CHAPTER 1

INTRODUCTION

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1.1 Geography and Population

Located in the middle of Central Asia between the two major rivers of Amudarya and Syrdarya, the Republic of Uzbekistan is a region with favorable climatic and geographical conditions. The territory of Uzbekistan is 447,400 square kilometers. The country borders Kazakhstan to the north, Kyrgyzstan and Tajikistan to the south and east, Afghanistan to the south, and Turkmenistan to the west.

Uzbekistan's landscape is a unique combination of plains and mountains. The western part of Uzbekistan consists of plains, Kizilkum deserts and lowland areas, such as Fergana Valley, Tashkent and the Hunger Steppe, and the Sanzaro-Nuratim, Samarkand, Kashkadarya and Surkhandarya lowlands. The mountains in Uzbekistan, which are branches of the West Tien-Shan and Gissaro-Alay ranges, cover about one-third of the country's territory and are located mainly in the south and southeast of Uzbekistan.

Uzbekistan consists of 12 administrative regions (oblasts) and the Autonomous Republic of Karakalpakstan. Each region is further broken down into administrative areas called raions. There are 157 raions in Uzbekistan.

With a population of 22.5 million, Uzbekistan is the third most populous country in the former Soviet Union after Russia and the Ukraine. Approximately 61 percent of the population resides in rural areas. The country is characterized by a high rate of population growth which is mainly due to the high birth rate (29.4 per 1,000 population) and relatively low death rate (6.6 per 1,000 population) (Goskomprognostat, 1995). With an average annual population growth rate in excess of 2.5 percent, the population in Uzbekistan has increased by 12 million during the last three decades (Akhmedov, 1993). As a result of high fertility and population growth rates, Uzbekistan has a young population: 41 percent of the population are children under 15 years of age, while the population over 65 years of age is relatively small at less than 5 percent (Ministry of Health, 1995).

The population density of Uzbekistan is 47 persons per square kilometer. However, the population is unevenly distributed among the different regions. The population is mainly concentrated in the grasslands and in the industrialized urban areas. Five oblasts of Uzbekistan have population densities of more than 150 per square kilometer, while in areas such as Karakalpakstan and Navoi oblast, which consist mainly of deserts, the population density is very low at 8 and 6 per square kilometer, respectively (Akhmedov, 1993). The most industrially developed region of Uzbekistan, Tashkent oblast, has a population density of 278 per square kilometer. The capital of Uzbekistan, Tashkent City, with a population of more than 2 million, is the largest city in Central Asia.

Uzbekistan is a multinational country. According to the 1989 Population Census, people of more than 130 nationalities live in Uzbekistan. The majority of the population are Uzbeks, constituting more than 71 percent of the population. Other significant ethnic groups are Russians, Tajiks, Kazaks and Tatars (Akhmedov, 1993). The Uzbek culture is influenced by the religion of Islam, and the language belongs to the Turkik group of languages. Family ties are strong, especially among Uzbeks living in rural areas, and this plays an important role in the formation of their values, attitudes, behavior, and goals.
1.2 History of Uzbekistan

People who lived in the territory of Uzbekistan in ancient times were mainly nomadic and involved in primitive agriculture and cattle breeding. Nevertheless, as early as the fifth and sixth centuries B.C., centralized states were established throughout the territory of Uzbekistan: Baktria (Southern Uzbekistan), Khorezm (Aral Sea Region), and Sogd (Zaravshan Valley and Kashkadarya Region). During that time, the large cities of Samarkand, Kyuzelgir and Kalagyr were built.

During the sixth century, the territory of Uzbekistan was conquered by Turkik tribes who introduced their language and culture. Arab invasions in the seventh and eighth centuries brought Islam, which unified many settled and seminomadic Turkik speaking tribes of Fergana Valley, Tashkent and Khorezm Regions and completed the formation of the Uzbek nation. The period between the ninth and 13th centuries is characterized as the epoch of renaissance in Uzbekistan. Trade, craftsmanship, construction, science and poetry became well developed.

In the beginning of the 13th century, Central Asia was invaded by Genghis Khan who initially destroyed the cities and then established his ruling dynasty which dominated Central Asia for several centuries. In 1370, Tamerlan (Timur), one of the Genghis Khan’s descendants (Genghizid), came to power. He created an empire which became one of the most powerful forces in Asia. It extended from the Middle East to India and from Caucasus to Russia. Despite being brutal, Tamerlan promoted fine art and architecture. Such masterpieces of Uzbek architecture as Gur-Emir, Shaki-Zinda, and Biby-Khanym in the capital city of Samarkand were built during Tamerlan’s reign. Tamerlan established Timurids dynasty which successfully ruled in many regions of Central Asia even after the collapse of his empire. One of the Timurids, Emir Ulugbek, became famous as a scientist-astronomist. He shaped the borders of his state, which eventually became the borders of Uzbekistan.

