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ADOLESCENTS' MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING AT SCHOOLS

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The study 'Adolescents' mental health and psychosocial well-being at schools', carried out as part of broader collaboration between the Government of Uzbekistan and UNICEF, is the first comprehensive study of adolescent school students' needs, school-related factors impacting the mental health and well-being of adolescent students, and review of existing policies and school strategies and actions for recognizing, mitigating and addressing adolescents' mental health issues both inside and outside of Uzbekistan's schools.

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LIST OF ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
CRPD	Convention of the Rights of Persons with Disabilities
FGD	Focus Group Discussions
IASC	Inter – agency Standing Committee
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MMFA	Ministry of Makhalla and Family Affairs
MoH	Ministry of Health
MoI	Ministry of Interior
MoPE	Ministry of Public Education
NCDs	Non – Communicable diseases
SDG	Sustainable Development Goals
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organisation

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EXECUTIVE SUMMARY

Adolescence is a unique phase in human development, during which young boys and girls have just started on the path to finding their identities, and becoming independent and self-sufficient adults. It is a crucial period for developing the social and emotional habits important for mental and emotional well-being. Rapid physical, cognitive, emotional and psychosocial development affect the way adolescents think, feel and interact with their external and internal environments. Globally it is estimated that one in seven adolescents (from 10 to 19 years old) suffers from a mental disorder, with depression, anxiety and behavioural disorders being leading ones.

In Uzbekistan the national authorities have included mental health in the sphere of public health, because there are clear indicators that mental health is a serious public health problem in the country. Psychosocial services are provided by the Ministry of Mahalla and the Elder Generation, the Ministry of Public Education at schools, and also the Ministry of Internal Affairs. According to the draft National Strategy and Action Plan for Adolescents Health and Well-being 2022-2026, adolescent girls and boys have experienced depression, mood swings and suicidal ideation as a result of psychologically-abusive school experiences. Likewise, recent data on suicide mortality among adolescents show a con-

cerning increasing trend in self-harm and suicide rates.

Aim and objectives of the study.

The main purpose of this study is *to explore the needs of school adolescents, school related factors impacting their mental health and well-being, and to review the existing policies, school strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents inside and outside school.*

The specific objectives of the study are to:

- Conduct an overview study of available evidence and analysis of school adolescents' mental health situation and needs school-related factors affecting mental health of adolescents in Uzbekistan; and key stakeholders, policies, legislations, standards and programmes related to mental health and well-being among Uzbekistan's adolescents.

- Review existing policies and schools' strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents inside and outside school.

- Provide recommendations and action plans on using the school platform to provide mental health and psychosocial support, and to mitigate and prevent school-related mental health risks, especially those related to the COVID-19 pandemic.

Methodology

This study used a mixed methods approach, with a parallel design. The model used for the quantitative component was a cross-sectional survey. A questionnaire was developed for this purpose, which was piloted and resulted in satisfactory reliability results (Cronbach $\alpha > .7$). Multi-stage stratified sampling was applied in this study, in order to avoid any potential biases in the sample, with random selection of schools based on probability proportional to enrolment from the sampling framework. A total of ***299 schools*** from all ***14 regions*** of Uzbekistan, with ***N = 22,854 students*** in the 6th, 9th and 11th grades, participated in the study. There were almost equal representations of schools from urban and rural areas, of adolescent boys and girls, and of 6th and 9th graders. Slightly less students participated from the 11th grade. Qualitative primary data collection was carried out through focus group discussions with adolescents, their parents and school professionals (school psychologists, medical workers and inspector psychologists), along with interviews with key stakeholders at the central level. Data triangulation and deeper exploration of key issues was achieved through this component. A total of 219 participants engaged in the qualitative part of the study.

MAIN FINDINGS

Survey findings

- 5 per cent of adolescents were working, and 1 out of 3 of them held a full-time job. This trend was more present at the 11th grade.

- 1 out of 5 students (20 per cent) had at least one parent living away from home during the last year for at least one month, usually the father. Adolescents from rural areas were more likely to be in this category, along with students who had a part-time or full-time job.

- While the majority of adolescent boys and girls had satisfactory family relations, almost 9 per cent of them did not

feel supported by their family, in regards to school or friendship issues. In line with this, 10 per cent of them were not satisfied with their school and friendship experience, although most of them were satisfied with other different life aspects (such as their place of living, family life, and themselves).

- A total of 85 to 89 per cent of students had positive perceptions of their teachers, and of their interactions with teachers. Girls, students from urban areas, and 6th graders reported a more positive experience. In contrast with this, there was a consistent 10 to 15 per cent of students who had a negative perception of their teachers, the relations they have with their students, and their overall attitudes and interactions. Working students and those with high anxiety and depression levels prevailed in this group.

- A lack of social connectedness and isolation was experienced by more than 10 per cent of students. Almost 1 out of 10 felt that they didn't belong to their school (8.7 per cent), while even more said that they were not part of their school (13.1 per cent), or that they were lonely in the classroom (16.7 per cent). This is in line with their overall perception of their peers and the way they interact with each-other.

- The majority of students declared that they can ask questions during lessons and that exams are clear and understandable, but still they ranked 'exams' as being one of the top three worries they had during the last month. Other worries were about their future, their health and school.

- 18 per cent of adolescent boys and girls perceived that students in their schools fight a lot, and 13 per cent of them reported that they had been teased or picked on because of their nationality, the economic status of their family, or for other reasons. Overall there seems to be a constant percentage of students varying among 1 to almost 2 out of 10 students who believe that school is not safe, because of students' risky, violent and discriminatory behaviours.

- Adolescent boys, working students, students whose parents have been living/working far from home, and 6th graders, all had greater chances of being teased, called unkind names, or physically hit by their peers.

- 22 per cent of students said they had some problems during the last month, but they did not feel they needed professional help. On the other hand, 7 per cent of them needed professional help but had not asked for it.

- The study found a concerning number of students that had moderate to extremely-severe anxiety (15.4 per cent) and depression (9.8 per cent). Almost 1 out of 10 students suffered from moderate to extremely-severe depression, and even more from moderate to extreme anxiety. Students whose parents lived out of home for at least one month, working students, and girls all featured more in these groups.

- Students with moderate to extremely-severe levels of depression, anxiety and/or stress had a less positive perception of the way students interacted with each-other, lacked school connectedness, and were more likely to be hit by other children, called unkind names, and be put down and bullied online, but still some of them have not asked for help. It is not clear if it is the presence of a mental health condition that puts these students at a greater risk, or if it is the fact that they are victims of all sorts of violence that amplifies or causes mental health conditions. In both cases, these boys and girls need additional psychosocial support.

- Trusted persons to ask for help in difficult life situations were initially parents (77 per cent), followed by friends (55 per cent), and other relatives (21 per cent). School psychologists are ranked low in this list, with only 17 per cent of adolescent boys and girls stating that they would go to them for help.

- The COVID-19 pandemic and lockdowns made adolescents lonelier and more worried about their health and their family members. Nevertheless, their overall experience of the COVID-19 pandemic was both positive and negative.

Qualitative primary data collection

The qualitative part of the study shed light on some of the survey's findings, but also identified and explored new issues about mental health of school adolescents in Uzbekistan.

- Participants were able to describe some mental health concerns in adults and adolescents, yet the stigma of persons with mental health issues being perceived as 'crazy' or 'insane' was common, and hampered help-seeking behaviours.

- Self-harming behaviour was less recognized to parents and adolescents, in contrast with suicidal attempts that were more known.

- Several risk and protective factors were mentioned by participants, that can worsen adolescents' mental health and psychosocial well-being or improve it, respectively. Good family relations, quality friendships and social networks, inclusive and supportive teachers, good school conditions in terms of teacher-student ratio, and modern teaching methods and engagement in extra-curricular activities, were all main protective factors.

- The most common risk factors were family conflicts/violence, and general lack of communication and understanding in the family environment, lack of friendships or superficial friends, unsupportive teachers, academic pressure, bullying, bad school conditions, excessive screen time, poverty and parents' migration.

- Gender had a two-fold effect. Girls seemed to be favoured by teachers, because of their good grades, while boys felt discriminated against. However, present gendered norms are restrictive, such as not allowing girls to attend higher education, forcing them to marry, and restricting their out-of-school activities.

- The most common barriers to help-seeking behaviours of adolescents and parents were linked to stigma and embarrassment, lack of information about school psychologists and other community resources for mental health and psychosocial support, and lack of trust by both adolescents and their parents regarding psychologists' skills and qualifications.

- Service provision by school psychologists had its own challenges, including long working hours (including work in communities), lots of paperwork, lack of appropriate office space, and low salaries.

- The new function of inspector psychologists was unclear, with them conducting both security officer and social worker tasks, like monitoring of undesirable behaviours and referral to other systems/services.

- While the policy and legal framework was an improved version of the previous ones and closer to international stand-

ards, it still lacked inclusion of rights of children and adolescents in making informed decisions, and provided different forms of social treatment for adults and adolescents. Service provision was in a worse position, it hadn't kept the pace of legal/policy framework. Currently it is concentrated mainly at the district level, with fewer choices for accessible, available and quality mental health and psychosocial support services at the community (mahalla) level.

- Some school-based initiatives directly or indirectly addressing the mental health and psychosocial well-being of adolescents have been put in place, which need to be replicated in other schools with consideration of evidence of good results.

- Participants claimed that they had good multidisciplinary collaboration within schools and with other sectors.

MAIN CONCLUSIONS

Employing a socio-ecological model, this study was focused on the psychosocial well-being of adolescent boys and girls psychosocial within family and school environments, and it also explored peers, community, organizations and legal/policy factors which may influence adolescents' mental health and psychosocial well-being.

Mental health conditions, like moderate to extremely-severe levels of anxiety, depression and stress, were connected to almost all factors of an adolescents' environment. Thus, the 10 to 15 per cent of students who showed moderate to extremely-severe levels of anxiety, depression and stress felt less satisfied with family relations and other life aspects, like school experience, friendships, themselves and their body image.

While most adolescents had positive relations and perceptions about teachers, peers, school social connectedness, school safety and tests and exams, correlations between those factors and levels of stress, anxiety and depression showed a negative relation (the worse the perception the higher the levels of these emotions, or vice versa).

Working students and those in higher grades faced more emotional and behavioural difficulties, while students whose parents lived far from family faced more emotional issues. Having parents who are both physically and emotionally close during those challenging years of adolescence can indeed act as a buffer for emotional and behavioural difficulties. Other risk factors include family's socio-economic status, school conditions, bullying and screen time. Participation in extra-curricular activities was the one believed to have only positive influence.

Help-seeking behaviour in both parents and adolescents was hampered by a series of negative factors, like stigma towards mental health, embarrassment, lack of accessible services in the community, or lack of trust towards practitioners. Earlier research also indicated the low capacity of public services for children and adolescents in the community, and the fact that these services are not accessible by people living in rural and remote areas.

In-school service provision by school psychologists has faced several barriers, like overload, long working hours, extensive bureaucracy, lack of qualifications to conduct their duties and low wages. Out of school service provision was concentrated at a district level, and was mainly institutionalized. Many parents and adolescents didn't have information about the availability and quality of current mental health services. Multidisciplinary and inter-sectorial collaboration was well-established, but the used protocols were not made available.

The country's current policy and legal framework was an improvement on previous ones, and closer to international standards. However, legislation lacked the inclusion of rights of children and adolescents in making informed decisions, and the modalities of social treatment for both adults and adolescents. In particular quality and accessible mental health and psychosocial support services, especially at the community level, have fallen behind. At a school level, there were some good initiatives of school-based programmes, but in a limited number of schools.

The COVID-19 pandemic's impact was twofold, being both positive and negative. On the one hand many adolescents reported that they have been lonely, been worried about their own health or that of their family members, and have faced difficulties with online education. However, others pointed out the freedom they gained during the lockdowns to schedule their own time, do things that they normally cannot do like sports and other activities, or spend more time with their families.

RECOMMENDATIONS

Recommendations are structured based on the three tiers of mental health interventions at schools, and are extended to partnerships with other sectors.

Provide universal mental health promotion for all students, parents and school staff

A. Short term

- Promote mental health awareness in schools for adolescents and parents. Parents and adolescents need to be informed of children's warning signs and symptoms of mental health problems.
- Provide opportunities for regularly-conducted capacity building activities, through which school staff can understand ways to maximise the mental health and psychosocial well-being of adolescents, and identify early warning signs of mental health problems and particularly that of suicide.
- Invest in inclusive extra-curricular activities for all students that will promote school and community connectedness, decrease isolation, and address bullying.
- Raise awareness of mental health conditions, particularly those most common (anxiety, depression or behavioural problems), and reduce stigma of mental health concerns and disorders.

B. Long-term

- Develop a mental health literacy curriculum at school level, that includes building life skills, investing in social and emotional learning, and decreasing behavioural and emotional problems.
- Integrate mental health and psychosocial well-being knowledge into pre and in-service education for teachers, or improve existing professional education in this direction. Teachers need to know about and be continually updated on mental health, common mental disorders with onset in adolescence, common signs of mental health conditions or psychosocial distress, and ways of responding to it, as well as trauma-related knowledge.
- Promote a safe school environment through child protection policies and interventions to ensure a positive school environment and safe schools.

Provide selective services for students identified as being at risk of mental health concerns or problems

A. Short-term

- Promote the professional role of school psychologists and inspector psychologists in schools and wider society. Students and parents need to be better informed about the fact that there is at least one psychologist in the school who is available to discuss issues of concern with them.

- Incentivize school psychologists to improve the quality of their service by decreasing paperwork and long working hours, providing them with an appropriate working space, and creating time to discuss different issues in the classroom.

- Conduct regular screening activities based on evidence-based methodology and tools within school for early identification of mental health conditions and psychosocial distress, and especially self-harm and suicide. In this line, application-based screenings can be considered.

- Create peer support groups to enhance school connectedness, help students who feel isolated, and act as agents to report cases of students that need help.

- Establish an intervention team that will be engaged in promoting mental health and intervening in cases where there are warning signs of mental health concerns and high-risk behaviours, including suicide.

- Develop and implement social and emotional learning programmes or life skills programmes for all students, with emphasis placed on supporting those who show warning signs for mental health concerns.

- Develop opportunities for adolescents to express concerns while keeping their anonymity, for instance by using a hotline.

- Introduce the position of school social worker, or reshape the role of inspector psychologists to perform the duties of social workers, particularly case management. In the latter case, their job position should be under either the Ministry of Public Education or one of the social sector ministries.

B. Long-term

- Enhance the qualifications and practical skills of schools' psychologists in terms of counselling techniques, and school-based intervention programmes and specific service provision, like cognitive-behavioural therapy, solution-focused therapy, and others.

- Include MHPSS-related training programmes in the curricula of mandatory trainings for upgrading the skills of school psychologists.

- Revise curriculum for psychologists to ensure consistency in the education requirements of psychologists graduating from different universities, with a focus on knowledge and practical skills around adolescent mental health conditions and counselling techniques.

Provide specialized services for individual students who already display a mental health concern or problem

A. Short-term

- Develop and implement intervention programmes for the most common mental health concerns (anxiety, depression, behavioural problems and others) and for suicide prevention and intervention. These programmes can focus on aggres-

sion replacement treatment, adolescents with depression, cognitive behavioural interventions for schools, and other related matters.

B. Long-term

- Invest in evidence-based targeted service provision programmes for mental health and psychosocial well-being inside and outside of schools, that help students develop coping behaviours and avoid risky behaviours. These programmes can include solution-focused brief therapy, attachment-based therapy, integrated cognitive behavioural therapy, and others.

Build upon and develop purposeful partnerships between schools and other systems

A. Short-term

- Assist parents and caregivers in developing a supportive family environment. Parents need to understand how to create a supportive family environment, and be available when their children need their help.
- Collaborate with health and social sectors for better identification and referral pathways of adolescents with poor psychosocial well-being and mental health concerns, as well as for further coordination of service provision in cases of referrals.
- Invest in community-based initiatives to promote mental health among parents and communities.
- Enhance collaboration with mahallas and their structures (youth leaders, women activists or others) to understand the full picture of an adolescent life, and address the potential risk factors and social determinants of mental health such as migration, poverty, discrimination and so-forth, in the framework of Integrated Social Service Delivery, through a case management approach.
- Develop new or improve existing protocols for intersectoral collaboration and referrals carried out by school and inspector psychologists to support health and justice sectors, or local level authorities.

B. Long-term

- Expand and make comprehensive the community-based mental health and psychosocial support services available for adolescents.
- Initiate and expand provision of psychotherapy for adolescents, for both moderate and severe cases of mental health disorders (not based in psychiatry), without use of medications. Such psychotherapy could include cognitive behavioural therapy, psychodynamic psychotherapy, group therapy, and other options.

Приключения
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1 INTRODUCTION AND BACKGROUND

Adolescence is a key period in life for establishing foundations for adulthood health and well-being [1]. Existing evidence in the literature suggests that a substantial proportion of mental health problems in adults originate in mid-to-late adolescence and contribute to the existing burden of mental illness among young people, and in later life [2]. Three quarters of mental health problems start before people's early 20s, and are among the leading causes of health-related disability among children and adolescents worldwide [3]. Worldwide estimates indicate that up to 20 per cent of children and adolescents have mental health disorders, accounting for a large portion of the global burden of the disorders [4].

Mental health is an integral and essential component of health, and it does not mean just the absence of mental disorders or disabilities. The World Health Organization (WHO) constitution states that: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. Mental health is fundamental for human beings to think, emote, interact with each other, earn a living, and enjoy life. That is why its promotion, protection and restoration is of vital concern [5].

Among different mental health concerns, emotional disorders are a leading cause of related global burden of disease in young people. Emotional disorders are characterized by increased levels of anxiety, depression, fear and somatic symptoms. Children and adolescents often present with symptoms of more than one condition, and sometimes the symptoms overlap. The quality of home, social and educational environments influence the well-being and functioning of children and adolescents. Exploring and addressing psychosocial stressors, along with opportunities to activate supports and develop systems, is critical [6].

Probably the most devastating result of a mental health related situation is suicide. Over 700,000 people lose their lives to suicide every year. Globally, suicide is the fourth leading cause of death in 15–29-year-olds, and the third leading cause of death among girls in the same age group. The majority of deaths by suicide (77 per cent) occur in low- and middle-income countries [7]. Reducing the global suicide mortality rate by one third by 2030 is both an indicator and a target (the only one for mental health) in the United Nations Sustainable Development Goals (SDGs) and in WHO's Comprehensive Mental Health Action Plan 2013–2030 [8]. WHO's 13th General Programme of Work 2019–2023 includes the same indicator, with a reduction of 15 per cent by 2023 [9].

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[8] WHO (2021). Comprehensive Mental Health Action Plan 2013-2030. Available at: *https://www.who.int/publications/i/item/9789240031029*, accessed on 18 November 2021.

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According to the latest WHO factsheet (2021):

- Globally, one in seven 10-19-year old experience a mental disorder, accounting for 13 per cent of global burden of disease in this age group.
- Mental health conditions account for 16 per cent of the global burden of disease and injury in people aged 10-19 years.
- Half of all mental health conditions start by 14 years of age, but most cases are undetected and untreated.
- Depression, anxiety and behavioural disorders are among the leading causes of illness and disability among adolescents.
- Suicide is the fourth leading cause of death among 15–19-year-olds.
- The consequences of failing to address adolescent mental health conditions extend to adulthood, impairing both physical and mental health, and limiting opportunities to lead fulfilling lives as adults[10].

1.1. SCHOOL IMPACT ON ADOLESCENTS' MENTAL HEALTH

In a recent UNICEF study undertaken in 2022, adolescents around the globe presented school as being a source of self-esteem, a place that fosters greater awareness of the world at large, an environment for spending time with friends, a venue for emotional support and an escape from toxic home environments. But school was also presented

www.who.int/publications/i/item/9789240026629, accessed on 18 November 2021

[10] WHO newsroom (2021, September 17). Adolescent mental health. Available at *https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health*, accessed on 18 November 2021

as a setting for violence and abuse – a far too common experience – which can undercut its protective role. In addition, extreme academic pressure and a lack of supportive school personnel can increase young people's vulnerability [11].

Besides being structures for academic learning, schools are also places where many adolescents spend most of their time – places where they interact with peers and develop their social and emotional skills. Educators, school support staff and peers are well-placed to identify and respond to risk factors and emerging mental health conditions in adolescents, and also connect adolescents to additional resources [12]. Psychological problems among children and adolescents can be wide-ranging and may include attention deficit hyperactivity disorder (ADHD), disruptive conduct, anxiety, eating and mood disorders and other mental illnesses. Schools have an important influence on the onset, identification and management of these issues. For instance, consistent evidence shows the links between adolescents' mental health and the experience of bullying as well as school connectedness – for instance, perceived inclusion and respect within the school environment [13]. School is also associated with health-risk behaviours, which in the worst cases can lead to self-harm and suicidal behaviour [14].

The school climate defined as the "pattern of students', parents', and school personnel's experience of school life [that] reflects norms, goals, values, interpersonal relationships, teaching and learning practices, and organizational structures" can have a significant impact on adolescent health outcomes. Lack of physical and emotional safety, poor relations between teachers and students and with peers, pressure for academic performance from both teachers and parents, experience of bullying, feelings of isolation and lack of school-connectedness, are only some of the daily stressors for adolescents at school. School curriculum and types of assessment can also influence adolescent's emotional well-being. Poor-quality school environments have been associated with worsened academic performance, increased poor mental health conditions, increased violence, risky sexual and reproductive health behaviours, tobacco use and higher levels of problem behaviour. However, developing a positive school climate creates conditions that are conducive to better mental health and educational outcomes and influences health behaviours to the benefit of students, school personnel and the broader community [15].

[11] Johns Hopkins Bloomberg School of Public Health and United Nations Children's Fund, On My Mind: How adolescents experience and perceive mental health around the world, JHU and UNICEF, Baltimore and New York, May 2022. Available at *https://www.unicef.org/media/119751/file* accessed on 23 August 2022.

[12] WHO and UNICEF (2021). Helping Adolescents Thrive Toolkit. Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours. Available at: *https://www.who.int/publications/i/item/9789240025554*, accessed on 20 November 2021, p. 35.

[13] See for example Perren, S., Dooley, J., Shaw, T., et al. (2010). Bullying in school and cyberspace: Associations with depressive symptoms in Swiss and Australian adolescents. Child Adolescent Psychiatry Mental Health (4), 28, *https://doi.org/10.1186/1753-2000-4-28*; Sochet, I.& Smith, C. (2014). A prospective study investigating the links among classroom environment, school connectedness, and depressive symptoms in adolescents. Psychology in the Schools, 51(5), pp. 480-492. Available at: *https://eprints.qut.edu.au/79912/3/__staffhome.qut.edu.au_staffgroup$_hollambc_Desktop_79912m.pdf*.

[14] Freeman, J.G., King, M., Pickett, W., Craig, W., Elgar, F., Jansen, I., Klinger, I. (2011). The Health of Canada's Young People: A mental health focus, Health Behaviour of School-aged Children, Public Health Agency of Canada. Available at: *https://www.jcsh-cces.ca/upload/hbsc-mental-mentale-eng.pdf* accessed on 20 November 2021; Bruckauf, Z. (2017). Adolescents' Mental Health: Out of the shadows Evidence on psychological well-being of 11-15-year-olds from 31 industrialized countries. Policy Brief, UNICEF Research Office Innocenti. Available at: *https://www.unicef-irc.org/publications/pdf/IRB_2017_12.pdf* accessed on 20 November 2021.

[15] WHO and UNICEF (2021). Helping Adolescents Thrive Toolkit. Strategies to promote and protect adolescent mental health and reduce self-harm and other risk behaviours. Available at: *https://www.who.int/publications/i/item/9789240025554*, accessed on 20 November 2021, p. 35.

1.2. INTERNATIONAL POLICY FRAMEWORK

According to the UN Convention on the Rights of the Child (UNCRC), all states have an obligation "to implement measures for the prevention of mental health conditions and the promotion of mental health of adolescents" and "to ensure that health facilities, goods, and services, including counselling and health services for mental health, of appropriate quality and sensitivity to adolescents' concerns are available to all adolescents" [16]. Furthermore, Principle 1 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the UN Principles) also sets out the right to the "best available mental health care." The principles recommend that care be administered, when possible, in the community. Principle 9 sets out a duty to treat patients in the least restrictive environment, and to maintain and improve their autonomy, thus also indicating a preference for community care [17].

The right to health and mental health is enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), as the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" [18]. In the General Comment No 14, paragraph 9 of the UN Committee for ESCR, it is stated that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health" [19]. A Special Rapporteur on the Right to Physical and Mental Health was originally established by the Commission on Human Rights in April 2002 by resolution 2002/31. In his first report to the United Nations Commission on Human Rights, the Special Rapporteur Paul Hunt identified a number of issues that needed particular attention, including mental health as a subcategory of the right to health. Professor Hunt argued that the right to health "must be integrated into national and international policy-making processes" in order to "shape laws, policies, programmes and projects" [20].

The Sustainable Development Goal (SDG) target 3.4 is to reduce premature mortality from non-communicable diseases (NCDs) – including suicide rates – by a third by 2030 relative to 2015 levels, and to promote mental health and psychosocial well-being [21]. This is the only target related to mental health.

Addressing social and economic challenges posed by mental health conditions was highlighted during the High-level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs in 2018. In addition, WHO's Thirteenth General Programme of Work (2019–2023) and the Programme of Work 2020–2025 of the WHO Regional Office for Europe both place strong emphasis on

[16] Ibid.

[17] Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the UN Principles), GA Res 119, UN GAOR, 46th Session, 3d Communication, 75th Plen Mtg, A/RES/46/119, 17 December 1991, reprinted in [1991] 45 UNYB 620 at 621. Available at: *https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-protection-persons-mental-illness-and-improvement* accessed on 10 October 2022.

[18] International Covenant on Economic, Social and Cultural Rights. G.A. Res. 1966;2200A(XXI).

[19] UN Committee on Economic, Social and Cultural Rights, The Right to the Highest Attainable Standard of Health (Art 12 of the International Covenant on Economic, Social and Cultural Rights), General Comment No 14 (22nd Sess), UN Doc E/C12/2000/4.

[20] McSherry, B. (2008). Mental Health and Human Rights: The Role of the Law in Developing a Right to Enjoy the Highest Attainable Standard of Mental Health in Australia. Available from: *https://www.researchgate.net/publication/5279479_Mental_Health_and_Human_Rights_The_Role_of_the_Law_in_Developing_a_Right_to_Enjoy_the_Highest_Attainable_Standard_of_Mental_Health_in_Australia*, accessed on 10 October 2022.

[21] Imperial London College. NCD Countdown 2030: pathways to achieving Sustainable Development Goal target 3.4. Lancet 2020; 396: 918–34. Available at *https://www.thelancet.com/action/showPdf?pii=S0140-6736 per cent2820 per cent2931761-X*, accessed on 18 November 2021.

responding to the epidemic of NCDs and on promoting mental health. Mental health has been more than ever included in the agenda of international organizations after the outbreak of the COVID-19 pandemic.

The Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings were initially developed to offer essential advice on how to facilitate an integrated approach to address the most urgent mental health and psychosocial issues in emergency situations, but nowadays they are incorporated and used more widely. These guidelines place emphasis not only on management and treatment, but also on preventing mental health and emotional problems. Also, they explain the composite term 'mental health and psychosocial support', which is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder [22].

UNICEF has developed the 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings'. Through this framework, the agency has committed to a collaborative and multisectoral-spanning approach across health, social welfare and child protection, education, gender and other sectors to truly be effective in addressing the global burden of mental health conditions. This direction is incorporated also in the new Strategic Plan (2022–2025), and is an important step towards strengthening UNICEF institutional capacity and accountability to respond to the MHPSS needs of children, adolescents and families, in a way that ensures quality and scalable response within and across sectors of operation. There are three main underpinning principles of the global MHPSS framework:

a) well-being depends upon the interplay of physical, social, cognitive, emotional and spiritual elements; b) MHPSS has a critical role in creating and supporting conditions for children's optimal development and well-being; and c) engagement and participation of families, caregivers, educators, communities and children themselves is central to ensuring enabling environments for children's development and securing their protection, well-being, and future potential [23].

1.3. COVID-19 PANDEMIC IMPACT

Worldwide, adolescents and young people are an at-risk group in the present crisis caused by the COVID-19 pandemic, as most mental health conditions develop during this period of life. Many young people have seen their futures impacted. For example, schools have been closed, examinations have not been held, and economic prospects have diminished. The main sources of distress for

[22] Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. Available at: *https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf*, accessed on 17 November 2021.

[23] United Nations Children's Fund, Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children and Families across Settings (field demonstration version). New York, UNICEF, 2021. Available at: *https://www.unicef.org/media/109086/file/Global per cent20Multisectorial per cent20Operational per cent20Framework.pdf.*

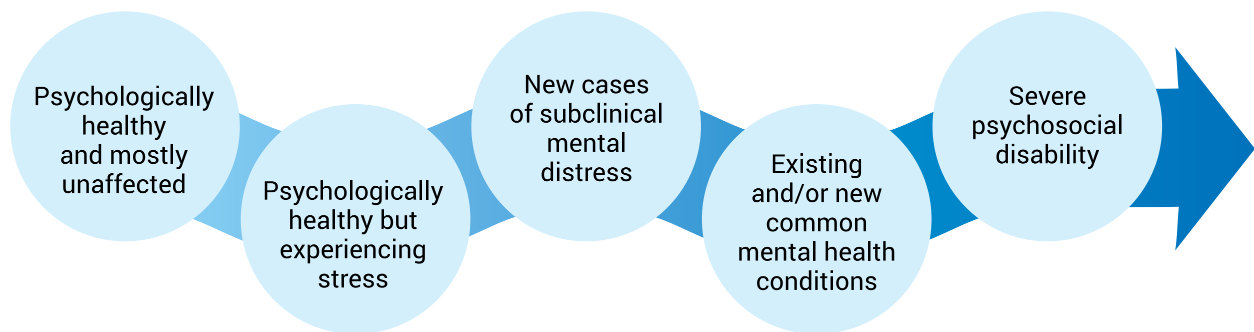


Figure 1. Mind matters: lessons from past crises for child and adolescent mental health during covid-19, Innocenti research report (2021).

adolescents include concerns about the health of family members, school and university closures, loss of routine, and loss of social connection. Provision of mental health services must include specific actions tailored to meet the needs of this population group [24].

However, when considering mental health, it is important to differentiate between normal reactions to abnormal stressors (i.e., psychological distress), reactions that begin to impact on functioning (i.e., poor mental health), and cases of severe pathology (i.e., serious mental disorders). Mental health is therefore best conceptualized along a continuum, which is a range of well-being whose extreme ends are mental health and mental illness. At the one end of this continuum, we feel good and positive about ourselves, our relationships and our place in the world, and can cope emotionally with stressors, including the recent pandemic. At the other end of the continuum we suffer from negative feelings and cannot cope with daily stressors or other challenges that life brings (see Figure 1).

Given the unprecedented nature of COVID-19 and the uncertainty of how it will evolve, an emotional reaction to the pandemic is normal and does not necessarily signal abnormal mental distress [25]. Having said that, it is even more important to address these emotional issues in order for them to not become a mental health condition.

1.4. NATIONAL CONTEXT

In Uzbekistan, national authorities have included mental health in the sphere of public health, because there are clear indicators that mental health is a serious public health problem in the country. The Development Strategy Framework of the Republic of Uzbekistan by 2035 lists several targets and strategic initiatives relevant for alleviating barriers to improved mental health service access and provision [26]. Defined by by WHO

[24] United Nations (2020). Policy Brief: COVID-19 and the Need for Action on Mental Health. Available at *https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf*, accessed on 21 November 2021.

[25] Sherr, L. et al. (2021). Mind Matters: Lessons from past crises for child and adolescent mental health during COVID-19, Innocenti Research Report. Available at *https://www.unicef-irc.org/publications/pdf/Mind-Matters-Lessons-from-past-crises-for-child-and-adolescent-mental-health-during-COVID-19.pdf* accessed on 21 November 2021.

[26] WHO (2021). Prevention and management of mental health conditions in Uzbekistan: The case for investment.

as being people aged 10 to 19, adolescents make up 16.2 per cent of Uzbekistan's population (around five and a half million adolescents) [27]. The rights and needs of adolescents have been recognized as priorities by the Ministry of Health, reflected in the draft National Strategy and Action Plan on Adolescent Health and Well-being 2022-2026. Recent trends in suicide mortality rates among adolescents show a concerning increasing trend in self-harm and suicide rates. In 2016 boys and girls aged 15 to 19 year had the highest share of self-harm, and of deaths caused by suicide, within the adolescent age group. In the age group of 10 to 19 years, the group of adolescents aged 15 to 19 years old prevailed in terms of cases of self-harm, and the suicide mortality rate. Boys in the 15 to 19 years old age-group stood for around 74 per cent of the self-harm and suicide mortality rate among boys in the age-group of 10-19 years. Girls in the 15-19 age-group represented around 80 per cent of self-harm and suicide mortality within the same group [28]. In 2019, there were 374 cases of self-harm among girls aged 10 to 14, and 355 cases among boys of the same age. For young women aged 15 to 19, there were 1,987 cases in the same year, and 1,460 cases for young men of the same age [29]. Both girls and boys in the adolescent age group have reported experiencing depression, mood swings, mental disorders, and suicide ideation as a result of psychological violence experienced in schools from both teachers and peers [30]. In regards to physical well-being, adolescent boys suffer most from injuries, while girls generally suffer most from non-communicable diseases [31].

Evidently, the rates of self-harm and the mortality rate due to suicide amongst children under 19 has been increasing consistently from year to year, and has almost doubled for boys and tripled for girls since 2008 (Graph 1) [32]. Even though in 2019 this rate decreased to 9.8 for adolescents aged 10-19 years per 100,000 relevant population, caution should be taken when addressing this issue [33].

A latest study conducted by WHO (2021) indicated that after a joint resolution adopted in 2018, the Ministry of Health started collaborating with the General Prosecutor's Office, the Ministry of Internal Affairs, the Ministry of Public Education, and the Ministry of Higher and Secondary Specialized Education, to strengthen intersectoral measures on suicide prevention. Yet, it is not clear whether there is a formal coordination mechanism, or if mental health is integrated into the work plan of a coordination mechanism for NCDs [34].

Uzbekistan was affected by the novel coronavirus (COVID-19) pandemic, the first case of which was recorded in the republic in March 2020. In April 2020, authorities introduced lockdown measures on all non-essential work and travel, to protect public health. As the health situation permitted, restrictions were gradually relaxed in May and June. However, national lockdowns were reintroduced on 10 July due to a resurgence in the rate of infection. These lockdowns have caused similar collateral economic damage that has been seen elsewhere in the world, leading to

[27] UNICEF Uzbekistan newsroom (August 4, 2020). Adolescents - the future of Uzbekistan. Available at: *https://www.unicef.org/uzbekistan/en/stories/adolescents-future-uzbekistan*, accessed on 21 November 2021.

[28] The State Committee of the Republic of Uzbekistan on Statistics, 2020.

[29] UNICEF, National strategy and Action plan on adolescent health and well-being (2021-2025), 2021, p.30.

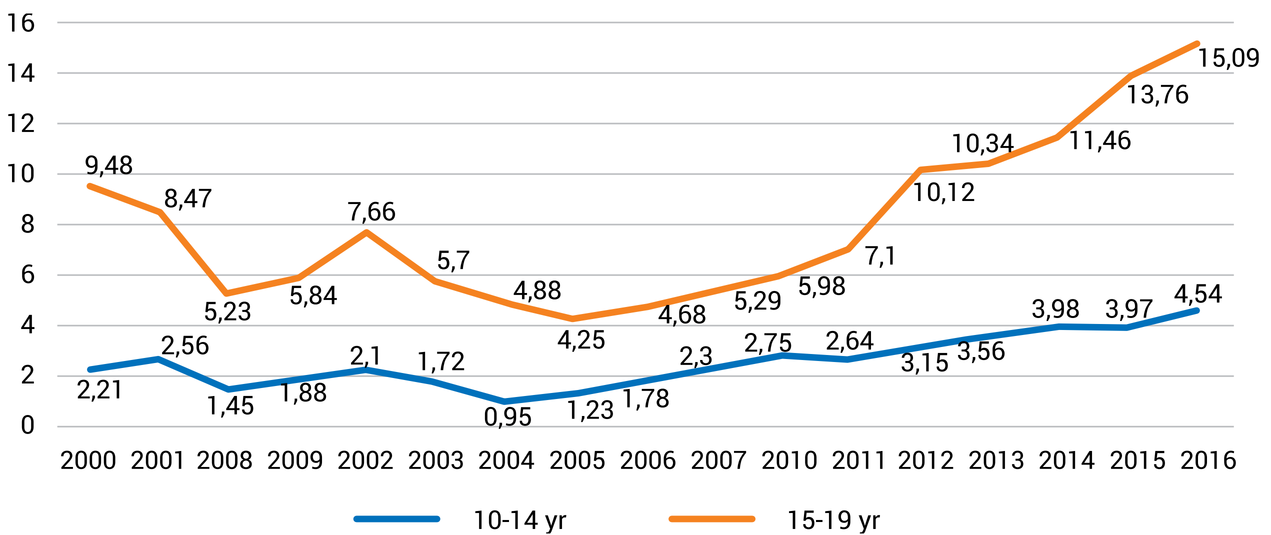
[30] Ibid, p.32.

[31] Ibid, p.26.

[32] TransMonEE Database (2016), available at *http://transmonee.org/moneeinfo/libraries/aspx/dataview.aspx, graph* processed by the author, accessed on 20 November 2021.

[33] The State Committee of the Republic of Uzbekistan on Statistics, 2020.

[34] WHO (2021). Prevention and management of mental health conditions in Uzbekistan: The case for investment. WHO: Italy.



Graph 1. *Suicide mortality rate, Deaths per 100,000 average relevant population*

sharp declines in employment, income and other measures of economic well-being [35].

The country managed to avoid a sharp increase in the number of people affected, and gained time to prepare for the fight against the pandemic. According to national sources, the mortality rate from the number of registered cases of infection was recorded as being below indicators of world statistics, amounting to 0.4 per cent by the end of March 2020 and 0.7 per cent by mid-March 2021 [36].

In Uzbekistan, despite some improvement in the situation in communities, the continuation of the nationwide quarantine and a set of restrictive measures had a negative impact on the population's well-being, especially that of people in the most vulnerable situations. Some of the negative dynamics that appeared during this crisis mainly related to intra-family problems such as divorce, conflicts, domestic violence against women and children, psychological tension, and an increase in cases of suicide or suicidal attempts. The number of cases of placing children in orphanages (Houses of Mercy) and boarding schools also increased. These indicators can be indirect evidence of a decrease in the level of income in families, caused by the fact that often material problems complicate and exacerbate tensions in households and, as a result, worsen these problems [37].

1.5. CONCEPTUAL FRAMEWORK

A socio-ecological model was used to guide this research, with the individual adolescent at the centre of it and including all the other factors that may influence their psychosocial well-being. This model was initially

[35] Seitz, W. et al. (2020). Uzbekistan: Dynamically identifying community level COVID – 19 impact risks. Available at *https://openknowledge.worldbank.org/bitstream/handle/10986/34925/Uzbekistan-Dynamically-Identifying-Community-Level-COVID-19-Impact-Risks.pdf* accessed on 21 November 2021.

[36] Ministry of Mahalla and Family Support and UNDP Uzbekistan (2021). Assessment of the socio-economic impact of COVID-19 on the population of Mahallas in Uzbekistan; WHO (2021). Prevention and management of mental health conditions in Uzbekistan: The case for investment.

[37] Ibid

Some of the negative dynamics evolved during this crisis considered mainly with intrafamily problems such as divorce, conflicts, domestic violence against women and children, psychological tension and an increase in cases of suicide or suicidal attempts. The number of cases of placing children in orphanages and boarding schools has also increased.

proposed by Stokols (1996), who suggested that health is a complex issue, and it cannot be addressed through only a single variable analysis [38]. This model is currently employed widely for gauging mental health and psychosocial well-being at different ages. In relation to adolescents' psychosocial well-being, the first tier of mental health is ***at an individual level***. As such, factors like age, gender, other genetic factors, body image, academic performance, geographic location, economic status and others, are all ones assessed and analysed at this level. In the second tier, which relates to ***relationships***, formal and informal support is explored, mainly that from family members, peers and teachers. ***Organizations*** are at the third tier, such as schools and mental health services within or outside of schools, or referrals to other services. ***Communities*** are important because people are shaped by their social environments, and social well-being is a public phenomenon and not a private one. Thus, a toxic, stigmatizing or discriminatory community environment, housing instability or living in disadvantaged neighbourhoods, may put adolescents in greater vulnerability regarding their mental health. ***Policy level*** refers to the legal and policy framework, regulations and funding that shows government investment in the sector. Finally, the sixth tier is ***society*** as a whole, encompassing issues like poverty, stigma and bias, general and family knowledge about mental health, as well as the resources for families and schools which shape the way mental health is perceived, experienced and managed for adolescents and adults [39].

1.6. RESEARCH AIM AND OBJECTIVES

Evidence about the causes of mental health conditions, negative impacts on psychosocial well-being, or self-harming behaviours and suicide in Uzbekistan, is very limited. It consists largely of the statistical data mentioned above, anecdotal resources about these topics, media reports or experiences of professionals working in this field, but has not been systematically studied. Hence, to improve the current situation of adolescent

[38] Guo, Y., Hopson, L. and Yang, F. (2018). Socio-ecological Factors Associated with Adolescents' Psychological Well-being: A multilevel analysis. International Journal of School Social Work, 3 (1). 1. *https://doi.org/10.4148/2161-4148.1032.*

[39] University of Minnesota, School of Public Health (2021). Mental health and well-being: a socio-ecological model. Available at: *https://mch.umn.edu/resources/mhecomodel/* accessed on 12 October 2022.

mental health and psychosocial well-being in Uzbekistan through interventions at different levels, it is necessary to understand the magnitude of the phenomenon, and to explore its causes and consequences.

Thus, the main purpose of this research is ***to explore adolescents' needs and school-related factors influencing their mental health and psychosocial well-being, and to review existing policies, strategies and actions in and outside of school in recognizing, mitigating and addressing mental health issues of adolescents.***

More specifically, the research will:

- Provide an overview of available evidence and analysis of:
    - adolescent school students' mental health situation and needs;
    - school-related factors influencing the mental health issues of adolescents in Uzbekistan; and
    - key stakeholders, policies, legislation, standards and programmes relating to mental health and well-being among adolescents in Uzbekistan.

- Review existing policies, strategies and actions in and outside school in recognizing, mitigating and addressing the mental health issues of adolescents.

- Provide recommendations and action plans on using school platforms to provide mental health and psychosocial support, and to mitigate and prevent school-related mental health risks especially during the COVID-19 pandemic.

RESEARCH QUESTIONS

Specific research questions guiding the research study are:

- What is the current situation of mental health and psychosocial problems of adolescent boys and girls in Uzbekistan?

- What are the needs related to mental health and psychosocial support of adolescents in the schools of Uzbekistan?

- Which factors in the Uzbekistan school context place children and adolescents at risk, and which factors act as protective factors for mental health and psychosocial problems, including suicide?

- What is the legal and policy framework in place around mental health and psychosocial well-being in Uzbekistan?

- What kind of mental health and psychosocial service provisions and programmes exist for children and adolescents in Uzbekistan?

- How can the legal and policy framework and service provision improve?

The study will contribute to the current knowledge of the mental health and psychosocial well-being of adolescents, by shedding light on the situation of mental health and psychosocial well-being of adolescent boys and girls in Uzbekistan, the legal and policy framework and service provision, and further needs in relation to them. The research findings and recommendations will form the basis of future guidelines for strengthening the work of UNICEF Uzbekistan, partners and donors in their mental health programme design, implementation, and monitoring and evaluation.

