproductive health knowledge  H – Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

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| **HEALTH В** | |
| **В1. How do you assess health status of \_\_\_\_\_\_\_(name)?** | 1 - Excellent  2 - Good  3 - Satisfactory  4 - Poor |
| **В2. In your opinion, what factors influence the health status of your child?** | A - lifestyle;  B – specifics of nutrition;  C – heredity;  D – harmful habits;  E – environmental situation;  F – family’s financial status;  G – sports activities;  H – others (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **В3. Who do you think should be responsible for the child’s health status?** | A – Parents  B – Relatives who take care of the child  C – Health workers  D – Educational facility (school/college)  E – The child him/herself is responsible for own health  F - Other  G – Don’t know |

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| **EDUCATION, PHYSICAL EDUCATION / SPORTS С** | |
| **С1. Is physical activity necessary for fully-fledged development of your child?** | 1 - Yes  2 - No 🡺**С4**  99 - Don’t know 🡺**С4** |
| **С2. How often should a child engage in physical activity?** | 1 – Every day  2 – Every other day  3 – Once-twice a week  4 – Once-twice a month |
| **С3. How many hours should a child exercise every day at the age of…** | **А) 10-14 years** \_\_\_\_ hours a day  **В) 15-19 years**\_\_\_\_ hours a day |
| **С4. Who, in your opinion, has a greater influence on the development of the child’s motion activity?** | 1 – Father  2 – Mother  3 – Caretakers/teachers  77 – Somebody else (*specify*)\_\_\_\_\_\_\_\_ |
| **С5. Which of the parents has ever engaged in physical activity/sports?** | 1 – Adolescent’s father  2 – Mother  3 – Both parents  4 – None of the parents  99 - Don’t know |
| **С6. Is there a tradition in your family to jointly go in for sports?** | 1 - Yes  2 - No  99 - Don’t know |
| **С7. Which member of your family, except for \_\_\_\_\_\_\_ (name), currently engages into physical activities/goes in for sports?** | А – Adolescent’s father  В – Mother  С – Brothers/sisters  D – Someone else (*specify*)\_\_\_\_\_\_\_\_  E – No one  Z - Don’t know |
| **С8. Do you think you should encourage \_\_\_\_\_\_\_ (name) in for sports?** | 1 - Yes 🡺**С10**  2 - No  99 - Don’t know |
| **С9. Under what conditions, would you encourage \_\_\_\_\_\_\_ (name) to go in for sports?** | 1 – The adolescent engages in physical activities /goes in for sports  2 – Proximity of sports facilities  3 – Affordable payment  4 – Absence of payment  5 – Presence of skilled coaches  6 – Under no conditions  99 – Don’t know |
| **С10. How do you assess \_\_\_\_\_’s (name) learning performance at school (lyceum or college) during the recent year (during the past 12 months)?** | 1 – Excellent  2 – Good  3 – Satisfactory  4 – Poor  5 – did not study during the past 12 months |
| **С11. How often did \_\_\_\_\_\_\_(name) do homework with the father (mother) during the past academic year?** | 1 – daily  2 – weekly  3 – sometimes/once a month  4 – did not do this even once  99 – don’t know |
| **С12. Has \_\_\_\_\_\_\_(name) participated in any out-of-school activities such as an Olympiad (academic competition), tournaments or contests during the recent academic year?** | А – an Olympiad (academic competition)  В – Tournaments  С – Contests  D – Has not participated  Z – Don’t know |
| **С13. What, in your opinion, should a family and school (lyceum, college) pay attention to, when taking care of the child’s health?** | A – Keep regular hours, rest, and sleep  B – Healthy nutrition  C – Physical exercise  D – Health/clean environment  Е – Favorable psychological environment  F - Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **С14. Does \_\_\_\_\_\_\_(name) exercise at home?** | 1 - Yes  2 - No 🡺**С16**  99 - Don’t know 🡺**С16** |
| **С15. How regularly does \_\_\_\_\_\_\_(name) exercise at home?** | 1 – regularly every day  2 – every other day  3 – 1-2 times a week  4 – less frequently than once a week  99 – don’t know |
| **С16. Does \_\_\_\_\_\_\_(name) visit any additional fitness/sports classes other than physical education classes at school (lyceum, college)?** | 1 – Studies at sports school, goes in for professional sports 🡺 *С18*  2 - Yes, has regular classes at sports clubs 🡺 *in С18*  3 - Yes, has irregular classes at sports clubs🡺 *С18*  4 *-* Yes, works out/goes in for sports in informal groups🡺 *С18*  5 – Does not exercise |
| **С17. What prevents \_\_\_\_\_\_\_ (name) from active exercise / sports?**  *Several answers are possible* | A – Health status  B – Lack of time / Household chores  C – Remoteness of sports facilities  D – Lack of funds / expensive  E – This is not a tradition in our family / We believe the child should devote his/her time to something more useful (studies, learning a language, and etc.)  F – Child’s reluctance  X – Other factors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***Filter F1: If a respondent answers question С17, then go to Section D*** | |