After the collapse of the Timurids dynasty in the 18th century, three states were established in the territory of Uzbekistan: Bukhara Emirate, Kokand Khanate and Khiva Khanate. In the second half of the 19th century, the Russian Empire established a protectorate over Khiva Khanate and Bukhara Emirate and incorporated Kokand Khanate as part of its Turkestan regional administrative unit. The Russian conquest played a positive role in cultural and economic development by breaking the region’s economic isolation and introducing industries, technology and advanced culture.

The First Russian Revolution in 1905-1907 had a tremendous political impact in the Turkestan Region initiating a nationalistic movement which later became a major force against Russian Tzarism in the area. After the 1917 Bolshevik Revolution, several autonomous states were established in Central Asia. In 1924, the Soviet Government granted Uzbekistan the status of Soviet Socialist Republic incorporating the Republic to the Soviet Union. This event became a landmark in the economic and social reconstruction of Uzbekistan and led to industrial development, eradication of illiteracy, the granting of women’s rights, and the introduction of a Western health care system. The system of compulsory secondary education was introduced during the Soviet era and this created a skilled labor force which became the keystone of the Republic’s development.

During World War II, many industries were evacuated from Russia and other European parts of the former Soviet Union and brought to Uzbekistan. These industries became the principal basis for the postwar economic development of Uzbekistan. As a Soviet republic, Uzbekistan for many years relied on a planned economic system, which was tightly controlled, but on the other hand, generously supported by the central Soviet Government.
With the collapse of the former Soviet Union in 1991, Uzbekistan was granted independence and became a sovereign republic. The country opened its doors to the world community and became a member of the United Nations as well as other international organizations. Under transition from a centrally planned economy to a market economy, Uzbekistan is now experiencing rapid social and economic changes. The process to date has produced disruption in most sectors of the economy, causing economic decline, inflation, and instability of the new national currency. In order to stabilize the economy, the Government of Uzbekistan has taken a number of steps to restructure the economy by attracting foreign investments and rebuilding economic relations with the other former Soviet republics.

1.3 Economy

Uzbekistan is self-sufficient in terms of agricultural production. However, during the Soviet era, cotton production became the number one priority in order to meet the strategic objectives of the former Soviet Government. In some areas of Uzbekistan, this policy required that 85-90 percent of the arable land be devoted to cotton production (Akhmedov, 1993). This has had a tremendously negative impact on the other sectors of agriculture. Currently, the Government of Uzbekistan is reconsidering this policy and is promoting the development of livestock farming, production of crops, grapes, melons, silkworm breeding, etc.

Uzbekistan is rich in mineral resources, such as copper, gold, lead, zinc, and bauxite. The country also has substantial energy resources, such as oil and gas. During the last two decades, Uzbekistan developed national industries in copper, machinery, chemical fertilizers, and construction of oil, gas and hydroelectric plants. Under the new economic policy of attracting foreign investments, several joint enterprises with Korean, Italian, Turkish, American and other firms have been established during the last few years.

1.4 Health Care System

The health care system in Uzbekistan was developed as part of the Soviet-planned system and was intended to provide adequate access to health services to all citizens and to maintain a focus on prevention. With these goals, a nationwide network of over 6,000 primary, secondary and tertiary health care facilities was created under the auspices of the Ministry of Health. The health care system in Uzbekistan is state-owned and almost all health personnel, of which more than 70,000 are physicians and 240,000 are mid-level professionals, are government employees (Ministry of Health, 1995). Throughout all regions of Uzbekistan, health services, including antenatal care, delivery assistance, neonatal care, pediatric services, immunizations, family planning, outpatient services and specialized health care, are provided free of charge.

Primary health care in Uzbekistan is provided in such institutions as polyclinics, outpatient clinics (ambulatories), doctor's assistant/midwife posts (FAPs), primary health facilities at large enterprises, women’s consulting centers (which are a primary source of family planning services in urban areas) and delivery hospitals. The main focus of the health services in these institutions is disease prevention (for example, immunization against infectious diseases), and providing antenatal care services, delivery assistance and family planning services.

On the secondary level, health services are provided by specialized dispensaries, departments of polyclinics and hospitals in which screening programs are carried out to identify individuals with early manifestations of disease and to prevent disease progression.