2 RESEARCH METHODOLOGY

2.1. SCOPE OF THE STUDY

This study came as a result of the knowledge gap identified in literature about school adolescents' mental health situation and psychosocial well-being in Uzbekistan. In view of the analysis of the literature presented above in this report and the identified gap, the main purpose of this study is to provide a comprehensive overview of issues related to adolescent school students' psychosocial well-being. It especially seeks to overview adolescents' needs, school-related factors influencing mental health and well-being of adolescents and reviewing of existing policies and schools' strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents in and outside school.

2.2. METHODOLOGICAL APPROACH

This study has been carried out using a *convergent parallel design*, being a mixed methods design. The research process can be

symbolized as being qualitative and quantitative (QUAL+QUAN) [40]. A convergent parallel design entails that the researcher concurrently conducts the quantitative and qualitative elements in the same phase of the research process, weighs the methods equally, analyses the two components independently, and interprets the results together [41]. The research design, planning and data collection were guided by the principles of the UNICEF Ethical Standards on Research [42].

Mixed methods of research are a best fit when addressing research questions which require accuracy in measurement, reliability and validity of results on the one hand, and deeper exploration of phenomena and their causes and effects on the other. These methods enable the participants to have an important role throughout the entire research process, while providing additional research opportunities that improve the data, and also enabling provision of in-depth and detailed answers for research questions [43]. With this in mind, mixed methods of research were employed for this study and more specifically the survey as the research instrument for the quantitative component and semi-structured in-depth interviews and FGDs with the target population and key informants, for the qualitative task.

[40] Morse, J. M. (1991). Approaches to qualitative & quantitative methodological triangulation. Nursing Research, 40(2), 120–123. *https://dx.doi.org/10.1097/00006199-199103000-00014*.

[41] Creswell, J. W., & Plano Clark, V. L. (2011). Designing and conducting mixed methods research. Thousand Oaks, CA: Sage.

[42] UNICEF (2021). UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis. Available at *https://www.unicef.org/evaluation/media/1786/file/UNICEF%20Procedure%20on%20Ethical%20Standards%20in%20Research,%20Evaluation,%20Data%20Collection%20and%20Analysis.pdf* accessed on 23 November 2021.

[43] Wisdom, J. and Creswell, J.W. (2013). Mixed methods: integrating quantitative and qualitative data collection and analysis while studying patient-centred medical home models. Rockville, MD: BMJ Publishing Group.

The development of the research instruments was preceded by a thorough desk review of national and international documents related to the mental health and psychosocial well-being of adolescents, current worldwide and national trends, national legal and policy frameworks, and the latest international standards and action plans.

All these components of the research approach are detailed in the following paragraphs by providing the data collection strategy, instruments used to collect such data, and analysis strategy, as well as other important issues related to the planning, implementation, professional and ethical reporting of scientific research.

Human rights-based, child rights-based, equity-based and gender sensitive approaches guided the research design and the data collection approach. Particular attention was paid to exploring the topic's equity dimensions. For UNICEF, equity means that all children have an opportunity to survive, develop and reach their full potential, without discrimination, bias or favouritism. Equity-based studies provide insight about the role of inequity, such as that related to the mental health and psychosocial well-being of adolescents, especially for the most vulnerable groups.

To the extent possible, mental health conditions and risk and protective factors for different subgroups of vulnerable children and families were explored in this research, and the groups least reached were identified, including adolescents with migrant parents, the most poor, people living in remote areas, and others. For the qualitative component, instructions for the composition of focus group discussions suggested that adolescents and parents from families with different socio-economic statuses, gender, academic performance, and those based in urban and rural areas should be targeted. For the quantitative component the multi-stage sampling survey in essence avoids any biases in respondents' selections. A gender perspective was employed during the research design

and data collection, particularly during the collection of qualitative primary data. When significant, gender-based data disaggregation and results interpretation was used. Also, all field researchers were trained psychologists or social scientists with experience in conducting Focus Group Discussions (FGDs) with children and adolescents, and creating a safe and inclusive environment for all of them.

2.2.1. SECONDARY DATA REVIEW

The aim of reviewing secondary data, including statistical data on school mental health issues, recent studies, documents, legal and policy framework, programmes' and projects' evaluations and other relevant sources of information, has been two-fold:

i. to provide an overall picture of the situation and causes of mental health conditions, including suicide, with a focus on adolescents in Uzbekistan, and;

ii. to inform the preparation of tools for primary data collection and analysis, including for identifying information gaps.

2.2.2. QUANTITATIVE RESEARCH MODEL

The model used for the quantitative part of the study has been a cross-sectional survey, which is the most appropriate approach to collecting data at a specific point on time, and to analyse different variables such as gender, age, education and others. To implement this model a questionnaire was developed and administered to adolescent boys and girls aged 12 to 18, in the Republic of Uzbekistan over March-April 2022.

A. DATA COLLECTION INSTRUMENT

The questionnaire was used as a main instrument for quantitative data collection. Following a review of methodological approaches

and research instruments used in the area of assessing evaluating the mental health and psychosocial well-being of adolescents and school factors affecting them, as well as known issues in the local context and the COVID-19 impact, the questionnaire used in this study was comprised of the following topics and sections:

- General information about oneself, including questions about demographic data, presence of any disabilities, and about working;
- Family environment covering housing conditions, family members' disability or chronic illness, parental education levels, parents living outside the home, and family relations;
- School climate covering perceptions and experiences about teachers, other students, feelings of social connectedness, perceptions about school safety and tests/exams, experiences of violence at school, and use of internet and technology;
- Life satisfaction section including questions about overall life satisfaction and satisfaction with specific life aspects and about ones' own appearance;
- Feelings and worries, focused on general worries and experience of problems, trusted persons to ask for help and their qualities, experience of behavioural and emotional problems, and experience of stress, anxiety and depression;
- Experience of the COVID-19 pandemic was the last section, focused on emotional reactions during the COVID-19 lockdowns, and the overall negative or positive impact of the pandemic.

Two standardized scales were incorporated in the questionnaire section on 'Your feelings and worries':

(a) The scale on 'Depression, Anxiety and Stress Scale – 21 Items' (DASS-21) developed by Lovibond & Lovibond (1995) that was administered only to children above the age of 15 year [44], and

(b) 'Me and My feelings' developed by Deighton et al. in 2013 [45].

Both scales reported a satisfying internal consistency.

The 'Depression, Anxiety and Stress Scale' has three main subcategories of emotional states, being depression, anxiety and stress. The scoring scale and cut-off points are provided by the authors. For each category there are five levels of experience, being normal, mild, moderate, severe and extremely severe. Each of the three DASS-21 scales contains seven items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/ involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive, and impatient. Scores for depression, anxiety and stress are calculated by summing up the scores for the relevant items [46].

The 'Me and My Feelings' scale is a brief 16 item school-based measure of child mental

[44] Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety & Stress Scales. (2nd Ed.) Sydney: Psychology Foundation.

[45] Deighton, J., Tymms, P., Vostanis, P., Belsky, J., Fonagy, P., Brown, A., Martin, A., Patalay, P. & Wolpert, W. (2013). The Development of a School-Based Measure of Child Mental Health. Journal of Psychoeducational Assessment, 31:247.

[46] Psychology Foundation of Australia (n.d.). Depression, Anxiety and Stress Scales. Available at *http://www2.psy.unsw.edu.au/groups/dass/* accessed on 28 August 2022

health, covering two broad domains including emotional and behavioural difficulties [47].

Both scales had satisfying reliability results when they were piloted with a Cronbach α >.7 and in most cases α >.8, which is very good for studies in social sciences.

Testing and piloting

The draft questionnaire was translated into the Uzbek, Russian and Karakalpak languages. It was consulted with a wide working group and piloted with 166 respondents in two schools in Tashkent city (urban area), and one in Tashkent region (rural area), in order to validate and adapt it based on context. The final questionnaire was approved after analysing feedback received on-site, after addressing issues identified in the pilot phase (mainly issues related to simplifying the questionnaire and the language used in translated questionnaires), and after analysing data collected from pilot phase. The final questionnaire, as administered at selected sampled schools, will be presented in the following section.

B. SAMPLING – SURVEY

Multi-stage stratified sampling was applied in this study, to avoid any potential biases in the sample.

Inclusion criteria

The inclusion criteria used for the initial selection of respondents from the students' population between 12 to 18 years old, were the students' year grades. All students studying in the 6th, 9th and 11th grades (approximate ages of 12, 15 and 18 years old) could be part of this study. This compromise to include only three grades was implemented in consultation with UNICEF Uzbekistan, due to time and resource limitations. However, the three selected grades and ages represent respectively the three different developmental stages of adolescence, and are sufficient to provide a great insight into the mental health issues adolescents face during this challenging phase of their lives. Early adolescence (ages 10 to 13 years old) is a period of life when major changes happen to the adolescent's body, thinking, emotional development, and socialization. The second stage, being middle adolescence (ages 14 to 17 years), marks the beginning of interest in romantic and sexual relations, while the body changes as puberty continues. Conflicts with parents often happen during this stage. Late adolescence starts at 18 years and continues up to 21 years of age. At this stage adolescents have better impulse control and can be able to gauge risks and rewards accurately. This is the period when adolescents or young adults establish their own individuality and set of values [48]. Hence, the selected grades represent all three major developmental stages of adolescence. Additionally, only regular

[47] Child Outcomes Research Consortium (n.d.). Me and My Feelings. Available at: *https://www.corc.uk.net/outcome-experience-measures/me-and-my-feelings-mmf/* accessed on 28 August 2022.

[48] "Stages of adolescence" (2021, 6 August). Available at: *https://www.emedicinehealth.com/what_are_the_three_stages_of_adolescence/article_em.htm*, accessed on January 12, 2022.

Table 1. *Information about secondary schools operating in the system of public education in the 2021-2022 academic year (2021 September status)*

№	Region	Total, September 2021	Number of students in grades 5-11 (ages 10 to 18 years old)	Schools in the city	Schools in the district center	Schools in rural areas	Schools located in remote areas
1	Republic of Karakalpakstan	726	21,1501	51	160	489	26
2	Andijan	767	347,054	103	144	520	0
3	Bukhara	537	199,254	58	61	413	5
4	Jizzakh	553	158,768	74	48	374	57
5	Kashkadarya	1,217	385,743	107	88	843	179
6	Navoi	368	109,502	41	66	188	73
7	Namangan	712	305,695	148	134	423	7
8	Samarkand	1,267	445,727	108	117	951	91
9	Surkhandarya	933	303,149	28	160	681	64
10	Syrdarya	318	96,131	35	44	237	2
11	Tashkent region	884	306,975	145	94	613	32
12	Ferghana	959	408,167	158	86	667	48
13	Khorezm	549	220,847	67	57	417	8
14	Tashkent city	340	292,855	340	0	0	0
	Total	**10,130**	**3,791,368**	**1,463**	**1,259**	**6,816**	**592**

Note*: Due to the expansion of the geographical area of Tashkent, 18 schools were transferred from Tashkent region to the city*

mainstream schools will be part of the study, because inclusion of schools for children with disabilities and special education needs would require more resources not available for this study.

Sampling frame

The total number of schools in Uzbekistan as of September 2021 is shown in the below table (Table 1) [49]. This is also the sampling framework for this study. The sampling method employed for the quantitative component of the study is based on the international practice of sampling (TIMSS and PIRLS and PISA). These international assessment programmes follow very strict school and classroom sampling techniques.

Sampling strategy

The first step for developing the sampling strategy was drafting a list of all schools that have grades 6, 9 and 11 in all 14 regions of Uzbekistan. In practice, this list included all schools in Uzbekistan, because all grades are in the same school, and many times in the same building. To meet the TIMSS and PIRLS precision requirements, a school sam-

[49] Official data received from the Ministry of Public Education.

ple of 150 schools for urban areas and another sample of 150 schools for rural areas was selected. For each grade a total number of 4,000 students was selected. According to TIMSS and PIRLS, these sample estimates of any student-level percentage estimate (e.g., a pupil's background characteristics) have a suitable confidence interval (e.g. of 3.5 per cent or more), which is possible with the number of schools and the number of students for each grade. Of the full list of schools in Uzbekistan, two explicit strata were created based on level of urbanization. Random selection of 150 schools within each subsample *with probability proportional to enrolment* was carried out. Classes that participated in the study were selected as *whole, intact classes*. Their selection was conducted randomly, with a random number generator used to choose a class for each school.

Of the selected schools two were replaced with the next school, because the former schools were under construction, or were operating in an online education format during the time of data collection. Both of these were in the Tashkent region [50]. Also, one school in the Khorezm region did not participate in the study, because it was a school only for children with visual disabilities, but this one was not replaced. The final sample of schools included in the sample study is presented in Annex 19.

[50] Initially at the inception report stage the need for replacement was not foreseen, because no refusals or other problems were expected based on the previous implementation of these studies in Uzbekistan, and on communication with national authorities. However, to respect the methodology to the fullest, the research team decided to go forward with replacement following the rules of the same methodology.

***Table 2.** Regional distribution of adolescent respondents*

№	Region	Frequency	Percent	Valid Per cent	Cumulative Per cent
1	Republic of Karakalpakstan	1,353	5.9	5.9	5.9
2	Andijan region	2,060	9.0	9.0	14.9
3	Bukhara region	1,067	4.7	4.7	19.6
4	Jizzakh region	936	4.1	4.1	23.7
5	Kashkadarya region	2,121	9.3	9.3	33.0
6	Navoi region	715	3.1	3.1	36.1
7	Namangan region	1,896	8.3	8.3	44.4
8	Samarkand region	2,581	11.3	11.3	55.7
9	Surkhandarya region	1,628	7.1	7.1	62.8
10	Syrdarya region	452	2.0	2.0	64.8
11	Tashkent region	1,943	8.5	8.5	73.3
12	Fergana region	2,468	10.8	10.8	84.1
13	Khorezm region	1,276	5.6	5.6	89.7
14	Tashkent city	2,358	10.3	10.3	100.0
	Total	**22,854**	**100.0**	**100.0**	

The initial sample for the study based on the above sampling methods was N = 24,107 with 300 selected schools. However, due to changes in the number of the students present in the class on the day the data collectors were there, the total sample of ***schools*** was ***299*** and the total number of respondents was ***N = 22,854 students***. There wasn't any change in the classes that participated in the research. The total number of students per region has been presented in the following table (Table 2).

C. DATA COLLECTION PROCESS

Data collectors were trained to undertake the whole process of data collection, the administration of questionnaire and ethical issues that could arise during field work, and processes for securely managing and sharing data. Several tools were used during the data collection process to ensure its quality. The data collectors on-site were requested to prepare and send daily reports, to report in advance before going out into the field, and to determine locations. UNICEF staff and the national consultant carried out random and regular checks and coordinated fieldwork along with staff from the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education of Uzbekistan.

D. DATA ENTRY

Data entry was carried out by a company with experience in conducting similar researches. This process was carried out in batches, and was regularly monitored for systematic

errors, outliers and other inaccuracies in the dataset. To ensure the accuracy of the entered data, a double data entry process was conducted twice. The first batch for double data entry had 688 entries, while the second one had 458. Errors found in the database in the first round of double data entry were corrected, questionnaires were re-checked and re-entered, and the data entry operators were retrained. The main errors found were those related to the coding of 'missing' variables and transition questions. During the second round of double data entry there were only insignificant changes between the first and the repeated data entry dataset. Questionnaires were re-checked, and the final database was cleaned of errors.

E. DATA ANALYSIS

The dataset was processed using the statistical package IBM SPSS, version 26. Descriptive statistics (frequency, percentage, crosstabs etc.) were used to present findings observed at the database. Data disaggregation was conducted for every question in the questionnaire. The main variables for data disaggregation were: gender (M/F), level of urbanization (urban/rural), employment (working/non-working students), parents living outside the house for more than one month (yes/no) and levels of depression, anxiety and stress (measured with the DASS scale described above). Cross tabulations were the main data disaggregation method used. Correlation was used to explore the relation between levels of depression, anxiety and stress, and quality of school experience.

Weighting. The methodology used by TIMSS and PIRLS is designed to accurately represent the target populations within a specified margin of sampling error. Essentially, a student's sampling weight is the inverse of the student's probability of selection, with appropriate adjustments for non-response. The initial sample frame was designed for 300 schools, but one school was out of scope, so 299 schools were ultimately selected. The weighting conducted for this analysis was comprised of three components:

1. weight of a school within a specific region;
2. weight of a class in the same grade;
3. weight of a student within the selected class.

An adjustment for non-response was conducted in each stage. A full description of the weighting procedure is provided in Annex 18.

2.2.3. QUALITATIVE PRIMARY DATA COLLECTION

To complement and triangulate findings from the secondary data review and survey results, and to address possible information gaps, primary qualitative data collection was conducted in selected regions of Uzbekistan. Qualitative primary data collection was carried out through focus group discussions with adolescents, their parents, and school professionals such as school psychologists, medical workers and inspector psychologists, in addition to interviews with key stakeholders at the central level. Details about this process are given below.

A. DATA COLLECTION INSTRUMENTS

Interviews and focus group discussions were the main tools for collecting qualitative primary data. The main parts of these instruments were: ***understanding mental health, personal experience or exposure to mental health issues, risk and protective factors for mental health in adolescence, help-seeking behaviour, professional practice in schools, inter-sectorial collaboration, and laws and policies around these issues.*** Specifically:

- ***FGD guide 1 – Adolescents.*** This guide included three sections focusing on adolescent's understanding of mental health issues and psychosocial well-being, the

factors they believe affect the onset of such problems and their help-seeking behaviour (Annex 1).

- ***FGD guide 2 – Parents.*** Again, this guide included three sections focusing on parent's understanding of mental health issues and psychosocial well-being, the factors they believe affect the onset of such problems among their own children or Uzbek children in general, and their help-seeking behaviour (Annex 2).

- ***FGD guide 3 – School psychologists, inspector psychologists and medical workers.*** This FGD guide focused on professionals' perception of factors affecting adolescents' mental health, their daily practices and challenges faced in helping adolescents with mental health problems, inter-sectorial and multidisciplinary collaboration, and their suggestions to improve existing services or establish new ones (Annex 3).

- ***FGD guide 4 – National and local service providers, NGOs and independent experts.*** This guide focused on the role of institutions, centres or agencies in the provision of mental health services, the current legal and policy framework and their understanding of it, potential gaps in the legal and policy framework and in service provision, inter-sectorial collaboration, and recommendations to improve the situation in service provision (Annex 4).

- ***Interview form 1 – Government representatives.*** Interviews on the role of represented institutions in addressing the mental health issues of adolescents, the current legal and policy framework and gaps in it, current service provision and inter-sectorial collaboration, and respective challenges and future recommendations (Annex 5).

- ***Interview form 2 – Community leaders and village elders.*** Interviews with community leaders and village elders, bringing community perspective to the study. These interviews focused on both their individual perception and their broader community's perception of mental health issues in general and for adolescents in particular, factors influencing them, help-seeking behaviour, and recommendations for improvement (Annex 6).

B. SAMPLING

Inclusion criteria were applied for the selection of adolescents and parents to participate in focus group discussions. A purposive and convenient sample was used, having in mind a maximum variation of different variables, like age, gender, urban and rural areas, socio-economic status, and years of experience (for practitioners). The selection of participants was done with the help of school principals and school psychologists. Adolescents who participated in the survey were not allowed to be part of the focus group discussions (FGDs). Also, following discussion and consultation with UNICEF Uzbekistan and national counterparts, it was decided not to segment the FGDs by gender because the discussed issues were not gender-related. The only segmentation was done by age, because the younger adolescents (12-15 years old) could feel intimidated when speaking in a group of elder adolescents (older than 16 years old). FGDs were carried out in both urban and rural areas, and efforts were made to ensure a gender balance within these.

The inclusion criteria for each data collection process are described below:

- ***Adolescents' FGDs*** – all adolescents between the ages of 12 and 18 could participate in the study, if their parents consented and gave their assent. Separate FGDs were conducted for adolescents aged 12 to 15 years, and for those aged 16 to 18 years. FGDs were not segmented by gender. A total of 7 FGDs were conducted with adolescents, 2 with those aged 12 to 15 years, and 5 with those aged 16 to 18 years. 71 adolescents participated in the FGDs, including 34 males and 37 females.
- ***Parents' FGDs*** – only parents of adolescent children attending school participated in the FGDs. 6 FGDs with parents were conducted, 2 of them in rural areas and 4 in urban areas. 73 parents participated, including 67 females and 6 males.
- ***FGDs for school psychologists and other related professionals*** – school psychologists, medical workers and inspector psychologists could participate in these focus groups, provided they had at least 3 months' work experience in their positions in urban and rural areas. 8 FGDs were conducted, 2 in rural areas, 5 in urban areas and one online. There were 66 participants, including 20 men and 46 women.
- ***Mental health and psychosocial service providers at the national level – Interviews.*** Two psychiatrists were interviewed for this purpose.
- ***Government representatives – Interviews.*** Interviews were conducted with representatives from different central institutions. Specifically these included key stakeholders from the Ministry of Public Education, the Ministry of Health, the Ministry of Interior, and the Youth Agency.
- ***Community level stakeholders (community leaders, village elders) – Interviews.*** Two interviews were conducted with community-level representatives to add a community perspective in the study about mental health awareness and other important issues.

Table 3. *Number of participants in FGDs and their regional distribution*

	Fergana region - Rural		Bukhara region - Rural		Andijan region - Urban		Samarkand region - Urban		Khorezm region - Rural	
12-15 years old	10	3 M 7 F								
16-18 years old			10	5 M 5 F	10	6 M 4 F	10	2 M 8 F		
Parents			15	2 M 13 F	8	8 F	15	1 M 14 F		
Psycholo-gists etc			8	2 M 6 F	7	7 F	18	11 M 7 F	7	3 M 4 F
Total	**10**	**3 M 7 F**	**33**	**9 M 24 F**	**25**	**6 M 19 F**	**43**	**14 M 29 F**	**7**	**3 M 4 F**

	Sukhandarya region - Urban		Tashkent region - Urban		Tashkent region - Rural		Tashkent online	
12-15 years old			11	6 M 5 F				
16-18 years old	10	5 M 5 F			10	7 M 3 F		
Parents	11	11 F	10	10 F	14	3 M 11 F		
Psycholo-gists etc	13	2 M 11 F	7	7 F	7	7 F	6	2 M 4 F
Total	**34**	**7 M 27 F**	**28**	**6 M 22 F**	**24**	**10 M 14 F**	**6**	**2 M 4F**

Table 4. *Summary table of key stakeholders*

Profession/Institution	Number
Mahalla Administrator and Community Elder	2 (Fergana region, Rural area)
Ministry of Education	1
Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students	1
Ministry of Health	1
Ministry of Internal Affairs	1
Youth Agency	1
Psychiatrists	2
Total	**9**

A total number of 219 participants took part of the qualitative component of this study, as outlined in Table 3 and Table 4 below.

C. DATA COLLECTION PROCESS

Prior to the commencing of data collection, all focus groups facilitators were trained for screening participants prior to their participation in the study; organizing interviews and FGDs; ethical research and interview processes with children and adults; and processes for securely managing and sharing data. Written protocols were provided in the training, which all parties can refer to in case they need to refer to written instructions. Similar quality checks were conducted for the survey.

D. DATA ANALYSIS

Interviews and focus group discussions were tape-recorded (with the agreement of the participants), transcribed and then translated in English and processed for further analysis. A thematic analysis was performed to identify themes and patterns in the statements of adolescents, parents and other key stakeholders. The findings from FGDs and KIIs were coded based on words and phrases, and major themes and categories emerged after several readings and re-readings. Initial themes that appeared in the research were used to develop 'codes'. As the analysis proceeded, the emergence of new categories from the data led to the development of additional codes. All material were analysed this way, and were then subsequently re-read and re-analysed, in order to complete data interpretation and analysis.

2.3. DATA PROTECTION, HANDLING AND RECORD-KEEPING

Several steps were undertaken to ensure secure data handling and processing. Thus, all data from the FGDs and interviews was safely uploaded onto a UNICEF protect-

ed online space, with limited access by persons involved in the study. A coding system was established to manage participants' information without anyone outside the research team ever knowing the names or other personal details of the participants in interviews/FGDs. For each FGD a table with general details about the participants was created, not including any specific identification details. Regarding questionnaires, these were transferred to the contracted company with which an information security, privacy and confidentiality agreement was signed. Upon completion of the final report, the research team members were advised to delete any remaining electronic data. Also, UNICEF will maintain the data in line with its internal data storage policies for at least 3 years.

2.4. RESEARCH MANAGEMENT – ROLES AND RESPONSIBILITIES

The research was a collaborative effort of the international and national experts, the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education of Uzbekistan, and UNICEF Uzbekistan. The ***international expert*** was responsible for research planning, training field researchers, ethics application, data analysis, interviewing of key stakeholders at the national level, and report writing. The ***national expert*** engaged mainly in liaising with national institutions for any issue related to the research (like gathering official information), overseeing fieldwork, monitoring data collection, responding to queries from field researchers, and overall quality assurance of field work. The ***Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students*** was responsible for selecting interviewers for the quantitative and qualitative component of the research, for liaising with the schools/parents, national service providers, government representatives and community stakeholders on the purpose of the study, disseminating informed consent forms, organizing the survey and FGDs with adolescents/parents/school psychologists and national service providers/independent experts and community stakeholders, and conducting the interviews. The selected interviewers were responsible for transcription and anonymization of qualitative data from FGDs and KIIs. ***UNICEF Uzbekistan*** was responsible for coordinating the study, engaging central government and local government stakeholders and other partners, managing the work of the international and national consultants, and reviewing and commenting on the report.

Interviews and FGDs were conducted by experienced researchers with backgrounds in the social sciences and psychology. Also, all field researchers and national and international consultants completed the course and received a certificate about Ethics in Evidence Generation, as required by UNICEF Procedures on Ethical Standards in Research, Evaluation, Data Collection and Analysis (2021). All field researchers for both quantitative and qualitative primary data collection were trained on the research methodology, data collection process, research tools and informed consents and assents, and on conducting ethical and child-sensitive focus group discussions, all prior to the commencement of field work. Also, they were provided with clear instructions about reporting on and managing adverse situations.

The current draft of the report was written by the international consultant with the contribution and inputs of the national consultant, and UNICEF's responsible manager. It underwent a process of internal UNICEF review. Also, the findings of the research were presented to the public by the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students, through a press-conference held on 14 October 2022. Suggestions from stakeholders were taken into consideration to the extent possible.

2.5. DEPARTURE FROM ORIGINAL TORS

In consultation with UNICEF Uzbekistan, it was decided not to include interviews with adolescents who had attempted suicide, because the potential harm caused by their inclusion in the study exceeded any possible benefits gained. The same applied for adolescent girls or boys with early marriage experience, for the same reasons. Also, the study focused only on three grades in order to employ an optimal methodology, and to obtain robust data that will guide further programmatic interventions. However, these changes didn't affect the overall aim and objectives of the study.

2.6. ETHICAL ISSUES

The inception report of this study, which encompassed research tools and informed consents/assents forms, was reviewed by the UNICEF External Review Board and the national Ethical Review Board – important because data collection involved human subjects including vulnerable persons (adolescents aged 12 to 18 years) – and they received a positive review.

For this specific research, data collection and analysis phases followed the principles and procedures defined in UNICEF procedures for ethical standards in research, evaluation, data collection and analysis:

- UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2021);
- UNICEF Guidance Document for the Protection of Human Subjects' Safety;
- UNICEF Guidance Document for Protection of Research Data.

It upheld and applied in practice the fundamental standards:

- That subjects are not placed at undue risk;
- That participation is voluntary, and subjects are provided with and agree to informed consent prior to their participation; and
- That written protocols are in place to assure subjects' confidentiality or anonymity.

Both parents and students received an information sheet and an informed consent/assent form for their participation in the study. The informed assent form was written in a simple and child-friendly language. To ensure that adolescents were free to choose if they would participate in the study, it was emphasized that even if their parents had consented, they were not obliged to participate without suffering any sanctions. Also, a list of local psychologists and their contact numbers was provided to both parents and adolescents in case they became distressed or were deemed to be needing protection assistance.

2.7. LIMITATIONS

This study's participants were adolescent students in the 6th, 9th, and 11th grades. Therefore, not all adolescents from the age of 10 to 19 years old were included, mainly due to logistical reasons and in order to apply a specific rigorous methodological approach. Nonetheless, the included adolescents were representatives of excluded ones, respectively they were 12, 15 and 17 years old, and as such they were in early, middle and late adolescence periods. Also, all adolescents from the ages of 12 to 18 years had a chance to participate in focus group discussions.

Social desirability bias could be present among the adolescents who responded to the questionnaire or participated in the FGDs. For the survey, students were ensured of con-

fidentiality and anonymity through their information sheet and the active explanation of confidentiality and anonymity by field researchers. In FGDs, questions were posed about 'friends or acquaintances', because sometimes it is easier to speak on behalf of another person than to speak about oneself.

This study saw the participation of adolescents, parents, school professionals and key stakeholders. However, teachers were not included in the study. Perceptions about teachers, relations to students and their role were all part of the questionnaire, FGDs and KIIs. Hence, some issues related to teachers were partially addressed. Further exploration of teachers' perceptions on the mental health and psychosocial well-being of adolescents and their needs on this topic is suggested.

This study is focused mainly on what are called Common Mental Disorders (CMDs), like anxiety and depression, and not on the full spectrum of mental disorders (especially severe cases affecting children and adolescents). Future studies about these topics are suggested.

3

FINDINGS – SURVEY «THE MENTAL HEALTH SITUATION AND PSYCHOSOCIAL NEEDS OF ADOLESCENT BOYS AND GIRLS»

3.1. GENERAL DATA

The total number of this study's respondents was N = 22,854 students. Half of them were boys (49.1 per cent) and the other half girls (50.9 per cent) with an average age of 15 years old. Participation in rural and urban areas was almost equal, with 51.1 per cent of participating adolescents residing in urban areas and 48.9 per cent of them in rural areas (Table 1).

Based on the research methodology, only grades 6, 9 and 11 were selected for this research. The distribution of students in these three grades was 34.3 per cent in grade 6, 34.1 per cent in grade 9, and 31.6 per cent in grade 11 (the smallest percentage). While for grades 6 and 9 the distribution of girls and boys was almost equal, in grade 11 there were 10 per cent more girls than boys. The majority of students did not report having disabilities (98.4 per cent), whereas there was indeed a small percentage of them with different needs (0.9 per cent). All the above information is presented in Table 5.

Table 5. *Demographic data of adolescents*

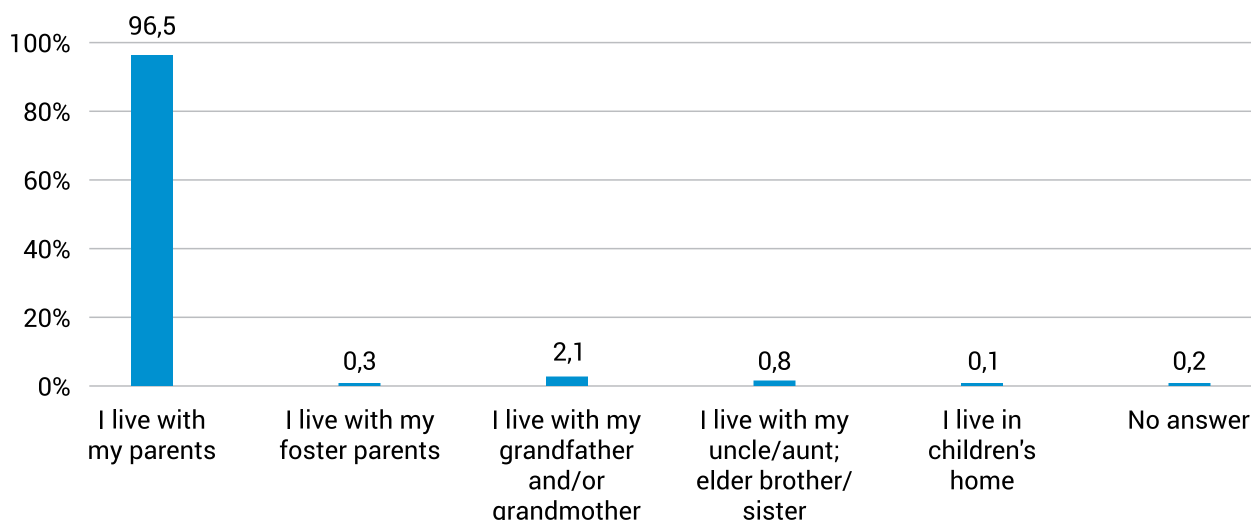
Settlement type	Urban	51,1%
	Rural	48,9%
What is your gender?	Male	49,1%
	Female	50,9%
What grade are you in school?	Grade 6	34,3%
	Grade 9	34,1%
	Grade 11	31,6%
Do you have any disabilities?	Yes	0,9%
	No	98,4%
	Do not wish to answer	0,7%
Do you work?	Yes	5,0%
	No	95,0%
Is it a full-time (8 hours in a day) or part-time job (less than 8 hours in a day)?	Full time	36,1%
	Part time	58,1%
	No answer	10,3%

During data collection, 5 per cent of participating students indicated they were working. Of those who said they worked, 31.6 per cent were working a full-time 8 hours/day job, while 58.1 per cent were working less than 8 hours. Also, adolescent boys prevailed compared to girls in relation to working: 79.4 per cent of working students were boys, while 20.6 per cent were girls. Of the working students 56.8 per cent were settled in an urban area, while 43.2 per cent were in rural areas. Adolescents of grades 9 and 11 comprised the largest part of the working students (41.6 per cent from grade 9 and 50.7 per cent from grade 11). It is worth noticing that 8 per cent of students in grade 6 also reported that they were working, and a small number of them worked a full-time job.

3. 2. FAMILY

Most of the adolescents in this study were living with their parents (96.5 per cent). The others were living with their grandparents (2.1 per cent), or with other relatives such as uncles/aunts or elder brothers/sisters (0.8 per cent). A small fraction of them were living with foster parents (0.3 per cent) or in children's homes (0.1 per cent) (Graph 2). The average number of persons living under the same roof with adolescents was m = 5.2 (SD = 2.1).

***Graph 2.** Living conditions*

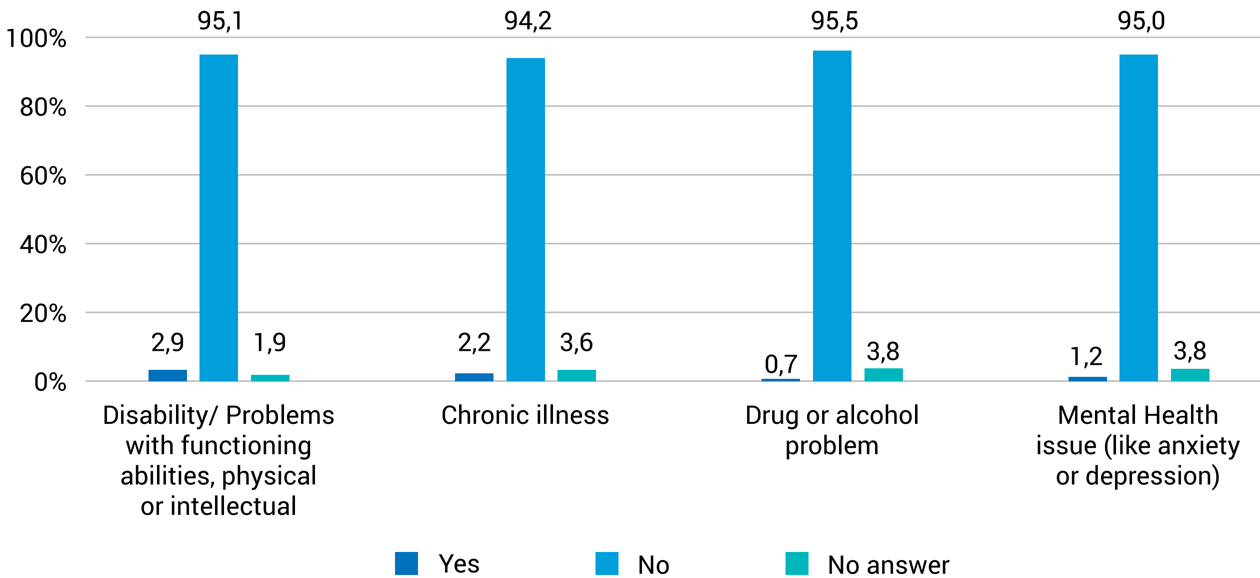


As indicated in Graph 3, most respondents reported that they did not have any family members with a disability (95.1 per cent), nor with a chronic illness (94.2 per cent), a drug or alcohol problem (95.5 per cent), or a mental health issue (95 per cent). Even though the percentages are low, there were indeed adolescents living with a family member with a disability (2.9 per cent) or a chronic illness (2.2 per cent).

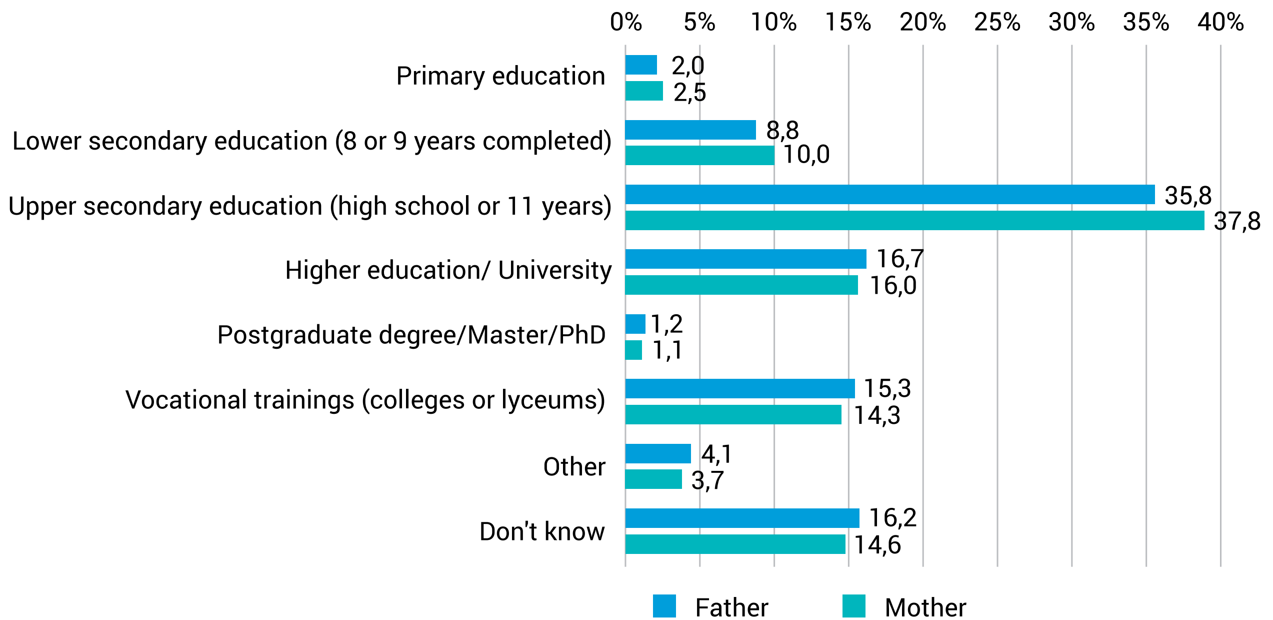
Evidence indicates that parents' educational level has an impact on children's upbringing in general, and on their psychosocial well-being in particular [51]. Graph 4 shows that the major part of adolescents' parents had an upper secondary education (35.8 per cent for fathers and 37.8 per cent for mothers), followed by higher education (16.7 per cent for fathers and 16 per cent for mothers), vocational training (15.3 per cent for fathers and 14.3 per cent for mothers), and lower secondary education (8.8 per cent for fathers and 10 per cent for mothers). A very small percentage of them had attended only primary education (2 per cent for fathers and 2.5 per cent for mothers). It is worth mentioning that many adolescents did not know their parents' level of education (16.2 per cent for their fathers and 14.6 per cent for their mothers), but more than half of these students were in grade 6. In this study, there was not any statistically significant difference between parents' education level and adolescents' emotional concerns.

[51] Sonego M, Llácer A, Galán I, Simón F. (2013). The influence of parental education on child mental health in Spain. Qual Life Res. Feb;22(1):203-11. doi: 10.1007/s11136-012-0130-x. Epub 2012 Feb 23. PMID: 22359237.

***Graph 3.** Family member with disability, chronis illness, drug or substance problem and mental health issue*



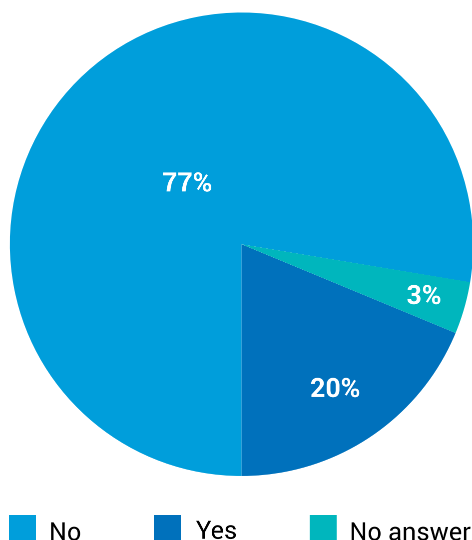
***Graph 4.** Educational level of father and mother*



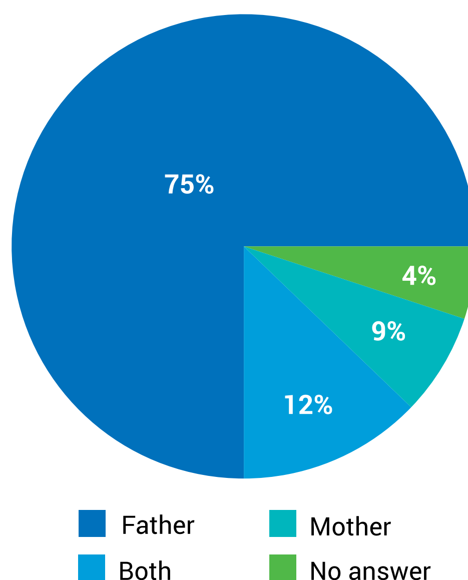
Migration to other countries is a common phenomenon in Uzbekistan. Sometimes one or both parents may migrate to another country or a bigger city to ensure financial stability for their families [52]. 20 per cent of the respondents had indeed one parent living or working away from the family for at least one month during the last year (Graph 5), and in most cases it was the father (75 per cent).