| **С18. Does \_\_\_\_\_\_\_ (name) have an opportunity to exercise/engage in sports near a place of residence?** | 1 – Yes  2 – No  99 – Don’t know |
| **С19. What sports does \_\_\_\_\_\_\_(name) go in for?** | 1 - Swimming, water sports  2 - Soccer, volleyball, basketball, handball  3 - Karate, Wushu, boxing, tae kwon do, unarmed self-defense, wrestling  4 – Olympic, artistic gymnastics  5 – Track and field athletics, tennis  6 – Bicycling, types of sports using sports equipment  77 – Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **C20. What is the category of a sports school/club that \_\_\_\_\_\_\_\_(name) goes to?** | 1 – State-owned (educational system)  2 – Under an agency / enterprise / organization  3 – Private  99 – Don’t know |
| **С21. Do you support \_\_\_\_\_\_\_’s (name) desire to go in for sports?** | 1 - Yes  2 - No  99 - Don’t know |
| **С22. How many times a week does \_\_\_\_\_\_\_(name) go to a sports club?** | \_\_\_\_\_\_ |
| **С23. How many years has \_\_\_\_\_\_\_(name) been going in for sports?** | 1 – Has started recently  2 – More than 6 months and less than a year  3 – One year or longer  4 – 2 -5 years  5 – More than 5 years |
| **С24. Why did \_\_\_\_\_\_\_(name) decide to take up sports?** | 1 – Wants to be strong / stand out among peers  2 – Parents offered to do so  3 – Friends asked to join  4 – A coach invited  77 – Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| **C25. In your opinion, what was the influence of regular sports activities on \_\_\_\_\_\_\_(name)?** | 1 – Falls ill less frequently/stronger health  2 – Became more active  3 – Became more sociable  4 – Lags behind others in his/her studies  99 – Don’t know |
| **С26. Do you pay for sports classes?** | 1 – Yes  2 – No 🡺**С29**  99 – Don’t know 🡺**С29** |
| **С27. How much do you pay (including informal payments) for \_\_\_\_\_\_\_’s (name) sports classes per month?** | 1 –\_\_\_\_\_\_Uzbek soums  2 – Sports classes are free, but participation in competitions is paid 🡺 *С29*  99 – Don’t know🡺 *С29* |
| **С28. Do you think these fees are:** | 1 – low  2 – adequate/satisfactory  3 – excessively high |
| **С29. Are you satisfied with a gym (sports grounds, room) where \_\_\_\_\_\_\_ (name)exercises?** | 1 – Yes 🡺 **C31**  2 – No  99 – Don’t know |
| **С30. If not, what don’t you like?** | 1 – the gym / room is located in an adapted building  2 – the gym / room is not heated in winter  3 – no sports equipment  99 – Don’t know |
| **С31. Are you satisfied with the coach’s/instructor’s competence level?** | 1 - Yes  2 - No  99 - Don’t know |
| **С32. For what reason would \_\_\_\_\_\_\_(name) quit going in for sports?** | 1 – Health status  2 – Lack of time / Household chores  3 – Remoteness of sports facilities  4 – Increase in fees  5 – Desire of the child  77 – Other factors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **REPRODUCTIVE ATTITUDES AND HARMFUL HABITS D** | |
| **D1. What main source does \_\_\_\_\_\_\_(name) receive knowledge about health from?** | 1 – Parents, relatives  2 – Friends, peers, course mates, classmates  3 – Health workers  4 – Teacher (school, lyceum, college)  5 – Newspaper, magazine, special books, brochures  6 – Radio, TV, Internet  77 – Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **D2. What aspects of reproductive health have you discussed with \_\_\_\_\_\_\_(name)?** | A – ability to reproduce;  B – questions related to preparation for family life  C – sexual life hygiene (during the menstrual cycle)  D – how pregnancy/conception occurs  E – methods of contraception  F – HIV/AIDS  G – sexually transmitted infections (venereal diseases)  H – never discussed  X – other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **D3. Have you ever talked to \_\_\_\_\_\_\_(name) about sexually transmitted infections including HIV, AIDS?** | 1 - Yes  2 - No  99 - Don’t know |
| **D4. In your opinion, what is the most important source of information for \_\_\_\_\_\_\_\_ (name) about sexually transmitted infections including AIDS?** (try to ask in a different way: where and from whom does your child receive information about these illnesses?) | 1 – Parents, relatives  2 – Friends, peers, course mates, classmates  3 – Health workers  4 – Teacher (school, lyceum, college)  5 – Newspaper, magazine, special books, brochures  6 – Radio, TV, the Internet  77 – Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **D5. Does any of your family members smoke?** | 1 - Yes  2 - No 🡺**D7**  99 - Don’t know |
| **D6. Who, among your family members, smokes?** | A – The adolescent’s father/mother  B – Brothers/sisters  C – Grandfather/grandmother  D – Someone else (specify)\_\_\_\_\_\_\_\_  E – No one |
| **D7. What, in your opinion, makes people start smoking?** | 1 – Loneliness / Life hardships  2 – Curiosity  3 – Influence of other people around  77 – Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  99 – Don’t know |