Tertiary health services in Uzbekistan are provided within the departments of regional, municipal and district general hospitals, specialized hospitals and dispensaries, and clinical research institutes. The clinical treatment offered at these facilities is aimed at minimizing the effect of disease and disability.
Maternal and child health services in Uzbekistan are mostly provided through primary health care institutions. Almost all deliveries occur at the delivery hospitals and, in rare cases, at regular hospitals or, in rural areas, FAPs. Antenatal care is provided mainly by doctors at the women's consulting centers (parts of urban polyclinics), rural hospitals and rural ambulatories, or by the doctors' assistants at the FAPs. Antenatal care starts early in pregnancy (usually during the first trimester of pregnancy) and continues on a monthly basis throughout the pregnancy.

One of the procedures that is used during antenatal care is to identify early complications of pregnancy and extragenital diseases. Pregnant women who have developed such conditions usually receive special attention from health personnel and may be treated further and hospitalized at the institutions of the secondary and tertiary levels. In certain cases, a woman is encouraged to postpone her next pregnancy by using contraception. The Ministry of Health of Uzbekistan promotes greater access of women to various methods of contraception, providing a better chance for safe motherhood. Sometimes when pregnancy complications or extragenital diseases are severe and threaten the outcome of pregnancy, a woman may be counseled by a doctor to terminate her pregnancy. After pregnancy termination, women are offered special rehabilitation courses to ensure that the next pregnancy will be safe.

Child health services in Uzbekistan include neonatal care, which is usually provided within the first week after delivery while a woman and her newborn stay in the delivery hospital, and other pediatric services at older ages. After discharge from the delivery hospital, a child is visited by a patronage nurse who provides the mother with general counseling on child care and carries out a physical examination of the child. Pediatric services are mainly provided by the institutions of primary health care. A mother is required to bring her child in for a regular checkup and vaccination at the polyclinic or outpatient clinic several times during the first two years of life. A doctor in the polyclinic can refer the child to a specialized pediatrician in case the child develops disease or other conditions that require special care or hospitalization.

The child vaccination schedule in Uzbekistan requires that BCG and oral polio vaccines are given in the delivery hospital during the first 3-4 days of life. Revaccinations with oral polio vaccine are usually done at 2, 3, 4, 16, and 18 months and 6-7 years of the child's life. The vaccination schedule for diphtheria, pertussis and tetanus toxoid (DPT or DT) is similar to the schedule for the polio vaccination, except that the first DPT vaccine is given at the age of 2 months. Measles vaccinations are given at 9 and 16 months of age (Ministry of Health, 1993).

The vaccination schedule is controlled throughout childhood by several mechanisms. During the first two years of life, the patronage nurse is responsible for maintaining vaccination records and ensuring that the child receives vaccinations at the appropriate time. After that period, the vaccination schedule may still be under the control of the pediatric department staff of polyclinics or the records can be transferred to a day care center if the child attends one. In the latter case, vaccination is coordinated by the day care nurse. Finally, when the child starts to attend primary school at the age of seven, the school nurse becomes responsible for the child's vaccinations.

The system of maternal and child health care has proven efficient and successful in providing adequate services for the majority of the population of Uzbekistan, including those who reside in rural and remote areas. However, maintaining such a system requires substantial and continuous budgetary support and enormous resources of manpower and managerial skill.

The challenge for the Uzbekistan Government is to reform the health system in such a way that it will be both financially viable and provide comprehensive service to the population. This can be
accomplished by preserving and improving the existing primary health care system, promoting new mechanisms of healthcare financing and focusing on emerging health issues. The Ministry of Health has developed the top priorities of health care reform, which can be outlined as follows:

- reorganize the network of public health institutions and the distribution of health manpower in order to provide better control, management and quality of health services on each level of health care;
- focus on maternal and child health by integrating forces of health institutions, public and community based services, religious organizations, and attracting state legislative and executive power to protect and strengthen the health of mothers and children;
- reform the health care financing system by using a long-term approach with the focus on individual community members instead of a curative approach which is oriented to cover hospital bed spending;
- focus on disease prevention and promote outpatient medical services by introducing new efficient forms of preventive and curative medicine, such as day hospitals, home medical care, centers of outpatient surgery, specialized health complexes providing ambulatory treatment, and community health centers; and make the best use of local, regional, and national resources, and potential community-based services;
- optimize the distribution and relative size of health facilities in terms of their capacity and optimal staffing requirements and reduce the number of hospital beds;
- improve the quality of health services in rural areas, and provide adequate access for people living in rural areas to the primary, secondary and tertiary levels of health services;
- reform the medical education system by optimizing the medical training curricula with a focus on training general practitioners; and reconsider the capacity of the national medical training system to train only the required number of health professionals;
- develop the national pharmaceutical and medical industry to meet the country’s requirements in supply of medicine and medical equipment; promote research and development in the area of medicine and medical technology; attract foreign investments and resources of other sectors of the medical industry;
- assign top priority to efforts to identify the most frequent and serious conditions affecting the health of community members; develop and implement programs addressing socioeconomic, environmental and other causes of these conditions; develop vertical programs to prevent tuberculosis, cancer, viral hepatitis, HIV infection, drug abuse, sexually transmitted diseases, etc.;
- develop and introduce new forms and principles of health care financing and management based on fee-for-services, market orientation and private competition.