[52] Prague Process (August 31, 2022). Uzbekistan migration country profile. Available at *https://www.pragueprocess.eu/en/countries/426-republic-of-uzbekistan#:~:text=In%202020%2C%20only%201.105%20persons,most%20populous%20in%20Central%20Asia.*

***Graph 5.** During the last year (12 months) did any of your parents lived or worked far from the family for more than a month?*



***Graph 6.** Parent lived/worked far from family*

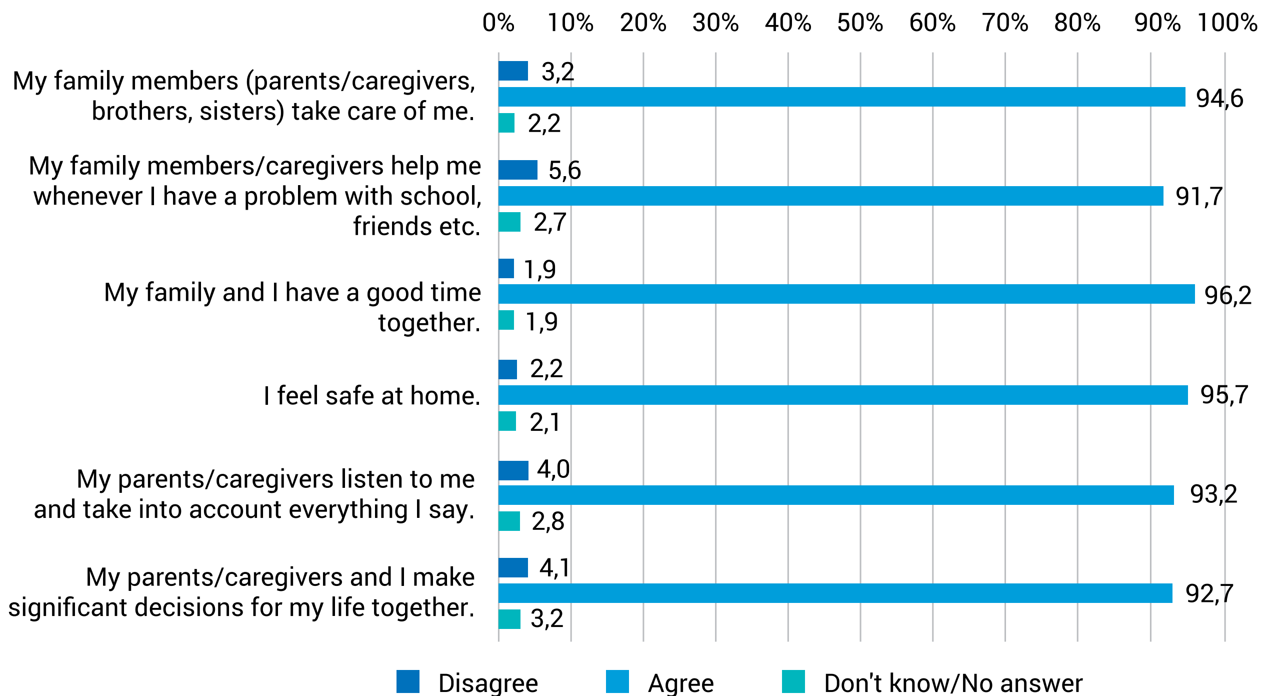


It is worth highlighting that in 12 per cent of cases, both the mother and father had left the house to live/work abroad for at least a month (Graph 6). Of the students whose parents lived/worked far from the family abroad, 59.7 per cent were from rural areas and 40.3 per cent were from an urban area. Working students featured more in the category of having at least one parents living/working far from family, particularly if both parents are not with them.

While families could play a strong protective role in their lives, evidence shows that adolescents repeatedly indicated that they would often like more support and validation from their parents. Unsupportive family relationships are considered directly detrimental to adolescent well-being, and they also indirectly increase harm by preventing adolescents from obtaining much-needed help for mental health conditions[53]. In this study the predominant part of respondents said that their parents and family members take care of them (94.6 per cent), that they have a good time together (96.2 per cent), they feel safe at home (95.7 per cent), they are listened to (93.2 per cent), and their thoughts are taken into consideration when significant life decisions are made (92.7 per cent). Regarding support from families whenever problems with school arise, there was a small decline in the percentage – 91.7 per cent of adolescents had parents' help in this case. Almost 6 per cent of adolescent boys and girls reported that they didn't have their family's support in regards to a problem with school or friends, and about 4 per cent said their thoughts weren't listened to or taken into consideration by their family members (Graph 7). Overall girls seem to have better relations with their families, as they offered greater agreement with all statements compared to boys, but nonetheless the difference was small. Compared to non-working students, the ones that worked reported less that their families cared for them, helped them with school or friendship problems, or that their parents take into

[53] Johns Hopkins Bloomberg School of Public Health and United Nations Children's Fund, On My Mind: How adolescents experience and perceive mental health around the world, JHU and UNICEF, Baltimore and New York, May 2022. Available at *https://www.unicef.org/media/119751/file* accessed on 23 August 2022.

Graph 7. *How strongly do you agree or disagree with the following statements about your family?*



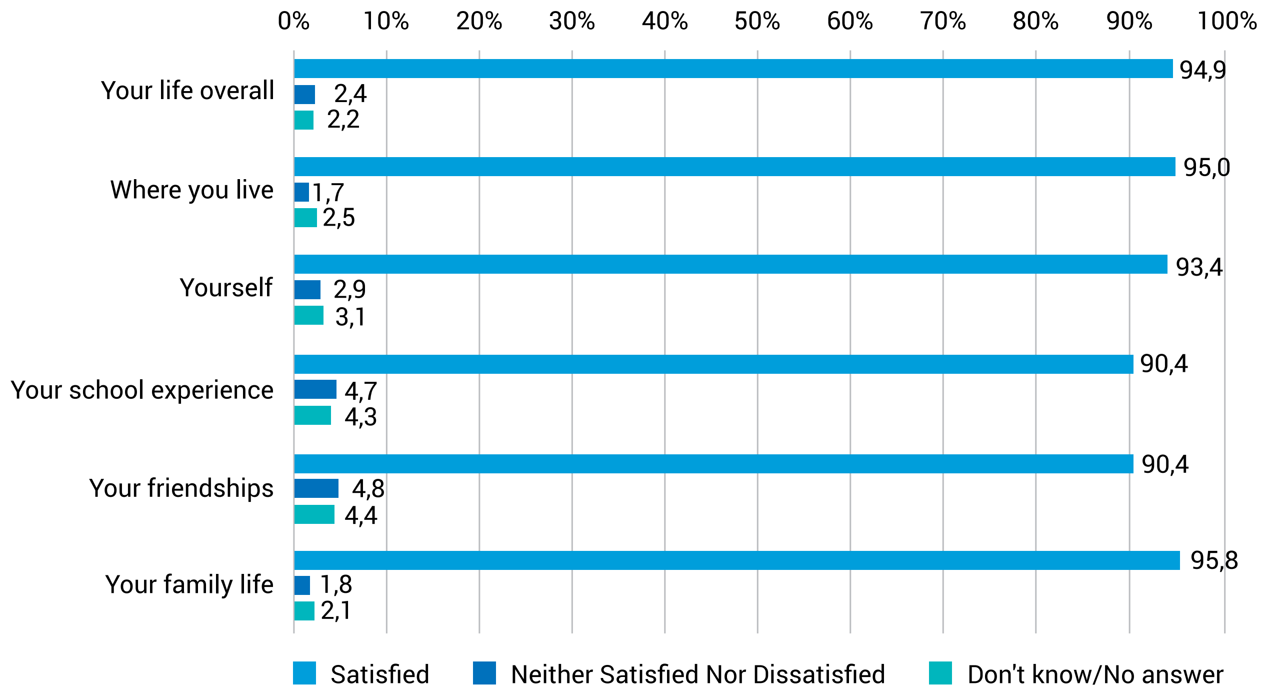
account what they say. Students with moderate to extremely-severe levels of anxiety and depression (respectively 9.8 per cent and 15.5 per cent) had an overall gloomy perception of their relations with their families, particularly in relation to having a good time with them, their opinions being taken into consideration, or being able to make significant life decisions together (see section 'Feelings and worries', Graph 21 about the classification of depression and anxiety levels).

3.3. OVERALL SATISFACTION

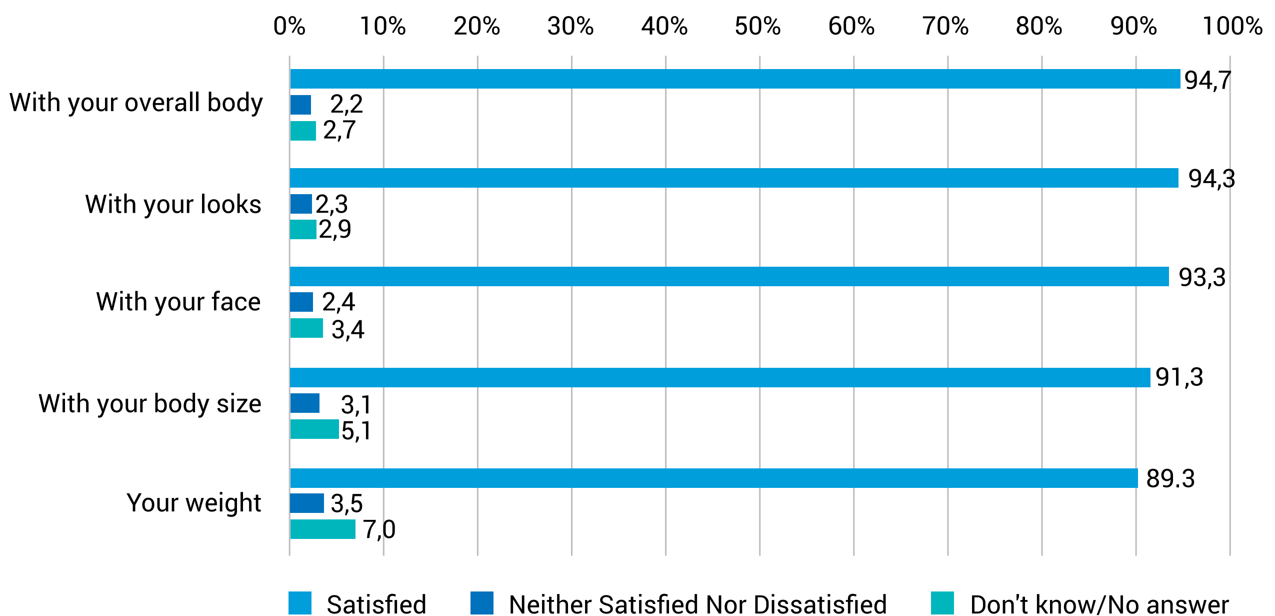
Graph 8 shows adolescents' satisfaction with different aspects of their lives, while Graph 9 specifically refers to satisfaction with their overall appearance and body. Overall, adolescents reported being satisfied with their family life (95.8 per cent), the place where they live (95 per cent), their life overall (94.9 per cent), and themselves (93.4 per cent). Their lowest levels of satisfaction were with their school experience (90.4 per cent), and their friendships (90.4 per cent), which are closely related considering that school actually serves as a place for socialization for many teens. There were no significant gender differences in all aspects of life satisfaction. While teens from rural areas expressed greater levels of satisfaction in all aspects, the middle and elder adolescents were less satisfied with their friendships, school experience, themselves, the places where they lived, and their lives overall.

Working students' satisfaction with family life and friendships was lower compared to that of non-working students. They were even less satisfied with school life. Students with emotional or behavioural difficulties, or with higher levels of anxiety, depression and stress were less satisfied with all aspects of their life, including their family, friendships, themselves, their school experience, and their life overall (see section on 'Feelings and worries', Graph 20 and 21 for classifica-

***Graph 8.** Life satisfaction*



***Graph 9.** Satisfaction with appearance*



tion of these groups). For example, students with moderate to extremely-severe levels of depression or stress were 10 per cent less satisfied with school experience, themselves, and their family life. They showed similar but declining trends in other life aspects (ranging from 4 to 8 per cent). These co-existing factors can be a 'red alarm' for families and

schools and other youth-related institutions, indicating that they need to act towards preventing or managing these symptoms at an early stage.

Even though adolescents were reportedly satisfied with their overall body (94.7 per cent), their looks (94.3 per cent) and their face (93.3 per cent), there was a small decline in relation to their satisfaction with their body size (91.3 per cent) and their weight (89.3 per cent) (Graph 9). While gender didn't have an impact in all aspects of satisfaction with own appearance, it looks like young adolescents, ones from rural areas, and those that didn't work had higher levels of satisfaction in all aspects. As in the previous question, students with moderate to extremely-severe levels of stress, anxiety and depression exhibited less satisfaction mainly with their body weight (18 per cent of them were less satisfied than those with normal to mild levels of stress, anxiety and depression). They showed similar patterns of dissatisfaction with all other aspects, but at lower levels (ranging from 6 to 10 per cent).

3.4. SCHOOL EXPERIENCE

Second only to families, school is a deeply influential socializing force in the lives of most adolescents around the world. Evidence shows that school environment has been largely described by adolescents as a risk to mental health rather than a protective factor, due to high academic pressure and unsupportive teachers. Despite this negative description, schools have a great potential to support mental health and well-being, even if this potential is not always realized [54].

Adolescents' perceptions of their teachers' attitudes and interactions towards them vary, as seen in Graph 10. The largest part of adolescents described their teachers having a respectful attitude towards all students (89.6 per cent), understanding their problems (85.2 per cent), being available to talk to them (85.8 per cent), caring about their students (85.5 per cent), and making them feel good about themselves (84.5 per cent). However, there is a consistent percentage of students who believe the opposite about their teachers, the relations they have with their students, and their overall attitudes and interactions. This percentage varies from 10 per cent to almost 15 per cent, meaning that at least 1 out of 10 adolescents do not have supportive relationships with their teachers. In a similar study that explored trajectories of student-teacher relations, it was determined that 10 per cent of students that had initially an average positive relation with teachers tended to have a decline after the 7th grade [55]. Notwithstanding students reporting that teachers treated all students equally, the later option – 'Teachers are only interested in good students' – seems to have divided them, with half the respondents agreeing to and the other half disagreeing with this statement (Graph 10).

Adolescent girls and students of urban areas had a better perception of teachers compared to adolescent boys. Reportedly they agreed with all positive statements for teachers, more than boys or students from rural areas. Sixth graders also had a better perception of their teachers compared that of ninth and eleventh graders. Specifically, ninth graders were prone to be less satisfied with their teachers' attitudes.

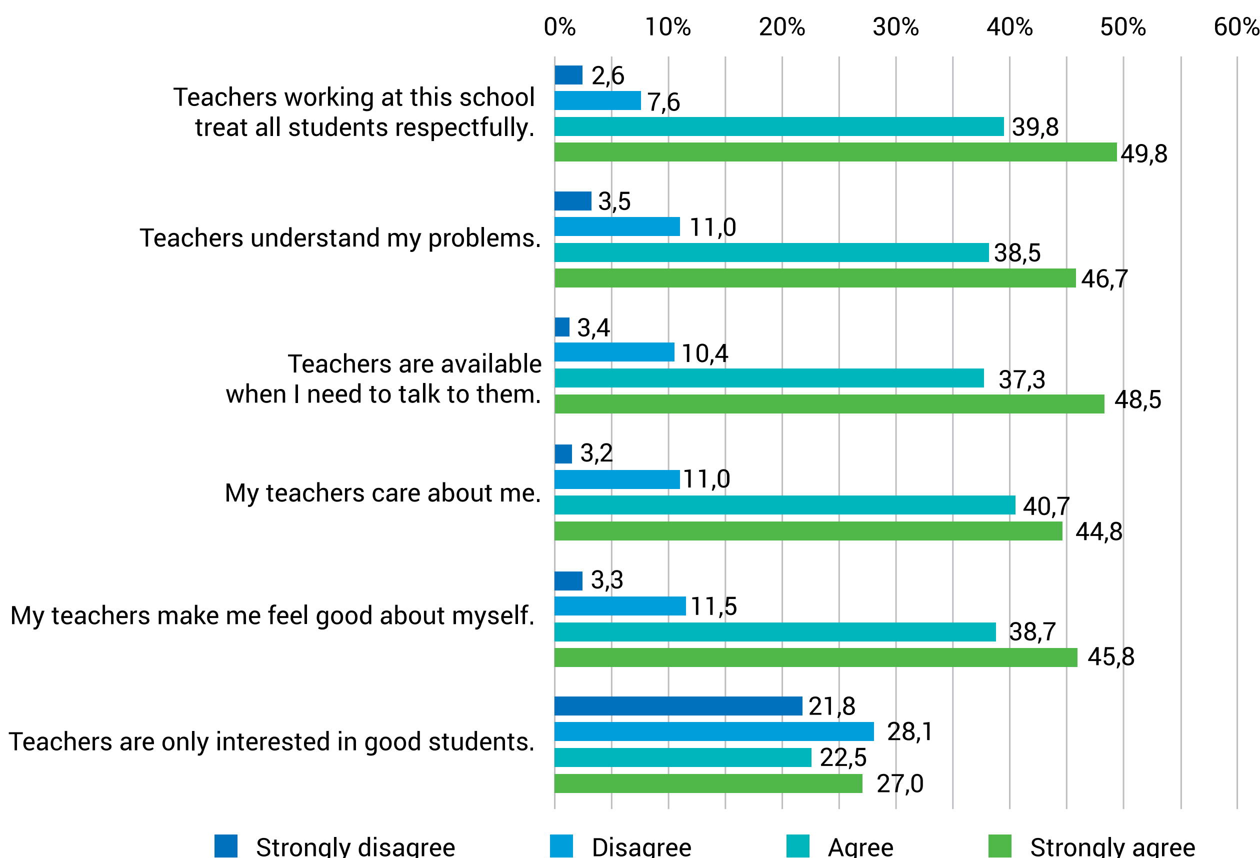
Working students conveyed that they felt less understood by their teachers, and that their teachers didn't make them feel good about themselves. Overall their interactions with teachers were gloomy.

As with previous questions, students with high levels of anxiety, depression and stress tended to have negative perceptions of their

[54] Ibid.

[55] Bayram Özdemir, S., Özdemir, M. (2020). How do Adolescents' Perceptions of Relationships with Teachers Change during Upper-Secondary School Years? Journal of Youth Adolescence 49, 921–935. *https://doi.org/10.1007/s10964-019-01155-3.*

Graph 10. Perception about teachers



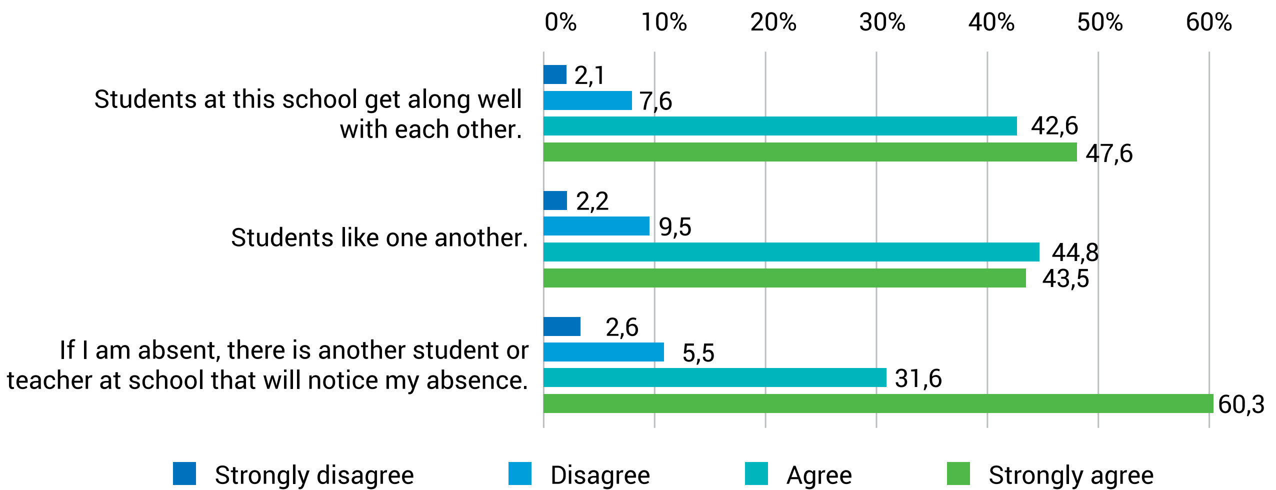
teachers, the relations they have with them, the level of understanding, and other indicators (See Section 'Feelings and Worries', Graph 21). Good relations with teachers are very important for students to feel included in classrooms and in school in general. Meanwhile, unsupportive teachers may have the opposite effect.

When social support exists, it is a powerful buffer against distress [56]. That said, adolescents often do not know who they can trust with their problems, and many experience negative peer interactions that cause emotional distress. It looks like adolescents in Uzbekistan have good relations with their fellow students in most cases, with above 90 per cent of them stating that the students in their schools like each other and get along well. Also, they have stated that their absence would have been noted by a teacher or another student (91.9 per cent). Again, a small percentage of them believe the opposite about students' interactions at school (approximately 10 per cent). While there were no significant gender differences nor any work-related differences in the way other students were perceived, students from rural areas seemed to have a better perception about interactions other than these. In one case this was true for sixth graders too (for the statement "Students in this school like one another").

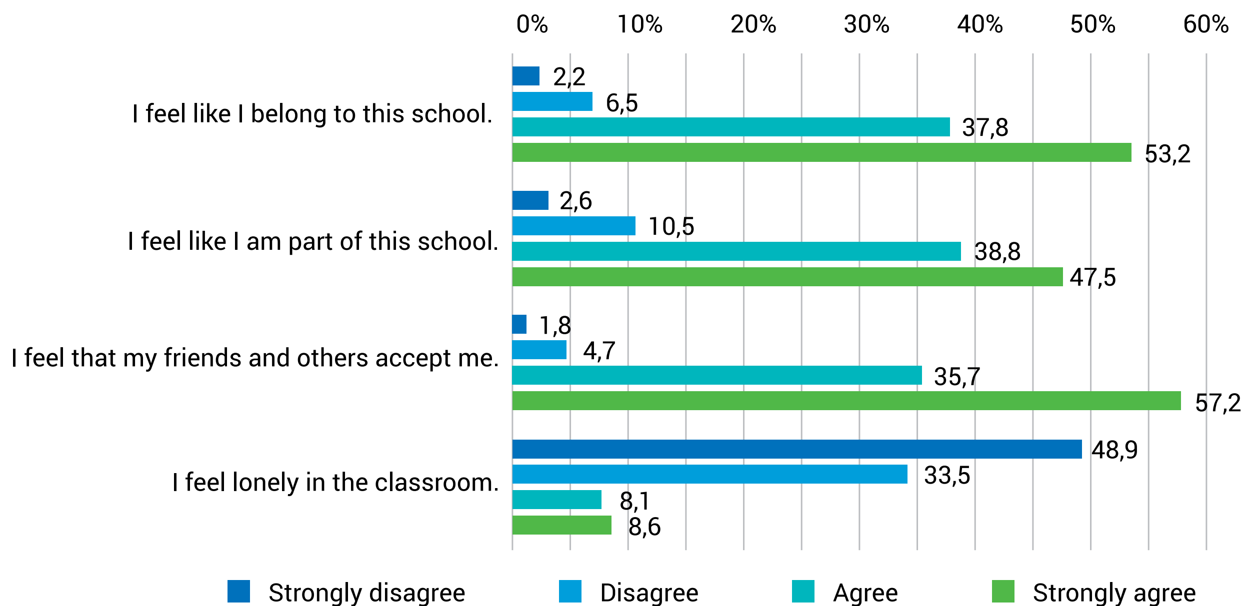
Social connectedness has been shown to decrease perceived stress from school, and hence influences students' psychosocial well-being within school. Lack of school-con-

[56] Ibid.

Graph 11. *Perception about students*



Graph 12. *Social connectedness*



nectedness and feelings of isolation are only some of the daily stressors for adolescents at school which contribute to the onset of mental health problems, or a lack of reporting or seeking help [57]. Graph 12 shows that again a small part of students experience feelings of lack of social connectedness: almost 1 out of 10 felt that they didn't belong to their school (8.7 per cent), and even more felt that they weren't part of their school

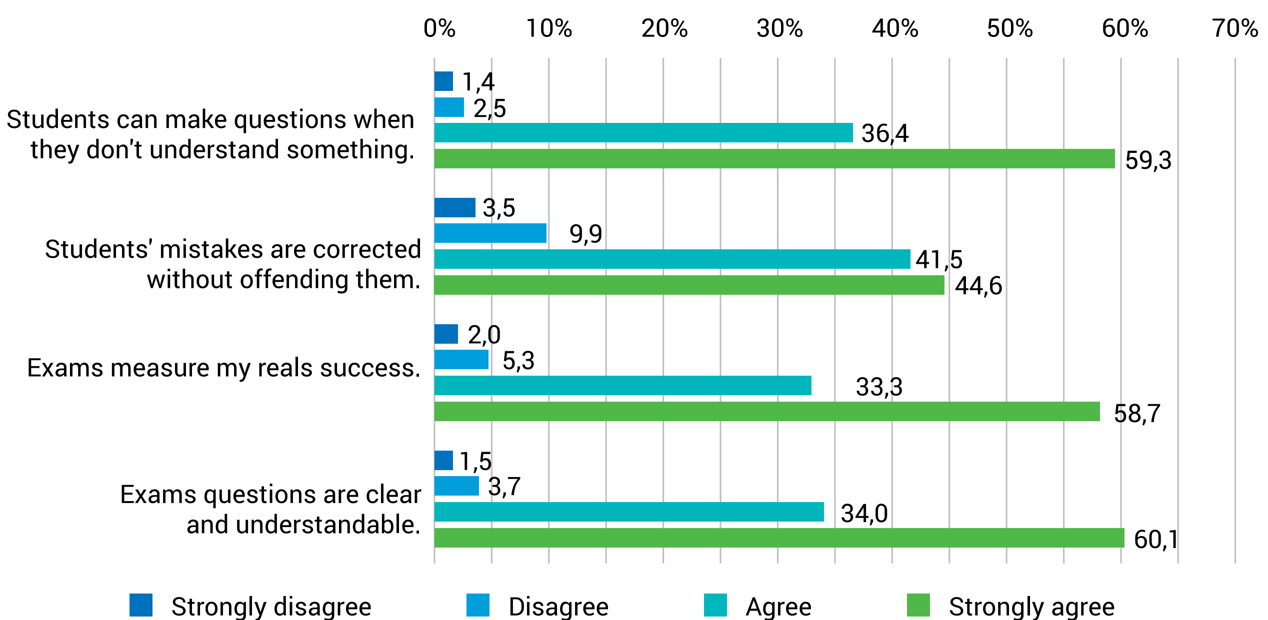
[57] Schulte-Körne, G. (2016). Mental Health Problems in a School Setting in Children and Adolescents. Dtsch Arztebl Int. 18;113(11):183-90. doi: 10.3238/arztebl.2016.0183. PMID: 27118666; PMCID: PMC4850518.

(13.1 per cent). Lastly, there was an increase in the number of students feeling lonely in their classrooms to 16.7 per cent, being the highest percentage in this category (Graph 12). With a slight difference adolescent girls and students from rural areas felt more that they belonged and were part of the school, and felt less lonely in the classroom. On the other hand, almost twice as many students in grades 9 and 11 felt they didn't belong to their school compared to sixth graders. In the same line, working students lacked connectedness with school compared to their non-working peers.

In relation to students' perceptions of tests and exams, which can often be stressful, the respondents said that overall they can ask questions when they don't understand something (95.7 per cent), that exam questions are clear and understandable (92 per cent), and that they measure their real success (94.1 per cent). Concerning the way their mistakes are corrected, it looks like there is a slight decline in the percentage of students who believe that these mistakes are corrected without students being offended (Graph 13). There were no significant gender differences about exams' perception, yet students from rural areas and non-working students had a more positive perception of them.

School safety plays a crucial role in youth development and academic success. Students who feel safe at school tend to have better emotional health, and are less likely to engage in risky behaviours. That sense of safety contributes to an overall feeling of connection. Adolescent girls and boys who participated in this study overall reported that they felt safe at their schools (92.5 per cent) and safe when going from home to school (92.9 per cent). However, some students stated that they sometimes stayed at home because of not feeling safe at school (16.5 per cent). In regards to students' interactions and violent behaviours or bullying, 17.8 per cent of participating students said that their peers fight a lot, 13.1 per cent that they are being teased or picked on for their nationality, economic status of their family or other reasons, 12.6 per cent that they use/try

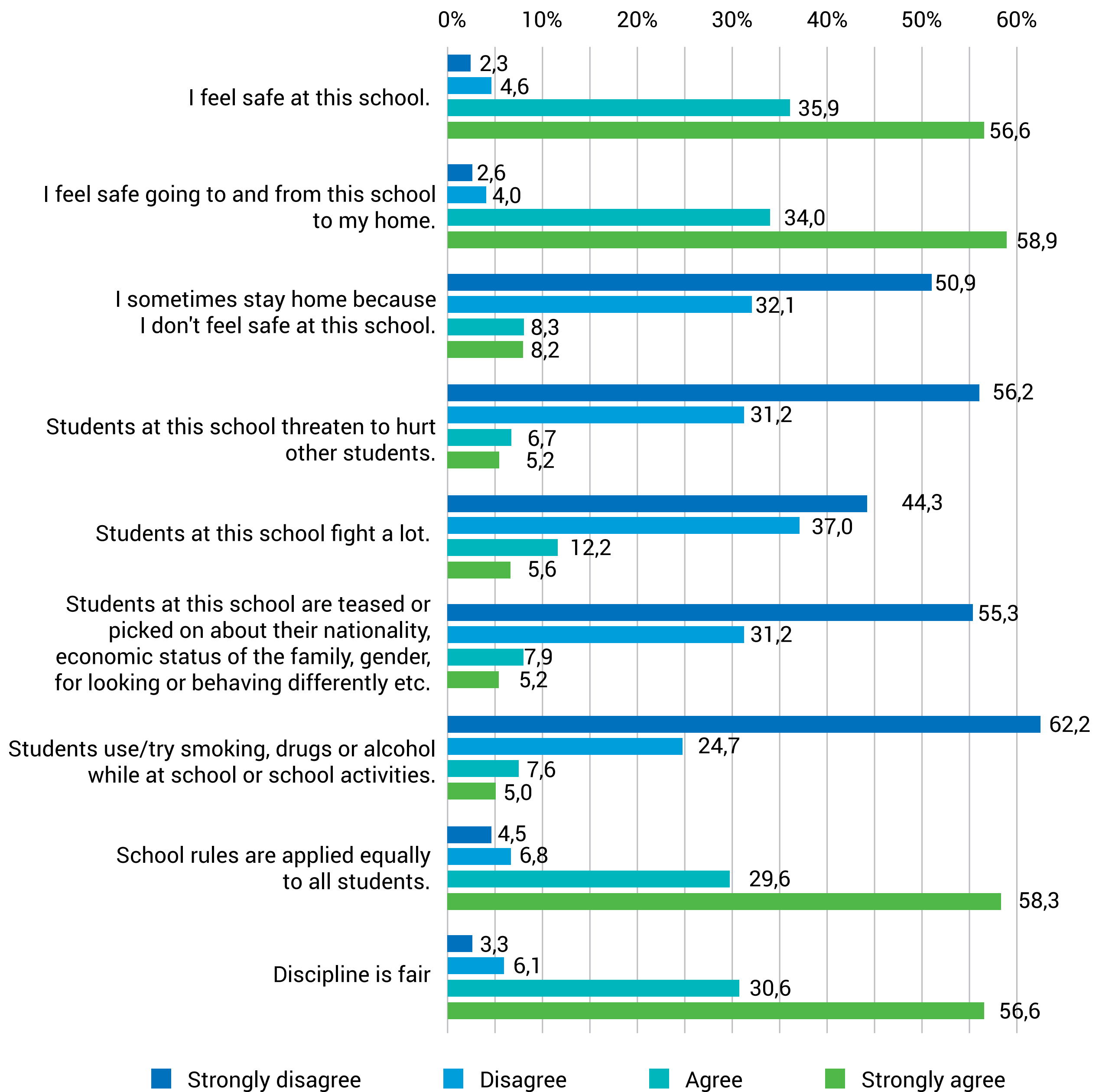
Graph 13. *Perception about tests and exams*



tobacco, drugs or alcohol, or undertake other risky activities while at school, and 11.9 per cent of them noted that students at their schools have threatened to hurt other students. As such, there seems to be a constant proportion of students (varying from 1 to almost 2 out of every 10 students) who believe that schools are not safe due to students' risky, violent and discriminatory behaviours. Lastly, 1 out of 10 adolescents reported that school discipline is not fair and school rules are not equally applied to all students (Graph 14). Adolescent boys perceived the school environment and the behaviour of other students as being riskier, compared to girls. For instance, 59.2 per cent of boys strongly agreed that students fight a lot, as opposed to the 40.8 per cent of girls who shared the same opinion. The same difference is true for students being teased for different reasons. Also, sixth graders believed more that students were teased in their schools. Middle adolescents in grade 9 agreed slightly less that school rules are equally implemented, and that discipline is fair. questions about school, working students generally perceived school to be less safe (by more than 10 per cent).

Almost 2 out of every 10 adolescents participating in this research said that other children in their school called them unkind names at least once during the previous month (18.8 per cent). In line with this, 15.5 per cent of them reported feeling left out in their class, while 10.8 per cent of them were hit by other children in their school. Online bullying was a little less present in these schools, where 9.4 per cent of adolescents said they were put down or bullied online at least once, with someone posting cruel gossip, rumours or other material harmful to them (Graph 15). The likelihood of being hit at least once, or being called unkind names, was higher for adolescent boys, working students, students whose parents have been liv-

Graph 14. *Perception about school safety*



ing or working far from home, and for sixth graders participating in this study (by at least 7 per cent).

Students with moderate to extremely-severe levels of depression, anxiety and stress had a less positive perception of the way students interacted with each-other. Also, they lacked school connectedness which made them even more vulnerable to isolation, and elevated levels of negative emotions. Table 6 shows statistically-significant correlations (p = .00) between stress, anxiety and depression levels, and quality of school experience. A negative relation can be seen between perception of teachers, peers, social connectedness, school safety, and of tests and exams. The greater power of these correlations is between perceptions about school safety (r = -.273 for stress, r = - .265 for anxiety and

Graph 15. *How often during the last month were you...*

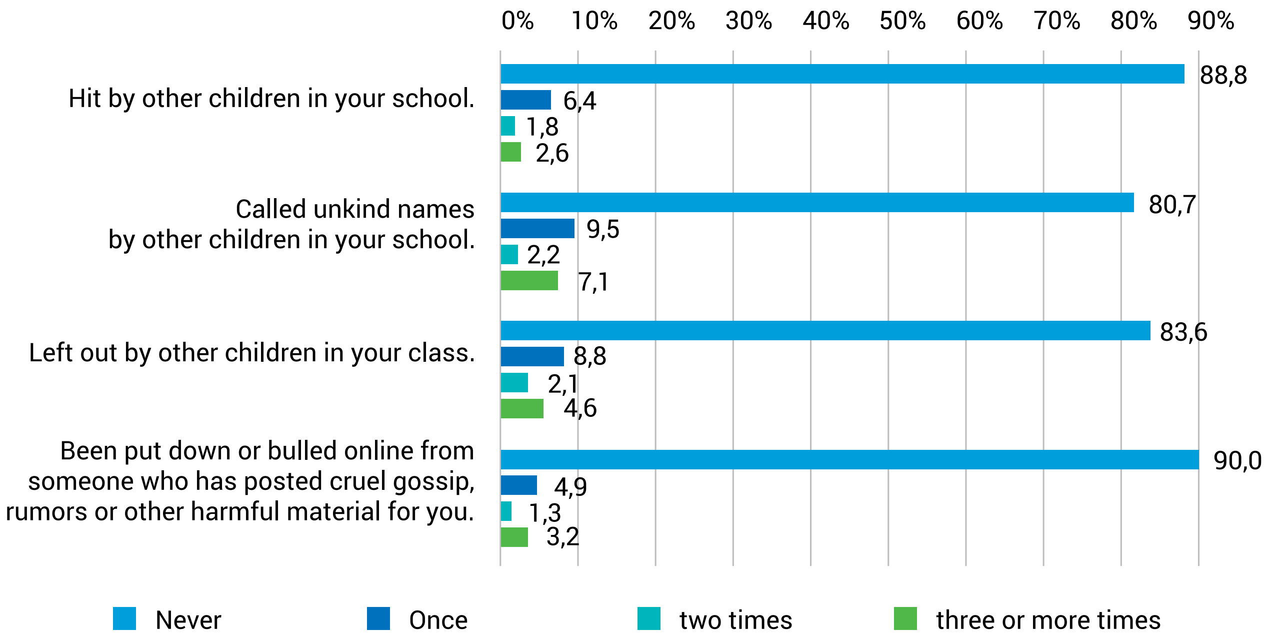


Table 6. *Correlations among stress, anxiety and depression levels and school experience (for students above the age of 15 years old)*

		Stress levels	Depression levels	Anxiety levels
Perception and relation to peers	Pearson Correlation	-.201**	-.173**	-.168**
	Sig. (2-tailed)	.000	.000	.000
Attitudes and relations to teachers	Pearson Correlation	-.267**	-.228**	-.219**
	Sig. (2-tailed)	.000	.000	.000
Social connectedness	Pearson Correlation	-.231**	-.229**	-.208**
	Sig. (2-tailed)	.000	.000	.000
School safety	Pearson Correlation	-.273**	-.255**	-.265**
	Sig. (2-tailed)	.000	.000	.000
Tests and exams	Pearson Correlation	-.184**	-.161**	-.163**
	Sig. (2-tailed)	.000	.000	.000

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

r = -.255 for depression, *p* = .00). The next correlation according to their power relates to attitudes and perceptions of teachers, followed by social connectedness. Perception of peers and tests and exams are again statistically correlated, but to a slightly less extent.

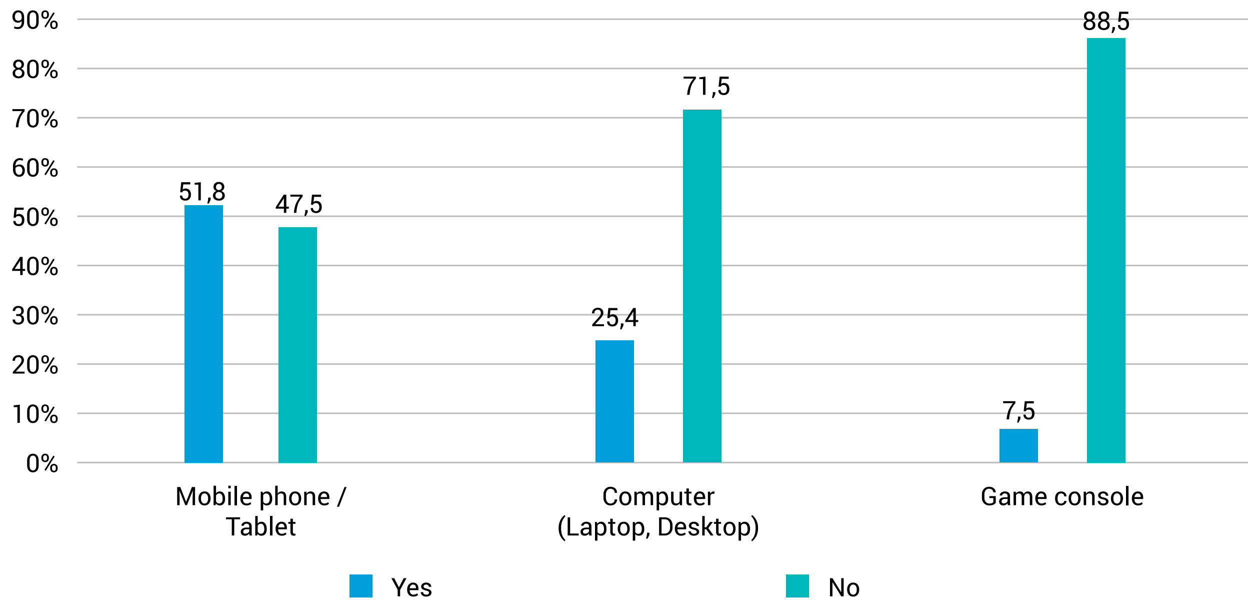
Additionally, adolescents with moderate to extremely-severe levels of stress, anxiety and depression were also more likely to be hit by other children, be called unkind names and be put down and bullied online. This placed them in an ever more difficult and risky situation. Identifying these adolescents within schools, families or communities, and taking measures to reduce their negative emotions and exposure to episodes of violence and bullying as well as increasing their school connectedness, becomes an issue of outmost importance.

The next two questions aimed to explore more about adolescents' exposure to screen time during a school day. Graph 16 shows that slightly more than half of the students had a mobile or tablet (51.8 per cent), much less owned a computer or laptop (25.4 per cent) and even fewer a game console (7.5 per cent) (Graph 16).

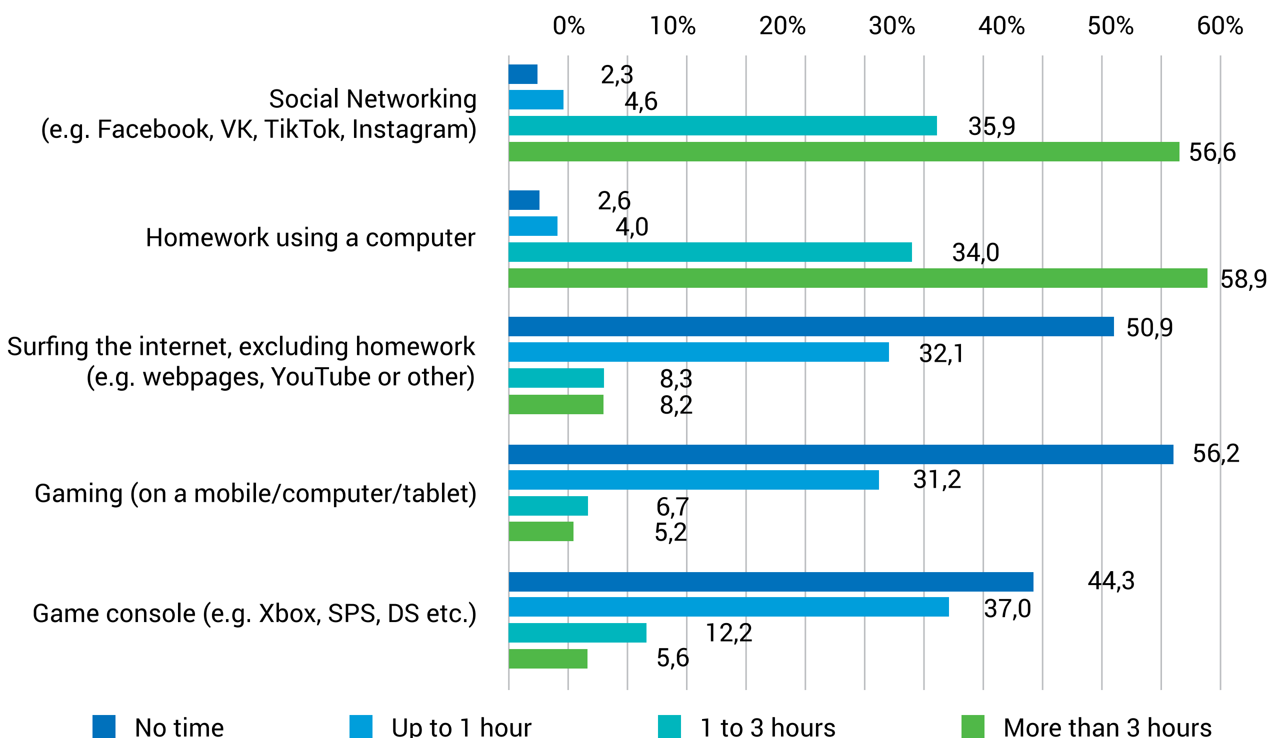
The next two questions explore more about adolescents' exposure to screen time during a school day. Graph 16 shows that slightly more than half of students had a mobile or tablet (51.8 per cent), while much less owned a computer or laptop (25.4 per cent), and even fewer owned a game console (7.5 per cent) (Graph 16). Students who owned at least one of these electronic devices were asked about the time they spent using them during a school day. Almost half of them didn't use them at all for social networking (44.3 per cent), nor for homework (51.9 per cent of computer users), just to surf the internet (45.5 per cent), or gaming (49.4 per cent). The least-undertaken activity was gaming using game consoles. Five to six per cent of adolescents spend more than 3 hours per day using mobile phones or tablets for social networking and surfing the internet, but not for homework (Graph 17). There were gender differences in either owning a mobile phone or tablet (20 per cent more boys had one), or amounts of screen time per day. For example, boys tended to spend more time in social networking and surfing the internet through their devices, but not for homework. The biggest difference between the two was on gaming online: of adolescents that spent more than 3 hours per day gaming, 78.5 per cent were boys. Sixth graders spent less time online

for social networking, surfing the internet, or gaming (approximately 15 per cent less than ninth and eleventh graders). Working students reported spending more time online compared to non-working students, for social networking, surfing and gaming purposes, but not for doing homework.