| **SELF-ASSESSMENT OF THE HOUSEHOLD E** | | | | | | | | |
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| E1. Please tell me, what your household’s is the regular income size and irregular (seasonal) earnings per month? | | | | | | | | |
| Considered as income | | | | | Not considered as income | | **1** – up to 199,999 UZS  **2** – 200,000-599,999  **3** – 600,000- 999,999  **4** – 1,000,000 – 1,999,999  **5** – 2,000,000 and more  **99** – Don’t know | |
| * remuneration of labor (size in monetary terms and in kind including envelope wages, all bonuses and financial aid); * payment from a legal entity to an individual in the form of goods, works, services (kindergarten, utility services, travel cards, and etc.); * income from industrial products produced (processed) by HH members (total amount of income from products sold at the market and/or hypothetical price/cost of labor for production of goods used for own consumption) exclusive of expenses on entrepreneurial activities; * income from selling plant and animal products of dehkan farms both for sales and own consumption exclusive of expenses; | | * income from services delivered by HH members outside home (transportation, trade and etc.); * income of HH members who worked at construction of residential and nonresidential buildings; * income from property/assets (interests, dividends, rent, copyright fees as well as profit of a legal entity transferred to the disposal of an owner of an enterprise or a head of farm); * current transfers: pension fees, welfare, student allowances, child support payments, money transfers from places outside the place of residence and other regular transfers and incomes of a HH | | | * gifts, inheritance, insurance payments, gains, and other irregular earnings of a HH; * cost of domestic services rendered by HH member in their home (cleaning, cooking, childcare) | |
| E2. How do you assess current wellbeing of your household? | | | | | | | | |
| **1 –** affluent | **2** – higher than average | | **3** – average wellbeing | **4** – lower than average | | **5** – low income | | **99** – Don’t know |

***Annex 2***

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| *Interviewer, if the respondent is a man or a woman aged older than 49 years, then thank him/her for the answers and finish the interview, but if younger than 49 years, then continue as follows:*  ***Do you mind if we talk about issues that are directly related to you? These questions are about your reproductive health and where you go to seek medical assistance.***  ***All information, which you will provide, will be kept confidential. The response is fully voluntary; if you do not wish to answer some quation, just let me know and we will move on to the next question. The interview will take about 20 – 30 minutes of your time.*** |

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| **RESPONDENT INFORMATION R** | |
| **R1. Respondent’s code and name.** *To be filled in by the interviewer without asking questions.* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_|\_\_| |
| **R2. Respondent’s age.**  *To be filled in by the interviewer without asking questions.* | Age (full years) \_\_\_ |
| **R3. Respondent’s gender.** *To be filled in by the interviewer without asking questions.* | 1 - male 2 - female |

**R4. Do you agree to continue the interview?** 1 - Yes *🡪 module RH*

2 – No *🡪filter F2*

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| **Filter F2: If the respondent disagrees, then the respondent’s spouse may be offered to fill in the questionnaire on Reproductive Health.** |

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| **RESPONDENT INFORMATION R** | |
| **R1. Respondent’s code and name.** *To be filled in by the interviewer without asking questions.* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |\_\_|\_\_| |
| **R2. Respondent’s age.**  *To be filled in by the interviewer without asking questions.* | Age (full years) \_\_\_ |
| **R3. Respondent’s gender.** *To be filled in by the interviewer without asking questions.* | 1 - male 2 - female |

**R8. Do you agree to continue the interview?** 1 - Yes *🡪 module RH*

2 – No *🡪end of the interview*

INDIVIDUAL QUESTIONNAIRE

REPRODUCTIVE HEALTH AND REPRODUCTIVE ATTITUDES

| **MARRIAGES, PREGNANCIES RH** | | |
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| **RH1**. **Are you currently in an official marriage, civil marriage, separated, divorced, widowed, or have never been married?** | | 1 – In an official marriage 🡪RH4  2 – In a civil marriage 🡪RH4  3 - Separated 🡪RH4  4 - Divorced 🡪RH4  5 – Widow/widower 🡪RH4  6 – Have never been married |
| **RH2. Have you ever lived with a girlfriend (boyfriend) or partner?**  *(cohabitation implies sexual relation and living at the same address)* | | 1 – Yes 🡪 RH4  2 – No |
| **RH3. If you were to decide, how many children would you like to have?** | | |\_\_\_|\_\_\_| children  22 – as many as God sends  33 – as many as my spouse wishes  99 – don’t know |
| ***GO TO 🡪 RK*** | | |
| **RH4. How old were you, when you entered your (first) marriage?** | |\_\_\_|\_\_\_| years  99 - Don’t know | |
| **RH5. How many children do you have?** | |\_\_\_|\_\_\_| children | |

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| **AWARENESS OF THE POPULATION ABOUT**  **CONTRACEPTIVES AND CONTRACEPTIVE PRACTICES** | | | | | | | | | | | **RK** |
| **For each of the following methods, please tell me:** | | | **RK1** | | | **RK2** | | | **RK3** | **RK4** | **RK5** |
| **Have you heard about it?** *(read А through K)* | | | **Do you know how to use it?** | | | **Have you ever use it?** | **Do you know where to buy/get this method?** | **How did you find out about this method*?*** *(see codes below)* |
| **А.** | Contraceptive pills (Oral contraception) | | 1 – Yes  2 – No **🡪**B | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **B.** | IUD (Intrauterine Device) | | 1 – Yes  2 – No **🡪**C | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **C.** | Condom | | 1 – Yes  2 – No **🡪**D | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **D.** | Foam/Gel/Cream/Foaming tablets (local spermicides, for example, “Farmatex”) | | 1 – Yes  2 – No **🡪**E | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **E.** | Tubal ligation (female sterilization) | | 1 – Yes  2 – No **🡪**F | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **F.** | Male sterilization (vasectomy) | | 1 – Yes  2 – No **🡪**G | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **G.** | Injectable contraceptives (for example, “Depo-Provera”) | | 1 – Yes  2 – No **🡪**H | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **H.** | Emergency hormonal contraception (“postcoital pill”, “Postinor”) | | 1 – Yes  2 – No **🡪**I | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| **I.** | Basal/Calendar Method | | 1 – Yes  2 – No **🡪**J | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | **Х** | **|\_\_\_|\_\_\_|** |
| **J.** | Coitus Interruptus | | 1 – Yes  2 – No **🡪**K | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | **Х** | **|\_\_\_|\_\_\_|** |
| **K.** | Lactational Amenorrhea | | 1 – Yes  2 – No **🡪**L | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | **Х** | **|\_\_\_|\_\_\_|** |
| **L.** | Other methods of contraception *(specify*): | | 1 – Yes  2 – No **🡪**RK6 | | | 1 – Yes  2 – No | | | 1 – Yes  2 – No | 1 – Yes  2 – No | **|\_\_\_|\_\_\_|** |
| 1 – Mother  2 – Father  3 – Relative  4 – Beloved  5 – Friends  6 – Colleague at work | | 7 - Colleagues, peers  8 – Partner / husband  9 – General practitioner  10 – Obstetrician-gynecologist  11 – Nurse at a polyclinic  12 – Midwife | | | | | | 13 – Pharmacist (chemist)  14 – Teacher  15 – Books  16 – Newspapers, magazines, brochures, leaflets  17 – Radio | | 18 – Television  19 – the Internet  77 – Other (specify) \_\_\_\_\_\_\_  99 – Don’t know | |
| **RK6. Do you (or your partner) currently (during the last 30 days) use any method of contraception?** | | | | | 1 – Yes  2 – No 🡪 RK9  99 – Don’t know 🡪 RK9 | | | | | | |