Graph 16. *Do you have a mobile phone/tablet, computer or a game console?*



Graph 17. *Screen time per school day*

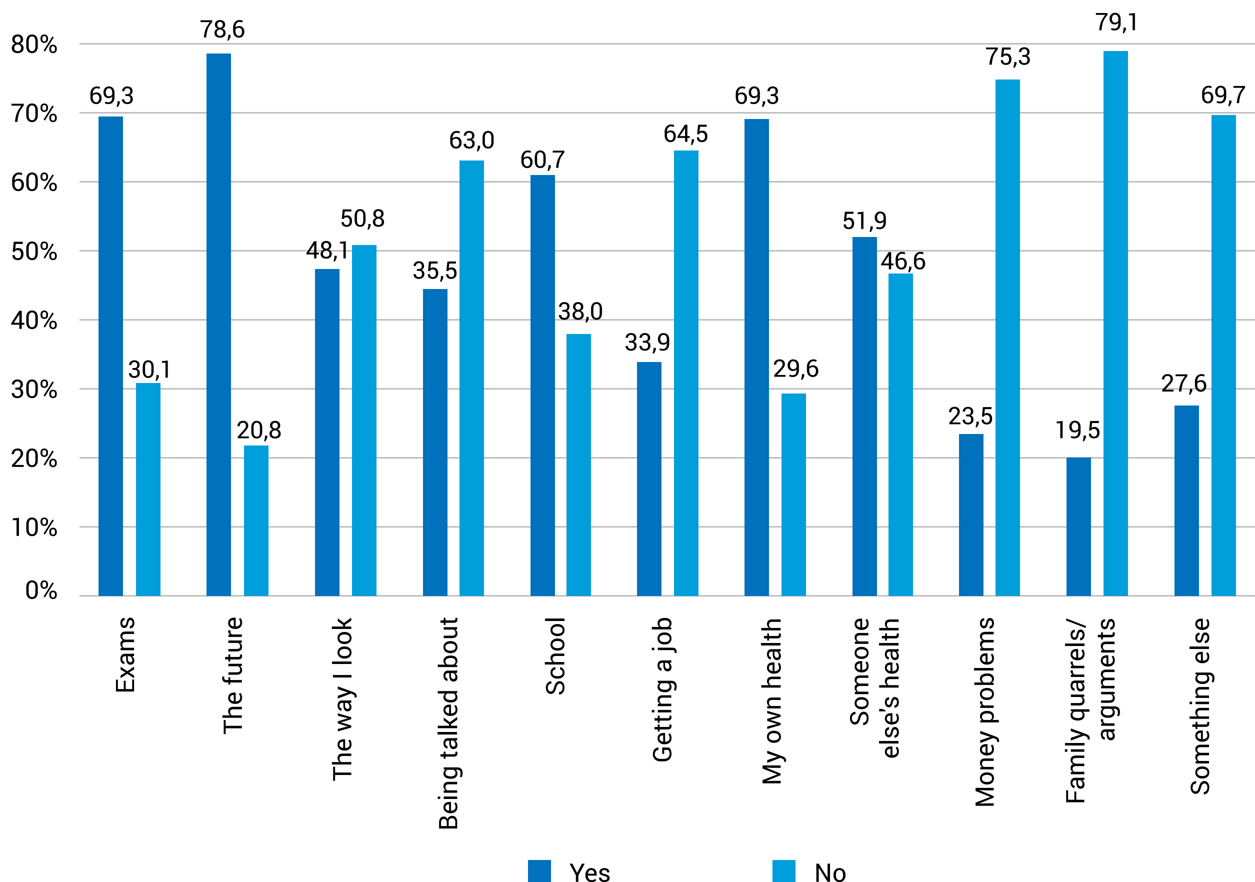


3.5. FEELINGS AND WORRIES

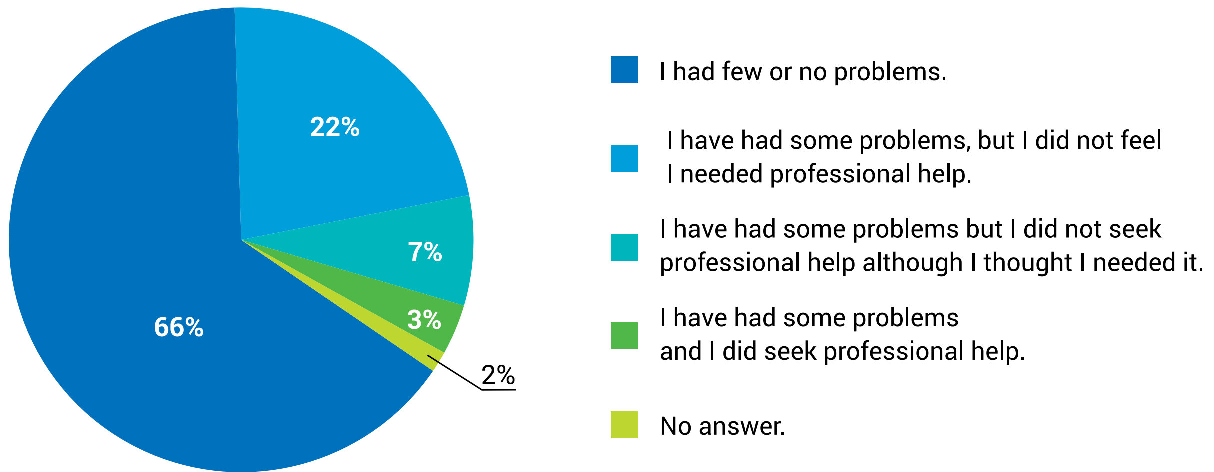
Respondents' feelings and worries are further explored in this section, in order to better understand what brings them emotional distress. Hence, the following graph (Graph 18) indicates that adolescents are mostly concerned about their future (78.6 per cent of them), followed by their health (69.3 per cent), and by exams (69.3 per cent). While they reported earlier that exams are fair, and are good means of assessing their success, they are still worried about them. School was the next thing that adolescents worried about (60.7 per cent), followed by someone else's health (51.9 per cent), and the way they look (48.1 per cent). Family quarrels and money problems are issues that worry approximately one fifth of adolescents. Comparison between boys and girls showed that girls were more worried about exams and being talked about, whereas boys were more worried about their future, their health or someone else's health, and by a greater difference boys worry about getting a job. The latter seems to be in compliance with the male gender role of being a breadwinner. Young adolescents from rural areas worry more about school. As their ages increase, so do their concerns about exams, getting jobs, money and the future. For instance, eleventh graders were twice as much worried about money problems than sixth graders. Working students are also twice as worried about getting a job, and about money problems, compared to non-working adolescents.

22 per cent of students said that they had some problems during the last month, but they did not feel like they needed profession-

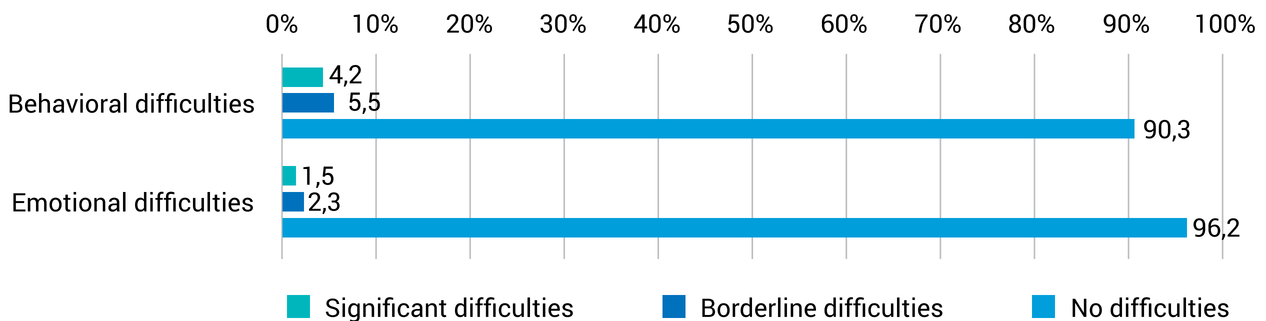
Graph 18. *During the last month did you worry about any of the following things?*



Graph 19. *Have you had any serious problems in the past year (12 months)?*



Graph 20. *Me and my feelings*



al help. On the other hand, 7 per cent of them needed professional help but they did not ask for it. Lastly, 3 per cent of adolescents indeed sought help for their problems (Graph 19). Elder adolescents at the 11th grade were inclined to not seek help (34 per cent), even though they had problems (compared to 22 per cent in sixth grade and 32 per cent in ninth grade). The same holds true for adolescents whose parents live far from family, who feature more in the category of those who do not seek help.

Students with high anxiety, depression or stress levels (See Graph 21) were more present among those students who are having problems and needing professional help, but who are not asking for it.

Emotional and behavioural difficulties were assessed through a standardized scale used in previous surveys and developed by Deighton et al (2013) [58]. Based on the cut-off points for this questionnaire, only 2.3 per cent of students had borderline emotional difficulties and 1.5 per cent of them showed clinically-significant emotional difficulties. Behavioural difficulties were a more significant issue with 5.5 per cent of adolescents having borderline difficulties, and 4.2 per cent having clinically significant behavioural difficulties

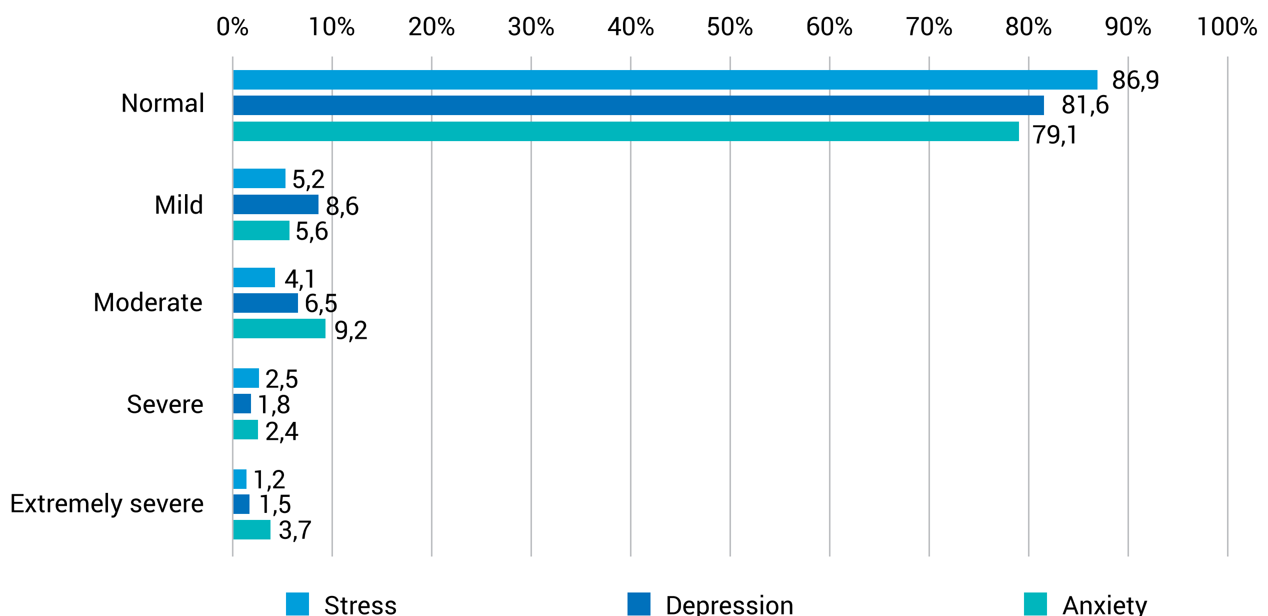
(Graph 20). Girls made up slightly more of the percentage of students facing borderline or clinically-significant emotional or behavioural difficulties. While working students and adolescents in higher grades faced greater emotional and behavioural difficulties, those whose parents lived far from family faced more emotional issues. There was no significant difference between students from urban and rural areas.

Another standardized scale used to measure the emotional states of depression, anxiety and stress was the Depression, Anxiety and Stress Scale - 21 Items (DASS-21), a set of three self-report scales. Graph 21 shows that the majority of students have normal emotional states for all three components: 86.9 per cent of students fall into the "normal" category for stress, 81.6 per cent for depression, and 79.1 per cent for anxiety. However, there is a concerning number of students that had moderate to extremely-severe anxiety (15.4 per cent) and depression (9.8 per cent). Levels of stress are slightly lower, but it should be highlighted that almost 1 out of 10 students suffer from moderate to extremely-severe depression, and even more from moderate to extreme anxiety.

Compared to young boys, girls had a slightly higher chance of having any level of stress and anxiety from mild to extremely severe, but differences in depression levels were lower. The same was true for working students compared to those who are not working, but with a greater difference, and for students whose parents had spent at least one month living/working far from the family. There weren't any significant differences between students from urban and rural areas, nor among those from different grades.

Help seeking behaviour in cases of distress can be hampered by different factors, like stigma or accessibility, availability and quality of mental health services. Hence, often adolescents cope on their own with these issues. When the adolescents boys and girls that participated in this study were asked about the person they would go for help in case they faced social or emotional problems the greater percentage of them said they would go to their parents (76.7 per cent),

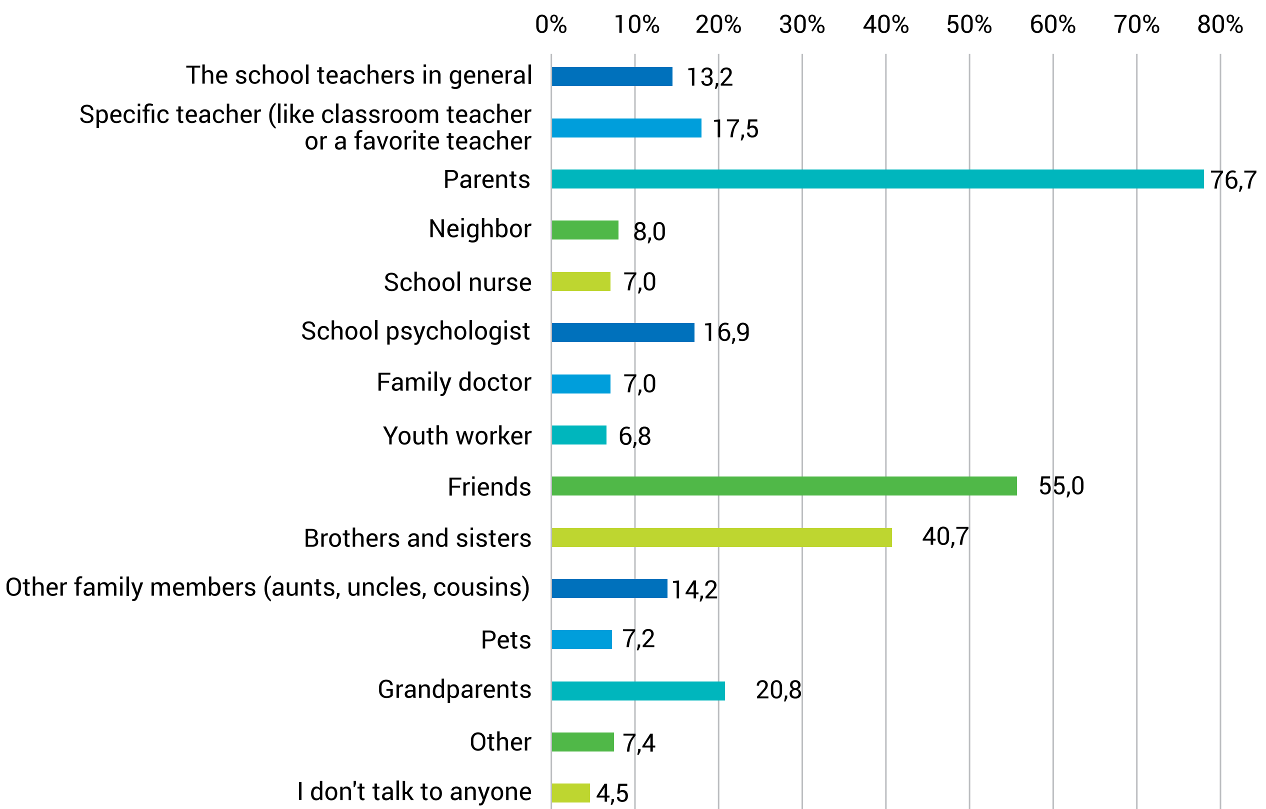
Graph 21. Depression, Anxiety and Stress Levels



their friends (55 per cent), brothers and sisters (40.7 per cent) and even grandparents (20.7 per cent). School psychologists and specific teachers, like the classroom teacher are quite low in this ranking (approximately 17 per cent for each of them). Finally, although the percentage is small, there is yet a number of students who wouldn't talk to anyone in such cases (4.5 per cent). (Graph 22). Overall, young boys were more open to seek help than girl from all the mentioned persons. Also, younger adolescents were more prone to ask teachers, parents, grandparents and other relatives for help compared to elder adolescents. School psychologists were chosen by 20 per cent of sixth graders and by 10 per cent of ninth and eleventh graders.

The main qualities of a trusted person for the adolescents to go for help were: "helping me to make decisions" (51.4 per cent), "be a good listener" (48.5 per cent) and "be understanding" (46.1 per cent).

Graph 22. *Person to ask for help*



3.6. IMPACT OF COVID-19 PANDEMIC

The COVID-19 pandemic has had an undisputable impact on all people's lives. Social distancing and lockdowns, worries about health or online learning, and many other changes have affected the mental health of many people, including that of youth.

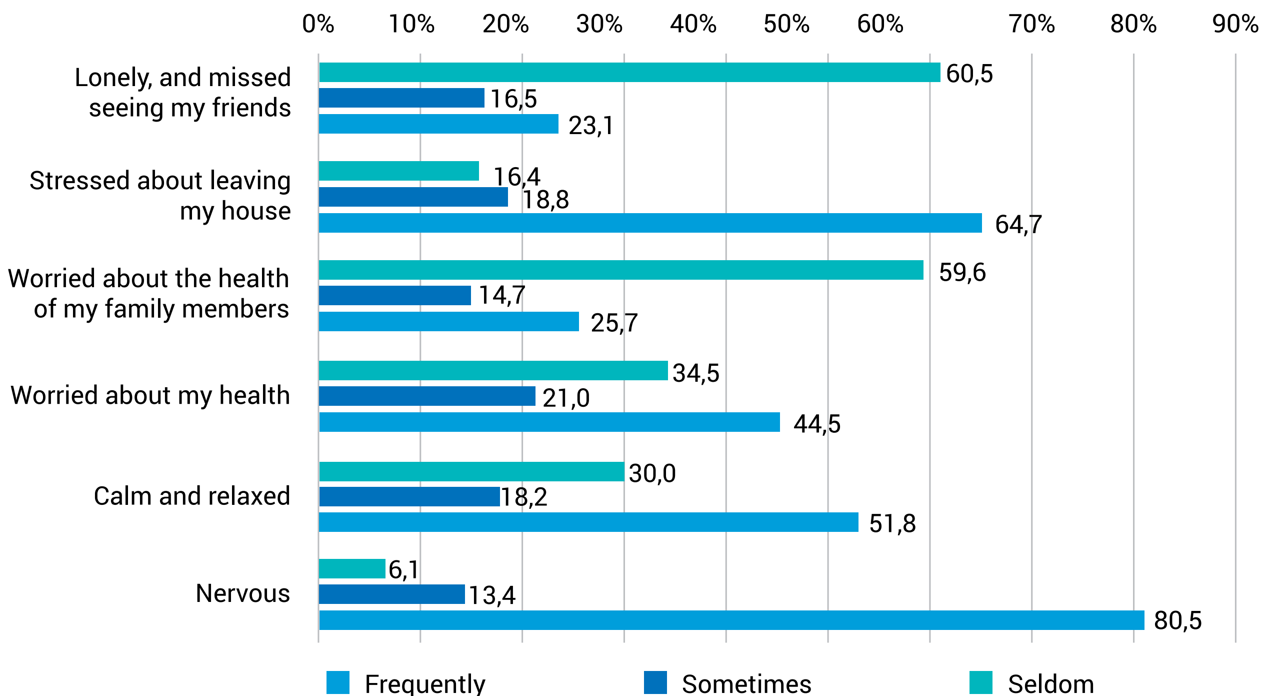
As Graph 23 suggests, the most concerning effect of the last lockdown for adolescents was not being able to see their friends, feeling lonely and missing them (60.5 per cent of them), followed by worries about the health of family members (59.6 per cent), and of their own health (34.5 per cent). While elder adolescents were less nervous, lonely and worried about a family member's health, younger adolescents experienced more of these negative emotions. Non-working students reported more of these worries, compared to working students.

When asked if the COVID-19 pandemic had affected their lives in a good or bad way, adolescents were almost divided in their experiences, as can be seen in Graph 24. The differences between a good and bad effect are minimal, indicating the variety of experiences that children and adolescents had during this time.

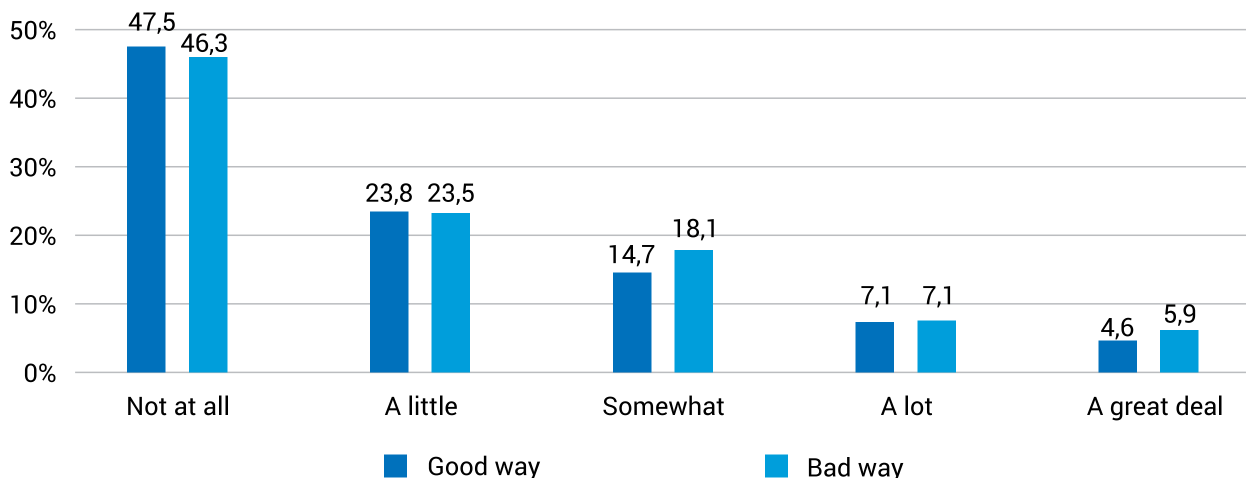
Among the different positive effects of the COVID-19 pandemic, spending more time with family was ranked higher than all other alternatives by the respondents (85.8 per cent). The second and third positive effect was the time they had to go outside and exercise (72.8 per cent), and time for doing things they don't usually do (71.1 per cent), indicating probably a need for more free time in their lives. Freedom to create their own

schedule and time to relax were the next two positive effects (60.8 per cent mentioned each of them). Ninth and eleventh graders also reported these positive effects more than sixth graders: more time to relax due to reduced homework, getting to do things they don't usually do, and having recreational time on their mobiles or computers. In addition, they mentioned that one of the benefits was not having to deal with some people at school.

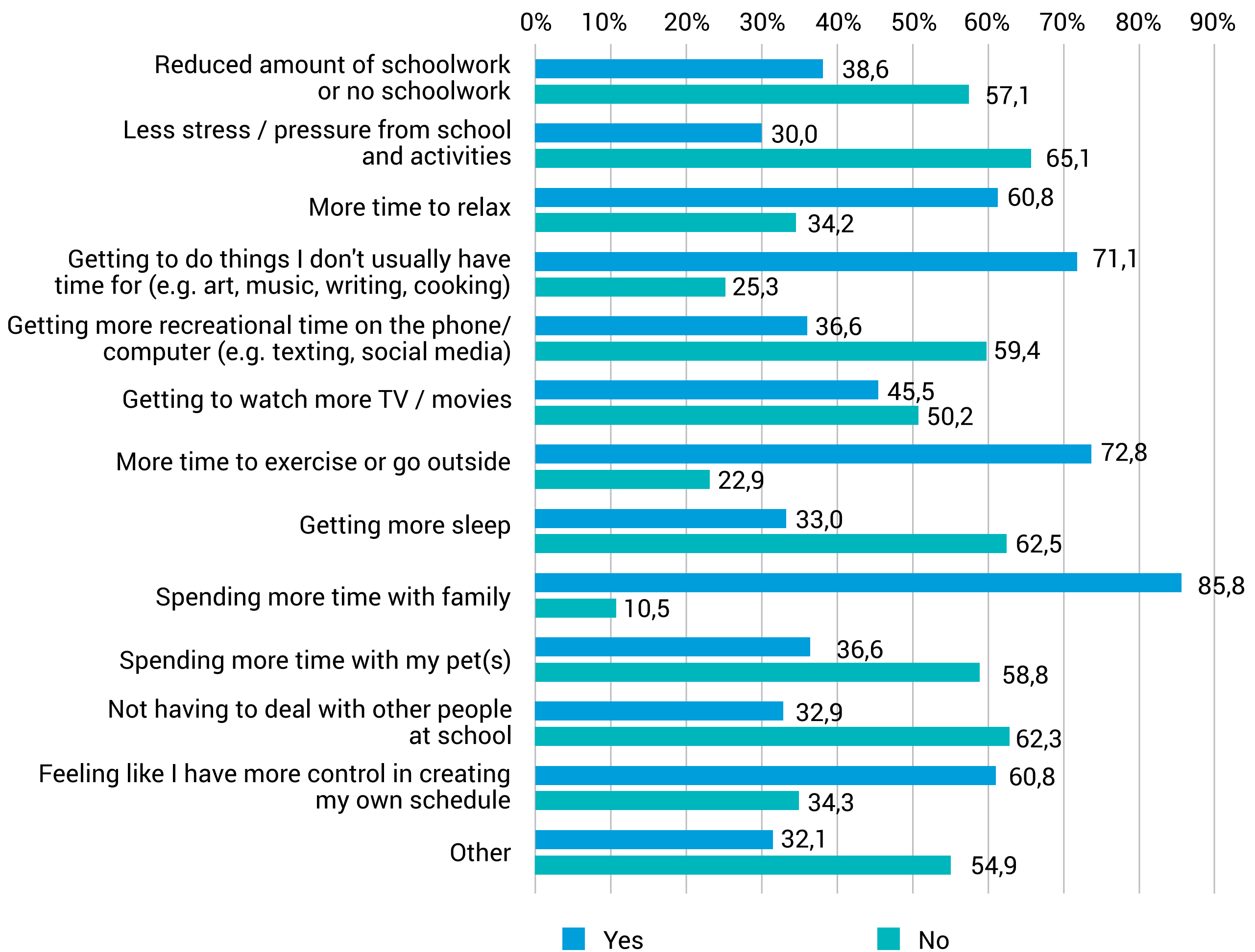
Graph 23. *During the last lockdown how often have you felt each of the following when you think about COVID-19?*



Graph 24. *Impact of COVID-19 pandemic*

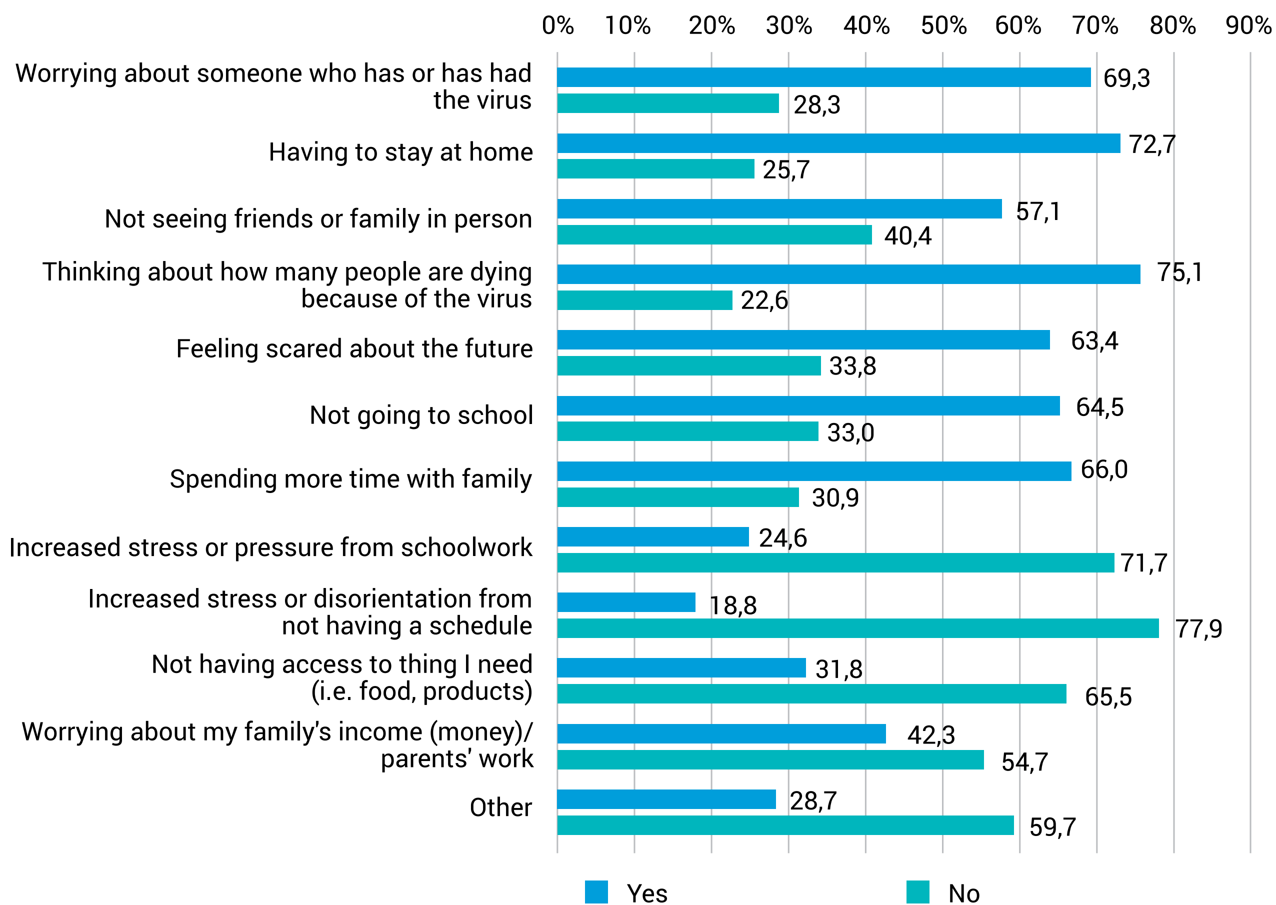


***Graph 25.** Positive impact of COVID-19 pandemic*



The main negative effect conveyed by students was the thoughts about how many people were dying because of the virus (75.1 per cent of respondents), having to stay at home (72.2 per cent), or worrying about someone that may have had the virus (69.3 per cent). Paradoxically, for 66 per cent of students spending time with family was considered a negative effect as well, so it looks like family relations can be a moderating factor here. Not seeing friends in person was a negative effect for ninth and eleventh graders, along with having to spend more time with family, which is in alignment with their previous responses about seeking help from friends rather than family. Reportedly they were also more scared about the future.

Graph 26. *Negative impact of COVID-19 pandemic*



4

FINDINGS – QUALITATIVE DATA ANALYSIS

To examine the risk and protective factors affecting the mental health and psychosocial well-being of school adolescents in Uzbekistan, including service provision, as well as to shed light on some of the findings from the survey overviewed in the previous section, a series of focus groups discussions were conducted with adolescents, parents and practitioners, along with interviews with key stakeholders. The results of qualitative data collection will be presented in this section.

4.1. RISK AND PROTECTIVE FACTORS

The protective and risk factors affecting a child and their mental health can be of biological, psychological or social nature. The results from current data collection from this study are in alignment with what literature suggests about different influencing factors.

Yet, prior to understanding the risk and protective factors, it is important to explore the level of awareness among parents and adolescents about mental health in general, and adolescents' mental health in particular. Having such awareness can contribute to these group's knowledge of risk and protective factors, and eventually their help-seeking behaviour.

> **The ability to think, the ability to speak and be understood. I understand that a person can walk the right path, behave in a way that does not lose his humanity.**
>
> *Community elder, Fergana region*

Evidence shows that mental health and mental illness is misunderstood in many cases. In the past, persons with mental illness were thought to be those with psychosis and particularly schizophrenia. This left aside many other groups of people with mental disorders, like ones suffering from common mental disorders like anxiety disorders, mood disorders, somatoform disorders, and others [59]. In other cases, mental illness was confused with developmental disorders like autism spectrum disorders or intellectual disability.

Comments by study participants showed similar trends in terms of mental health and mental illness understanding. A considerable part of the participating parents of adolescents, and the adolescents themselves, described mental health in their own words. Some of them said that mentally-ill persons have their "psyche" affected, they sometimes don't want to live and they don't like to speak to anyone (when asked about depression), and that anxiety is an attitude to life and to themselves that can be improved with better problem-solving techniques. Mental health was related to being calm, controlling anger, behaving according to the norms of society, and having common sense. Even though these are only some of all mental health aspects, it is still evident that participants are aware of them.

When asked about children and adolescents' mental health, the vast majority of persons believed that it is different from the adults' mental health and that children need more support in their upbringing to overcome mental health issues or to prevent them. During focus group discussions, they pointed out the ways they would change their attitudes and behaviour towards their children if some-

[59] Sickel, A.E, Seacat, J., & Nabors, N. (2014). Mental health stigma update: A review of consequences, Advances in Mental Health, 12:3, 202-215, DOI: 10.1080/18374905.2014.11081898.

thing like this happened to them: being more supportive, not being authoritative, guiding children, listening to them, and letting them play more, and through other means.

Notwithstanding the above spot-on perceptions on mental health and mental illness, some confusion and misunderstandings were present among the participants. Some of them mentioned "crazy or insane people" when asked about what mental health brought to their minds, while in some cases they referred to intellectual disability.

> ***I understand that mental illness is for a mentally retarded people.*** *Bukhara, mother, 42 years old.*

These are common misconceptions about mental health that can affect the way these participants interact with persons with psychosocial disability, and the level to which they understand other symptoms of mental health that maybe they see in their adolescent children. For instance, if they think that people with mental health conditions are only those suffering from psychosis, then it would be challenging for them to understand their children's anxiety or distress, and to ask for professional help.

Other participants mentioned that mental illness is related to a lack of education, having a weak soul ("psyche"), or is a deliberate act/state of mind intended to disrupt society or other people. Also, some declared that spirituality and faith could solve mental health issues. Using religion to cope with negative feelings and to build relationships does not have the desired outcome, because religion does not build coping mechanisms and does not help in dealing with strong emotions.

> *...[they should have]* ***high trust in faith and Allah, believing that he will solve all their problems.*** *Fergana, Community administrator*

> ***My son hates such things*** *[speaking about suicide]****. Because he knows about Islam. He considers it a sin to die until God takes his soul. There was such an incident in college, he was in shock for 3 days.*** *Andijan, mother, 42 years old.*

Thus, confusion and lack of awareness on mental health conditions may put adolescents at greater risk and distress. Other risk and protective factors are listed below.

4.1.1. FAMILY ENVIRONMENT AND FAMILY RELATIONS

According to the vast majority of participants, including adolescents, parents and psychologists, the family environment and the way children are raised are the number one protective factor (if they are supportive), or a risk factor if the environment and raising methods are unsupportive, violent or neglectful.

Many adolescents in the study mentioned that their family and the way they are supported by their parents is something that makes them happy. Particularly being able to be heard in the family, and knowing their perspectives were being taken into consideration, was something of worth for adolescent boys and girls alike.

On the other hand, participants have also pointed out the negative effect of an unsupportive family environment, such as those with conflicts or neglect, or with couples in the process of divorce, by referring to peers or other friends they knew who were in such families. In rural areas the need for children to help their families early in their development was mentioned. Others brought up community disconnection or isolation, meaning non-participation in community activities like sports or clubs.

At home, my parents consult with me and discuss things with me. The absence of quarrels at home, the unity of all of us, the solidarity with relatives, makes me feel happy.

Fergana, adolescent boy, 14 years old

This morning I had an incident with one of my peers: his family has a negative influence on him, they are saying wrong things to him and they are being rude. He comes to school in a bad mood; he is in such a bad mood during the whole day. *Andijan, adolescent girl, 16 years old.*

The majority of the psychologists emphasized that parents' migration is also an important factor that negatively influences their children's emotional state. They pointed out that children and adolescents are in need of parental support and presence, but during these crucial times parents are not there. This was also a finding of survey results, which indicated that children whose parents have migrated are teased more at school.

Adolescents whose parents have gone abroad face mental health problems. When a child is in need of parental affection... that is... when the child is of school age, they are left to fend for themselves. *Bukhara, school psychologist.*

Finally, many key stakeholders and psychologists referred to a strict parenting style as a negative factor for adolescents' psychosocial well-being. It looks like some parents are controlling towards their children, particularly when it comes to choosing a profession. This is even truer for girls, as will be discussed later.

Some parents try to keep their child under too much control. And these kids are coming to me when they come to school. They are disobeying the teacher and bullying their classmates. *Andijan, school psychologist.*

4.1.2. SOCIAL NETWORK

Friends and social network are ranked among the protective factors for psychosocial well-being in adolescents. Again, as in the family case, this is true when they act as a support for adolescents, and not undermine them or put pressure on them.

It looks like in some cases friends can be "psychologists" for the participants, but in other cases they can have the opposite effect. For example, a girl from the Fergana region says that "***Some of our friends make us fight with other friends. There is jealousy among excellent students. They may be jeal-***

ous and stop talking with you if you give a good answer in class. That's too bad." Another boy mentions that some friends can lie to you and treat you bad, in which case they are not real friends.

4.1.3. TEACHER – STUDENT RELATION

The relation between students and teachers was typically mentioned as having a positive effect in students' mental health and psychosocial well-being. Overall, parents thought of their children's teachers as supportive towards them, even though they still use traditional teaching methods.

> ***At school the teacher should understand that the student is alone and they should be friends … in the family the parents should be friends with the child. The teacher must also be a psychologist. The children need to know that they can talk to their teacher.***
> *Bukhara, mother, 38 years old.*

> **These cases** [violent teacher behavior] **almost do not take place in our country, because teachers are taught how to teach children. Every 6 months teachers are screened by psychologists or neurologists. If** [violence] **happens, measures are taken by the regional departments of education.**
>
> *Government representative*

In some cases, a classroom teacher is even closer to children than a psychologist. Parents and adolescents stated that they felt more open to speak with one of the teachers, than to a school psychologist, at least as a first step.

According to key stakeholders and parents/adolescents, teachers are generally not violent towards adolescents. There are several screenings and severe disciplinary measures taken for teachers that may act this way.

In contrast with the above statement, other participants described cases when teachers had a negative impact on adolescents' school life. These were usually incidents of discrimination and favouritism between students, or a mere preference to work with good students and leave the others aside. Sometimes, they put good students at the front of the class and others at the back. Also, in some occasions adolescents mentioned that their teachers scold them a lot. This may be an indication that the use of physical violence towards adolescents is less present, but verbal and psychological violence is still there in a subtle form.

4.1.4. SCHOOL CONDITIONS AND SAFETY WHEN GOING SCHOOL

School conditions were mentioned predominantly in a positive way. A great part of the adolescents perceived that their schools had sufficient conditions, and provided them with enough opportunities to continue with higher education.

> ***The most satisfying part for us today is that we have a lot of opportunities to get an education and find our own way. In addition, our family and the school has all the conditions we need.***
> *Bukhara, adolescent girl, 17 years old*

Having said that, parents and sometimes psychologists brought another perspective

of schools. Their concern was connected primarily to the high number of students per class (being an average of 35 to 40 students, sometimes up to 50), which makes it hard for a teacher to pay attention to all students. Teachers that typically have to manage an overcrowded class of adolescent boys and girls may find it difficult to identify early warning signs of different mental health conditions. The high turnover of teachers that obliges adolescents to frequently adopt to new teachers and teaching styles and traditional teaching methods, were two added concerns of parents and psychologists.

> ***Teachers use traditional teaching techniques. The number of students per class should be reduced because they are difficult to handle by the teachers.*** *Andijan, mother, 47 years old.*

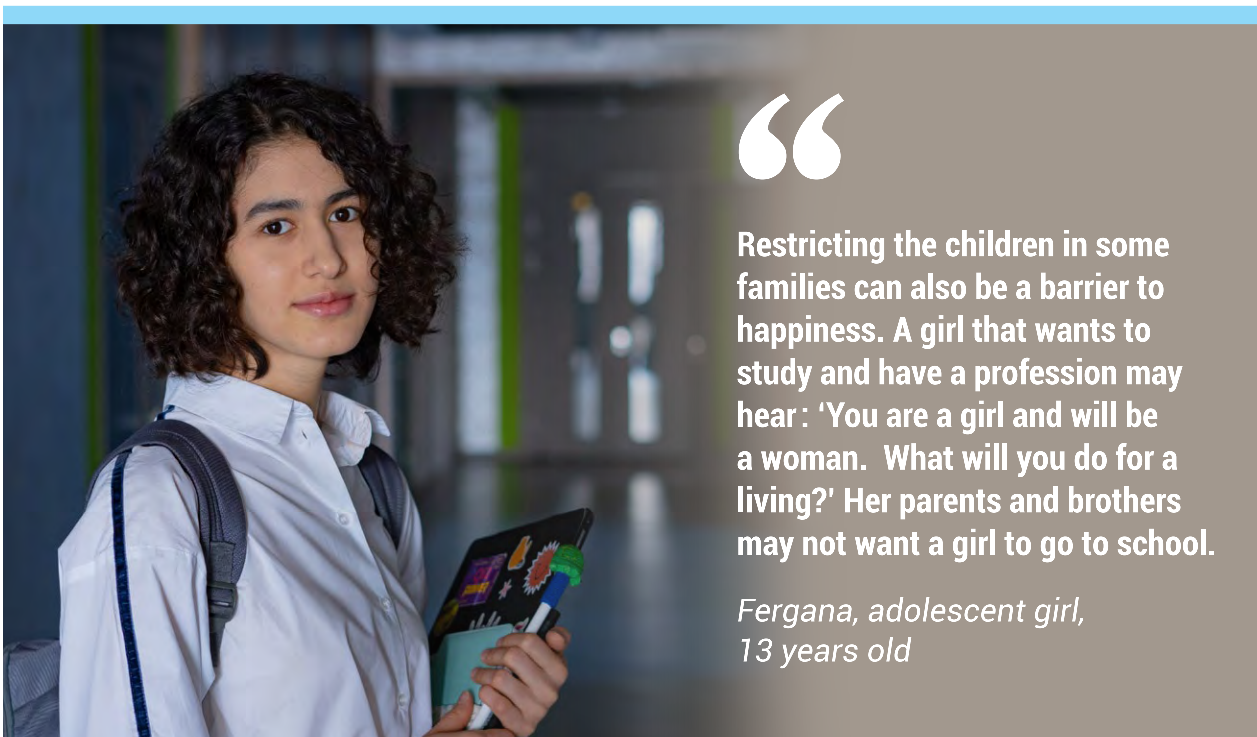
In regards to safety on the way to school, only a few parents from urban areas stated that they felt their children were unsafe on their way to school, so they often accompanied them, but the majority of them believed that it was safe for both boys and girls.