| **RK7. What birth control method do you use?** | | | | | 1. Pills 2. IUD (Intrauterine Device) 3. Condom 4. Condom + spermicide 5. Condom + coitus interruptus / calendar method 6. Foam / gel / cream / vaginal film 7. Female sterilization 8. Emergency hormonal contraception / (Postinor) 9. Injectable contraceptives (Depo-Provera) 10. Other modern method (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11. Calendar method 12. Coitus interruptus 13. Coitus interruptus and calendar method   77- Other treaditional method (specify) | | | | | | |
| **RK8. What was the main reason for you to choose this method?**  *(choose one answer)* | | | | | 1. Recommended by a general practitioner 2. Recommended by an obstetrician-gynecologist 3. Recommended by a nurse at a polyclinic 4. Affordable price 5. Very effective   6 – Very safe (few or no side effects)  7 – Saw advertisement (on television, radio, in press, in brochures)  8- Easy to use  9- The partner prefers using this method  10- Knows people who use this method  11- Curiosity / desire to try  12 – Allows for spontainety (freedom) of sexual contact  13 – Religious concerns  14 – Method is available free-of-charge  77 - Other (specify) \_\_\_\_\_\_\_\_\_\_\_  99 - Don’t know | | | | | | |
| ***GO TO RK10*** | | | | | | | | | | | |
| **RK9. What is the main reason why you or your partner do not currently use this method of contraception?** | | | | 1 – Currently has no partner  2 – The couple is trying to conceive  3 – Postpartum period / breastfeeding period  4 – The woman is currently pregnant  5 - Uterectomy / menopause 🡪 module RA  6 – The doctor said the couple cannot have children 🡪 module RA  7 – The couple has been trying to conceive for 2 years, but unsuccessfully 🡪 module RA  8 – Fear of side effects  9 – Coitus may be interrupted  10 – The respondent does not think about using contraceptives  11 – Cannot affort to buy birth control methods (too expensive)  12 – Contraception is the responsibility of the partner  13 – Contraception is not (very) effective  14 – Does not want to use the method / does not like using the method  15 – Partner is against contraception  16 – Due to religious concerns  17 – Does not know where to get the contraceptive method  18 – Does not know how to use birth control methods  19 – Does not think pregnancy is possible  20 – The woman uses douching  77 - Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  99 - Don’t know | | | | | | | |
| ***GO TO RA*** | | | | | | | | | | | |
| **RK10. Where did you get the last of the contraception methods you used?** | | | | | | | 1 – Republican Medical Center for Obstetrics and Gynecology  2 – Regional Perinatal Center / Branch of the Republican Medical Center for Obstetrics and Gynecology  3 – City hospital  4 – District hospital  5 – District medical association  6 – Family polyclinic  7 – Rural outpatient clinic  8 – Private clinic/hospital  9 – Pharmacy  10 – Market / bazaar / shop  11 – Partner / husband  12 – Girlfriend / boyfriend  13 – Relative  77 – Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  99 – Don’t know | | | | |
| **RK11. Have you paid for this contraceptive method?** | | | | | | | 1 - Yes  2 - No🡪 RK14 | | | | |
| **RK12. Have you paid for: .......**  *READ OUT THE OPTIONS* | | | | | | | 1 – The contraceptive method?  2 – Doctor’s consultation?  3 – For both of them? | | | | |
| **RK13. How much have you paid in total for the contraceptive method?** | | | | | | | \_\_\_\_\_\_\_\_\_\_ thousand UZS  88 – More than 100 thousand UZS  99 - Don’t know | | | | |
| **RK14. When have you started to use the last contraceptive method who consulted you about how to use it?** | | | | | | | 1 – General practitioner  2 – Obstetrician-gynecologist  3 – Patronage nurse  4 – Nurse from a polyclinic  5 – Midwife  6 – Pharmacist  7 – Mother, father  8 – Other relative  9 – Girlfriend/boyfriend  10 – Partner  11 – Nobody  77 – Other (specify) \_\_\_\_\_\_\_\_\_\_ | | | | |