> ***Fear is natural. People have changed. In the dumps ... there are all kinds of people. I'm scared too. My son goes to sports close to some risky streets.. This is also a cause for concern – so as not to be attacked by anyone on the street.*** *Andijan, mother, 38 years old.*

4.1.5. GENDER

Based on the attitude and mentality of a family towards their daughter(s) their school life can take a very different course. In the focus groups boys discussed that sometimes teachers favour girls, and this is mostly because they are better students. This is the case when families are supportive of their daughter's education.

> ***In a word, INJUSTICE, INJUSTICE! For example, there is injustice in some disciplines. More and more teachers are working more with girls. Boys don't get much attention.*** *Fergana, adolescent boy, 14 years old.*



However, some participant parents and adolescents expressed concerns about the restrictions that some families put to their adolescent daughters. These attitudes were more dominant for the conservative community, where girls wear a hijab and are restricted from different activities. Early marriages were present as well, particularly in rural areas.

4.1.6. SCREEN TIME

To a great extent parents were concerned about the use of mobile phones by their children. They considered it to be a big distraction for adolescents that can have an impact on their mental health and psychosocial well-being. They were concerned both for the content they watch, and the time spent watching the content. This started from COVID-19 pandemic lockdowns and online learning, but it continues to be a concern for them. Adolescents didn't support this view.

4.1.7. ENGAGEMENT IN EXTRA-CURRICULAR ACTIVITIES

Many adolescents and parents highlighted that adolescents' participation in extra-curricular activities was one of the things they enjoyed doing most. The most mentioned activities were sports clubs and other circles they could be a part of.

> *[speaking about her daughter]* ***She enjoys school, especially the circles/clubs. She wants to go to extra-curricular activities as well, even if she is sick.*** *Bukhara, mother, 38 years old.*

4.1.8. FAMILY'S SOCIO-ECONOMIC STATUS

Poverty can be a factor which contributes to the onset of mental health problems, usually linked to other issues like family conflicts, long-term unemployment and higher levels of stress in the family, parents that abuse alcohol or drugs, or other matters[60]. It looks like this is a finding of this research as well. Low economic status of families has also been mentioned primarily by psychologists and parents as a negative factor affecting the psychosocial well-being of children, especially in urban areas. Earlier in this section, this was also mentioned as a factor that can lead to suicide.

> ***It is observed that the children of rich families are indifferent to the children of poor families, especially in the city. In the villages this thing is less noticeable. Children become aware of things that they may not be able to buy, compared to others.*** *Bukhara, school psychologist*

[60] Johns Hopkins Bloomberg School of Public Health and the United Nations Children's Fund. On My Mind: How adolescents experience and perceive mental health around the world, JHU and UNICEF, Baltimore and New York, May 2022. Available at *https://www.unicef.org/media/119751/file* accessed on 23 August 2022.

4.1.9. ACADEMIC PRESSURE

Academic pressure is one of the main school-related factors brought up as having a negative impact on the mental health and psychosocial well-being of adolescents. This was mostly true for adolescents in grades 9 to 11, who are preparing for state exams. Further, often adolescents worry about difficult exam questions.

> *[Students in]* ***grades 9-10-11 have depression as a result of low self-esteem during state exams. The question of whether or not they will pass the exams can be said to be the cause of these problems. This depression is exacerbated in the classroom by strict teachers.*** *Samarkand, school psychologist*

In addition to the above factors, another one mentioned by parents in FGDs were the grades or academic achievements of their children. For example, if their children have worked hard but still get a lower grade, then they get distressed. Sometimes parents have discussed these situations with teachers to understand the problem. In some situations, this is believed to be a result of teachers' favouritism towards some children.

4.1.10. BULLYING

Bullying among peers is a common phenomenon throughout the world, and one that exists also in Uzbekistan. It is known to have long-lasting negative impacts on mental health and well-being. All adolescents, parents and psychologists expressed their concerns about incidents of bullying at school, even though it wasn't such a prevailing phenomenon.

> ***At school, a child may become depressed as a result of being given a nickname by a classmate.*** *Bukhara, father, 70 years old.*

> *[bullying]* ***is more common among boys. In school, the stronger boys are on one side and the weakest are on the other. Weak children are getting constant pressure from the stronger ones – they ask them for their money or they order them to do their work. They are afraid of them.*** *Andijan, school psychologist.*

4.2. PERSONAL EXPERIENCE OR EXPOSURE TO MENTAL HEALTH CONDITIONS, SELF-HARM AND SUICIDE

Personal experience with a mental health issue or exposure to a person in the close family or social environment can alter previously-held attitudes and perceptions about mental health disorders. As seen from the survey, 10 to 15 per cent of students indeed had moderate to extremely-severe symptoms of anxiety, stress or depression, or faced emotional and behavioural difficulties in their daily life.

Table 7. *Summary of protective and risk factors affecting adolescents' mental health in this study*

Factor	Positive	Negative
Within school		
Family	Supportive	Unsupportive
Social network/peers	Supportive	Unsupportive
Teachers	Inclusive, fair	Discriminative
School conditions	Equal and better opportunities	Number of students in class, high teacher turnover, traditional teaching methods
Safety to go to school	Safe	Unsafe
Academic pressure	-	Brings low self-esteem
Bullying	-	Fear to come to school
Outside school		
Gender	Girls as good students, non-discriminative attitudes	Gender-discriminative attitudes
Screen time	-	Content watched and overuse of mobile phones
Engagement in extra-curricular activities	Actively engaged	Disconnected
Poverty	-	Linked with other difficulties, comparison with peers

According to data collected through FGDs and interviews, it can be determined that few students and practitioners believe that there weren't any adolescents with mental health conditions in their schools. However, based on the survey data and the identified help-seeking difficulties that will be described below, this is an assumption that needs to be challenged.

> ***There are no students in our school with mental health problems. We conduct regular surveys and interviews to identify them.*** *Samarkand, school psychologist.*

> ***As we said, we study in a school with all the right conditions. I can fully say that there are no mentally ill children among our peers and younger than us.*** *Bukhara, adolescent boy, 17 years old.*

Mostly parents of adolescents, and also the adolescents themselves, indicated that they had faced emotional difficulties in the past and also currently. Others mentioned that they had friends or peers that experienced similar issues. For example, an adolescent girl from Fergana says:

> ***When I do something wrong, when I hear about it from my parents or someone, I get stressed and depressed. People say that you take a lot with you. I can cry in these situations.*** *Fergana, adolescent girl, 14 years old.*

Another adolescent boy from the Surkhandarya region said that his friend is facing such difficulties:

> ***My friend talks about his problems. Because his parents don't listen to him, he is in depression. My friend discusses***

some issues with me. He needs someone to listen to him. Unfortunately, such a person is not found in his family. His parents don't know what's going on with him, so my friend is often left alone. *Surkhandarya, adolescent boy, 17 years old.*

The psychologists explained that many times parents were not aware of the influence that some of their parenting styles may have on their children, and accordingly the psychologists try to explain this to the parents and make them more aware of the situation. Also, they inform them on the impact of violence against children or neglecting behaviours. A considerable part of the parents attending these FGDs were open to discuss mental health, and to receive information and advice from psychologists, but there were also others that showed distrust towards psychologists for reasons that will be discussed below.

SELF-HARM AND SUICIDE

One of the behaviours parents were least aware of is self-harm. Even though self-harm itself is not a mental illness, it is usually a behaviour that results from mental distress. Adolescents, on the other hand, were aware of these behaviours but also not fully about the reasons behind them. Self-harm is not always a suicidal attempt, but it is often linked to it, meaning that adolescents who engage in self-harming behaviour (mainly cutting) may be at greater risk of suicide. That is why it is very important for parents to be able to identify self-harming behaviours in their children, and for adolescents to have a comprehensive perception about it. This is how two adolescents described their understanding of self-harm:

> ***They hurt themselves as a result of being attached to something, for example, a girl.*** *Andijan, adolescent boy, 17 years old.*

> *[speaking about self-harm]* ***It can be an easy way to get rid of the problems in the family and the environment.*** *Fergana, adolescent girl, 14 years old*

In contrast to self-harm, suicidal attempts and death by suicide were more known among both adolescents and parents. Some parents had heard about suicidal attempts and death throughout their lifetime, whereas one of them had a personal experience with her daughter. The remaining parents and adolescents were aware of suicide attempts mainly through the media.

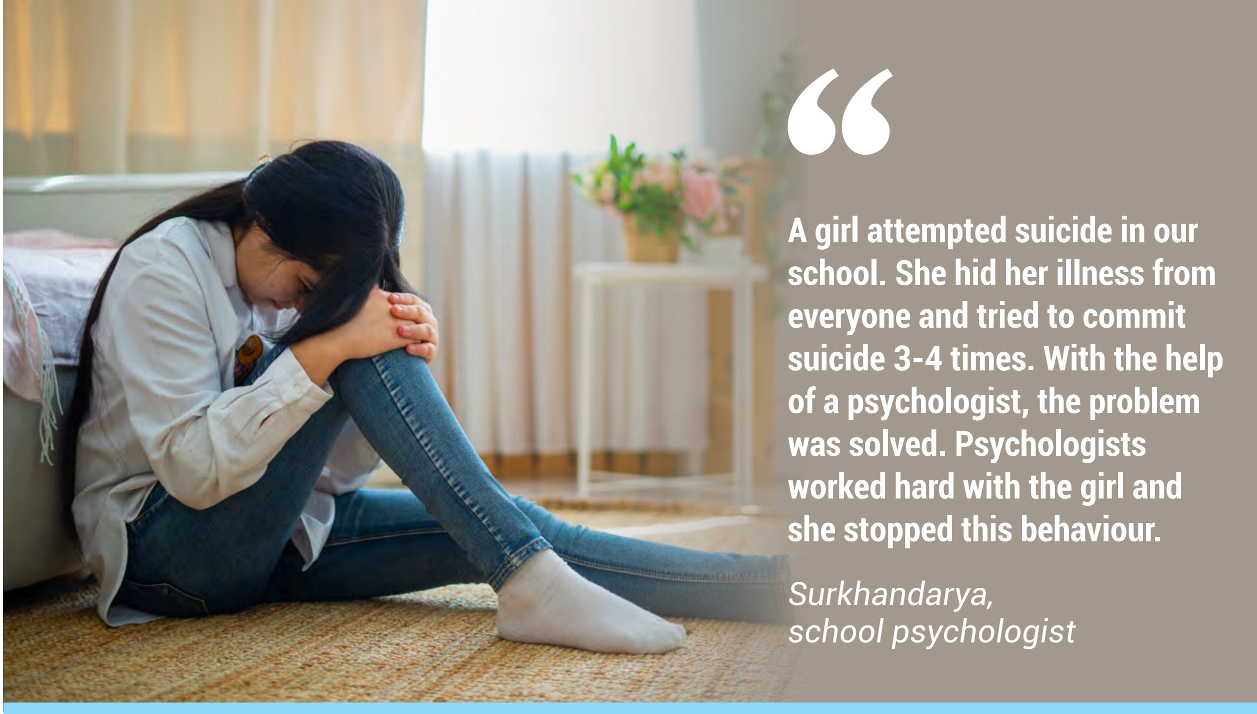
The most common perception among participants about reasons for attempting suicide, was that this is related to poverty and lack of financial means, family problems like alcoholic or non-understanding parents, or because of break-ups and problems in intimate relations in general. Another reason they mentioned was suicide because of debts resulting from gambling in 1Xbet games.

A mother whose daughter attempted suicide said:

> ***The boy's mother severely insulted my daughter because she fell in love (with the mother's son). My spouse has epilepsy and is addicted to alcohol. My daughter had a suicidal tendency. I went and rescued my child through the gate, I was one step away before my daughter hung herself. I climbed over the wall with my neighbour's child and rescued the child. She is OK now.*** *Surkhandarya, mother, 44 years old*

It is worth mentioning that in some cases parents said that the persons who attempted suicide did not ask for help beforehand. A psychologist in Sunkhandarya for example described the case of a girl that attempted suicide more than once.

A considerable part of psychologists and parents also mentioned that after the intervention of professionals, adolescents' emotion-



> **A girl attempted suicide in our school. She hid her illness from everyone and tried to commit suicide 3-4 times. With the help of a psychologist, the problem was solved. Psychologists worked hard with the girl and she stopped this behaviour.**
>
> *Surkhandarya, school psychologist*

al states improved and they didn't make any other attempts. They were helped in finding solutions to their problems, and in improving relations with family members. In some instances, professionals intervened by referring family members to services – such as an alcoholic father being referred to relevant services, or cooperating with mahalla (neighbourhood) authorities to improve family conditions and relations. This shows once more that if a person who thinks about suicide asks for help, and professionals can intervene in time, his or her emotional state can improve, and such behaviours can end.

In terms of intervention, the psychologists mentioned that they usually refer suicidal students to other services, like a psycho-neurologist. They can work with students who only have suicidal thought, but no intention and plan, the latter putting students at higher risk or in need of immediate specialized treatment. Before doing that, the healthcare providers have to inform the parents and have their consent.

> ***There were no reports of suicide. We identify students with suicidal symptoms through testing and other methods and call parents to talk about them.***
> *Khorezm, school psychologist*

According to a representative from the Ministry of Health, all adolescents have to have a general check-up on an annual basis before moving to the next grade. Also, a more thorough check-up is conducted for students in grade 9 and 11, which includes an examination from an endocrinologist, a stomatologist, a dermatologist and an ophthalmologist, along with blood tests and an electrocardiogram. The results of these examinations are included in the file of each child. However, there wasn't any suicide risk screening during this process.

4.3. HELP-SEEKING BEHAVIOR AND BARRIERS

Help-seeking behaviour is defined as any action of energetically seeking help from the health care services or from trusted people in the community, and includes understanding, guidance, treatment and general sup-

port when feeling in trouble or encountering stressful circumstances[61]. To ask for help a person should be aware of their symptoms, be able to articulate what they are, and be willing to disclose them to another person/professional. Also, accessible and available services should be in place, and the person should be informed on them. School psychologists are in every school in Uzbekistan with the purpose of providing counselling among other services, and yet there seems to be a reluctance among students to contact them.

The most common barriers to help-seeking by adolescents and parents are those linked to stigma and embarrassment, lack of information about school psychologists and other community resources for mental health and psychosocial well-being, and a lack of trust by both adolescents and their parents on psychologists' skills and qualifications. To add to this, psychologists themselves faced challenges in applying their practice within schools, like high workload, low salaries, lack of an appropriate office and necessary equipment, need for continuous qualification, and difficulties in cooperating with parents. On a positive note, many adolescents and parents were aware of school psychologists, and have stated that they would go to them to ask for help if necessary.

4.3.1. STIGMA AND EMBARRASSMENT

Survey data also indicated that adolescents prefer to tell their parents, their friends and other family members if they have an emotional issue. That means that they are open to discuss these issues with someone. However, all groups of participants mentioned that both parents and adolescents themselves would not prefer to go to a psychologist, because of the stigma they might become associated with for doing so.

> ***A person that goes to a psychologist is mentally ill – if he goes there he will be misunderstood by his peers.*** *Tashkent, adolescent boy.*

Parents and psychologists supported this view, as seen in the quote below:

> ***Parents do not go to such services, even if necessary. They hide. In our nation, society does not accept taking a child to a psychologist with a particular problem. Maybe psychologists should be thrown out of the room into the crowd.*** *Andijan, mother, 38 years old*

Often, a school psychologist is confused with a psychiatrist that treats another spectrum of mental health disorders. Therefore, the practitioners emphasized that it is important to inform students and the public in general about the differences between these two professions. Some of them even suggested to broadcast videos on TV or social media about the work of psychologists.

[61] Rickwood, D. and Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. Psychology Research and Behavior Management, 5:173–183. doi: 10.2147/PRBM.S38707.

4.3.2. AWARENESS ABOUT SCHOOL PSYCHOSOCIAL SERVICES

According to data provided by the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students, there are 14,637 school psychologists for a total of 10,189 schools. Depending on the size of the school, between one and three psychologists work in the same school. Most of the parents and adolescents at the focus group discussions were aware that there is a school psychologist at school, but there were a few that didn't even know they existed and were surprised when they heard about them.

4.3.3. LACK OF TRUST

The main reason why adolescents do not trust school psychologists is the fear that their secrets will be revealed to others. For example, they said that they didn't believe the psychologist would not tell things to their class leader. Very few of them showed lack of trust in their skills.

> ***It may be because I am afraid that if I express my grief, it will be spread to everyone.*** *Andijan, adolescent girl, 13 years old*

Some parents on the other side particularly mentioned that they didn't trust that the school psychologists were able to help with severe mental health conditions, or they thought they were not qualified. It is true that school psychologists do not provide systematic therapy within the school premises – rather they offer counselling. Still, it is important for them to be informed and cooperate with parents and teachers, in order to develop a plan for adolescents that suffer from these disorders, for instance for students who have attempted suicide.

> ***I did not go to the school psychologist*** *[referring to her daughter's suicidal plans and attempt]****. I know that he is not qualified. The specialization of school psychologists is limited, unable to provide the systemic treatment needed to help get [a student] out of a severe mental disorder.*** *Andijan, mother, 44 years old.*

4.4. SERVICE PROVISION IN AND OUTSIDE SCHOOL – CHALLENGES

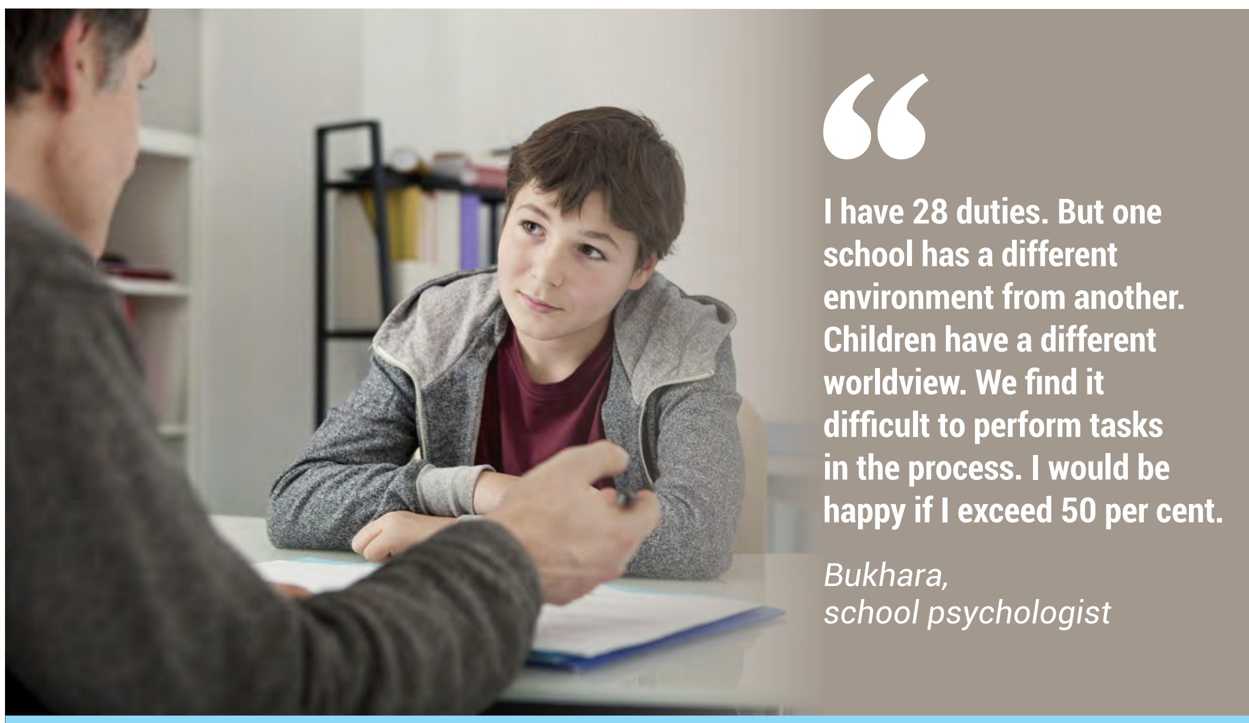
4.4.1. IN-SCHOOL SERVICE PROVISION

The school staff involved in providing psychosocial services is comprised of the vice principal for moral upbringing and social issues, classroom teachers (curators and classroom teachers), school psychologists (1-2 per school), and inspector school psychologists (1 for every 4-5 schools) [62]. Up to January 2022, the position of youth leader was also part of the school psychosocial service.

School psychologist. Each school has a psychologist who works with students, teachers and parents, and can refer students to specialized care. As of 2019, in line with a Decision of the Cabinet of Ministers, the provision of psychosocial services at schools was further regulated [63]. The school psychologists' job responsibilities are: a) increasing work effectiveness on the organization of psychological services in educational institutions, including making students aware of the profession through the use of modern information and communication technologies; b) helping students make the right career

[62] Columbia University, School of Social Work (2019). The Social Service Workforce (SSW) in Uzbekistan: stakeholder analysis. Tashkent: UNICEF Uzbekistan.

[63] Decision of the Cabinet of Ministers, no 577, date 12 July 2019 'On the organization of psychological services in general secondary and secondary special state educational institutions'.



choices based on their abilities, talents, interests and aptitudes; c) psychological monitoring of personal, mental and social development of students at different ages, identification of psychological problems in education, and prevention of any negative changes that may occur in their intellectual development; d) correction of cases of inability of students to adapt to the social environment of educational institutions, and organization and implementation of measures for their social rehabilitation; e) creating and maintaining a healthy psychological environment in pedagogical communities, correcting the emotional state of community members, interpersonal relationships and conflicting behaviours, and improving their psychological culture; f) identifying talented and gifted students, studying their individual psychological, physical characteristics and interests, and creating conditions for the manifestation and development of their abilities; g) taking measures to prevent the threat of information and psychological attacks, the negative impact of the global information network on the Internet, and the penetration of 'mass culture' that threatens the education of young people; and h) promoting the increase of psychological and pedagogical knowledge of teachers, students and parents, to ensure effective cooperation between teachers, parents and community organizations.

The participant psychologists listed several challenges faced in their work which can make informing all students about their role at schools complicated and problematic, and furthermore to fulfil their role sufficiently. Among these challenges, high workloads, lack of dedicated classroom hours for psychologists, work in the community (neighbourhood/mahalla), a lot of paperwork, the lack of diagnostic tools and an appropriate office, and low salaries, were all at the top of the list of challenges. Psychologists also mentioned that they should have ongoing trainings to improve their skills. Based on official data, less than half of school psychologists (45 per cent) have a bachelor's degree in psychology, while 20 per cent are those who have undergone trainings on psychology, and 34 per cent have not received any kind of specialized training preceding the provision of psychological services in schools (and are also teachers). The remaining 1 per cent are those who have graduated from spe-

cialized colleges/lyceums [64]. In addition, the lack of required skills for supporting adolescents with mental health conditions impacts the ability of psychologists to provide quality counselling. Furthermore, a lack of professional standards for school psychologists makes it challenging to ensure that they will have the appropriate qualifications, competence and experience now and in the future.

> ***There is no official room for a psychologist, I am still not well known by students for my new job at the school. The truth is there is still a distance between us and the kids. There is some alienation.*** *Samarkand, school psychologist.*

Inspector School Psychologist. The Resolution of the President of the Republic of Uzbekistan No. PK-5050 dated 02.04.2021 introduced the position of 'Inspector psychologist for juvenile affairs'. This position was developed following application of the principle of the 'Safe Education Institution'. Across the country 2,000 new staff positions were established, but currently only 1,100 of these are filled. One inspector psychologist is responsible for five schools. The main purpose of this staff member, according to the law, is to reduce juvenile offenses and promote a safe environment at school. Inspector psychologists are going to be further trained by juvenile inspectors. Recently sixty juvenile inspectors participated in a 'Training of Trainers' (ToT) programme, from which a pool of thirty-one juvenile inspectors were selected to be trainers of inspector psychologists.

The role of the inspector psychologist is new to schools, being introduced only in September 2021, with several duties resembling those of a school social workers on the one hand, and a school security officer on the other. Their role is largely focused on monitoring school attendance, addressing school-based conflicts, and doing work with families in the community whenever an adolescent does not attend school regularly. They may also engage other local authorities if parents don't comply or pay a fine for parental negligence. Also they can refer families to other services for different problems they may have, using the approach of case management. There is still a lack of clarity about how their future role will be shaped within school settings.

It is worth noticing that there isn't any structure for a school social worker. Sometimes psychologists have to carry out the duties of a social worker, like working with the family, home visiting, referral to other services, and others. Therefore, it seems like both psychologists and inspector psychologist carry out typical social work activities in their daily work, adding to their workload and reducing time available for meeting their own responsibilities

4.4.2. SERVICE PROVISION OUTSIDE SCHOOL – COMMUNITY, DISTRICT AND NATIONAL LEVELS

Mental health services in Uzbekistan are provided mainly by the public sector. After 2018 they have been also provided by the private sector. They exist at national, district and to a lesser extent community levels. ***Central hospitals/clinics*** are located mainly in large cities and they have a child psychiatrist in their structure. At a district level (***central polyclinic***) a psychiatrist is usually present to attend to psychiatric patients, but he or she may not be necessarily specialized to work with children and adolescents. Local/family polyclinics don't have a psychiatrist in their structure. The presence of psychologists in primary health care and in other mental health structures is very limited.

In regards to ***emergency services***, two psychiatrists who participated in the study said there are crisis beds in each ***district hospital*** which are necessary for people who have

[64] Data provided by the Republican Centre of Professional Orientation and Psychology Pedagogical Diagnostics of Students of the Ministry of Public Education of Uzbekistan.

attempted suicide, or who are high-risk patients. If a person has attempted suicide, a psychiatrist will visit the patient and conduct an assessment. Some of them may be referred to the central hospital, while others will stay only for a few days there and then they will be released. The Ministry of Emergency Situations is a government agency that would be called in the case of crisis within schools, such as a suicide threat happening on school grounds.

Also there are ***two hotlines*** to call, especially in emergency situations: one being run by the district psychiatric dispensary, and another coordinated by the Ministry for the Support of Mahallas and the Elder Generation. However their functionality is unclear because in the former case citizens have to receive a number from the polyclinic, which means it is not accessible by all, while the latter hotline has only just now begun operations. The representative from the Youth Agency explained that they were trying to start a hotline for children and adolescents in difficult situations.

The position of ***Youth Leader*** was introduced at a community level in January 2022, having previously been a position at schools. Also, a new post for a Deputy Mayor for Youth Affairs will be of help in addressing issues affecting youth, according to the community elder in the Fergana region. It seems as if the Youth Leader has similar duties to that of a social worker, doing outreach and mostly referrals to different services (not full case-management).

Additionally, there are six branches of the ***Republican Centre for Adaptation of Children/ Centres for Social Adaptation of Children***, which are focused mainly on children with different abilities and children from vulnerable groups. Child psychotherapy is one of their listed services, among those provided for children with different abilities [65].

Centres for Social and Psychological Support of Children have been established based on the President decree of 6 November 2020. One of their tasks is the protection of children's psychological health. According to the representative of the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students, there are currently 14 regional centres and 207 district centres (one for each district). Yet, consultation with school psychologists showed that this service is provided by the same school psychologists: each day two school psychologists should work at these centres, as part of their jobs. Parents and adolescents were not aware of this service, and they didn't mention it during focus group discussions.

In the private sector several ***psychiatric clinics*** have been established over recent years. ***Psychologists*** also prefer to have a ***private practice*** or to be employed at one of these clinics, because of better salaries. Nonetheless, parents that have contacted them or follow them on social media have expressed their reservations for the high fees they ask, which makes them non-accessible for a huge part of the population.

[65] For more information go to *https://rehabing.org/en/*.

NGOs and voluntary-based organizations play an important role in filling system gaps in the provision of mental health services for adolescents, and in capacity building. For example, there is the Uzbekistan Medical Students' Association which trains students to provide psychosocial support, and then they visit different schools within a certain time period. The Uzbekistan Psychologists' Association and Uzbekistan Volunteer Association has a similar volunteering basis – associated volunteers provide counselling services on a pro bono basis, while also benefiting from opportunities to practice their profession. According to the representative from the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students, collaboration with NGOs at central and local levels is very important for the work of school psychologists, and the work of the whole institution she directed. Overall it appears that NGOs operating in the field of mental health are scarce.

Despite the provided public or private services, there are still gaps in accessibility of provided services. For example, the Centre for Social Adaptation has only a few branches, whereas both of them were not known by parents nor adolescents in the study. Adolescents that don't live nearby will have to travel there for a counselling/therapy session, or will have to be satisfied with the services provided in their Mahalla. This is the case of course of adolescents in need of more specialized services like psychotherapy (without medication) or psychiatric treatment. Taking into consideration that counselling and psychotherapy sessions are usually conducted on a weekly basis, this would be a great challenge for families.

A lack of psychologists in the local structures was one of the concerns expressed by participants as well. For example, in the Fergana region with a population of 300,000 inhabitants there are only 3 psychologists. The majority of participating parents and practitioners recommended adding psychologists in the local polyclinic structures, and increasing the number of community centres providing mental health services. Furthermore, there is a greater need for psychologists with a specialization in adolescents and youth.

Other needed services, based on participants' views, are emergency centres at the local level to support adolescents in crisis, including those with a high risk of suicide. Another proposal was to introduce anonymous online services that would be helpful for adolescents living in remote areas, or for those who don't want to disclose their identity.

Community-based mental health services are scarce, particularly for adolescents with common mental disorders, like anxiety, depression or overall distress. Lack of psychologists and social workers at primary health care clinics and the local level is another gap. The community centres or other community-based initiatives should take a psychosocial approach, having a person in the centre, and depart from the traditional pharmacological approach.

4.5. MULTIDISCIPLINARY AND INTERSECTORAL COLLABORATION

Collaboration within schools among the different involved professionals, including teachers, school psychologists and medical workers, is of outmost importance. Further on, intersectoral collaboration with family and district polyclinics, public mental health service providers, and local structures like Mahallas, police and others, can all enhance the results of interventions for adolescents' mental health issues. Overall, psychologists and key stakeholders from different ministries confirmed that collaboration within schools and with other structures is very well established, and is regulated with inter-ministerial agreements. However these regulations were not publicly available, and as such were not read by the research team. For example, a school psychologist described that if an ad-

olescent needs to be referred to another service, he had to inform the classroom teacher, who they has to sign an information form. Afterwards, the medical worker (usually the school nurse) is informed and both of them (psychologist and school nurse) call the parents to inform them and advise them about potential referral to other services. Similar to that is the situation described below by a psychologist in Khorezm region:

> ***We will determine the development of the child based on the established work plan and methods. The mechanism works well and is set up correctly. In this case, the psychologist consults with the inspector [psychologist], who, in cooperation with the authorities, directs the child to the right centre. We have no right to make a diagnosis.*** *Khorezm, School psychologist.*

The referral mechanism for an adolescent with a mental health condition that needs a specialized service begins with a test or interview at school, followed by a referral to the child psychiatrist at a central level polyclinic, and if necessary to a more specialized psychiatrist at a central hospital. To do that, the child will be referred to the local Commission of Minors, which is responsible for making the most appropriate referral. This is a three-step process, and it means that in the face of emotional issues or even a suicide risk, the adolescent boy or girl would be interviewed three times: firstly by the school psychologist, secondly by the Commission of Minors, and thirdly by the respective institution they are referred to. Each step adds to distress or risk.

4.6. LEGAL AND POLICY FRAMEWORK

Provision of mental health and psychosocial services to students falls within the remit of a few ministries, including the Ministry of Health (MoH) and the Ministry of Public Ed-

ucation (MoPE) including the Youth Agency, and to varying degrees the provision of psychosocial support to adolescents is also the responsibility of the Ministry of Interior (MoI).

Law No. 265-I, 29 August 1996 'On the protection of citizens' health' refers only to medical and social assistance provided to adult citizens suffering from socially-significant diseases (Article 32), including mental illness [66]. Other important government decisions on mental health services include: Resolution of the Cabinet of Ministers No. 207 'On measures to further improve the activities of the psychiatric service of the Republic of Uzbekistan', 25 July 2013; Presidential decree No. 3606 'On measures to radically improve the system of providing mental health care', issued in March 2018 which allowed private providers to diagnose and treat mental and behavioural disorders and introduced new professions like 'social workers' and 'state expert forensic psychologist' [67]. Lately a new law on psychiatric care entered into force, being law No. ORQ-690, dated 12.05.2021 'About psychiatric care'.

In relation to education and the provision of mental health and psychosocial support within educational institutions, law No. LRU-637, dated 23 November 2020 'On Education' states that schools should create the necessary conditions for education, which take into account students' psychological characteristics and physical development, and also that they should provide free psychological and medical services (Article 47). The same article speaks about students' right to protection of their life and health from any physical and psychological violence, personal insults by teachers, and other participants in the educational process. Article 55 also declares the state's obligation to provide free primary, basic secondary, general and specialized secondary and out-of-school education for children, including children with physical, sensory or intellectual disabilities. The President decree No. 6108, 6 November 2020 'On measures to develop the spheres of education and upbringing, and science in the new period of development of Uzbekistan' put emphasis on the continuous education of all pedagogical staff, among other things.

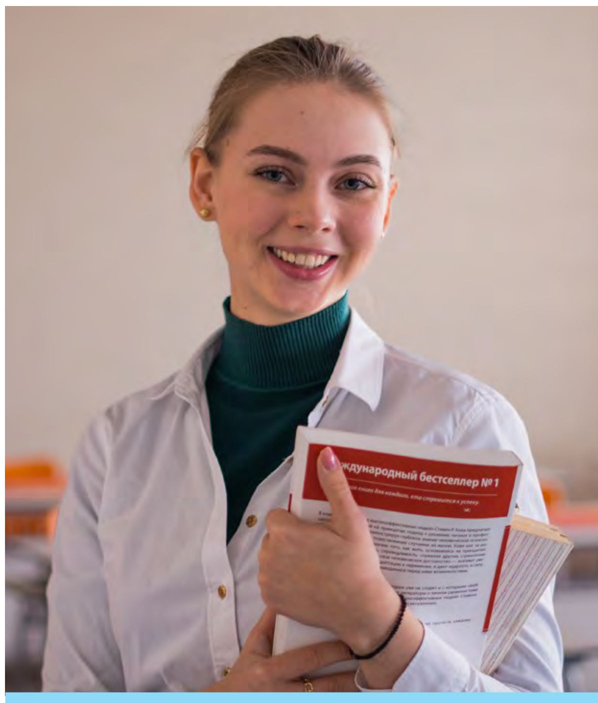
Psychosocial service provision was introduced with a Presidential decree released in 2019 'On the organization of psychological services in general secondary and secondary special state educational institutions'. A year later, through an internal order of the Minister of Public Education, required tasks and qualifications were defined for school psychologists. The specific qualifications for school psychologists are mentioned above (*See 4.4.1. In-school service provision*). Prevention, identification and intervention for mental health and psychosocial well-being concerns for adolescent boys and girls are included there. Through discussions at focus groups, it was determined that psychologists did not feel sufficiently qualified to provide counselling for different types of mental health conditions.

Centres for Social and Psychological Support have been established since 2020 with the Resolution of the President No. 4884 date 6 November 2020 'On additional measures to further improve the system of education and upbringing'. One of the tasks of these Centres is to *"improve of psychological service in schools, methodological support and professional development of psychologists and study of the professional suitability of public education workers for pedagogical activity"* [68]. However, based on the experience of the FGDs' participants, these centres are not functional and are more of a formal structure, rather than organically contributing to adolescents' psychosocial support. This is rein-

[66] Law no 265–I, date 29 August 1996 on "Health Protection of Citizens in the Republic of Uzbekistan". Available at *https://lex.uz/docs/-26013.*

[67] Presidential Decree no 3606, date 16 March 2018. National legislation database, 2018. Tashkent: Government of Uzbekistan; 2018. Available at *https://lex.uz/docs/3588132*.

[68] For more detailed information see *https://lex.uz/ru/docs/5085895.*



forced by the fact that both parents and adolescent participants were not aware of these centres. Also, currently school psychologists faced a high workload, lacked appropriate offices, and updated diagnostic tools and counselling trainings. Lack of professional standards for school psychologists' qualifications, practice and credentials adds to the picture of incomplete framework around this relatively new position. At the community level, based on the law No. ORQ-406 dated 14.09.2016 'About the State Policy on Youth', psychological, pedagogical, legal and counselling assistance should be provided to young citizens (of 14 to 30 years old) (Article 27). However, the participants mentioned that psychosocial services at the community level are scarce, mainly due to a lack of human resources.

At the policy level, in accordance with Presidential decree No. PP-4190, the 'Concept for the development of mental health services for the population of the Republic of Uzbekistan for 2019–2025' was adopted in February 2019 [69]. Recently, the National Strategy for Adolescent Health and Well-being 2022-2026 was discussed widely and it is in the process of being endorsed. The third objective of its Action Plan is to improve mental health among adolescents and build healthy relationships with peers, parents and community members, which is a positive step towards expanding mental health services for adolescent boys and girls, and strengthening existing ones.

The newly-established Ministry of Mahallas and the Elder Generation will work with mahallas (neighbourhoods) to collect patient information, and build relationships with affected households and psychologists [70].

Feedback given by participant psychologists, medical workers and inspector psychologists and key stakeholders, in regards to the respective ministries, were generally positive about the comprehensiveness of the legal and policy framework. Few of them expressed their concerns about the potential for implementing all policies and laws in practice. Yet, in both legal and policy frameworks, referral to a psychosocial approach and to community-based mental health services and initiatives is very limited. Even though they abide to the principle of least confinement, and they stipulate that persons with mental disorders should have both medical and social treatment, information about the implementation of social treatment is scarce. On the one hand these laws are mainly focused on severe mental conditions that would require psychiatric treatment, and leave aside more common mental conditions like elevated distress levels, or anxiety, depression and behavioural problems. Additionally, they don't mention the right of children and adolescents to age-appropriate infor-

[69] Concept of development of the mental health service of the population of the Republic of Uzbekistan for 2019–2025. National legislation database, 2019. Tashkent: Government of Uzbekistan; 2019 (*https://lex.uz/docs/4201083*); WHO (2021). Prevention and management of mental health conditions in Uzbekistan: The case for investment.

[70] WHO (2021). Prevention and management of mental health conditions in Uzbekistan: The case for investment.

mation about mental health conditions and psychosocial disabilities, the right to participate in decision-making and to be heard in regards to their mental health treatments, nor the right to have access to confidential mental health counselling and advice without the consent of a parent or guardian, if they so wish[71]. Therefore, it seems that there is a gap both in policy and legal frameworks, as well as in service provision, in relation to specific rights of the child/adolescent in regards to mental health, the application of community-based mental health services, and the overall comprehensive approach taken regarding adolescent mental health conditions and psychosocial disability.

4.7. SCHOOL-BASED PROGRAMMES RELATED TO MENTAL HEALTH

In general, school psychologists who participated in the study said that there weren't any programmes or school action plans for mental health awareness or psychosocial well-being implemented in their schools, particularly in rural areas. Yet, some of them mentioned programmes like 'Ahil oila va baxtli maktab' ('Strong families – Happy school') and 'Biz farzandlarimiz kelajagiga befarq emasmiz' ('We are not indifferent to the future of our child'), and the 'Life Skills' course for students of grades 9 to 11, which have had good results and have strengthened the family-school partnership. The representative of the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students provided a comprehensive list of school-based programmes directed towards among other things mental health literacy, auto-destructive behaviours, and the provision of psychological assistance like 'I see – I hear'. These programmes have had a positive impact on the schools in which they were implemented, however it looks like there is a necessity for a more comprehensive approach towards adolescents' mental health at school.

4.8. UNEXPECTED FINDINGS

Sometimes findings can occur that are outside the scope of the initial research, or that are unexpected. The overall findings of this research were within the expectations of the research team, based on evidence from other countries. However, some unexpected findings relate to:

- The fact that for some parents the existence of school psychologists as a position was not known. This can have a two-fold meaning: either parents are not interested in the school experience of their children, or school psychologists are not promoted sufficiently within their schools and beyond. Both of these matters would need to be addressed.

- School psychologists sometimes denied the existence of mental health issues among adolescent boys and girls attending the schools for which they were responsible. Therefore, we should not assume that having knowledge about an issue (if we take it for granted that they studied psychology, even though this is not possible to know) doesn't translate to 'understanding' the issue and taking steps to address it.

[71] The most recent recommendations for mental health legislation can be found at WHO and OHCHR (2022). Draft Guidance on mental health, human rights, and legislation. WHO/OHCHR.

5 LESSONS LEARNT

Several efforts to prioritize mental health in the sphere of public health have been undertaken over the last few years in Uzbekistan, which has been a very positive step towards change. However, despite the fact that they were conducted with the best intentions, sometimes they were done quickly without giving the system a chance to assimilate them. For example, establishing the new position of a school inspector psychologist was an innovative solution for school safety and case management as well. Yet, this merging of responsibilities may result in a low quality of service provision: a security-oriented professional takes different approaches compared to one oriented towards social work. Saying this, there is a risk that none of these positions/professions fulfil their job successfully.

The involvement of community leaders (elders and administrators) through interviewing represented only a small proportion of this study. However, it provided insight into some common misbeliefs about mental health conditions (about conditions being a sign of having a 'weak psyche') and the role of religious beliefs in shaping these perceptions, that were not brought to light by other participants. By considering people with mental health conditions as having a 'weak psyche', it makes it seem as if people can be blamed for their poor mental health and that is not the case.

Gender is accepted as an influencing factor in relation to mental health conditions and their prevalence, particularly for depression and anxiety. This was confirmed by this study, because adolescent girls were found to have slightly higher levels of anxiety, stress and depression. However, there were several cases which applied more to boys. For instance, in terms of school safety adolescent boys tended to perceive school as being less safe. School safety was positively correlated to low levels of stress, anxiety and depression. Thus, boys that are more exposed or involved in risky behaviours at schools (due to their gender role) may be at a higher risk of mental health conditions. Another example is the way teachers interact with boys and

girls. Due to the gendered roles of girls requiring them to be more obedient and good students, compared to boys who are allowed to be more disobedient and not so good students, teachers preferred working with girls than with boys. This makes the teacher-student relationship less supportive for boys.

Suicidal attempts are often made public either by mouth-to-mouth rumour spreading, or through them receiving media attention. However, another risky activity – self harming – does not receive the same attention, making it more subtle and less possible to address. This study showed that adolescent boys and girls are more aware of self-harming behaviours, whereas parents and other participants not so much.

The COVID-19 lockdown experience or crisis had no precedent in modern times. Evidence gathered from past experience of public health crises has raised concerns about their impact on youth mental health. This was also deemed to be true through this study. However, it was not expected that adolescents would be divided in relation to their negative or positive experiences of COVID-19 lockdowns. Even though someone may suggest that adolescents enjoyed lockdowns because they wouldn't have to go to school, or because of less academic pressure during those periods, their responses revealed that the positive part related to having more family time and time for recreational activities. Now may be a time for educational institutions to reflect on the level of educational requirements they place on students and families, and to rethink how children's time may be utilized.

CONCLUSIONS

The This study's participants were adolescent boys and girls of the 6th, 9th and 11th grades, from 14 regions of Uzbekistan. Out of the total only a small percentage of adolescent boys and girls were working, mainly boys of upper grades, and some of them were working full-time. Often students from rural areas and working students both had parents living and/or working outside the home for at least one month over the last year.

Based on data analysis, spending good time with their family, having a feeling of being taken care of, and being listened to, are all things important for adolescents and most of them enjoyed these benefits. However, they felt less supported in terms of issues related to school and their peers or friendships. Adolescent boys and girls with higher levels of depression, anxiety or stress, experienced a lack of family support, connection, or having their views listened-to and taken into consideration in regards to important life decisions.

Parents need to change their attitudes towards and interactions with their children, in regards to mental health and conditions, and psychosocial distress. Thus, information and awareness are important. In focus group discussions, stakeholders emphasized the lack of understanding and confusion that exists about mental health and specific risky behaviours like self-harm. Also, stigma or embarrassment make parents and adolescents less prone to discussing these issues, or to help themselves and other people around them. Some study participants had relied on their own personal resources to solve mental health issues, sometimes arguing that professionals were not qualified to do this.

In focus group discussions, adolescents, parents and other stakeholders pointed out the role the family plays in raising mentally-healthy children. This starts with listening to them, not putting pressure on them in regards to their important life decisions like choice of profession, and more importantly treating them well.

Overall satisfaction about lives, home living conditions and families was at sufficient levels, and comparable to that found in the results of international studies [72]. Yet, it appears that there is a decline in these levels in terms of school experience and friendships. This is even lower among working students and those with higher levels of emotional or behavioural difficulties, which require more focus from families and schools.

The need to connect to other people and to feel included and accepted in school and wider society is inherent in every individual. In this study feelings of loneliness and isolation in class, and the experience of not being connected, were present for at least one to two out of ten students. This indicated a need to intervene early and develop programmes that enhance student's relationships with school. Additionally, perceptions about other students' attitudes and behaviours towards each other and school can influence these experiences, for better or worse. Adolescent boys and girls indeed had a good perception about the way other students interact with each other, besides a small percentage of them believing the opposite.

Teacher-student relations play an important role in ensuring students' school connectedness, satisfaction and motivation. Despite there being overall good relations between

[72] See for example Orben A., Richard E., Fuhrmann D., and Kievit Rogier A. (2022). Trajectories of adolescent life satisfaction. Research Open Science, 9. doi.org/10.1098/rsos.211808.

students and teachers, as evident in this study, a consistent 10 to 15 per cent of students did not have their teachers' support – receiving neither fair nor equal treatment. Boys and students of upper-level grades were more prone to experience these relations as being less supportive.

In terms of their experience of exams and tests, students were prone to think that the assessment content was clear and understandable, and that it measured their success. However, this did not change the fact that students worried about exams and tests. The elder adolescents had greater levels of worry about exams and school. They ranked these among the top five issues they had for the last month, after their future or family. Discussion in focus groups highlighted that students were often stressed about their success in exams, and sometimes their parents had to intervene and have discussions with their teachers. Academic pressure was one of the listed reasons affecting the mental health and psychosocial well-being of adolescents.

Schools ought to provide a safe and secure space for students, both physical and emotional. Even though the overall school climate was perceived as being good, for some adolescents (1 to 2 out of 10 and especially boys), violent and discriminatory attitudes and bullying were present at schools, making them a less safe space. While physical violence was less present, exclusion from social groups in class and teasing existed, particularly among sixth graders.

Students with moderate to extremely-severe levels of depression, anxiety and stress had a less positive perception about the way students interacted with each-other. Also, they lacked school connectedness, making them even more vulnerable to isolation and elevated levels of negative emotions. They were also more likely to be hit by other children, be called unkind names, and be put down and

bullied online, making them even more vulnerable and in a risky situation. Identifying these vulnerable adolescents within schools, families or communities, and taking measures to reduce their negative emotions and exposure to episodes of violence and bullying, as well as increasing their school connectedness, become issues of outmost importance.

Adolescent boys were more exposed to mobile phones, PCs or games consoles, and also to large amounts of screen time. They spent more time online for the purpose of social networking and surfing the internet. In focus group discussions, it became evident that adolescents did not consider technology to be a risk factor for mental health conditions. Parents and school psychologists on the other side expressed many concerns about how much time their children spent with screens.

Working students and ones in higher grades faced more emotional and behavioural difficulties, while students whose parents lived far from the family faced more emotional issues. Having parents both physically and emotionally close during those challenging years of adolescence can indeed act as a buffer for emotional and behavioural difficulties.

To add to that, a concerning number of students had moderate to extremely-severe anxiety and depression. From the survey, it looks like girls, working students and ones with parents living far from the family were at a higher risk. Focus group discussions and interviews revealed other risk factors like family environment and socio-economic status, lack of social networks, academic pressure within teacher-student relations, issues regarding school conditions and safety in going to school, bullying and screen time. Of these some can be protective factors depending on the quality of the relation – for instance, a good family environment or good relations with peers can act as buffers for mental health problems. Participation in extra-curricular activities was a factor believed to have only positive influence.

The persons adolescents trusted most to provide help if needed were parents or peers. Yet, it appears that help-seeking behaviour in all these groups is hampered by a series of negative factors like stigma towards mental health, embarrassment, lack of accessible services in the community, or lack of trust towards practitioners. Earlier research also indicated a low capacity of public services for children and adolescents in the community, and the fact that these services are not accessible for people living in rural and remote areas[73].

Within schools, the provision of psychosocial services by psychologists had its own challenges. School psychologists claimed they often faced many challenges in their work: overload and long working hours, difficulties in updating skills continuously, and lack of an appropriate working space and paperwork to name a few. This was true for other mental health service providers, like psychiatrists or suicidologists. The function of the new role of inspector psychologists was unclear, with them fulfilling both security officer and social worker tasks, like monitoring undesirable behaviours and providing referrals to other systems and services.

Service provision out of school was concentrated at a district level, and was mainly institutionalized. Many parents and adolescents didn't have information about the availability and quality of the current mental health services. Multidisciplinary and inter-sectorial collaboration was well-established, but the protocols used were not made available to the public.

The current policy and legal framework of the country was an improvement of previous ones, and close to international stand-

[73] WHO (2021). Prevention and management of mental health conditions in Uzbekistan: The case for investment. WHO: Tashkent, Uzbekistan.

ards. During the last years there were several endorsed or soon-to-be endorsed policies addressing mental health in the wider population, and particularly that of children and adolescents. Nevertheless, legislation lacked the inclusion of rights of children and adolescents in making informed decisions, and the modalities of social treatment for both adults and adolescents. Particularly, quality and accessible mental health and psychosocial support services (especially at the community level) have fallen behind. At the school level, there were some good initiatives of school-based programmes but those took place in a limited number of schools.

The impact of the COVID-19 pandemic on adolescent boys and girls was two-fold, being both positive and negative. While many reported that they had been lonely, worried about their own health or other family members' health, and facing difficulties with online education, others pointed out the freedom they had gained during the lockdowns to schedule their own time, do things that they normally could not like sports and other activities, or spend more time with their families.

7 RECOMMENDATIONS

These recommendations are structured according to the three tiers' model for addressing mental health and psychosocial well-being at schools, and the suggested interlinks with other sectors [74].

1. Provide universal mental health promotion for all students, parents and school staff

A. Short term

- Promote mental health awareness in schools for adolescents and parents. Parents and adolescents need to be informed about children's warning signs and symptoms for mental health problems.
- Provide opportunities for regular capacity building activities, through which school staff can improve their understanding of the mental health and psychosocial well-being of adolescents, and identify early warning signs for mental health problems and particularly for suicide.
- Invest in inclusive extra-curricular activities for all students that will promote school and community connectedness, decrease isolation and address bullying.
- Raise awareness around mental health conditions, particularly those most common (anxiety, depression or behavioural problems) and reduce stigma for mental health concerns and disorders.

B. Long term

- Develop and integrate a mental health literacy curriculum at the school level, that includes building life skills, investing in social and emotional learning, and decreasing behavioural and emotional problems.
- Integrate mental health and psychosocial well-being knowledge into pre and in-service education for teachers, or improve existing ones. Teachers need to know about and be continually updated about mental health, common mental disorders which onset in adolescence, along with common signs of mental health conditions or psychosocial distress and ways to respond to it, as well as trauma-related knowledge.
- Promote a safe school environment through child protection policies and interventions to ensure a positive and safe school climate.

2. Provide selective services for students identified as being at risk of mental health concerns or problems

A. Short term

- Promote the professional role of school psychologists in schools and in wider society. Students and parents need to be better informed about the fact that there is at least one psychologist in the school who is available to have discussions with them on issues of concern.
- Incentivize school psychologists to improve the quality of their service by de-

[74] Every Moment Counts (n.d). Public Health Framework. Available at: *https://everymomentcounts.org/public-health-framework/* accessed on 13 October 2022; Center for Health and Health Care in Schools, School-Based Health Alliance, National Center for School Mental Health (2021). Addressing Social Influencers of Health and Education Using a Multi-Tiered System of Supports Framework. Washington, D.C.: School Health Services National Quality Initiative; KAPPAN Connection Education Research, Policy and Practice (December 1, 2014). Improving mental health in schools. Available at *https://kappanonline.org/improving-mental-health-schools-rossen-cowan/* accessed on 13 October 2022.

creasing paperwork and long working hours, providing them with an appropriate working space, and including hours to discuss different issues in the classroom.

- Conduct regular screening activities based on evidence-based methodology and tools within the school for early identification of mental health conditions and psychosocial distress, and especially self-harm and suicide. In this line, application-based screenings can be considered.

- Create peer support groups to enhance school connectedness, help with students feeling isolated, and act as agents for reporting cases of students that need help.

- Create an intervention team that will be engaged in promoting mental health and intervening in cases when warning signs are identified for mental health concerns and high-risk behaviours, including suicide.

- Develop and implement social and emotional learning programmes or life skills programmes for all students, with emphasis placed on ones showing warning signs for mental health concerns or psychosocial distress.

- Develop opportunities for adolescents to express their concerns while ensuring their anonymity is protected, for instance through a hotline.

- Introduce the position of school social worker, or reshape the role of inspector psychologists to perform the duties of social workers, particularly case management. In the latter case, their job position should be under the Ministry of Public Education or one of the social sector ministries.

B. Long term

- Enhance the qualifications and practical skills of school psychologists in terms of counselling techniques and school-based intervention programmes and specific service provision, like cognitive-behavioural therapy, solution-focused therapy, etc.

- Include MHPSS-related training programmes in the curriculum in the mandatory trainings for upgrading the skills of school psychologists.

- Revise curriculum for psychologists to ensure consistency in the education requirement of psychologists graduating from different universities, with a focus on knowledge and practical skills around adolescent mental health conditions and counselling techniques.

3. Provide indicated services for individual students who already display a mental health concern or problem

A. Short term

- o Develop and implement intervention programmes for most common mental health concerns (anxiety, depression, behavioural problems, etc.) and for suicide prevention and intervention, like aggression replacement treatment, support provided to adolescents with depression, cognitive behavioural interventions for schools, etc.

B. Long term

- Invest in evidence-based targeted service provision programmes for mental health and psychosocial well-being in and outside schools, that help students develop coping behaviours and avoid risky behaviours – these programmes can include solution-focused brief therapy, attachment-based therapy, integrated cognitive behavioural therapy, etc.

4. Build upon and develop purposeful partnerships between schools and other systems

A. Short term

- Assist parents and caregivers in developing a supportive family environment. Parents need to understand how to create a supportive family environment, and help their children in case they need them.

- Collaborate with the health and social sectors for better identification and referral pathways for adolescents with poor psychosocial well-being and mental health concerns, as well as for further coordination of service provision in cases of referrals.

- Invest in community-based initiatives to promote mental health among parents and communities.

- Enhance collaboration with mahallas and their structures and members (such as youth leaders, women activists or others) to understand the full picture of adolescent life and address potential risk factors and social determinants of mental health, such as migration, poverty, discrimination and others, in the framework of Integrated Social Service Delivery through a case management approach.

- Develop new or improve existing protocols for intersectoral collaboration and referrals by school and inspector psychologists to health and justice sectors, or to local level authorities.

B. Long term

- Expand and complete community-based mental health and psychosocial support services for adolescents.
- Initiate and expand the provision of psychotherapy (not based in psychiatry) for adolescents, for moderate and severe cases of mental health disorders, without medications (like cognitive behavioural therapy, psychodynamic psychotherapy, group therapy, and others).

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ANNEX 1

FOCUS GROUP DISCUSSION GUIDE – ADOLESCENTS (12-18 YEARS OLD)

INTRODUCTION

The moderator makes a presentation of the aim of the FGD, as an initiative of the Ministry of Health and the Ministry of Public Education in Uzbekistan. Then s/he explains that the aim of the FGD is to know more about the participants' experiences, perceptions and attitudes towards the mental health and psychosocial well-being of adolescents at schools. There are no right or wrong answers, so participants can feel free to express their opinions. They are not obliged to speak, yet their opinion is valuable. Every opinion is respected, but participants can state their own opinions if they don't agree with something. Their anonymity is going to be absolutely respected. Tape-recording will start AFTER all participants finish personal presentations, and the only reason for the recording is because it helps in remembering what was said and ensuring details are not lost. All participants should keep in mind that only one speaker can talk at a time. If somebody doesn't want to continue, it is his/her right to leave the group without having any sanctions about this.

Before continuing with the presentation, the moderators make sure that they have all the informed consent forms from the parents of children. Also, they give the children the information sheet and they ask them to read it thoroughly. If they don't understand any word/phrase they can explain them. They ask the adolescents if they agree to participate in the study, and if yes they should place their initials in the assent form or agree verbally. The interviewer and note-keeper should be cautious to look for any signs of distress among the adolescents, and to create a safe environment, in order for them not to feel intimidated and to feel free to express their opinions.

(Continue with the presentation of the moderator and then with participants' presentation.) You can use the introduction below:

Welcome to our discussion group for mental health and emotional problems of children at school, family and community. As children/adolescents, we would welcome all your opinions and experiences, because these are issues that you or your friends may face or have faced in your life. This meeting will take approximately 1 hour. The purpose of this discussion is to explore the main emotional concerns that children/adolescents have, that relate to school, family or other issues. This meeting can be tape-recorded if you agree to that, and otherwise we will try to take notes. However, tape-recording is very helpful for the flow of the discussion and for the sake of not losing important information that we can use when we write the report. Tape-recording will begin after you present yourself. I would like to continue with your presentation: your name, village/city you live in and your age?

Note for notekeeper: *The The note-keeper should write down this information in the table below and later when the participants*

make statements he/she should write who was the person who responded: their age, and the village/city they live in. (An easy way to do that is by writing initially the number of the participant when they respond, and later replace it with all the other details.)

Set/negotiate ground rules:

- *You can pass on any question that you do not want to answer.*
- *You can take time to think before answering a question.*
- *Let me know if I do not understand you, or if you do not understand what I mean.*
- *You can use any word that would express best what you want to say, and not what you think that I want to hear. There is no right or wrong answer.*
- *Respect each other and do not interrupt the other participants. Everyone will get a chance to speak. Speak one at a time. You do not have to put up your hand to talk.*
- *We can disagree, but we should not make fun of others' ideas.*

Confirm confidentiality and anonymity. *All answers and anything you say is confidential, which means that your names will not be shared with anyone else, and will not be put in the report. If someone wants to look back at them to know who said this or that, he/she will not manage to find out this information, because the names will not be recorded. Everything that is being said should stay within the group. But if I am concerned about you, I may ask to talk to you afterwards so we can decide the best way to help. This meeting can be tape-recorded if you agree to that, and otherwise we will try to take notes. However, tape-recording is very helpful for the flow of the discussion and for the sake of not losing important information that we can use when we write the report. Tape-recording will begin after you present yourself.*

For moderator and note-keeper:

1. Moderator ______________________________

2. Note-keeper ______________________________

Materials needed: sticker notes, pens, flip-chart.

Region: ______________________________

Place: Urban or rural ______________________________

Date of FGD: ______________________________

Group composition:

Nr of participants: ______________________________

of them girls : ______________________________

Notes

____

____

____

FGD participant's details

Nr of participant	Urban or rural	Place of living	Gender	Age
1				
2				
3				
...				
15				

DISCUSSION QUESTIONS

A. Introduction (15 minutes)

Now I would like to ask you to answer some questions on the post-its that you have in front of you. There is no right or wrong answer. You can talk from your personal experience or share your opinions.

1. What matters to you most in life?
2. How do you feel about life right now?
3. What makes you happy?
4. What makes you healthy?

The moderator invites children/adolescents to read what they have written and asks them the following:

5. Looking at how you feel about life right now and what makes you happy, can you share with me a little more about that?
6. If you are satisfied with your life, what makes you satisfied?
7. If you are not, why not?
8. What stops you from being happier?

B. Understanding mental health issues and factors that affect them (20 – 30 minutes)

9. Back to your post-it notes, I want you to write down the first words or thoughts that come to mind when I say *"mental health"* (use the word *"healthy mind"* for younger audiences).

The moderator writes the answers of children/adolescents in a flipchart and puts them at a visible place. .

Note: *Caution should be made here, because usually children and adolescents have wrong perceptions about mental health and connect it only with psychosis and extreme cases. The moderator should listen to children and adolescents' understanding and then give the right definition of mental health and mental health disorders, while providing some examples like anxiety, distress, isolation, low self-esteem, eating disorders, etc.)*

10. Do you know anyone ***at your age*** who have had mental health/emotional problems? What did he/she experience?
11. Thinking about these children/adolescents that had mental health/emotional problems, what do you think caused them?

    If children/adolescents don't bring the following up, probe for their thoughts on:

    - School demands: grades, exams, homework;
    - Relationships: teachers, friends at school and community, conflicts among them, intimate relations;
    - Family stress: family environment, economic problems, parents' quarrels, parent-children communication, relationships with siblings etc.;
    - Gender: what is different for girls and boys;
    - Tobacco, drug and alcohol use.
12. Have you ever experienced any emotional problem? When? What caused it, according to your opinion?
13. Thinking about the road you take to go to school and the school premises, is there any moment that you don't feel safe? If yes, why?
    - What about other children? Do they always feel safe at school and on the way to school? *(**Note**: Please keep in mind here to differentiate between boys and girls)*
14. Have you ever heard of children/adolescents wanting to hurt themselves?
    a. Where did you hear it (mahalla, school, media, other families, others)?
    b. If you remember, what do you think made them think/do that?

c. Do you know what happened after with these children/adolescents?

d. What would you do if you faced a difficult situation?

C. Help-seeking behaviour (15 minutes)

15. In general, if a child/adolescent in your school/community had an emotional problem, would they ask for help?
    a. If yes, where?
    b. If not, what stops them from doing so?

16. Where would you go if ***you*** needed such help? Why there?

ONLY FOR ADOLESCENTS 16 TO 18 YEARS OLD

17. Are you aware of things that are being done locally to help adolescents with mental health and emotional problems? If yes, what? Where are these activities/centers located? Discuss.

18. Are you aware of things that are being done locally to address issues such as alcohol, drugs, smoking?

19. Are you aware of things that are being done locally to address issues such self – harm or suicide prevention? Please tell me more about them. (hotline, suicide prevention programs from community of local NGOs, other)

20. If children/adolescents don't mention it in the previous question, ask about ***school psychologists***:
    a. Have you/other children ever contacted the school psychologist for an issue of concern? If yes, for what? If not, why not?
    b. Did he/she help you? How?

21. Have ***you / other children / adolescents*** contacted a counsellor or psychologist? If yes, how did you/they find out about them?
    a. Were they helpful? Why?
    b. If the services were not helpful, why not?

22. What would you suggest to stop children and adolescents from having emotional problems? *(Probe for ideas that relate to school, parenting, peer-to-peer support etc.)*

23. Do you have any further suggestions for the study?

Thank you for your participation!

ANNEX 2

FOCUS GROUP DISCUSSION GUIDE, PARENTS OF ADOLESCENTS

INTRODUCTION

The moderator makes a presentation of the aim of the FGD, as an initiative of the Ministry of Health and the Ministry of Public Education in Uzbekistan. Then s/he explains that the aim of the FGD is to know more about the participants' experiences, perceptions and attitudes towards the mental health and psychosocial well-being of adolescents at schools. There are no right or wrong answers, so participants can feel free to express their opinions. They are not obliged to speak, yet their opinion is valuable. Every opinion is respected, but participants can state their own opinions if they don't agree with something. Their anonymity is going to be absolutely respected. Tape-recording will start AFTER all participants finish personal presentations, and the only reason for the recording is because it helps in remembering what was said and ensuring details are not lost. All participants should keep in mind that only one speaker can talk at a time. If somebody doesn't want to continue, it is his/her right to leave the group without having any sanctions about this.

Before continuing with the presentation, the moderator gives the participants the information sheet and the informed consent form, and asks them to read thoroughly. If they agree to everything, they should sign the consent form. The interviewer and note-keeper should be careful to gather all the consent forms.

(Continue with presentation of moderator and then with participants' presentation). You can use the introduction below:

Welcome to our discussion group on the mental health and psychosocial well-being of adolescents at school. As parents of adolescent children, we would appreciate your opinion on these important issues that can affect our children and our families. This meeting will take approximately 1 hour – 1 hour and 30 minutes. We greatly value your opinions and ideas. The purpose of this discussion is to explore the main emotional concerns that adolescents have, that relate to school and beyond it. Also, it is important to have your opinions on what can be done collectively by schools, parents and communities to prevent mental health problems and to help and support children and adolescents when facing these issues. This meeting can be tape-recorded if you agree to that, otherwise we will try to take notes. However, tape-recording is very helpful for the flow of the discussion, and for the sake of not losing important information that we can use when we write the report. Tape-recording will begin after you present yourself. I would like to continue with your presentation: your name, village/city you live in, age, and how many children do you have and what are their ages?

Note for notekeeper: *The note-keeper should write down this information in the table below and later when the participants make statements he/she should write who was the person who responded: their age, and the village/city they live in. (An easy way to do that*

is by writing initially the number of the participant when they respond, and later replace it with all the other details.)

Continue by saying:

Group rules:

We do have some ***rules*** for our discussion:

a) Only use ***first names***. If you prefer, you can make up a name.

b) No side conversations or comments, meaning whoever is speaking will be given full attention and respect.

c) Children or other unauthorized visitors are not allowed in the group.

d) No one will discuss the information/ problems of any group member outside of the group

For moderator and note-keeper:

1. Moderator ____________________

2. Note-keeper ____________________

Region: ____________________

Place: Urban or rural ____________________

Date of FGD: ____________________

Group composition:

Nr of participants: ____________________

of them women: ____________________

Notes: ____________________

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FGD PARTICIPANT'S DETAILS

Nr of participant	Urban or rural	Gender	Age	Nr of children	Adolescent child gender
1					
2					
3					
...					
15					

DISCUSSION QUESTIONS

A. Introduction (10-15 minutes)

Now I would like to ask the group some questions about mental health and well-being. There are no right or wrong answers. You can talk from your personal experience/knowledge, or give opinions.

1. What is considered mental health here in your community/mahalla/city? What about mental health disorders?

2. When you hear the term ***mental health*** what comes in your mind? Please give me some examples.
   a. Are there any prejudices in your community related to mental health?
   b. If yes, what specifically?

Note*: Caution should be taken here, because usually people have prejudices about mental health, and connect it only with psychosis and extreme cases. The moderator should listen to the participants' understanding and then give the right definition of mental health*

and mental health disorders by providing some examples.

3. What about mental health in children and adolescents? Is there any difference?
    a. If yes, what are the differences between adult and child/adolescent mental health issues?
    b. If not, why not? Please give me some examples.

4. In your own words, how would you describe anxiety, depression, and stress?

B. Factors influencing psychosocial well-being and mental health concerns (30-45 minutes).

5. How do your children experience school: easy and enjoying or difficult and stressful? What about other children in your community?
    a. What are some factors that influence their experience?

6. Have you ever heard about adolescents having stress or ***anxiety*** that was related to school? Please tell me more about it. What is your experience? How was it in your family? *(The moderator explores more here in relation to the reasons why adolescents experience anxiety)*

7. What about ***depression or melancholia*** that was related to school factors?

8. If they are not mentioned the moderator explores and probes more on the following issues that can cause anxiety and feelings of sadness/depression:
    a. Exams, testing and daily evaluation of their performance:
        i. What are the requirements of school in relation to testing and exams?
        ii. How are your children coping with them?
    b. Teaching and teachers:
        i. Thinking about ALL the teachers in the school, what would you say is their overall attitude towards students?
        ii. What is their teaching style?
        iii. How do they communicate with students?
        iv. Did your child ever have a misunderstanding with one or more teachers? How did they resolve it?
    c. Relations with peers:
        i. What are your children's relations to other students?
        ii. Did they ever have any problems with them? If yes, what were they? *(Probe for physical violence and bullying, isolation, and/or spreading rumours.)*
        iii. Have you ever heard of children being isolated, bullied or not accepted at school in your community? What happened to them?

9. Besides school, what else can influence adolescents' mental health and the probability to suffer from anxiety, depression or other disorders? If it not mentioned please probe for family environment – quarrels/violence, economic problems, divorce, one or two migrant parents etc. - community – related factors and the use of technology (mobile phones and internet use).

10. Thinking about the school premises, and the distance your children need to travel to go to school, would you say they are safe? If yes, how do you know? If no, what are your child's/your concerns about adolescents' physical safety? *(**Note**: Please keep in mind here to differentiate between parents of adolescent boys and girls.)*

11. Have you ever heard of adolescents wanting to hurt themselves? What about suicide?
    a. Where did you hear it (mahalla, school, media, other families, other)?
    b. If you remember, what were the reasons behind this action?
    c. What happened after? Did he/she receive any services?

12. We want to make sure to talk about the strengths of the community/schools/families, not just about problems. What aspects of your community/school/family support the mental health of those who live there, and particularly that of adolescents (e.g., social/family connections, parks and playgrounds, certain community organizations, etc.)? Please explain.

13. How has the COVID-19 pandemic affected your family? Your children? Their mental health and well-being?

C. Help-seeking behaviour (20-30 minutes)

14. Do adolescents and parents in your community ask for help in such situations? If yes, where?
    a. What do you think are the barriers to getting help for emotional problems?

15. How easy or hard is it for someone in your community/mahalla/city to get help for mental health issues for their children if they need it?
    a. What makes it easier for people to access these services?
    b. What helps them to seek care?
    c. What makes it difficult? (For example, are there enough doctors/counsellors available? In what languages? Do people know where to go?)
    d. Does it differ by the kind of mental health issue a person faces? Something else about who they are (e.g., younger children, adolescent girls and boys etc.)?

16. Where would you go for help if ***you or your adolescent child*** needed help on the following problems?
    a. Individual counselling/psychotherapy for stress, anxiety, depression, eating disorders, trauma etc. Why? What are the barriers to accessing these services?
        i. Probe for : prejudice, financial constraints and availability of services in urban and rural areas
    b. Parenting help.
    c. Medications for anxiety, depression or other problems.
    d. Evaluation of child development or school problems.
    e. Help with child's behavioural problems.
    f. Emergency services (where to call if your child or someone else is suicidal or having some other kind of crisis).
    g. Drug or alcohol services.

17. If participants don't mention it in the previous question, ask about the ***school psychologists***:
    a. Has your child or you ever contacted school psychologists for an issue of concern? If yes, for what? If not, what are the barriers for contacting him/her?
    b. Was his/her service helpful? In what ways? What changes did it bring to your child's life?

18. If you feel comfortable doing so, can you share some of your own experiences in seeking mental health services for your child, if any? Have you known someone else who has sought help? If yes, how did you/they find out about the available help?

a. How many visits did they/you have, and how long were they?
b. Why or when did they/you quit using the services or help?
c. Were the services helpful? Why?
d. Were you able to make the changes you wanted to?
e. If the services were not helpful, why not?
f. What kind of mental health services is missing in your community?

19. How has the COVID-19 pandemic affected access to and availability of these services?

D. Recommendations and closure (10-15 minutes)

20. What would you suggest to prevent the onset of emotional problems in adolescence and suicide?
    a. What is the role of schools to prevent and manage these issues?
    b. What about the role of families?
    c. Primary health care/polyclinics?
    d. Other important services/institutions (NGOs, religious institutions, etc.)?

21. What can be done to make the available mental health services better?

22. Do you have any further suggestions for the study?

Thank you for your participation!

ANNEX 3

FOCUS GROUP DISCUSSION GUIDE – SCHOOL PSYCHOLOGISTS, INSPECTOR PSYCHOLOGISTS, YOUTH LEADERS

INTRODUCTION

The moderator makes a presentation of the aim of the FGD, as an initiative of the Ministry of Health and the Ministry of Public Education in Uzbekistan. Then s/he explains that the aim of the FGD is to know more about the participants' experiences, perceptions and knowledge of the mental health and psychosocial well-being of adolescents at schools, and in families and communities. There are no right or wrong answers, so they can feel free to express their opinions. They are not obliged to speak, yet their opinion is valuable. Every opinion is respected, but participants can state their own opinion if they don't agree with something. Their anonymity is going to be absolutely respected. Tape-recording will start AFTER all participants finish personal presentations, and the only reason for the recording is that it helps with remembering what was said, and not losing important details. All participants should keep in mind that only one speaker can talk at a time. If somebody doesn't want to continue, it is his/her right to leave the group without having any sanctions about this.

Before continuing with the presentation, the moderator gives the participants the information sheet and informed consent form, and asks them to read thoroughly. If they agree to everything, they should sign the consent form. The moderator and note-keeper should be careful to gather all the consent forms.

(Continue with the presentation of the moderator and then with the participants' presentations.) You can use the introduction below:

Welcome to our discussion group on the mental health and psychosocial well-being of adolescents at school. As school psychologists and medical workers at schools, we would appreciate your opinions on these important issues that can affect children at schools. This meeting will take approximately 1 hour – 1 hour and 30 minutes. We greatly value your opinions and ideas. The purpose of this discussion is to explore the main emotional concerns that adolescents have, that relate to school and beyond it. Also, it is important to have your opinions on what can be done collectively by schools, parents and communities to prevent mental health problems and to help and support children and adolescents when facing these issues. This meeting can be tape-recorded if you agree to that, and otherwise we will try to take notes. However, tape-recording is very helpful for the flow of the discussion and for the sake of not losing important information that we can use when we write the report. Tape-recording will begin after you present yourself. I would like to continue with your presentation: your name, the school you work at, your age and years of work experience?

Note for note-keeper: *The note-keeper should write down this information in the table below and later when the participants offer*

views he/she should write who was the person who responded: their age, school, years of experience, and whether they are a school psychologist or medical worker. An easy way to do that is by writing initially the number of the participant when they respond, and later replace it with all other details.

Continue by saying:

GROUP RULES:

We do have some rules for our discussion:

a) Only use ***first names***. If you prefer, you can make up a name.

b) No side conversations or comments, and whoever is speaking will be given full attention and respect.

c) Children or other unauthorized visitors are not allowed in the group.

d) No one will discuss information/problems of any group member outside of the group.

IMPORTANT! Caution should be taken for teachers and school principals NOT to be present during the focus group discussion. If they are present, the moderator should kindly ask them to leave the group, as it is ONLY for school psychologists and medical workers.

For moderator and note-keeper:

1. Moderator ______________________

2. Note-keeper ______________________

Region: ______________________

Place: Urban or rural ______________________

Date of FGD: ______________________

Group composition:

Nr of participants: ______________________

of them women: ______________________

Notes: ______________________

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FGD PARTICIPANT'S DETAILS

Nr of participant	Name of school	Urban or rural	Gender	Age	Years of experience	School psychologist or medical worker
1						
2						
3						
...						
15						

DISCUSSION QUESTIONS

A. Introduction (10-15 minutes)

Now I would like to ask the group some questions about mental health and well-being based on your experience. There are no right or wrong answers. You can talk from your personal experience/knowledge or give opinions.

1. What mental health issues do children and adolescents in the schools you work face, based on your experience? During which times of the year/moments are these issues more present? *(**Note**: they will probably mention different problems, including developmental problems like autism, Down syndrome etc. The moderator listens to all of them, and at the end he/she highlights that this discussion will be focused more on emotional problems, like anxiety, depression, isolation, low self-esteem, self-harm, somatization etc.)*

2. Based on your experience, what are the factors that affect adolescents' mental health and well-being at school? Probe for:
   a. Teacher-student relation;
   b. Peer-to-peer communication;
   c. School violence from teachers and among adolescents;
   d. Family problems: physical or emotional violence, divorce, poverty, migration;
   e. School demands: exams, tests, homework.

3. How has the COVID-19 pandemic influenced these issues?

B. School psychologists' practice (30-40 minutes)

4. How can children/adolescents at your school approach you? Are they informed that the school has a psychologist? A medical worker?
   a. What is the most usual way they choose to contact you?
   b. What are factors that stop them from asking for your help?

5. What are some practices that you use to prevent and manage mental health issues at your school? What about for suicide?
   a. Probe for: counselling, awareness-raising activities for mental health issues, or other issues of concern at school.

6. How do you conduct assessment of mental health issues? Do you have any standardized procedures / tests / measures?
   a. If yes, which ones? Are they helpful for your work?
   b. What else would you need to make your work with assessment of mental health problems better?

7. Do you feel you can carry out all the job responsibilities that your job description includes?
   a. In what specific fields/topics you think you could benefit from further qualification and training? (Probe for counselling, crisis management, suicide prevention, managing conflicts, how to work with teachers, and other similar matters.)

8. What are the challenges you face in effectively implementing your job at schools? Probe for:
   a. Physical settings (private room at school);
   b. Diagnostic tools;
   c. High workload;
   d. Working with parents, teachers.

9. What programmes/action plans has your school implemented until now related to psychosocial well-being and mental health? Any best practices from these programmes?

C. Intersectoral and multidisciplinary collaboration (10 – 20 minutes)

10. Have you referred children/adolescents with mental health issues to other facilities/agencies/institutions?
    a. If yes, in which cases? What about in cases of suicidal ideations?
    b. Where have you referred them to? (Probe for: social services, child protection services, hospitals, psychiatrists, primary health care centres, private psychotherapists/counsellors, community centres, and other sources of help.)
11. How does the referral mechanism function?
12. What are the criteria, if any, you use in order to understand when an adolescent needs to be referred to other services?
13. What about within the school? How is your collaboration with teachers and medical workers?
14. How is the collaboration with other sectors/within school? Are there any challenges? What would you suggest to improve it?

D. Recommendations and closure (10-15 minutes)

15. What would you suggest to prevent the onset of emotional problems in adolescence and to prevent suicide?
    a. What can be done at schools to prevent and manage these issues and to improve adolescents' psychosocial well-being?
    b. What can be done with families and at the community level?
16. Are there any new services needed? What specifically?
17. What can be done to make available mental health services better?
18. Do you have any further suggestions for the study?

Thank you for your participation!

ANNEX 4

FOCUS GROUP DISCUSSION GUIDE/KEY INFORMANT INTERVIEW – NATIONAL AND LOCAL SERVICE PROVIDERS, INCLUDING NGOS AND PRIVATE PRACTICE PROFESSIONALS, AND INDEPENDENT EXPERTS

INTRODUCTION

The moderator makes a presentation of the aim of the interview/FGD, as an initiative of the Ministry of Health and the Ministry of Public Education in Uzbekistan. Then s/he explains that the aim of the FGD is to know more about the participants' experiences, perceptions and knowledge of the mental health and psychosocial well-being of adolescents in schools, families and communities. There are no right or wrong answers so they can feel free to express their opinions. They are not obliged to speak, but their opinion is valuable. Every opinion is respected, but participants can state their own if they don't agree with something. Their anonymity is going to be absolutely respected. Tape-recording will start AFTER all participants finish their personal presentations, and the only reason for recording is because it helps with remembering what was said and for not losing important details. All participants should keep in mind that only one speaker can talk at a time. If somebody doesn't want to continue, it is his/her right to leave the group without having any sanctions about this.

Before continuing with the presentation, the moderator gives the participants the information sheet and informed consent form, and asks them to read thoroughly. If they agree to everything, they should sign the consent form. The moderator and note-keeper should be careful to gather all the consent forms.

(Continue with the presentation of the moderator and then with participants' presentations.) You can use the introduction below:

Welcome to our discussion group on the mental health and psychosocial well-being of adolescents at schools. As service providers at a national or local level in the public, private and non-profit sectors, we would appreciate your opinion on these important issues that can affect children in schools, families and communities. This meeting will take approximately 1 hour – 1 hour and 30 minutes. We greatly value your opinions and ideas. The purpose of this discussion is to explore the main emotional concerns adolescents have, that relate to school and beyond it. Also, it is important to have your opinions on what can be done collectively by schools, parents, communities and central/local government to prevent mental health problems, and to help and support children and adolescents when facing these problems. This meeting can be tape-recorded if you agree to that, and otherwise we will try to take notes. However, tape-recording is very helpful for the flow of the discussion and for the sake of not losing important information that we can use when we write the report. Tape-recording will begin after you present yourselves. I would like to

continue with your presentation: your name, profession, the institution you represent, and your years of work experience?

Note for note-keeper: *The note-keeper should write down this information in the table below and later when the participants make statements, he/she should write who was the person who responded: their profession, institution, years of experience and gender. An easy way to do that is by writing initially the number of the participant they respond, and later replace it with all the other details.*

Continue by saying:

Group rules:

We do have some rules for our discussion:

a) Only use ***first names***. If you prefer, you can make up a name.

b) No side conversations or comments, and whoever is speaking will be given full attention and respect.

c) Children or other unauthorized visitors are not allowed in the group.

d) No one will discuss information/problems of any group member outside of the group.

IMPORTANT! If this is conducted as a focus group discussion, the moderator should be careful to not let highly-distinguished professionals (e.g. psychiatrists) dominate the group. The moderator should leave space and time for other professionals to engage and share their experiences.

For moderator and note-keeper:

1. Moderator ______________________________

2. Note-keeper ______________________________

Region: ______________________________

Place: Urban or rural ______________________________

Date of FGD: ______________________________

Group composition:

Nr of participants: ______________________________

of them women: ______________________________

Notes: ______________________________

____

____

FGD PARTICIPANT'S DETAILS

Nr of participant	Profession	Institution	Urban or rural	Gender	Years of experience
1					
2					
3					
...					
15					

INTERVIEW /DISCUSSION QUESTIONS

A. Introduction (10-15 minutes)

Now I would like to start with some questions about your role and your institution's role in addressing the mental health issues of adolescents and children.

1. What is the role of your institution in children/adolescents' mental health and psychosocial well-being? What part of it relates to school? What about family and community?

2. What is your personal role and responsibility for these issues?

3. Are there any organizations at a local level, in the mahalla or village, that depend on your institution? What is their role?

4. Based on your experience, what are factors that affect adolescents' mental health and well-being at school? Probe for:
   a. Teacher-student relations;
   b. Peer-to-peer communication;
   c. School violence from teachers and among adolescents;
   d. Family problems: physical or emotional violence, poverty, migration;
   e. School demands: exams, tests, homework.

5. How has the COVID-19 pandemic influenced these issues?

B. Legal and policy framework and service provision (20-30 minutes)

6. Based on your experience and knowledge, what are the current laws/policies/strategies related to the mental health and psychosocial well-being of adolescents? Do they target schools? In what ways?

7. What are the services available from the public sector, NGOs or private sector related to the mental health and well-being of adolescents? Please be as comprehensive as possible. (Including mental health, social, health and educational services, and others.)

8. Which of them had an impact in children's/adolescents' lives, and which worsened their situations?

9. What are the obstacles that limit the services' impact on the situation of adolescents in need of these services? Probe for:
   a. What are the economical obstacles?
   b. What are the institutional obstacles?
   c. What are the social/cultural obstacles?
   d. What other obstacles do you identify?
   e. Any differences between rural and urban areas? Other differences?

10. What are the gaps in these existing services? (If not mentioned, probe about emergency services, suicide prevention services, and school-based services.)
    a. Why? *(Arguments for your response)*
    b. How can these gaps be reduced?
    c. What types of interventions are needed?
    d. What types of resources are needed?

11. How can these services be made more accessible and sensitive for boys and girls?

C. Intersectoral collaboration (10 minutes)

12. How does your institution collaborate with other ministries/agencies/institutions at the central and local level for the provision of services related to the mental health and psychosocial well-being of adolescents, including suicide prevention?

13. Are there any formal procedures (referral protocols) that promote this collaboration? If yes, which ones? If not, what do you think is needed to strengthen this collaboration?
14. What are the challenges in respect to intersectoral collaboration? What can be done more?

D. Recommendations and closure (10-15 minutes)

15. Where do you think efforts should be more urgently concentrated to improve the situation of adolescents with mental health issues? *Probe about: specific areas in the country, school/family/community?*
16. What would you suggest to prevent such issues from worsening at the policy level? Within schools? At family and community levels? What about service provision? *Probe about suicide.*
17. *(If not mentioned at the previous section ask)* Are any new services needed?
18. What can be done to make available mental health services better?
19. Do you have any further suggestions for the study?

Thank you for your participation!

ANNEX 5

KEY INFORMANT INTERVIEW – GOVERNMENT REPRESENTATIVES

INTRODUCTION

The interviewer makes a presentation – of the aim of the interview, as an initiative of the Ministry of Health and the Ministry of Public Education in Uzbekistan. Then s/he explains that the aim of the interview is to know more about the attending government representatives' experience, perception and knowledge of the mental health and psychosocial well-being of adolescents in schools, families and communities, and the respective policies and practices about them. There are no right or wrong answers, so they can feel free to express their opinions. Their anonymity is going to be absolutely respected. The way they are going to be cited is by the institution they represent, such as 'representative of the Ministry of Public Education'. Tape-recording will start AFTER the stakeholder finishes his/her personal presentation, and the only reason for recording is because it helps in remembering what was said and for not losing important details. The interview will last for approximately 1 hour.

Before continuing, the interviewer gives participants the information sheet and informed consent forms, and asks them to read thoroughly. If they agree with everything, each participant should sign the consent form.

The following text can be used:

Good morning / day / afternoon, my name is ______________________. I am working as an interviewer of the ______________________ (name of the institution that will conduct the study), which regularly conducts studies into school-related matters and children/adolescent topics. In this context, your information on the policies and services offered to these children/adolescents would be very valuable. I would appreciate if you answered some questions for me, and if we could discuss them together.

Your participation in this study is purely voluntary, and your decision whether or not to participate will not change your future relations with the ministries of public education and of health. If you do decide to participate, you may choose not to answer any individual questions for any reason. If you decide to participate you are also free to completely withdraw your participation at any time without penalty.

For moderator and note-keeper:

1. Moderator ____________________________
2. Note-keeper ___________________________
(if necessary)

Region: ________________________________

Institution/Department within the institution

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____

Years of experience in this position: ________

Date of the interview : ____________________

Notes: ______________________________

____

____

INTERVIEW QUESTIONS

A. Introduction (10-15 minutes)

Now I would like to start with some questions about your role and the function of your institution regarding mental health issues of adolescents and children.

1. What is the role of your institution in addressing children/adolescents' mental health and psychosocial well-being? What part of it relates to school? What about family and community?

2. What is your personal role and responsibility for these issues?

3. Are there any institutions at the local level/mahalla/village that depend on your institution? What is their role?

4. Based on your experience, what are the factors that affect adolescents' mental health and well-being at school? Probe for:
   a. Teacher-student relations;
   b. Peer-to-peer communication;
   c. School violence from teachers and among adolescents;
   d. Family problems: physical or emotional violence, poverty, migration;
   e. School demands: exams, tests, homework.

5. How has the COVID-19 pandemic influenced these issues?

B. Legal and policy framework and service provision (20-30 minutes)

6. What are the current laws/policies/strategies and action plans related to mental health and the psychosocial well-being of adolescents? Do they target schools? In what ways?

7. How are they being implemented? How do you measure their impact?

8. Based on your knowledge and experience, what are the services available through the public sector, NGOs or private sector, related to the mental health and well-being of adolescents? Please be as comprehensive as possible.

9. What are the obstacles that limit services' impact on the situation of adolescents in need of these services? Probe for:
   a. What are the economical obstacles?
   b. What are the legal obstacles?
   c. What are the institutional obstacles?
   d. What are the social/cultural obstacles?
   e. What other obstacles do you identify?
   f. Any differences between rural and urban areas? Other differences?

10. What are the gaps in these existing services? *(If not mentioned, probe about emergency services, suicide prevention services, and school-based services.)*
    a. Why? *(Arguments for your response)*
    b. How can these gaps be reduced?
    c. What types of interventions are needed?
    d. What types of resources are needed?

C. Intersectoral collaboration (10 minutes)

11. How your institution collaborates with other ministries / agencies / institutions at central and local level for developing policies / strategies, and for providing services related to the mental health and psychosocial well-being of adolescents, including preventing suicide?