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| **ACCESSIBILITY OF REPRODUCTIVE HEALTH SERVICES RA** | | | | | | | |
| **I would like to ask you several questiona related to receiving reproductive health services, specifically, in relation to care during pregnancy and childbirth, contraception, childlessness issues, prevention of STIs including HIV and others.** | | | | | | | |
| **RA1. Are there any health facilities where you can seek reproductive health care or consultations?** | | | | | | | 1 – Yes  2 – No **🡪**RA3 |
| **RA2. What kind of facility is this?**  **Mark the health facilities, where you seek health care services:**  **(***READ A– H)* | | | | | | | **1 – Yes**  **2 – No** |
| **А.** | | Family polyclinic | | | | | 1 2 |
| **B.** | | Rural outpatient clinic | | | | | 1 2 |
| **C.** | | District hospital | | | | | 1 2 |
| **D.** | | City hospital | | | | | 1 2 |
| **E.** | | Emergency care center | | | | | 1 2 |
| **F.** | | Republican Medical Obstetrics and Gynecology Center | | | | | 1 2 |
| **G.** | | Provincial perinatal center/branch of the Republican Medical Obstetrics and Gynecology Center | | | | | 1 2 |
| **H.** | | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | 1 2 |
| **RA3. How long does it take you to get to the facility from your home?** *(in case there are several of them, record the distance to the closest one)***?** | | | \_\_\_\_\_\_\_\_\_ minutes  00 – At work, at home  99 – Don’t know | | | | |
| ***GO TO RA5*** | | | | | | | |
| **RA4. What is the main reason why you do not present to an appropriate facility for reproductive health care?** | | | | 1 – There is no health facility nearby  2 - No sense, since I rarely fall ill / No need  3 – Dissatisfaction with quality of care  4 – Cannot afford to pay fees for services  5 – Recently moved here  7 – Others (specify)\_\_\_\_\_\_\_\_\_\_  99 – Don’t know | | | |
| **RA5. Have health workers visited you during the past 12 months to inform you about reproductive health and contraception?** | | | | 1 – Yes  2 – No **🡪**RA7 | | | |
| **RA6. Please tell us how often you have been visited by health workers during the past 12 months?** | | | | 1 – Once a month  2 – Once every 3 months  3 – Once every 6 months  4 – Less than once every 6 months | | | |
| **RA7. What health care services have you received during the past 12 months? You have received (***READ A–G***)** | | | | | | | |
|  |  | | | | **NO** | **YES** | |
| **A.** | Antenatal care | | | | 0 | 1 | |
| **B.** | Family planning advice | | | | 0 | 1 | |
| **C.** | Receiving a contraceptive method | | | | 0 | 1 | |
| **D.** | In relation to side effects of contraception | | | | 0 | 1 | |
| **E.** | In relation to abortion | | | | 0 | 1 | |
| **F.** | Childbirth | | | | 0 | 1 | |
| **G.** | Other | | | | 0 | 1 | |
| **RA8. Are you satisfied with the reproductive health care service, in general?** | | | | | 1 – Very satisfied  2 – Satisfied  3 – Somewhat satisfied  4 – Dissatisfied  99 – Don’t know | | |
| **FILTER F3: IF THE RESPODENT IS MALE 🡪 RA11,**  **IF THE RESPONDENT IS FEMALE – CONTINUE** | | | | | | | |
| **RA9. When was the last time you visited a general practitioner or gynecologist for examination (unrelated to pregnancy)?** *(read answer options)* | | | | | 1 – During the past 6 months  2 – During the past 12 months  3 – 13-24 months ago  4 – More than 2 years ago  99 - Don’t know 🡪 RA11 | | |
| **RA10. Did you visit …** | | | | | **А.** A general practitioner **1 – Yes 2 – No** | | |
| **B.** A gynecologist **1 – Yes 2 – No** | | |
| **RA11. Do you think that a woman always has a right to determine the fate of her pregnancy including a right to abortion?** | | | | | 1 - Yes 🡪 go to RA13.  2 - No | | |
| **RA12. Who influences the decision:** | | | | | **А.** Husband **1 – Yes 2 – No**  **B.** Mother-in-law **1 – Yes 2 – No**  **C.** Father-in-law **1 – Yes 2 – No**  **D.** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **1 – Yes 2 – No** | | |
| **RA13. In your opinion, if the woman’s pregnancy is unwanted, what should she do?***(read 1–3):* | | | | | 1 – Give birth to the child and raise him/her  2 – Give birth to the child and have him/her adopted  3 – Have an abortion  99 – Don’t know | | |