12. Are there any formal procedures that promote this collaboration? If yes, which ones? If not, what do you think is needed to strengthen this collaboration?

13. What are the challenges in respect to intersectoral collaboration? What more can be done?

D. Recommendations and closure (10-15 minutes)

14. Where do you think efforts should be more urgently concentrated to improve the situation of adolescents with mental health issues? *Probe about: specific areas in the country, school / family / community?*

15. What would you suggest to prevent such issues from worsening at a policy level? Within schools? At family and community levels? What about service provision? Probe about suicide.

16. *(If not mentioned in the previous section, ask)* Are any new services needed? What specifically?

17. What can be done to make available mental health services better?

18. Do you have any further suggestions for the study?

Thank you for your participation!

ANNEX 6

KEY INFORMANT INTERVIEW – COMMUNITY LEADERS/ELDERLY

INTRODUCTION

The moderator makes a presentation of the aim of the interview, as an initiative of the Ministry of Health and the Ministry of Public Education in Uzbekistan. Then s/he explains that the aim of the interview is to know more about the participants' experiences, perceptions and attitudes towards the mental health and psychosocial well-being of adolescents at schools. There are no right or wrong answers, so participants can feel free to express their opinions. They are not obliged to speak, yet their opinion is valuable. Every opinion is respected, but participants can state their own if they don't agree with something. Their anonymity is going to be absolutely respected. Tape-recording will start AFTER all participants have finish personal presentations and the only reason for recording is it helps in remembering what was said and for not losing important details. All participants should keep in mind that only one speaker can talk at a time. If somebody doesn't want to continue, it is his/her right to leave the group without having any sanctions about this.

Before continuing with the presentation, the interviewer gives the participants the information sheet and the informed consent forms and asks them to read thoroughly. If they agree with everything, they should sign the consent form.

The following text can be used:

Good morning / day / afternoon, my name is ____________________. I am working as an interviewer for the ___________________ (name of the institution that will conduct the study), which regularly conducts studies for school-related matters and children/adolescents' topics. In this context, your experience about these issues in your community would be very valuable. I would appreciate if you answered some questions for me and if we could discuss them together.

Your participation in this research is purely voluntary, and your decision whether or not to participate will not change your future relations with the ministries of public education and of health. If you do decide to participate you may choose not to answer any individual questions for any reason. If you decide to participate you are also free to completely withdraw your participation at any time without penalty.

For interviewer and note-keeper:

1. Moderator ______________________________

2. Note-keeper ______________________________
(*if necessary*)

Region: ______________________________

Place: Urban or rural ______________________

Date of interview ________________________

Position of the interviewee: Community leader / elderly / other ____________________

Notes: ______________________________

____

INTERVIEW QUESTIONS

A. Introduction (10-15 minutes)

Now I would like to ask the group some questions about mental health and well-being. There is no right or wrong answer. You can talk from your personal experience/knowledge or opinion.

1. What is considered to be mental health here in your community / mahalla / city? What about mental health disorders?

2. When you hear the term mental health, what comes to your mind? Please give me some examples.
   a. Are there any prejudices in your community related to mental health?
   b. If yes, what specifically?

***Note:** Caution should be taken here, because usually people have prejudices about mental health and connect it only with psychosis and extreme cases. The interviewer should listen to the participants' understanding, and then give the right definition of mental health and mental health disorders by also providing some examples.*

3. What about mental health in children/ adolescents and adults? Is there any difference?

4. In your own words, how would you describe anxiety, depression and stress?

5. What mental health concerns do adolescents in your community face? Have you ever been involved in a case like this? What happened?

B. Factors influencing psychosocial well-being and mental health concerns (30-45 minutes)

6. What is the role of school in preventing or worsening mental health problems in your community? How do children in your community experience school: Is it easy and enjoyable, or difficult and stressful?
   a. What are some factors that influence their experience?

7. Have you ever heard about adolescents having stress/anxiety/depression related to school? Please tell me more about it. What is your experience? How was the experience of families in your community? *Probe for: teachers and communication with them, parents' demands for academic performance, family conflicts, families with limited resources, relations with peers, school demands, violence, and other factors. (The interviewer explores more here in relation to reasons why adolescents experience anxiety.)*

8. Thinking about school premises, and the distances children in your community need to travel to get to school, would you say they are safe? If yes, how do you know? If no, what are your concerns about adolescents' physical safety? *(**Note**: please keep in mind here to differentiate between adolescent boys and girls.)*

9. Have you ever heard about, or had in your community adolescents wanting to hurt themselves? What about children who have attempted or committed suicide? What happened to them? What caused their situation? Did they receive any services after the attempt?

10. We want to make sure to talk about the strengths of community, schools and families, not just about their problems. What aspects of your community, school or family support the mental health of those who live there, and particularly that of adolescents? *(For instance, social/family connections, parks and playgrounds, and certain community organizations.)* Please explain in detail.

11. How has the COVID-19 pandemic affected your community? The children? Their mental health and well-being?

C. Help-seeking behaviour (20-30 minutes)

12. Do adolescents and parents in your community ask for help in such situations? If yes, from where?
    a. What do you think are the barriers to getting help for emotional problems?
13. How easy or hard is it for someone in your community, mahalla or city to get help for mental health issues for their children if they need it?
    a. What makes it easier for people to access these services?
    b. What helps them to seek care?
    c. What makes it difficult? *(For example, are there enough doctors/counsellors available? Language? Do people know where to go?)*
    d. Does it differ by the kind of mental health issue a person faces? Something else about who they are? *(For example, if they are younger children, adolescents, girls and boys, etc.)*
14. How has the COVID-19 pandemic affected access to and availability of these services?

D. Recommendations and closure (10-15 minutes)

15. What would you suggest to prevent the onset of emotional problems in adolescence, and to prevent suicide?
    a. What is the role of community leaders/the elderly in preventing and managing these issues?
    b. What about the role of families?
    c. Primary health care/polyclinics?
    d. Other important services/institutions ? (NGOs, religious institutions, etc.)
16. What can be done to make available mental health services better?
17. Do you have any further suggestions for the study?

Thank you for your participation!

ANNEX 7

QUESTIONNAIRE

TO BE FILLED BY THE INTERVIEWEE BEFORE ENTERING THE CLASSROOM

Students' code ____________ Region ____

1. District ☐ 2. Centre of city ☐ 3. Village ☐ 4. Remote area ☐

Name of the village/city ____

Name of school ____

Address of the school ____

School type (main secondary, general secondary) ________________________________

(At the end) Time for completion of questionnaire ______________________________

TO BE FILLED BY THE INTERVIEWER BEFORE ENTERING THE CLASS

Field researcher code: __________________ Students' code (number): ________________

Region ____ 1. Urban ☐ 2. Rural ☐

Name of the village/city ____

Name of school ____

Address of the school ____

(At the end) Time for completing of questionnaire ______________________________

The Ministry of Health and the Ministry of Public Education in Uzbekistan would like to find out how adolescents in Uzbekistan feel about their lives, and their emotions at school and in their families and communities. They are asking you to complete a survey to help them understand your feelings and views. They would like to know:

- *How satisfied you are with your life.*
- *What makes you feel good about your life.*
- *What makes you feel anxious, sad or stressed.*
- *Who do you turn to when you feel anxious or stressed.*

Your answers will inform the work of the Ministry of Health and the Ministry of Public Education, in helping you to live better lives.

We do not ask your name, and all your answers will be confidential.

There are no right or wrong answers, so please feel free to express your views.

The survey will only take 20-30 minutes to complete.

SECTION 1. ABOUT YOU

In the following section we would like to ask you questions about yourself. We will be using this information to understand who is completing the survey and the information will be kept strictly confidential. Tick the boxes that correspond with your answers.

100. How old are you? ______________ *(Write your age in years, as of the date of undertaking this survey)*

101. What is your gender?

Male ☐ Female ☐

102. What grade are you at school? *(Tick **one** box)*

Grade 6 ☐ Grade 9 ☐ Grade 11 ☐

103. What is the main language(s) you speak at home? *(Tick **all** the options that apply to you)*

1. Uzbek	☐	4. Kazakh	☐	7. Pashto	☐
2. Russian	☐	5. Kyrgyz	☐	8. Dari	☐
3. Tajik	☐	6. Karakalpak	☐	9. Other	☐

104. Do you have any disabilities?

1. Yes ☐ 2. No ☐ 3. Do not wish to answer ☐

105. Do you work? *(Tick "yes" only for a paid job, not house chores or other activities that you do to help the family)*

1. Yes ☐ 2. No ☐ *(Go to Question 200)*

106. If you answered "Yes" in question 105, is it a full-time job (8 hours in a day) or part-time job (less than 8 hours in a day)?

1. Full time (8 hours in a day) ☐
2. Part time (less than 8 hours in a day) ☐

SECTION 2. YOUR FAMILY

In this section we will ask you some questions about your family and the relations you have with your parents and siblings.

200. Which of the following best describes your home? *(Tick only **one** option, which refers to the home you are living **most of the time**)*

1	I live with my parents	☐
2	I live with my foster parents	☐
3	I live with my grandmother and/or grandfather	☐
4	I live with my uncle/aunt; elder brother/sister	☐
5	I live in a children's home	☐

201. With how many other persons do you live under the same roof? ______________________
(Please write the total number of persons you live with together in a house, excluding yourself, even if they are not all members of the same family)

202. Do any of your family members have ... ? *(Answer all sentences from A to D below. Check **one** option for **each** sentence, either "Yes" or "No")*

		Yes	No
A	Disabilities/problems with functioning abilities, either physical or intellectual		
B	Chronic illness		
C	Drug or alcohol problems		
D	Mental health issues (like anxiety or depression)		

203. What is your parents' highest level of education? (*Tick only **one** option for "Father" and **one** for "Mother"*)

	Father		Mother	
1	Primary education	☐	Primary education	☐
2	Lower secondary education (8 or 9 years of education completed)	☐	Lower secondary education (8 or 9 years of education completed)	☐
3	Upper secondary education (high school or 11 years)	☐	Upper secondary education (high school or 11 years)	☐
4	Higher education/university	☐	Higher education/university	☐
5	Postgraduate degree/master/PhD	☐	Postgraduate degree/master/PhD	☐
6	Vocational training (at colleges or lyceums), e.g. to become a plumber, electrician, auto-technician, etc	☐	Vocational training (at colleges or lyceums), e.g. to become a hairdresser, tailor, etc.	☐

	Father		Mother	
7	Other		Other	
8	Don't know		Don't know	

204. During the last year (12 months) did either of your parents live or work far from the family for more than a month?

1. Yes ☐ 2. No ☐ *(Go to Question 206)*

205. If you answered "Yes" to question 204, which parent lived and worked at another place for more than a month?

1. Father ☐ 2. Mother ☐ 3. Both ☐

206. How strongly do you agree or disagree with the following statements about your family? *(Answer all sentences below from A to F, where 1 is "Strongly disagree" and 4 is "Strongly agree". Check **one** option for **each** sentence.)*

		Strongly Disagree	Disagree	Agree	Strongly Agree	I don't know/ don't wish to answer
		1	2	3	4	5
A	My family members (parents/caregivers, brothers/sisters) take care of me.					
B	My family members / caregivers help me whenever I have a problem with school, friends etc.					
C	My family and I have a good time together.					
D	I feel safe at home.					
E	My parents/caregivers listen to me and take into account everything I say.					
F	My parents/caregivers and I make significant decisions for my life together.					

SECTION 3. OVERALL SATISFACTION

In this section we will ask you some questions about your satisfaction with your life, family, relations, your body, etc. Please answer the questions. There are no right or wrong answers.

300. How satisfied or dissatisfied are you with?.. *(Answer all sentences below from A to F, where 1 is for "Very dissatisfied" and 5 is for "Very satisfied". Check **one** option for **each** sentence).*

		Very dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied
		1	2	3	4	5
A	Your family life					
B	Your friendships					
C	Your school experience					
D	Yourself					
E	Where you live					
F	Your life overall					

301. How satisfied or dissatisfied are you with?.. *(Answer all sentences below from A to E, where 1 is for "Very dissatisfied" and 5 is for "Very satisfied". Check **one** option for **each** sentence)*

		Very dis-satisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Very satisfied
		1	2	3	4	5
A	Your weight					
B	With your body size					
C	With your face					
D	With your looks					
E	With your overall body					

SECTION 4. SCHOOL LIFE AND FRIENDS

In this section there are questions about your life at school (teaching, classroom, school performance, friends, etc.) Again, there are no right or wrong answers.

400. How strongly do you agree or disagree with the following statements about your school? *(Answer all sentences from A to Z below, where 1 is for "Strongly disagree" and 4 is for "Strongly agree". Check **one** option for **each** sentence.)*

		Strongly disagree	Disagree	Agree	Strongly agree
	Teachers	1	2	3	4
A	Teachers working at this school treat all students respectfully				
B	Teachers understand my problems				
C	Teachers are available when I need to talk to them				

		Strongly disagree	Disagree	Agree	Strongly agree
D	My teachers care about me				
E	My teachers make me feel good about myself				
F	Teachers are only interested in good students				
	Students	1	2	3	4
G	Students at this school get along well with each other				
H	Students like one another				
I	If I am absent, there is another student or teacher at school that will notice my absence				
	Social connectedness	1	2	3	4
J	I feel like I belong to this school				
K	I feel like I am part of this school				
L	I feel that my friends and others accept me				
M	I feel lonely in the classroom				
	School safety	1	2	3	4
N	I feel safe at this school				
O	I feel safe going to and from this school to my home				
P	I sometimes stay home because I don't feel safe at this school				
Q	Students at this school threaten to hurt other students				
R	Students at this school fight a lot				
S	Students at this school are teased or picked on about their nationality, the economic status of their family, their gender, or for looking or behaving differently, etc.				
T	Students use/try cigarettes, drugs or alcohol while at school or during school activities				
U	School rules are applied equally to all students				
V	Discipline is fair				
	Testing	1	2	3	4
W	Students can ask questions when they don't understand something				
X	Students' mistakes are corrected without them being offended				
Y	Exams measure my real success				
Z	Exam questions are clear and understandable				

401. How often during the last month were you?.. *(Answer all questions below from A to D, where 1 is "Never" and 4 is "3 or more times". Check* ***one*** *option for* ***each*** *question.)*

		Never	Once	2 times	3 or more times
		1	2	3	4
A	Hit by other children in your school				
B	Called unkind names by other children in your school				
C	Left out by other children in your class				
D	Been put down or bullied online, such as through someone posting cruel gossip, rumours, or other harmful material about or towards you				

402. Do you have a mobile phone/tablet, computer or a game console?.. *(Answer all questions below from A to C and check* ***one*** *option for* ***each*** *question.)*

	Item	Yes	No
A	Mobile phone/Tablet		
B	Computer (Laptop, Desktop)		
C	Game console		

403. If you answered "Yes" to at least one option in question 402, how much time, if any, during a day (after classes) do you spent on a mobile phone/tablet, or on a computer or games console? *(Answer all sentences from A to E, where 1 is for "No time" and 4 is for "More than 3 hours". Check* ***one*** *option for* ***each*** *sentence.)*

		No Time	Up to 1 hour	1 to 3 hours	More than 3 hours
		1	2	3	4
A	Social Networking (e.g. Facebook, VK, TikTok, Instagram)				
B	Homework using a computer				
C	Surfing the internet, excluding homework (e.g. webpages, YouTube or other platforms)				
D	Gaming (on a mobile/computer/tablet)				
E	Games console (e.g. Xbox, SPS, DS, etc.)				

SECTION 5. YOUR FEELINGS AND WORRIES

In this part of the questionnaire, we want to know more about your worries and concerns that may make you feel bad, anxious and sad or happy and joyful. Again, there are no right or wrong answers.

500. During the last month did you worry about any of the following things? *(Answer all sentences below from A to K, where 1 is for "Yes" and 2 is for "No". Check **one** option for **each** sentence)*

		Yes (1)	No (2)
A	Exams		
B	The future		
C	The way I look		
D	Being talked about		
E	School		
F	Getting a job		
G	My own health		
H	Someone else's health		
I	Money problems		
J	Family quarrels/arguments		
K	Something else		

501. Have you had any serious problems in the past year (12 months)? *(For example, personal, emotional or behavioural problems that caused you a lot of stress, and made you feel you needed help from a psychologist, psychiatrist or family doctor.) (Choose only **one** option.)*

1	I had few or no problems	☐
2	I have had some problems, but I did not feel I needed professional help	☐
3	I have had some problems, but I did not seek professional help although I thought I needed it	☐
4	I have had some problems and I did seek professional help	☐

502. Below are some statements which are designed to understand how you feel. There are no right or wrong answers. You should just pick the answer which is most accurate for you. *(Answer all sentences below from A to P, where 1 is for "Never" and 3 is for "Always". Check **one** option for **each** sentence)*

		Never (1)	Sometimes (2)	Always (3)
A	I feel lonely			
B	I cry a lot			

		Never (1)	Sometimes (2)	Always (3)
C	I am unhappy			
D	Nobody likes me			
E	I worry a lot			
F	I have problems sleeping			
G	I wake up in the night			
H	I am shy			
I	I feel scared			
J	I worry when I am at school			
K	I get very angry			
L	I lose my temper			
M	I hit out when I am angry			
N	I do things to hurt people			
O	I am calm			
P	I break things on purpose			

503. When you have emotional or social problems, do you talk about them with anyone? If yes, who would you most talk to? *Check all the persons (tick the box) that you would most likely ask for support/help*.

A	The school teachers in general	☐
B	Specific teacher *(like classroom teacher or a favourite teacher)*	☐
C	Parents	☐
D	Neighbour	☐
E	School nurse	☐
F	School psychologist	☐
G	Family doctor	☐
H	Youth worker	☐
I	Friends	☐
J	Brothers and sisters	☐
K	Other family members *(aunts, uncles and cousins)*	☐
L	Pets	☐
M	Grandparents	☐
N	Other	☐
O	I don't talk to anyone	☐

504. What would make a person appropriate for you to ask help when you have social or emotional problems? *(Check all the answers that would make a person appropriate for you to ask for help)*

	S/he should:	
A	Be calm	☐
B	Be a good listener	☐
C	Be objective to the problem (see both sides of the problem)	☐
D	Be positive	☐
E	Be understanding	☐
F	Help me make decisions	☐
G	Be encouraging	☐
H	Other	☐

Pupils in grade 6 please continue to Section 6, Question 600.

505. ***(This question is only for adolescents in grades 9 and 11)*** **Please read each statement and circle a number 1, 2, 3 or 4, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.** *It is important to complete all statements in the following table from 1 to 21, and to check only one option for each statement. 1 is for "Did not apply to me at all" and 4 for "Applied to me very much or most of the time".*

		Did not apply to me at all	Applied to me to some degree, or some of the time	Applied to me to a considerable degree or a good part of time	Applied to me very much or most of the time
1	I found it hard to wind down	1	2	3	4
2	I was aware of dryness in my mouth	1	2	3	4
3	I couldn't seem to experience any positive feeling at all	1	2	3	4
4	I experienced breathing difficulties *(e.g. excessively rapid breathing, or breathlessness in the absence of physical exertion)*	1	2	3	4
5	I found it difficult to work up the initiative to do things	1	2	3	4
6	I tended to over-react to situations	1	2	3	4
7	I experienced trembling *(e.g. in the hands)*	1	2	3	4
8	I felt that I was using a lot of nervous energy	1	2	3	4

		Did not apply to me at all	Applied to me to some degree, or some of the time	Applied to me to a considerable degree or a good part of time	Applied to me very much or most of the time
9	I was worried about situations in which I might panic and make a fool of myself	1	2	3	4
10	I felt that I had nothing to look forward to	1	2	3	4
11	I found myself getting agitated	1	2	3	4
12	I found it difficult to relax	1	2	3	4
13	I felt down-hearted and blue	1	2	3	4
14	I was intolerant of anything that kept me from getting on with what I was doing	1	2	3	4
15	I felt I was close to panic	1	2	3	4
16	I was unable to become enthusiastic about anything	1	2	3	4
17	I felt I wasn't worth much as a person	1	2	3	4
18	I felt that I was rather touchy	1	2	3	4
19	I was aware of the action of my heart, even though I wasn't doing any physical activities *(e.g. sense of heart rate increase, heart missing a beat)*	1	2	3	4
20	I felt scared without any good reason	1	2	3	4
21	21. I felt that life was meaningless.	1	2	3	4

SECTION 6. EXPERIENCE OF COVID-19 PANDEMIC

600. During the last lockdown, how often did you feel each of the following when you thought about COVID-19? *(Answer all statements below from A to F, where 1 is for "Never" and 5 is for "Always". Check one option for each sentence)*

		Never	Seldom	Sometimes	Frequently	Always
		1	2	3	4	5
A	Nervous					
B	Calm and relaxed					
C	Worried about my health					
D	Worried about the health of my family members					

		Never	Seldom	Some-times	Fre-quently	Always
		1	2	3	4	5
E	Stressed about leaving my house					
F	Lonely, and missed seeing my friends					

601. Overall, how much has COVID-19 pandemic affected your life in a *good* way? *(Tick only **one** box)*

1	Not at all	☐ *Go to question 603*
2	A little	☐
3	Somewhat	☐
4	A lot	☐
5	A great deal	☐

602. If answered "2 – A little", "3 – Somewhat", "4 – A lot" and "5 – A great deal" in question 601, please tell us what have been the best things for you during the pandemic? *(Read until the end and select 1 for "Yes" and 2 for "No" in each sentence)*

		Yes 1	No 2
A	Reduced amount of schoolwork or no schoolwork		
B	Less stress / pressure from school and activities		
C	More time to relax		
D	Getting to do things I don't usually have time for *(e.g. art, music, writing, cooking)*		
E	Getting more recreational time on the phone / computer *(e.g. texting, social media)*		
F	Getting to watch more TV / movies		
G	More time to exercise or go outside		
H	Getting more sleep		
I	Spending more time with family		
J	Spending more time with my pet(s)		
K	Not having to deal with other people at school		
L	Feeling like I have more control in creating my own schedule		
M	Other		

603. Overall, how much has COVID-19 (coronavirus) affected your life in a *bad* way? *(Tick only **one** box)*

1	Not at all	☐ *This is the end of the questionnaire!*
2	A little	☐
3	Somewhat	☐
4	A lot	☐
5	A great deal	☐

604. If answered "2 - A little", "3 – Somewhat", "4 – A lot" or "5 – A great deal" in question 603, please tell us what have been the worst things for you due to COVID-19 (coronavirus)? *(Read until the end and select 1 for "Yes" or 2 for "No" in each sentence)*

		Yes 1	No 2
A	Worrying about someone who has or has had the virus		
B	Having to stay at home		
C	Not seeing friends or family in person		
D	Thinking about how many people are dying because of the virus		
E	Feeling scared about the future		
F	Not going to school		
G	Spending more time with family		
H	Increased stress or pressure from schoolwork		
I	Increased stress or disorientation from not having a schedule		
J	Not having access to things I needed *(i.e. food, products)*		
K	Worrying about my family's income (money)/parents' work		
L	Other		

Thank you for your participation!

ANNEX 8

INFORMATION SHEET 1 – SURVEY, ADOLESCENTS

Full title of study: A comprehensive study on adolescent school students' needs, and school-related factors impacting the mental health and well-being of adolescents

With this questionnaire we want to know more about how you feel about your life, your emotions at school, in your family and community, and how you experienced the COVID-19 pandemic. The questions on this survey will help us understand your feelings and views. Specifically, we would like to know:

- How satisfied you are with your life?
- What makes you feel good about your life?
- What makes you feel anxious, sad or stressed?
- Who do you turn to when you feel anxious or stressed?

At the end of this study we will provide recommendations, based on the results, on how to improve the situation of adolescents in Uzbekistan.

Who is conducting this study?

The Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education, and the Ministry of Health, are both conducting the study. There are several researchers, like the one in your classroom, that will visit 300 schools in Uzbekistan, and gather approximately 24,000 questionnaires.

Why me?

We are asking you to fill in the questionnaire because you are in one of the grades containing the age groups we are focused on, including grades 6, 9 and 11.

What will happen?

You will fill in a questionnaire that will be distributed in class by the researcher. The researcher will explain to you what you need to do. You will have sufficient time to fill in the questionnaire. There are no right and wrong answers, because for us it is important to understand your opinions and experiences. If you have any questions, you can ask them to the researcher and they will try to explain everything you don't understand.

Where and when will the study take place?

This study started in November 2021 and it will end in July 2022. The research will take place in all 14 regions of Uzbekistan.

Do I have to take part?

You are not obliged to take part. However, this could be an interesting experience for you. It also gives you the opportunity to share your

concerns about problems you may be experiencing, and help the government make better decisions about these issues.

Both you and your parent/guardian must agree to you being in the study. Even if your parent or guardian says yes, you may still say no, and that is okay. You do not have to be in this study if you do not want to. Nothing bad will happen to you if you say no now, or change your mind later after starting the study. You just need to tell me if you want to stop being in the study. I will ask you later if you want to stop or if you want to keep going. It’s okay to say yes or no.

If you decide not to take part in the study, while the other students are filling in the questionnaire you can do your schoolwork, homework or ask your teacher what else you can do outside the classroom.

Will all information be kept confidential?

Yes. Our work is for study purposes only. We will keep the information we collect for the study safe and secure. The Ministry of Public Education and UNICEF in Uzbekistan have access to the data, and will both be responsible for its safe storage.

We will not share information that has your name on it with people who are not part of the research team, unless we have to. However, if I notice or if you tell me that you may be in danger from other people (like if you are experiencing violence, bullying or other negative experiences) or if you want to hurt yourself, I am obliged to share this information with your parent or to a professional, for you to get help. We can discuss together to whom you would like to address this concern (to a parent, school psychologist or another person).

How can I contact the researcher?

If you have any concerns or questions, please contact:

____

Director of the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education

If you need to contact a professional and discuss your concerns, please contact one of the persons on the list.

Thank you very much!

ANNEX 9

ASSENT STATEMENT 1– SURVEY, ADOLESCENTS

I ____ agree to be in this study, titled
(your name)

____.
(the name of the study)

What I am being asked to do has been explained to me by __________________________.
(name of the researcher in your classroom)

I understand what I am being asked to do and I know that if I have any questions, I can ask ____

____ at any time. I know that I can quit
(name of the researcher in your classroom)

this study whenever I want to and it is perfectly OK to do so. It won't be a problem for anyone if I decide to quit.

Name: ____ Signature _________________

Researcher's Name: ________________________________ Date __________________

ANNEX 10

INFORMATION SHEET 2 – FOCUS GROUP DISCUSSION, ADOLESCENTS

Full title of study: A comprehensive study on adolescent school students' needs, and school-related factors impacting the mental health and well-being of adolescents

Below you can find information about the study we are conducting. If you don't understand any of the questions, or if you want to ask about something that is not clear, you can ask the researcher who is going to conduct the discussion with you and the other adolescents.

What is the purpose of this study?

With this discussion we want to know more about how you feel about your life, your emotions at school, in your family and community, and how you experienced the COVID-19 pandemic. The questions will help us understand your feelings and views. Specifically, we would like to know about how school affects your feelings and behaviour, your satisfaction with life, school, family and relations, about children who want to hurt themselves and how to prevent this situation, who are the persons you or your friends can ask for help insider and outside of school, your personal experience with contacting these persons (psychologists or others), your recommendations to improve their work, and other matters.

Also, at the end this study we will develop recommendations, based on the results, on how to improve the situation of adolescents in Uzbekistan.

Who is conducting this study?

The Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education, and the Ministry of Health, are both conducting this study. There are several researchers, like the one that is doing the focus group discussions, that will visit 300 schools in Uzbekistan and will gather approximately 24,000 questionnaires. Also, other children like you will participate in focus group discussions.

Why me?

We are asking you to participate in the focus group discussion because of your age. This study will be carried out with adolescents aged 12 to 18 years.

What will happen?

We will talk for 1 - 1 ½ hours in a group with other adolescents about the topic explained above. You can decide whether you want to talk to me [the researcher] or not. I will ask you some questions and will record the conversation on a tape-recorder or will take notes, depending on your wish. You can de-

cide whether you want to answer any of the questions, and what you want to say to me. In case you do not want to continue the talk, you can leave at any time. If in doubt, you can ask me to change the information you gave me. Although I would highly appreciate if you decided to talk to me and take part in the research, it is not possible for me to compensate you in money for your time and effort.

Where and when will the study take place?

This study started in November 2021 and it will end in July 2022. The research will take place in all the 14 regions of Uzbekistan.

Do I have to take part?

You are not obliged to take part. However, this could be an interesting experience for you. It also gives you the opportunity to share your concerns about problems you may be experiencing, and help the government make better decisions about these issues.

Both you and your parent/guardian must agree to you being in the study. Even if your parent or guardian says yes, you may still say no, and that is okay. You do not have to be in this study if you do not want to. Nothing bad will happen to you if you say "no" now, or change your mind later after starting the study. You just need to tell me if you want to stop being in the study. I will ask you later if you want to stop or if you want to keep going. It's okay to say yes or no.

Will all information be kept confidential?

Yes. Our work is for study purposes only. We will keep the information we collect for the study safe and secure. The Ministry of Public Education and UNICEF in Uzbekistan have access to the data, and both are responsible for storing it safely.

We will not share information that has your name on it with people who are not part of the research team, unless we have to. We will use pseudonyms, instead of your name or your initials. Your identity will be known to other focus group participants, and the researcher cannot guarantee that others in the group will respect the confidentiality of the group. As a researcher, I ask that you will keep all comments made during the focus group confidential, and not discuss what happened during the focus group outside the meeting with other people.

However, if I notice or if you tell me that you may be in danger from other people (like if you are experiencing violence, bullying or other negative experiences) or if you want to hurt yourself, I am obliged to tell this information to your parent or to a professional, for you to get help. We can discuss together to whom you would like to address this concern (parent, school psychologist, or another person).

How can I contact the researcher?

If you have any concerns or questions please contact:

____

Director of the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education.

If you need to contact a professional and discuss your concerns, please contact one of the persons on the list.

Thank you very much!

ANNEX 11

ASSENT STATEMENT 2 – FOCUS GROUP DISCUSSION, ADOLESCENTS

I ____ agree to be in this study, titled
(your name)

____.
(the name of the study)

What I am being asked to do has been explained to me by __________________________.
(name the group moderator)

I understand what I am being asked to do and I know that if I have any questions, I can ask ____

____ at any time. I know that I can quit
(name the group moderator)

this study whenever I want to and it is perfectly OK to do so. It won't be a problem for anyone if I decide to quit.

Name: ______________________________________ Signature ___________________
(your name)

Researcher's Name: ________________________________ Date __________________

I agree with my responses expressed in this group being tape-recorded, and then written in a word document for later analysis. I understand that I will not be identified when these responses are referred to.

Name: ______________________________________ Signature ___________________
(your name)

Researcher's Name: ________________________________ Date __________________

ANNEX 12

INFORMATION SHEET 3 – SURVEY, PARENTS/GUARDIANS

Full title of study: A comprehensive study on school adolescents’ needs, school related factors impacting mental health and wellbeing of adolescents

This This form contains information about the study. Please note that this information is not exhaustive. You can ask any questions that may arise to the teacher who will distribute this sheet, or directly to the field researcher who will be in the classroom.

What is the purpose of this study?

The purpose of this study is to explore the needs of adolescent school students (aged 12 to 18 years old), school-related factors impacting their mental health and well-being, and mapping existing policies and schools’ strategies and actions for recognizing, mitigating and addressing mental health issues of adolescents in and outside school. Some of the topics of this study include: perception about oneself, perception about family, school life and friends, feelings and worries, life satisfaction and COVID-19 experience. In its conclusion this study will provide recommendations, based on the results, on how to improve the situation.

Who is conducting this study?

The Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education, and the Ministry of Health, is conducting this study. The researchers involved in the study are experienced staff from the above institutions. The study will be conducted at 300 schools in Uzbekistan, and will involve gathering approximately 24,000 questionnaires.

What will happen if my child takes part in the study?

Your child will fill a questionnaire that will be distributed in the class by a researcher. The researcher will explain to your child what he/she needs to do. Your child will have sufficient time to fill in the questionnaire. There are no right and wrong answers, for us it is important to understand your child’s opinions and experiences. If you have any questions, you can ask the researcher or the classroom teacher and they will try to explain everything you don’t understand.

Where and when will the study take place?

This study started in November 2021 and it will end in July 2022. The research will take place in all regions of Uzbekistan.

What information will be collected?

I will ask your child about his/her experience in relation to understanding mental health for adolescents, how school can affect their psychosocial well-being, adolescents’ satis-

faction with life, school, family and relations, suicide and its prevention, mental health services that are provided inside and outside of school, personal experience with contacting and receiving these services, recommendations to improve them, and other matters.

Is my child obliged to take part?

Your child is not obliged to take part. However, this can be an interesting experience for them. It also gives them the opportunity to share their concerns about problems they may be experiencing, and influence the attitude of institutions and government towards the mental health needs of adolescents in Uzbekistan.

Will all information be kept confidential?

Yes. Our work is for study purposes only. Therefore, the information you will give me will be read only by the research team. The Ministry of Public Education and UNICEF in Uzbekistan can have access to the data, and both are responsible for its safe storage. We will not include your child's name or other indicators that may disclose them and their experiences to others, unless you prefer for them to not remain anonymous.

However, if I notice or if your child tells me that they may be in danger from other people or if they want to hurt themselves, I am obliged to tell this information to you (parent/guardian) or to a professional, for them to get help.

How can I contact the researcher?

If you have any concerns or questions please contact:
Director of the Republican Center of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education

If you need to contact a professional and discus about your concerns please contact one of the persons in the list.

Thank you very much!

ANNEX 13

INFORMED CONSENT FORM 3 – SURVEY, PARENTS

Full title of study: A comprehensive study on adolescent school students’ needs, and school-related factors impacting the mental health and well-being of adolescents

Yes	No	
☐	☐	I confirm that the purpose of the study has been explained and that I have understood it.
☐	☐	I have had the opportunity read the information sheet and ask question, and they have been successfully answered.
☐	☐	I understand that my child’s involvement in this study is voluntary and that my child is free to stop the process or withdraw from it at any time, without giving a reason and without consequence.
☐	☐	I confirm that I have received information about, and understand the research being conducted, and I agree that my child participates in this study.
☐	☐	I consent to my child’s questionnaire being used for this study and that I understand that my child will be referred to anonymously in any publications.

By signing this form, I agree that my answers, which I have given voluntarily, can be used for research purposes.

Researcher	**Participant**
______________________	______________________
______________________	______________________
(Signature)	*(Signature)*
Date ______________________	Date ______________________

ANNEX 14

INFORMATION SHEET 4 – FOCUS GROUP DISCUSSION, PARENTS/GUARDIANS

Full title of study: A comprehensive study on adolescent school students' needs, and school-related factors impacting the mental health and well-being of adolescents

Below you can find information about the study we are conducting. If you don't understand any of the questions or if you want to ask something that is not clear, you can ask the classroom teacher who provided you with this letter, or the researcher.

What is the purpose of this study?

The purpose of this study is to explore the needs of adolescent school children (12 to 18 years old), school-related factors impacting their mental health and well-being, and mapping of existing policies and schools' strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents in and outside school. Some of the topics of this study are perception about oneself, perception about family, school life and friends, feelings and worries, life satisfaction, and COVID-19 experience. Also, at the end of this study recommendations will be developed based on the results on how to improve the situation.

Who is conducting this study?

The Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education, and the Ministry of Health, are conducting the study. There are several researchers, like the one who is undertaking the focus group discussions, who will visit 300 schools in Uzbekistan and gather approximately 24,000 questionnaires. Also, other children will participate in focus group discussions, like your child.

Why my child?

We are asking your child to participate in the focus group discussion because of their age. This study will be carried out with adolescents aged 12 to 18 years old.

What will happen?

We will talk with your child for 1- 1 ½ hours in a group with other adolescents about the topic explained above. They can decide whether they want to discuss with me or not. I will ask them some questions and will record the conversation in a tape-recorder, or will take notes, depending on your wishes and those of your child. Your child can decide whether they want to answer any of the questions and what they want to say to me. In case they do not want to continue the talk, they can leave

at any time. If in doubt, they can ask me to change the information they gave me. Although I would highly appreciate it if you decided to give permission to your child to participate in the research, it is not possible to me to compensate you or your child in money for your time and effort.

Where and when will the study take place?

This study started in November 2021 and it will end in July 2022. The research will take place in all 14 regions of Uzbekistan.

Is my child obliged to participate?

Your child is not obliged to take part. However, this can be an interesting experience for them. It also gives them the opportunity to share their concerns about problems they may be experiencing, and help the government and other specialized institutions take better decisions about these issues.

You do not have to allow your child to be in the study if you do not want to. Nothing bad will happen to you or your child if you say "no" now or change your mind later after starting the study. You or your child just need to tell me if you want to stop being in the study.

Will all information be kept confidential?

Yes. Our work is for study purposes only. We will keep the information we collect for the study safe and secure. The Ministry of Public Education and UNICEF in Uzbekistan have access to the data, and both are responsible for its safe storage.

We will not share information that has your child's name on it with people who are not part of the research team, unless we have to. We will use pseudonyms instead of your child's name or initials. However, your child's identity will be known to other focus group participants and the researcher cannot guarantee that others in the group will respect the confidentiality of the group. The researchers will ask them to keep all comments made during the focus group confidential and to not discuss what happened during the focus group outside the meeting with other people.

However, if we notice or if they tell us that they may be in danger from other people (like if they are experiencing violence, bullying, or other negative things) or if they want to hurt themselves, we are obliged to tell this information to you (parent or guardian) or to a professional, for them to get help.

How can I contact the researcher?

If you have any concerns or questions please contact:
Director of the Republican Center of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education

If you need to contact a professional and discus about your concerns, please contact one of the persons on the list.

Thank you very much!

ANNEX 15

INFORMED CONSENT FORM 4 –
FOCUS GROUP DISCUSSIONS, PARENTS

Full title of study: A comprehensive study on adolescent school students' needs, and school-related factors impacting the mental health and well-being of adolescents

Yes	No	
☐	☐	I confirm that the purpose of the study has been explained and that I have understood it.
☐	☐	I have had the opportunity to read the information sheet and ask questions, and they have been successfully answered.
☐	☐	I understand that my child's involvement in this study is voluntary and that my child is free to stop the process or withdraw from it at any time, without giving a reason and without consequence.
☐	☐	I confirm that I have received information about, and understand the research being conducted, and I agree that my child participates in this study.
☐	☐	I consent to my child's verbal responses being used for this study and that I understand that my child will be referred to anonymously in any publications.
☐	☐	I agree to have my child's responses tape-recorded and then write them in a word document for analysis. I understand that he/she will not be identified with these responses.

By signing this form, I agree that my child's answers, which he/she has given voluntarily, can be used for research purposes.

Researcher	**Participant**
______________________________	______________________________
(Signature)	*(Signature)*
Date ______________________	Date ______________________

ANNEX 16

INFORMATION SHEET 5 – INTERVIEWS AND FGDS, WITH PARENTS, SCHOOL PSYCHOLOGISTS, MEDICAL WORKERS, GOVERNMENT REPRESENTATIVES, SERVICE PROVIDERS, INDEPENDENT EXPERTS, THE ELDERLY AND COMMUNITY LEADERS

Full title of study: A comprehensive study on adolescent school students’ needs, and school-related factors impacting the mental health and well-being of adolescents

This form contains information about the study. Please note that this information is not exhaustive. You can ask any questions that may arise during individual interviews or group discussions.

What is the purpose of this study?

The purpose of this study is to explore the needs of adolescent school students (aged 12 to 18 years old), school-related factors impacting mental health and well-being of school adolescents, and mapping of existing policies and schools’ strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents inside and outside of school. Also, at the end of this study, recommendations will be provided based on the results on how to improve the situation.

Who is conducting this study?

The Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education is conducting this study about the mental health needs of children and adolescents inside and outside of school. Field researchers are experienced staff from the above institutions.

What will be involved if I take part in this study?

The interview/focus group discussion will last approximately 1 - 1 ½ hours, focused on the topic explained above. You can decide whether you want to be part of the interview or participate in the focus group discussion. During the process the interviewer will ask you some questions, and will record the conversation in a tape-recorder or they will take notes, depending on your wish. You can decide whether you want to answer any of the questions and what you want to say. In case you do not want to continue the interview/group discussion, you can leave at any time. If in doubt, you can ask me to change the information you gave me. Although I would highly appreciate it if you decided to talk to me, it is not possible to me to compensate you in money for your time and effort.

Where and when will the study take place?

This study started in November 2021 and will end in July 2022. The research will take place in all regions of Uzbekistan.

What information will be collected?

The collected information will relate to the understanding of the mental health of adolescents, how schools can affect their psychosocial well-being, adolescents' satisfaction with life, school, family and relations, suicide and its prevention, mental health services provided inside and outside of school, adolescents' personal experience with contacting and receiving these services, recommendations to improve them, and other matters.

Do I have to take part?

Participation in the study is absolutely voluntary. You are not obliged to take part. However, this can be an interesting experience. It also gives professionals/policy-makers the opportunity to share their concerns about problems they are experiencing and influence the attitudes of institutions and government towards the mental health needs of adolescents in Uzbekistan.

Will all information be kept confidential?

Yes. Our work is for study purposes only. Therefore, the information you give me will be read only by the research team. I will transcribe and analyse your interview/focus group discussion and may include some of your expressions as you say them in my writings. I will not include your name or other indicators that may disclose you and your experiences to others, unless you prefer not to remain anonymous. I will not talk about you or our discussion with other people, and will treat the recorded material with great care.

Also, the Ministry of Public Education and UNICEF in Uzbekistan have access to the data and are both responsible for safely storing it.

Who can I contact if want to?

If you have any concerns or questions please contact:
Director of the Republican Center of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education

Thank you very much!

ANNEX 17

INFORMED CONSENT FORM 5 - PARENTS, SCHOOL PSYCHOLOGISTS, MEDICAL WORKERS, GOVERNMENT REPRESENTATIVES, SERVICE PROVIDERS, INDEPENDENT EXPERTS, THE ELDERLY AND COMMUNITY LEADERS

Full title of study: A comprehensive study on adolescent school students' needs, and school-related factors impacting the mental health and well-being of adolescents

Yes	No	
☐	☐	I confirm that the purpose of the study has been explained and that I have understood it.
☐	☐	I have had the opportunity read the information sheet and to ask questions and they have been successfully answered.
☐	☐	I understand that my involvement in this study is voluntary and that I am free to stop the interview/FGD participation and withdraw at any time, without giving a reason and without consequence.
☐	☐	I confirm that I have received information about, and understand the research being conducted, and I agree to participate in this study.
☐	☐	I consent to my interview/FGDs responses being used for this study and that I understand that I will be referred to anonymously in any publications.
☐	☐	I agree to have my verbal responses tape-recorded and then transcribe them for analysis. I understand that I will not be identified with these responses.

By signing this form, I agree that my answers, which I have given voluntarily, can be used for research purposes.

Researcher

____
(Signature)

Date ______________________________

Participant

____
(Signature)

Date ______________________________

ANNEX 18

WEIGHTING

Based on the TIMSS and PIRLS methodology, the sample of this study was designed for 300 schools. One school was out of the study's scope, because the children studying there were with visual disabilities. So the final school selection was 299.

The total number of persons who responded to the questionnaires were 22,854, while the initial intended sample was 24,107 students.

Overall, 299 schools and a total of 877 classes participated in the study. Of the selected schools, 10 didn't have any students in one class, in grades 6, 9 or 11.

Two schools were replaced with the previous one in the list. Those schools were under construction or were in online learning mode. Both of them were in Tashkent region. So, the sample schools were adjusted for this region, because of the replacement. All short-listed classes participated in the survey.

The initial and final sample appears in Table 8.

The below Table 9 presents the distribution of schools according to regions.