***Annex 3***

**QUESTIONNAIRE**

**for an in-depth interview held with a chairperson of a civil assembly of a**

**community (*mahalla*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Influence of healthy nutrition, sanitary and hygienic, environmental, hereditary factors as well as exercise and sports on the development of school-aged children and adolescents and shaping of healthy lifestyles)

Respondent’s background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Full Name*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*position, work experience, scope of key official duties*

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| **#** | Question | **Answer** | | | **Venue\*** |
| 1 | Mark factors according to their importance, which influence healthy lifestyles of adolescents  *\*Note: (the most important ranks first, the next important ranks second, and the rest following this order)* | A | Adequate and healthy nutrition | |  |
| B | Following the rules of personal anf common hygience | |  |
| C | Physical education and sports | |  |
| D | Influence of hereditary factors | |  |
| E | Absence of harmful habits *(tobacco and alcohol use)* | |  |
| F | Following safety precautions to prevent accidents | |  |
| G | Environmental situation | |  |
| H | Family’s financial status | |  |
| I | Lifestyle | |  |
| J | Other (indicate) | |  |
| K | Other (indicate) | |  |
|  | | | | | |
| 2 | Who is responsible for shaping healthy lifestyles of adolescents? Mark answers according to their importance.  *\*Note: (the most important ranks first, the next important ranks second, and the rest following this order)* | A | Parents / Caregiver / relatives who are raising the adolescent | |  |
| B | Neighbours | |  |
| C | Community (*mahalla*) representatives | |  |
| D | Teachers at education facilities *(at school, college)* | |  |
| E | Health workers | |  |
| F | Adolescent him/herself | |  |
| G | Other (indicate) | |  |
| Н | Other (indicate) | |  |
|  | | | | | |
| 3 | How many families engage into mass sports? | 1 – running \_\_  2 – swimming \_\_  3 – gymnastics \_\_  4 – soccer \_\_  5 – volleyball \_\_  6 – basketball \_\_ | | 7 – tug-of-war \_\_  8 – running race and shooting at aims\_\_  9 – *kurash* (wrestling) \_\_  10 – boxing \_\_  11 – tennis \_\_  12 - Other \_\_\_\_\_\_\_\_\_\_\_\_ \_\_  13 - Other \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ | |
| 4 | What mass sports are developed in a community (*mahalla*) or have opportunities for their development? | 1 – a dynasty of *palwans* (strongmen)  2 – a dynasty of football players  3 – a dynasty of tennis players  4 – a dynasty of *kupkari\** participants  *(kupkari is a mass sports game where two teams of horsemen compete over throwing a goat or sheep carcass into the rival’s finish ring more times than the other team)*  5 – dynasty of wrestlers  6 – Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  7 – Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 5 | Are there any sports grounds on the premises of the community, where adolescents can exercise? | 1 – Yes, there are  2 – No, there are not 🡺 go to question 7  3 – The new one is under construction 🡺 go to question 7  4 – Far away from the community 🡺 go to question 7 | | | |
| 6 | If there is a sports ground / stadium / gym within the community, then what kind of sports equipment is available there? | 1. Football field, gates 2. Balls for football and basketball 3. Basketball court 4. Pull-up bars 5. Race tracks 6. High jump stand 7. Gym bench 8. Barriers for track and field athletics 9. Rackets for badminton 10. Tennis table 11. Different weights 12. Punching bag 13. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 14. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 15. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 7 | Which events aimed at shaping healthy lifestyle in families with small children using the funds of the community, sponsors and entrepreneurs have been organized in the recent 12 months? | 1. No events 2. Procuring food stuffs 3. Tours to summer recreation camps 4. Clothing 5. Procurement of sports garments / equipment 6. Sending children to sports clubs / subscription to a fitness center 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 10. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| 8 | What activities are carried out in your community following the implementation of the State Program “The Year of Healthy Child”? |  | | | |
| 9 | What barriers and obstacles does the community’s “Commission on Minors, Youth, and Sports” face in shaping healthy lifestyles among young people and organizing their physical education and sports? |  | | | |
| 10 | What are the proposals for more effective implementation of sports and fitness activities for minors and young people? |  | | | |

**QUESTIONNAIRE**

**for an in-depth interview of an educator from an academic institution** *(director, deputy director, head of research department, physical education instructor and teachers of other subjects)*

(Influence of healthy nutrition, sanitary and hygienic, environmental and hereditary factors as well as physical education and sports classes on the development of schoolchildren and adolescnetns and shaping of healthy lifestyles)

Key information about the respondent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Full Name*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name/number of the academic institution (school, lyceum, college), position, work experience, scope of key office duties*