Table 8. *Initial and final sample*

	Grade 6	Grade 9	Grade 11	Total
Initial sample	8,207	8,186	7,714	24,107
Actual sample	7,830	7,793	7,231	22,854
Difference	377	393	483	1,253

Table 9. *School distribution according to region*

Region	Number of school sampled
Republic of Karakalpakstan	18
Andijan	26
Bukhara	14
Jizzakh	13
Kashkadarya	29
Navoi	10

Region	Number of school sampled
Namangan	24
Samarkand	34
Surkhandarya	24
Syrdarya	7
Tashkent	24
Fergana	30
Khorezm	16
Tashkent city	30
Total	**299**

Sampling frame

The target population for this study is the total number of children attending schools. So, there are 10,130 schools and a total of 6,175,972 students from 14 different regions.

Weighting

Weighting was comprised of three components:

1. Weight of the school within the region.
2. Weight of the class within the grade.
3. Weight of the student within the selected grade.

In each step, an adjustment for non-response was conducted

Selected classes

In each school 3 classes from 3 different grades were selected. In 10 schools there wasn't any student in a selected class, so only 2 classes participated in the study in those schools (Table 10).

School weighting component

Given that schools in this study (following the TIMSS and PIRLS methodology) are sampled with probability proportional to school size (to enrolment), the basic school weight for the ith sampled school (i.e., the inverse of the probability of the ith School being sampled) is defined as:

$$W^{i}sc = \frac{M}{n \cdot m_i}$$

where: n is the number of sampled schools,
m_i is the measure of size for the ith school,

$$M = \sum_{i=0}^{N} m_i$$

where: N is the total number of schools in the explicit stratum.

Regions are used as stratum in our frame. So, in total we have 14 stratums.

School Nonparticipation Adjustment – if a sampled school does not participate in the study and neither does either of its two designated replacement schools, it is necessary to adjust the basic school weight to compensate for the reduction in sample size. For this study, there was only one school that did not participate and it was not replaced. The

school-level nonparticipation adjustment is calculated separately for each explicit stratum, as follows:

$$Asc=\frac{n_s+n_{r_1}+n_{r_2}+...+n_{n_r}}{n_s+n_{r_1}+n_{r_2}}=\frac{24+1+1+2}{24+1+1}=$$
$$=1.07692$$

where n_s is the number of originally sampled schools that participated,

n_{r_1} and n_{r_2} are the number of first and second replacement schools, respectively, that participated,

n_{n_r} is the number of schools that did not participate. Sampled schools that are found to be ineligible are not included in the calculation of this adjustment,

$n_s=17$,

$n_{r_1}=1$,

$n_{r_2}=1$,

$n_{n_r}=2$.

Combining the basic school weight and the school nonparticipation adjustment, the final school weighting component for the ith school becomes:

$$Wsc^i = Asc \cdot W^i sc$$

Classes weighting component

Given that schools in this study were sampled with probability proportional to school size, the basic school weight for the ith sampled school (i.e., the inverse of the probability of the ith class being sampled) is defined as:

$$W_{cl}^i=\frac{M}{n \cdot m_i}$$

$$M=\sum_{i=0}^{N} m_i$$

where n is the number of sampled classes within the grade (in our case is n=1),

m_i is the measure of size for the ith class,

N is number of classes in this school in that grade.

Students weighting component

The students weighting component represents the student-within-class selection probability. The basic student weight is the inverse of the probability of a student in a sampled class being selected. According to the methodology we do not have subsampling in selected class. So, all students inside the selected class is selected.

For an intact class with no student subsampling, the basic student weight for the jth class in the ith school is computed as follows:

$$W_{st}=1$$

Adjustment for Student Nonparticipation — student nonparticipation adjustment for the jth classroom in the ith school is calculated as:

$$Ast=\frac{S_{r_s}+S_{n_r}}{S_{r_s}}$$

where S_{r_s} – Number of students selected and responded,

S_{n_r} – Number of students selected but not responded

The final student weights formula is

$$W_{st}=W_{sc} \cdot W_{cl} \cdot W_{st}$$

ANNEX 19

TERMS OF REFERENCE

Background

In Uzbekistan, the national authorities appreciate mental health as being a new priority in public health, although there are still clear indicators that mental health remains a serious public health problem in the country. Uzbekistan has among the highest mortality rates related to suicides and self-harm among children aged 10-19 years, of all the Central Asian countries. The suicide mortality rate in 2019 was 9.8 for 100,000 adolescents aged 10 to 19 years. Boys and girls in the age group of 15 to 19 years represent the highest share of deaths caused by suicide and self-harm. Boys aged 15 to 19 represent 74 per cent of the 10-19 year male mortality rate due to suicide and self-harm. Girls in the 15 to 19 year age group represent 80 per cent of the 10-19 year female mortality rate due to suicide and self-harm. The mortality rate due to suicide and self-harm amongst children aged 19 years and less has been increasing consistently from year to year, and has almost doubled for boys and tripled for girls since 2008. Never in history has it been higher than now.

The leading five causes that contribute to the disability-adjusted life years (DALYs) lost among adolescents in 2019 present a clear prevalence of mental disorders (depressive and eating disorders) among adolescent girls 10 to 19 years, and among adolescent boys after unintentional injuries.

Addressing mental health needs in school is critically important, as school is where children and adolescents spend a large part of their time – at school there are social experiences and challenges, learning demands and mental overload, and psychological stress.

Being able to recognize and support childrens' mental health in schools matters because:

- Mental health problems are common and often develop during childhood and adolescence.
- They are treatable!
- Early detection and intervention strategies work. They can help improve resilience and young people's ability to succeed in school and life.

Therefore it is important to use the school platform to understand the mental health needs of the student population and school-related factors that impact the mental health and well-being of adolescent boys and girls. This is because school-related factors, such as socio-emotional and physical safety, connectedness to schools, relationship between teachers and students and among peers, capacity of teachers and the learning environment, are all key factors impacting the mental health and well-being of adolescent boys and girls. School-related factors influence the risk of adolescents' exposure to depressive symptoms, anxiety, violence, and bullying/mobbing, but they also serve as an opportunity to contribute to the better mental health development of adolescents. In addi-

tions, academic pressure, which is the mental distress related to anticipated frustration associated with academic failure or awareness of the possibility of such failure, is increasingly prevalent. Apart from parental expectations and social norms, factors of the content or organization of learning, such as overloaded curriculum, rigid assessment criteria and high stake exams, all contribute to the increasing academic pressure placed on adolescent boys and girls.

In Uzbekistan, the provision of mental health and psycho-social services to students falls within the remit of a few select ministries, including the Ministry of Health (MoH) and the Ministry of Public Education (MoPE). To varying degrees the provision of psycho-social support to adolescents is the responsibility of the Ministry of Interiors (MoI) and the Ministry on Mahalla and Family affairs (MMFA). Each Ministry has a different paradigm of administration, with different areas of responsibility, roles and functions, and has their own programmes and models for dealing with mental health and psychosocial issues. However, there is a need for multitiered mental health services providing primary, secondary and tertiary interventions for which different sectors play different roles in delivery. Currently there is a lack of coordination between sectors and tiers in the provision of services, as well as a lack of quality and gender-responsive services and human resources needed for the care and treatment of people in psychosocial distress. Stigma around mental health disorders, and a lack of awareness of mental health and psychosocial-related issues, as well as limited knowledge of the availability of existing mental health services, also hinders practices in seeking qualified help. In addition, the current service delivery is mainly targeting a limited group of people with severe mental disorders, and pays relatively little attention to the provision of services for adolescents' mental health and for those in psychosocial distress.

Meanwhile professional psychological support and counselling for children and adolescents, otherwise regarded as an essential part of the solution to mental health issues currently faced in schools, is scarce or inaccessible. According to official data only a half (45 per cent) of school psychologists have a bachelor's degree in psychology, while 20 per cent have undergone trainings in psychology, 34 per cent have not received any kind of specialized training preceding their provision of psychological services in schools and are themselves teachers, and the remaining 1 per cent are those who have graduated from specialized colleges/lyceums. In addition, a lack of required skills for supporting adolescents with mental health issues impacts the ability of psychologists to provide quality counselling.

Moreover the COVID-19 pandemic, in relation to both its containment measures and its socio-economic impact, has created uncertainties, stress and distress. This has impacted the mental health and psychosocial well-being of large numbers of children, adolescents and caregivers, and worsened existing mental health issues, especially for those whose support and/or treatment may have been disrupted as a result of containment measures. In fact, the pandemic also revealed the stark realities of the limitations of current mental health and psycho-social services provision, highlighting significant gaps in systems, services and the related workforce. It also highlighted barriers to accessing available support, including for marginalized and vulnerable groups (including children with disabilities and migrant children), and for those living outside urban centres.

To address these matters, UNICEF Uzbekistan seeks International and National Consultancies to better understand school adolescents' needs; the impact of school-related factors on the mental health and well-being of adolescent boys and girls; and to map mental health services for adolescents in school in Uzbekistan. It will also explore the role of the education system in reducing stress and anxiety of adolescents, and building the social and emotional skills they need to succeed in

life. The research findings and recommendations will form the basis of future guidelines to strengthen the work of UNICEF Uzbekistan and its partners in the design, implementation, and subsequent monitoring and evaluation of their mental health programme. The national consultant will work jointly with the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education, which has technical expertise in the research and analysis of mental health and psychological well-being of adolescents, to address this complex and multi-layered issue in Uzbekistan's context.

The study will inform UNICEF, partners and donors about school adolescents' needs, school-related factors impacting the mental health and well-being of school adolescents, and mapping existing policies and schools' strategies and actions for recognizing, mitigating and addressing the mental health issues of adolescents both inside and outside of school.

Purpose and objectives

The main objective of this consultancy is to provide support to the Ministry of Public Education of Uzbekistan in better understanding adolescent school students' needs, the school-related factors impacting the mental health and well-being of these students, and mapping existing policies and schools' strategies and actions for recognizing, mitigating and addressing mental health issues of adolescents inside and outside of school. Based on the evidence, the study will provide age-disaggregated and gender-sensitive recommendations to address the mental health and psychosocial needs of younger and older adolescent boys and girls through the school platform.

More specifically, the consultancy will need to:

- Provide an overview of available evidence and analysis of:
    - i) school adolescents' mental health needs;
    - ii) school-related factors affecting the mental health issues of adolescents in Uzbekistan; and
    - iii) taking stock of the key stakeholders, policies, legislations, standards and programme relating to the mental health and well-being of adolescents in Uzbekistan.
- Map existing policies and schools' strategies and actions in recognizing, mitigating and addressing mental health issues of adolescents inside and outside of school.
- Provide recommendations and action plans on using the school platform to provide mental health and psychosocial support, and to mitigate and prevent school related mental health risks, especially during the COVID-19 pandemic. Consider different modalities for reaching younger and older adolescents.

Methodology/activities

The study will consist of two stages. The first will be a review of secondary materials, while the second entails primary data collection in a number of sites in Uzbekistan.

Secondary data review. The aim of reviewing secondary data, including statistical data on school mental health issues, recent researches, documents, legal and policy framework, programmes' and projects' evaluations and other relevant sources of information, will be twofold:

i) to provide an overall picture of the situation and causes of mental health issues, including suicide, focusing on adolescents in Uzbekistan; and

ii) to inform the preparation of primary data collection and analysis, including identifying information gaps.

To complement and triangulate findings from the secondary data review, and to address possible information gaps, ***primary qualitative and quantitative data collection*** should be carried out in selected regions of Uzbekistan and an in-depth analysis of key school-related risk factors and their impacts on the mental health and psychological well-being of adolescent boys and girls in Uzbekistan with new qualitative and quantitative evidence should be undertaken and generated.

Site selection criteria should be decided jointly with the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education of Uzbekistan, and guided by:

i) the importance of obtaining both an urban and rural perspective, given that there are likely to be differing risk factors in these areas and arguably, as the literature also shows, higher risk factors (such as substance abuse and violence) in urban areas;

ii) the importance of ensuring that the unique features of different areas are captured; and

iii) the need to ensure a selection of areas where there are relatively high levels of mental health issues or risk factors and/or where there are high levels of poverty, which tends to translate into high levels of stress, anxiety and other mental health risk factors.

Purposive sampling should be used to ensure that the kinds of study respondents required to meet the overall study objectives are included in the sample.

The study will start with the collection of quantitative data, followed by the collection of qualitative data to explain and enrich the quantitative findings. A school-based cross-sectional study should be conducted to investigate school-related factors affecting mental health among adolescents, and their correlates in a representative sample of adolescents aged 10 to 19 years.

Ethical considerations

The selected international and national consultants jointly with the Republican Centre of Professional Orientation and Psychology-Pedagogical Diagnostics of Students of the Ministry of Public Education of Uzbekistan will identify and specify potential ethical considerations, approaches and review processes in their research methodology and tools, including on harms and benefits, informed consent, privacy and confidentiality, payment and compensation, and conflicts of interest. Researchers will have to adhere to the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis, requiring contractors to clearly identify any potential ethical issues and approaches, as well as processes for the ethical review and oversight of research, evaluation and data collection processes in their proposal. All researchers engaged in this assignment must complete UNICEF's online training module on ethics.

As outlined in the UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis, and the UNICEF Strategic Guidance Note on Institutionalizing Ethical Practice for UNICEF Research, the qualitative part will go through the national Ethics Review Board and get approval prior to field work.

Timeline and deliverables

This consultancy is expected to be carried out within 56 working days for the international consultant, and 74 working days for the national consultant, starting on 1 October 2021 and ending on 31 December 2021. Delivery dates (based on the work plan).

The assessment should be designed to ensure participation and inputs from a broad variety of stakeholders, including students,

parents, psychologists, health care providers and administrators.

I. Inception phase

1. Desk review of secondary data, including statistical data on school mental health issues (including suicide), recent studies, documents, legal and policy framework, programmes' and projects' evaluations, and other relevant sources of information.
2. Develop a conceptual framework and tools for the quantitative study, IDIs, FGDs, and KIIs, with ethical considerations based on stakeholders mapping.
3. Develop the proposal to the External Review Board (ERB) in English and to the Institutional Review Board (IRB) in Uzbek for ethical review.
4. Test, evaluate and adjust tools developed.

II. Data collection phase

1. Train researchers to collect qualitative data.
2. Conduct surveys, IDIs, FGDs and KIIs in selected regions with stakeholders including teachers, parents, adolescents and government counterparts.
3. Provide support to researchers in data collection.

III. Data analysis

1. Conduct analysis of quantitative and qualitative data.
2. Consult with, receive and reflect on feedback/inputs from UNICEF, especially regarding the interpretation of data.

IV. Finalization phase

1. Develop a draft report with recommendations.
2. Prepare materials (ppt presentations) and conduct a one-day consultation and feedback meeting with key national stakeholders dealing with mental health issues, to familiarize them with the methodology and findings of the analysis.
3. Finalize the report and produce an advocacy brief on the mental health problems of adolescent school students in Uzbekistan.

Management

It is expected that this work will be conducted by the international consultant paired with the national consultant. Both consultants will work under the direct supervision of the UNICEF Health Officer (adolescents).

Resource requirements

This assignment will be fully funded through the RR. Payment will be done in a few instalments with no advance payment envisioned.

To qualify as an advocate for every child you will have:

Qualification and Experience

1. A postgraduate degree in Psychology, Psychiatry, Social Work, or other relevant discipline(s). Candidates with doctorate level degrees will be an asset.
2. At least ten years of solid professional work experience at national and international levels with a focus on adolescent mental health and psychosocial well-being analysis.

Knowledge and Skills

- Demonstrated ability to produce high quality analytical reports.
- Understanding of Uzbekistan's context in relation to mental health and/or education is an asset.

Competencies

- Knowledge and experience of UNICEF programmes of cooperation and the human rights-based approach to programming. Prior experience working with the UN/UNICEF will be an asset.

Languages

- Excellent writing skills in English language. Knowledge of Russian would be an advantage.

Procedures and working conditions

UNICEF undertakes no liability for taxes, duties or other contributions payable by the institutions and/or individuals on payments made under the contract. UNICEF will ensure the detailed briefing of the contracted institution. All necessary documents pertaining to the assignment will be provided..

Reservations

UNICEF reserves the right to withhold all or a portion of payment if performance is unsatisfactory, if deliverable(s) are incomplete, not finalized, or for failure to meet deadlines. UNICEF will reserve copyright of all developed materials and own primary data collected through this assignment. The materials cannot be published or disseminated without the prior written permission of UNICEF. UNICEF will be free to adapt and modify them in the future. The contractor must respect the confidentiality of the information handled during the assignment. Documents and information provided must be used only for the tasks related to these terms of reference.

UNICEF undertakes no liability for taxes, duties or other contributions payable by the consultant on payments made under this contract.

For every child, you demonstrate…

UNICEF's values of Care, Respect, Integrity, Trust, and Accountability (CRITA) and core competencies in Communication, Working with People and Drive for Results.

The UNICEF competencies required for this post are...

UNICEF is committed to diversity and inclusion within its workforce, and encourages all candidates, irrespective of gender, nationality, religious and ethnic backgrounds, including persons living with disabilities, to apply to become a part of the organization.

UNICEF has a zero-tolerance policy on conduct that is incompatible with the aims and objectives of the United Nations and UNICEF, including sexual exploitation and abuse, sexual harassment, abuse of authority and discrimination. UNICEF also adheres to strict child safeguarding principles. All selected candidates will be expected to adhere to these standards and principles, and will therefore undergo rigorous reference and background checks. Background checks will include the verification of academic credential(s) and employment history. Selected candidates may be required to provide additional information to conduct a background check.

Remarks

Mobility is a condition of international professional employment with UNICEF and an underlying premise of the international civil service.

Only shortlisted candidates will be contacted and advance to the next stage of the selection process.

Individuals engaged under a consultancy or individual contract will not be considered "staff members" under the Staff Regulations and Rules of the United Nations and UNICEF's policies and procedures, and will not be entitled to benefits provided therein (such as leave entitlements and medical insurance coverage). Their conditions of service will be governed by their contract and the General Conditions of Contracts for the Services of Consultants and Individual Contractors. Consultants and individual contractors are responsible for determining their tax liabilities and for the payment of any taxes and/or duties, in accordance with local or other applicable laws.

ANNEX 20

Research Ethics Approval

22 February 2022

Mrs. Veronika Duci
assoc. professor, Department of Social Work and Social Policy, Faculty
of Social Sciences, University of Tirana
Place, "Mother Tereza"
Tirana, Albania. Post box #183

RE: Ethics Review Board findings for: *A comprehensive study on school adolescents' needs, school related factors impacting mental health and wellbeing of adolescents*
(HML IRB Review #514UZBE22)

Dear Veronika Duci,

Protocols for the protection of human subjects in the above study were assessed through a research ethics review by HML Institutional Review Board (IRB) on 04 – 22 February 2022. This study's human subjects' protection protocols, as stated in the materials submitted, received **ethics review approval.**

You and your project staff remain responsible for ensuring compliance with HML IRB's determinations. Those responsibilities include, but are not limited to:

- ensuring prompt reporting to HML IRB of proposed changes in this study's design, risks, consent, or other human protection protocols and providing copies of any revised materials;
- conducting the research activity in accordance with the terms of the IRB approval until any proposed changes have been reviewed and approved by the IRB, except when necessary to mitigate hazards to subjects;
- promptly reporting any unanticipated problems involving risks to subjects or others in the course of this study;
- notifying HML IRB when your study is completed.

HML IRB is authorized by the United States Department of Health and Human Services, Office of Human Research Protections (IRB #1211, IORG #850, FWA #1102).

Sincerely,

D. Michael Anderson, Ph.D., MPH
Chair & Human Subjects Protections Director, HML IRB

cc: Zhanar Sagimbayeva, Zokir Nazarov, Olga Kim, Fakhriddin Nizamov, Penelope Lantz, JD

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Washington, DC 20036 USA
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unicef@hmlirb.com www.hmlirb.com

Table 10. *Total sample of schools with urban and rural areas*

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
1. Republic of Karakalpakstan											
1	6	6	Nukus city	№ 6	1		846	81	76	56	213
2	21	21	Nukus city	№ 21	1		1,177	134	102	93	329
3	32	32	Nukus city	№ 32	1		1,757	167	112	112	391
4	46	46	Nukus city	№ 46	1		2,415	294	278	215	787
5	63	1	Beruni district	№ 1	1		827	73	63	54	190
6	87	26	Karauzyak district	SPSS № 26	1		499	44	42	25	111
7	107	33	Kungrat district	№ 40	1		985	95	65	56	216
8	133	2	Takhiatash district	№ 2	1		1,453	164	115	80	359
9	151	18	Turtkul district	№ 18	1		1,034	97	100	72	269
10	168	26	Khojayli district	№ 26	1		882	103	71	62	236
11	191	46	Chimbay district	№ 48	1		447	50	32	15	97
12	29	33	Amudarya district	№ 33		1	556	54	60	37	151
13	101	29	Beruni district	№ 29		1	586	49	56	41	146
14	174	13	Karauzyak district	№ 13		1	393	43	34	18	95
15	282	28	Nukus district	№ 29		1	153	12	17	5	34
16	342	35	Turtkul district	№ 35		1	575	52	56	50	158

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
17	431	9	Chimbay district	№ 9		1	398	45	28	32	105
18	504	49	Ellikkala district	№ 49		1	404	39	36	20	95
2. Andijan region											
19	204	4	Andijan city	№ 4	1		3,272	397	300	108	805
20	212	12	Andijan city	№ 13	1		4,273	471	381	182	1,034
21	222	22	Andijan city	№ 23	1		2146	228	188	151	567
22	232	32	Andijan city	№ 34	1		492	40	39	31	110
23	246	46	Andijan city	№ 50	1		1,858	229	125	81	435
24	264	33	Andijan district	№ 33	1		2,132	244	180	85	509
25	275	59	Asaka district	№ 60	1		1,468	166	98	82	346
26	296	29	Buston district	SPSS № 48	1		1,120	129	99	49	277
27	311	38	Markhamat district	№ 40	1		566	156	122	88	366
28	330	54	Kurgontepa district	№ 55	1		1,176	150	101	57	308
29	550	24	Andijan district	№ 24		1	1,885	206	159	113	478
30	587	7	Asaka district	№ 7		1	1,451	150	92	88	330
31	621	42	Asaka district	№ 42		1	1,106	119	60	66	245
32	665	29	Balikchi district	№ 29		1	323	50	42	19	111
33	705	10	Bulokboshi district	№ 10		1	982	108	87	54	249
34	752	17	Jalakuduk district	№ 17		1	1,026	111	92	68	271
35	798	15	Izboskan district	№ 15		1	1,310	141	107	69	317

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
36	835	52	Izboskan district	SPSS № 15		1	314	0	70	44	114
37	876	1	Oltinkul district	№ 1		1	1,940	223	160	112	495
38	911	36	Oltinkul district	№ 37		1	560	79	46	45	170
39	949	19	Pakhtaabad district	№ 20		1	856	134	90	78	302
40	996	17	Ulungor district	№ 17	0	1	532	59	35	36	130
41	1028	26	Shakhrikhan district	№ 26		1	1,429	146	124	76	346
42	1067	65	Shakhrikhan district	№ 67		1	859	79	66	90	235
43	1110	39	Kurgontepa district	№ 40		1	112	9	15	7	31
44	1154	30	Khojaabad district	№ 30		1	528	54	45	18	117
3. Bukhara region											
45	344	10	Bukhara шахри	№ 10	1		615	74	54	60	188
46	356	22	Bukhara шахри	SPSS № 22	1		1,369	134	108	64	306
47	369	35	Bukhara шахри	№ 35	1		2,690	317	191	147	655
48	391	10	Kogon city	SPSS № 10	1		1,283	119	106	92	317
49	1205	43	Bukhara district	№ 43		1	337	24	50	30	104
50	1255	40	Jandar district	№ 40		1	406	50	25	21	96
51	1301	11	Vobkent district	№ 11		1	573	57	34	51	142
52	1351	19	Olot district	№ 19		1	677	60	92	56	208
53	1404	36	Peshku district	№ 37		1	253	40	18	16	74

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
54	1449	34	Romitan district	№ 34		1	434	45	30	14	89
55	1493	35	Korakul district	№ 35		1	357	25	21	40	86
56	1535	16	Shofirkon district	№ 16		1	782	86	67	77	230
57	1583	8	Gijduvan district	№ 8		1	2,008	203	163	146	512
58	1611	36	Gijduvan district	№ 36		1	992	113	60	89	262
4. Jizak region											
59	417	4	Sh.Rashidov district	№ 4	1		965	133	87	53	273
60	432	2	Dustlik district	№ 2	1		960	111	67	58	236
61	444	10	Jizak city	№ 10	1		1,620	150	154	86	390
62	456	22	Jizak city	SPSS № 22	1		2,631	326	286	156	768
63	481	19	Bakhmal district	№ 19	1		457	48	43	32	123
64	509	56	Zamin district	№ 60	1		2,377	244	210	143	597
65	522	14	Zarbdor district	№ 14	1		431	40	38	23	101
66	1662	7	Arnasay district	№ 7		1	397	48	37	13	98
67	1734	64	Gallaaral district	№ 64		1	201	17	19	28	64
68	1786	24	Sh.Rashidov district	№ 24		1	518	38	44	39	121
69	1847	39	Bakhmal district	№ 39		1	279	24	21	20	65
70	1913	41	Zamin district	№ 43		1	178	13	15	10	38
71	2019	5	Zarbdor district	№ 5		1	754	87	59	28	174

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
5. Kashkadarya region											
72	542	94	Kitab district	SPSS № 1	1		496	0	146	83	229
73	563	4	Shakhrisabz city	№ 4	1		833	73	89	57	219
74	577	18	Shakhrisabz city	№ 18	1		468	47	41	33	121
75	597	17	Kamashi district	№ 17	1		869	83	75	56	214
76	613	1	Chirokchi district	№ 1	1		1,367	112	116	61	289
77	630	94	Koson district	№ 94	1		787	65	75	37	177
78	653	27	Yakkabog district	№ 27	1		506	42	45	35	122
79	665	102	Yakkabog district	SPSS № 14	1		263	0	65	25	90
80	680	15	Karshi city	№ 15	1		2,310	233	160	117	510
81	695	30	Karshi city	№ 30	1		670	60	51	55	166
82	710	45	Karshi city	№ 45	1		1,100	146	135	67	348
83	2074	26	Kitab district	№ 26		1	430	41	41	34	116
84	2128	81	Kitab district	№ 81		1	876	88	66	65	219
85	2195	32	Dehkanabad district	№ 32	0	1	239	37	26	13	76
86	2275	23	Guzar district	№ 23		1	538	47	54	52	153
87	2332	10	Kamashi district	№ 10		1	317	37	19	40	96
88	2379	58	Kamashi district	№ 58		1	734	79	80	12	171
89	2426	21	Nishan district	№ 21	0	1	1,070	101	65	91	257
90	2476	37	Chirokchi district	№ 37		1	868	88	76	47	211

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
91	2538	99	Chirokchi district	№ 99		1	430	45	39	23	107
92	2592	153	Chirokchi district	№ 153		1	518	47	60	41	148
93	2673	24	Koson district	№ 24		1	795	89	63	66	218
94	2727	78	Koson district	№ 78		1	205	24	21	10	55
95	2768	23	Karshi district	№ 23		1	937	92	80	71	243
96	2815	2	Shakhrisabz district	№ 2		1	505	64	45	18	127
97	2860	47	Shakhrisabz district	№ 47		1	1,056	98	78	71	247
98	2923	26	Mirishkor district	№ 26		1	409	38	46	30	114
99	2965	30	Kasbi district	№ 30		1	333	26	22	38	86
100	3019	37	Yakkabog district	SPSS № 37		1	758	74	57	59	190
6. Navoi region											
101	724	7	Navoi city	№ 7	1		1,871	158	168	91	417
102	734	17	Navoi city	№ 17	1		2,208	221	162	147	530
103	746	10	Zerafshan city	№ 10	1		1,660	174	136	114	424
104	761	5	Kiziltepa district	№ 5	1		1,649	116	126	96	338
105	790	27	Nurota district	№ 27	1		639	59	71	40	170
106	814	85	Khatirchi district	№ 85	1		337	37	35	31	103
107	3082	7	Karmana district	№ 7		1	744	87	63	34	184
108	3134	2	Navbakhor district	№ 2		1	492	53	47	30	130

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
109	3224	36	Nurota district	№ 36		1	149	20	15	5	40
110	3316	58	Khatirchi district	№ 58		1	306	40	24	24	88
7. Namagan region											
111	825	10	Namangan city	№ 11	1		1,653	149	137	104	390
112	838	23	Namangan city	№ 24	1		1,761	177	138	138	453
113	847	32	Namangan city	№ 34	1		2,463	392	284	160	836
114	858	43	Namangan city	№ 50	1		1,649	149	135	126	410
115	873	24	Namangan district	№ 25	1		871	94	59	49	202
116	883	9	Davlatabad district	№ 58	1		1,884	251	196	88	535
117	898	2	Kasansay district	№ 2	1		1,812	200	125	109	434
118	916	1	Norin district	№ 1	1		1,886	246	139	93	478
119	941	37	Pop district	№ 37	1		1,610	151	79	33	263
120	964	3	Uychi district	№ 3	1		1,590	182	129	99	410
121	979	40	Uychi district	№ 40	1		955	140	65	44	249
122	1001	33	Chartak district	№ 33	1		1,151	122	93	57	272
123	1022	6	Chust district	№ 6	1		833	87	75	45	207
124	1041	6	Yangi Namangan d-t	№ 59	1		1,563	160	131	108	399
125	1053	18	Yangi Namangan d-t	№ 86	1		984	124	68	29	221
126	3369	30	Namangan district	№ 32		1	407	25	0	0	25
127	3414	52	Косонсой district	SPSS № 52		1	724	60	107	79	246

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
128	3480	23	Norin district	№ 23		1	551	56	27	21	104
129	3523	41	Pop district	№ 41		1	486	51	41	25	117
130	3571	34	Turakurgan district	№ 36		1	766	78	47	41	166
131	3608	19	Uychi district	№ 19		1	490	57	55	15	127
132	3660	44	Uchkurgan district	№ 44		1	297	46	21	16	83
133	3709	28	Chust district	№ 28		1	567	54	47	40	141
134	3764	21	Yangikurgan district	№ 21		1	1,177	122	52	50	224
8. Samarkand region											
135	1078	11	Samarkand city	№ 5	1		2,623	241	222	154	617
136	1090	23	Samarkand city	№ 17	1		2,561	255	282	230	767
137	1103	36	Samarkand city	№ 30	1		1,468	146	121	82	349
138	1114	47	Samarkand city	№ 41	1		1,321	141	124	72	337
139	1124	57	Samarkand city	№ 51	1		2,283	245	275	190	710
140	1138	71	Samarkand city	№ 65	1		1,556	152	106	56	314
141	1159	3	Kattakurgan city	SPSS № 2	1		1,387	149	107	100	356
142	1177	22	Bulungur district	№ 22	1		1,429	158	114	64	336
143	1197	96	Ishtikhan district	SPSS № 1	1		752	165	113	26	304
144	1221	2	Nurabad district	№ 2	1		1,535	135	135	58	328
145	1236	79	Payarik district	№ 79	1		1,473	182	125	54	361

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
146	1253	16	Samarkand district	№ 16	1		2,509	273	206	133	612
147	1275	38	Samarkand district	№ 38	1		848	79	65	47	191
148	1296	5	Urgut district	№ 5	1		824	86	58	48	192
149	3818	12	Bulungur district	№ 12		1	600	70	50	45	165
150	3871	1	Jambay district	№ 1		1	628	76	55	35	166
151	3922	55	Jambay district	№ 55		1	651	60	51	49	160
152	3971	54	Ishtikhan district	№ 54		1	493	51	47	38	136
153	4022	16	Kattakurgan district	№ 16		1	526	45	38	36	119
154	4066	62	Kattakurgan district	№ 63		1	434	37	43	38	118
155	4146	40	Kushrabat district	№ 40		1	343	29	33	36	98
156	4213	23	Narbay district	№ 23		1	326	43	20	21	84
157	4268	22	Nurabad district	№ 22		1	1,065	74	74	71	219
158	4333	11	Okdarya district	№ 11		1	809	85	59	38	182
159	4384	9	Pasdargom district	№ 9		1	980	98	81	77	256
160	4424	51	Pasdargom district	№ 51		1	709	62	57	39	158
161	4480	107	Pasdargom district	№ 108		1	217	28	21	13	62
162	4535	37	Pakhtachi district	№ 38		1	565	49	44	39	132
163	4597	53	Payarik district	№ 53		1	409	41	30	34	105
164	4648	5	Taylok district	№ 5		1	764	64	55	52	171
165	4688	45	Taylok district	№ 45		1	1,067	106	107	72	285

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
166	4725	26	Urgut district	№ 27		1	1,023	99	92	48	239
167	4756	59	Urgut district	№ 61		1	1,093	111	69	75	255
168	4792	98	Urgut district	№ 102		1	1,617	141	128	124	393
9. Surkhandarya region											
169	1311	3	Termez city	№ 3	1		2,029	196	214	215	625
170	1321	13	Termez city	№ 13	1		2,398	239	189	184	612
171	1336	28	Termez city	SPSS № 9	1		503	71	92	0	163
172	1362	47	Boysun district	SPSS № 47	1		927	99	77	64	240
173	1379	99	Denau district	SPSS № 10	1		712	94	63	51	208
174	1401	9	Oltinsay district	№ 9	1		730	74	70	61	205
175	1428	20	Sariosiyo district	№ 20	1		758	68	57	39	164
176	1456	9	Uzun district	№ 9	1		876	94	64	60	218
177	1472	28	Sharabad district	№ 28	1		711	74	69	56	199
178	1498	83	Kumkurgan district	SPSS № 11	1		284	0	89	21	110
179	4847	16	Angor district	№ 16		1	524	56	33	26	115
180	4913	16	Boysun district	№ 16		1	246	19	22	15	56
181	4972	19	Denau district	№ 19		1	1,410	132	111	74	317
182	5008	55	Denau district	№ 55		1	521	79	47	38	164
183	5053	19	Jarkurgan district	SPSS № 19		1	1,143	96	91	99	286
184	5106	8	Muzrtabat district	№ 8		1	767	67	48	64	179

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
185	5165	28	Oltinsay district	№ 28		1	342	38	42	34	114
186	5216	33	Sariosiyo district	№ 33		1	201	17	10	18	45
187	5285	17	Uzun district	№ 17		1	782	87	66	47	200
188	5341	12	Shurchi district	№ 12		1	576	58	50	41	149
189	5389	61	Shurchi district	№ 61		1	171	18	10	11	39
190	5453	57	Sherabad district	№ 57		1	105	15	9	3	27
191	5511	13	Kumkurgan district	№ 13		1	901	77	73	56	206
192	5559	62	Kumkurgan district	№ 62		1	498	52	52	50	154
10. Sirdarya region											
193	1511	12	Guliston city	№ 12	1		1,048	94	101	62	257
194	1527	5	Yangiyer city	№ 5	1		866	83	75	41	199
195	5626	48	Bayavut district	№ 48		1	397	49	50	35	134
196	5689	20	Mirzaabad district	№ 20		1	307	20	22	26	68
197	5753	30	Saykhunabad district	№ 30		1	96	8	9	10	27
198	5807	21	Sirdarya district	№ 21		1	763	78	54	54	186
199	5856	25	Khavas district	№ 25		1	543	51	41	15	107
11. Tashkent region											
200	1548	14	Angren city	№ 17	1		1,370	148	136	65	349
201	1571	37	Angren city	№ 41	1		1,143	118	107	81	306

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
202	1588	11	Bekabad city	№ 11	1		703	88	59	48	195
203	1609	13	Almalik city	№ 14	1		980	122	86	46	254
204	1621	1	Akhangaran city	№ 1	1		1,630	189	144	56	389
205	1645	2	Chirchik city	№ 3	1		1,114	114	51	42	207
206	1657	14	Chirchik city	№ 15	1		2,424	234	206	126	566
207	1670	3	Yangiyul city	№ 3	1		1,516	185	129	58	372
208	1683	55	Bekabad district	№ 55	1		289	26	22	23	71
209	1700	14	Zangiata district	SPSS № 14	1		1,405	155	102	55	312
210	1720	1	Parkent district	№ 1	1		741	60	59	51	170
211	1742	6	Pskent district	№ 6	1		463	46	42	28	116
212	1758	1	Yangiyul district	№ 1	1		1,569	160	137	97	394
213	5907	48	Bekabad district	№ 48		1	542	71	46	44	161
214	5974	11	Bostanlik туман	№ 11		1	1,134	113	96	93	302
215	6032	21	Zangiata district	№ 21		1	680	65	40	29	134
216	6082	42	Kibray district	№ 48		1	603	56	49	28	133
217	6153	23	Akkurgan district	№ 23		1	769	76	56	47	179
218	6234	14	Parkent district	№ 14		1	441	0	38	34	72
219	6291	29	Pskent district	№ 29		1	430	42	33	35	110
220	6359	56	Urtachirchik district	SPSS № 72		1	1,110	162	137	75	374
221	6384	26	Tashkent district	№ 26		1	1,612	169	99	88	356

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
222	6437	8	Yukori chirchik d-t	№ 8		1	353	41	24	22	87
223	6482	15	Yangiyul district	№ 16		1	1,163	126	117	87	330
12. Fergana region											
224	1769	9	Fergana city	№ 9	1		2,556	235	218	142	595
225	1781	21	Fergana city	№ 21	1		2,466	366	235	151	752
226	1793	33	Fergana city	№ 33	1		748	83	61	49	193
227	1812	4	Kokand city	№ 4	1		1,560	120	174	131	425
228	1828	20	Kokand city	№ 20	1		2,305	220	210	151	581
229	1842	34	Kokand city	№ 35	1		1,215	131	117	97	345
230	1864	11	Kuvasay city	SPSS № 11	1		592	54	43	29	126
231	1889	6	Margilan city	№ 6	1		2,063	288	249	155	692
232	1900	17	Margilan city	№ 17	1		1,330	130	97	114	341
233	1914	31	Margilan city	№ 32	1		1,384	138	94	102	334
234	6523	2	Oltiarik district	№ 2		1	897	81	119	65	265
235	6553	32	Oltiarik district	№ 32		1	826	70	58	57	185
236	6586	18	Bagdad district	№ 18		1	1,201	108	101	93	302
237	6628	60	Bagdad district	SPSS № 3		1	422	0	134	42	176
238	6654	25	Buvayda district	№ 25		1	948	97	83	49	229
239	6689	5	Besharik district	№ 5	0	1	1,043	91	97	79	267
240	6723	39	Besharik district	№ 39	0	1	354	37	24	25	86

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
241	6761	17	Kuva district	№ 17		1	884	88	76	41	205
242	6813	1	Uchkuprik district	№ 1		1	710	77	82	44	203
243	6841	29	Uchkuprik district	№ 29		1	957	107	69	53	229
244	6886	16	Rishtan district	№ 16		1	438	33	41	35	109
245	6940	3	Sokh district	№ 3		1	322	34	34	35	103
246	6981	12	Tashlak district	№ 12		1	1,607	173	134	78	385
247	7028	8	Uzbekistan district	№ 8		1	1,436	128	120	80	328
248	7069	49	Uzbekistan district	№ 49		1	1,777	226	170	88	484
249	7113	22	Fergana district	№ 22		1	746	68	89	43	200
250	7164	9	Dangara district	№ 9		1	820	88	68	74	230
251	7200	2	Furkat district	SPSS № 2		1	980	116	82	52	250
252	7237	3	Yazyavan district	№ 3		1	1,220	107	98	42	247
253	7290	17	Kushtepa district	№ 17		1	804	73	63	47	183
13. Khorezm region											
254	1927	9	Urgench city	№ 9	1	0	816	71	75	54	200
255	1939	21	Urgench city	№ 22	1	0	1,669	169	131	106	406
256	1959	6	Khiva city	SPSS № 6	1		1,572	130	140	77	347
257	1975	22	Khiva city	SPSS № 121	1		191	9	18	37	64
258	1999	1	Kushkupir district	№ 1	1		1,274	153	134	58	345
259	2016	39	Khanka district	№ 40	1		1,079	86	95	55	236

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
260	2037	40	Yangiarik district	SPSS № 11	1		321	0	78	50	128
261	7330	12	Bogot district	№ 12		1	947	88	80	73	241
262	7373	17	Gurlan district	№ 17		1	701	86	72	40	198
263	7416	24	Kushkupir district	№ 24		1	771	88	69	60	217
264	7454	11	Urgench district	№ 11		1	860	84	79	63	226
265	7496	10	Khazarasp district	№ 10		1	1,170	121	79	110	310
266	7539	3	Khanka district	№ 3		1	444	29	46	34	109
267	7583	3	Khiva district	№ 3		1	660	48	53	44	145
268	7616	36	Khiva district	№ 36		1	428	42	31	48	121
269	7668	4	Yangiarik district	№ 4		1	1,128	127	119	55	301
270	7722	26	Yangibazar district	№ 26		1	433	46	35	28	109
14. Tashkent city											
271	2053	7	Bektemir district	№ 346	1		744	91	62	33	186
272	2062	7	Mirabad district	SPSS № 110	1		4,238	500	369	244	1113
273	2073	18	Mirabad district	№ 328	1		1,407	160	111	82	353
274	2084	10	Mirzo Ulugbek d-t	SPSS № 112	1		1,728	195	194	185	574
275	2094	20	Mirzo Ulugbek d-t	№ 211a	1		1,288	117	99	83	299
276	2108	35	Mirzo Ulugbek d-t	№ 343	1		888	98	70	69	237
277	2122	13	Almazar district	№ 146	1		1,504	144	98	81	323
278	2132	23	Almazar district	№ 234	1		1,835	191	185	173	549

TABLE 10. TOTAL SAMPLE OF SCHOOLS WITH URBAN AND RURAL AREAS

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
279	2138	29	Almazar district	№ 298	1		3,147	452	275	198	925
280	2149	5	Sergeli district	№ 68	1		1,433	138	186	103	427
281	2160	16	Sergeli district	SPSS № 300	1		5,343	590	444	290	1324
282	2173	3	Uchtepa district	№ 38	1		2,643	247	234	181	662
283	2182	12	Uchtepa district	№ 109	1		829	66	47	49	162
284	2191	21	Uchtepa district	№ 229	1		1,318	112	96	90	298
285	2202	32	Uchtepa district	№ 199	1		337	40	45	0	85
286	2212	10	Chilanzar district	№ 162	1		1,305	131	116	103	350
287	2224	22	Chilanzar district	SPSS №195	1		2,784	314	245	197	756
288	2235	1	Shaykhantaur d-t	№ 10	1		1,374	137	88	79	304
289	2246	12	Shaykhantaur d-t	SPSS № 59	1		1,666	238	171	108	517
290	2260	26	Shaykhantaur d-t	№ 186	1		1,520	158	132	123	413
291	2272	2	Yunusabad district	SPSS № 9	1		1,147	121	83	49	253
292	2286	16	Yunusabad district	№ 97	1		2,659	312	277	199	788
293	2295	25	Yunusabad district	№ 246	1		3,443	351	324	252	927
294	2304	34	Yunusabad district	№ 272	1		1,361	141	134	98	373
295	2316	4	Yakkasaray district	№ 89	1		1,757	175	150	117	442
296	2329	2	Yangihayot district	№ 3	1		1,965	184	165	136	485
297	2343	16	Yangihayot district	№ 336	1		581	63	51	33	147
298	2354	11	Yashnabad district	№ 155	1		1,153	127	85	62	274

			Region	Name (number) of School	Urban	Rural	Total number of pupils	Number of pupils in grade 6	Number of pupils in grade 9	Number of pupils in grade 11	Total number of pupils in grades 6, 9, 11
299	2366	23	Yashnabad district	SPSS № 227	1		1,163	118	107	96	321
300	2381	2	Mirzo Ulugbek d-t	SPSS for math, astro-nomy and IT subjects	1		2,175	265	276	213	754

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