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| --- | --- | --- | --- | --- |
| **#** | Question | **Answer** | | **Rank\*** |
| 1 | Mark factors according to their importance, which influence healthy lifestyles of adolescents  *\*Note: (the most important ranks first, the next important ranks second, and the rest following this order)* | A | Adequate and healthy nutrition |  |
| B | Following the rules of personal anf common hygience |  |
| C | Physical education and sports |  |
| D | Influence of hereditary factors |  |
| E | Absence of harmful habits *(tobacco and alcohol use)* |  |
| F | Following safety precautions to prevent accidents |  |
| G | Environmental situation |  |
| H | Family’s financial status |  |
| I | Lifestyle |  |
| J | Other (specify) |  |
| K | Other (specify) |  |
| 2 | Who is responsible for shaping healthy lifestyles of adolescents? Mark answers according to their importance.  *\*Note: (the most important ranks first, the next important ranks second, and the rest following this order)* | A | Parents / Caregiver / relatives who are raising the adolescent |  |
| B | Neighbours |  |
| C | Community (*mahalla*) representatives |  |
| D | Teachers at education facilities *(at school, college)* |  |
| E | Health workers |  |
| F | Adolescent him/herself |  |
| G | Other (indicate) |  |
| Н | Other (indicate) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 3 | If there is a sports ground / stadium / gym at your academic institution, then what kind of sports equipment is available there? | 1. Football field, gates 2. Balls for football and basketball 3. Basketball court 4. Pull-up bars 5. Race tracks 6. High jump stand 7. Gym bench 8. Barriers for track and field athletics 9. Rackets for badminton 10. Tennis table 11. Different weights 12. Punching bag 13. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 14. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 15. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 4 | What sports activity centers/clubs have been created at your academic institution for young people for classes during time after school? | А. Running  В. Swimming  С. Gymnastics  D. Soccer  Е. Volleyball | F. Basketball  G. Types of single combat sports  Н. Tennis  I. Other \_\_\_\_\_\_\_\_\_\_\_  J. Other \_\_\_\_\_\_\_\_\_\_\_ |
| 5 | How well is cooperation established between your academic institution with a family polyclinic / rural outpatient clinic located within a given territory and how many times a year do young people undergo medical checkups? |  | |
| 6 | For how many hours a week, have you organized classes on key concepts and areas of healthy lifestyles (including those for adolescent girls on key health concepts)? |  | |
| 7 | What activities have you implemented in the academic instutition in order to attract adolescent girls into sports? | 1. Activities to improve health of adolescent girls and boys 2. Holding competitions among girls artistic and rhythmic gymnastics and other sports 3. Talks to prepare girls for family life 4. Talks to prevent early marriages among girls 5. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| 8 | What activities are carried out at the academic institution within the state program “The Year of a Healthy Child”? |  | |
| 9 | What barriers and obstacles prevent the shaping of healthy lifestyles among young people and organizing their physical education and sports? |  | |
| 10 | What are the proposals for more effective implementation of sports and fitness activities for minors and young people? |  | |

**QUESTIONNAIRE**

**for an in-depth interview of a healthcare workers**

(Influence of healthy nutrition, sanitary and hygienic, environmental and hereditary factors as well as physical education and sports classes on the development of schoolchildren and adolescnetns and shaping of healthy lifestyles)

Key information about the respondent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Full Name*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name/number of the health facility, position, work experience, scope of key office duties*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **#** | Question | **Answer** | | **Rank\*** |
| 1 | Mark factors according to their importance, which influence healthy lifestyles of adolescents  *\*Note: (the most important ranks first, the next important ranks second, and the rest following this order)* | A | Adequate and healthy nutrition |  |
| B | Following the rules of personal anf common hygience |  |
| C | Physical education and sports |  |
| D | Influence of hereditary factors |  |
| E | Absence of harmful habits (tobacco and alcohol use) |  |
| F | Following safety precautions to prevent accidents |  |
| G | Environmental situation |  |
| H | Family’s financial status |  |
| I | Lifestyle |  |
| J | Other (specify) |  |
| K | Other (specify) |  |
| 2 | Who is responsible for shaping healthy lifestyles of adolescents? Mark answers according to their importance.  *\*Note: (the most important ranks first, the next important ranks second, and the rest following this order)* | A | Parents / Caregiver / relatives who are raising the adolescent |  |
| B | Neighbours |  |
| C | Community (*mahalla*) representatives |  |
| D | Teachers at education facilities *(at school, college)* |  |
| E | Health workers |  |
| F | Adolescent him/herself |  |
| G | Other (indicate) |  |
| Н | Other (indicate) |  |
| 3 | What activities did health workers carry out in the nearby communities during the last 12 months to develop healthy lifestyle skills? | 1. Talks about the health hazard of smoking / alcohol abuse / drug abuse (and prevention of early marriages / HIV / AIDS) 2. Medical checkups of women and girls in the community 3. Constant monitoring of the population (HH) on private and common hygiene 4. Taking measures to prevent various infectious diseases, vaccination of children 5. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 4 | What activities did health workers carry out at schools, lyceums and colleges during the last 12 months with a view to develop healthy lifestyles skills? | 1. Talks about health hazard of smoking / alcohol abuse 2. Talks about preventing early marriages among girls 3. Talks about private and common hygiene 4. Talks about health hazards of drug abuse 5. Talks about prevention of HIV/AIDS infection 6. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 5 | What is the percentage of coverage of students with health screening (complete medical checkup) with the purpose of early diagnostics and prevention of diseases? |  | | |
| 6 | What is the percentage of adolescents who were referred to hospitals/sanatoria to improve their health during the last 12 months? |  | | |
| 7 | How well is cooperation organized between the healthcare facility and an academic institution and how many times a year young people undergo health checkup? |  | | |
| 8 | What activities are carried out within the health care to implement the state program “The Year of a Healthy Child”? |  | | |
| 9 | What barriers and obstacles prevent the shaping of healthy lifestyles among young people and organizing their physical education and sports? |  | | |
| 10 | What are the proposals for more effective implementation of sports and fitness activities for minors and young people? |  | | |