1.5 Family Planning Policies and Programs

For many years, the Government of Uzbekistan promoted policies to encourage women to have more children. Women in Uzbekistan who, in the past, had seven or more children were traditionally glorified and recognized as "mother-heroes" and were provided with a number of benefits, including bonuses, housing assistance, extensive paid maternity leave, child benefits, support for day care, etc.
The Ministry of Health has revised this pronatalist policy and is now promoting family planning services to improve reproductive health. The Ministry of Health is responsible for providing family planning services throughout the country. The main goal of the family planning policy is to ensure low risk pregnancy and safe motherhood, to reduce complications due to inadequately spaced pregnancies and to reduce the incidence and prevalence of pregnancy complications and extragenital diseases among women of reproductive age.

The Ministry of Health manages a broad spectrum of activities including intensive family planning education of the population and supplying contraceptives throughout the country. The private sector is also involved in marketing contraceptives. While promoting awareness of family planning and access of women to a variety of contraceptives, the Ministry also is concerned with the quality, safety and effectiveness of contraceptive methods. In order to control family planning services, the Ministry of Health considers them as part of maternal and child health care and requires that adequate counseling on the selection and use of contraceptive methods be done by health professionals with skills in obstetrics and gynecology.

In Uzbekistan, one of the primary methods of birth control is induced abortion which is usually done at the outpatient departments of general hospitals or at delivery hospitals. Induced abortion is legal in Uzbekistan if done during the first 12 weeks of pregnancy. In some cases induced abortion can be performed after 12 weeks if certain medical or social conditions exist. These cases require strong supervision of qualified medical personnel in a hospital setting (Ministry of Health, 1996). Abortion can be done free of charge, but lately fee-for-services facilities became available to perform mini-abortions by the vacuum aspiration technique. Despite some indications that the number of induced abortions has declined in recent years, the abortion issue remains a great public health concern in Uzbekistan due to the prevalence of complications and the overall adverse effects on women's health.

Due to the policy of promoting use of safe methods of family planning, a strong trend of substituting contraception for abortion has been observed in Uzbekistan during the last several years. Among the most popular methods of contraception is the intrauterine device. Traditionally, many women continue to rely on the intrauterine device as a convenient and safe method. For many years oral contraceptives were much less available in Uzbekistan because of a document, On the side effects and complications of oral contraceptives, published by the Ministry of Health of the former Soviet Union in 1974 which practically banned the distribution and use of oral contraceptives (United Nations, 1995). Women in Uzbekistan now have broad access to a variety of methods of contraception including oral contraceptives, injectables, etc. They are distributed centrally through government pharmacies and women’s consulting centers and privately via private pharmacies.

Decreasing maternal mortality from a rate of 65 per 100,000 live births in 1991 to 39 in 1994 in part resulted from improved access of women to family planning services in Uzbekistan (Ministry of Health, 1995). In order to support this trend an International Charity Fund “Soglom Avlod Uchum” (For a Healthy Generation) has been established in Uzbekistan. The fund will coordinate multidisciplinary and international efforts to protect and improve the health of the mothers and children of Uzbekistan.

1.6 Demographic and Health Data Collection System in Uzbekistan

The demographic and health data collection system in Uzbekistan is based on the registration of events and periodic censuses. The data on births, deaths, marriages, and divorces are registered at the local administrative level of an internal passport control system. These data are then forwarded to the State Committee on Statistics and Analysis (“Goskomprognozstat”) through the raion and oblast level statistical offices. Goskomprognozstat is responsible for conducting censuses and maintaining this registration system. The last census in Uzbekistan was conducted in 1989, and the census results were published in 1990.
Collection of health data is a primary responsibility of the Statistical Department of the Ministry of Health. Health information is generated by staff at the facilities delivering services and then sent to the Statistical Department through the raion and oblast level health departments. The Statistical Department of the Ministry of Health compiles and analyzes these data and issues annual reports entitled Health of the Population of the Republic of Uzbekistan and Health Services.

The health data collected and published by the Statistical Department consist of the following major categories: 1) morbidity specified by type of disease (infectious and non-infectious); 2) mortality specified by causes of death; 3) infant deaths, including data on antenatal, perinatal, and early neonatal deaths; 4) maternal mortality specified by causes of maternal death; 5) data on maternal and child health, including antenatal care and delivery assistance, contraceptive clients, induced abortion rates, pediatric services, etc; 6) number of health facilities, medical personnel, hospital beds, and length of average stay in the hospital; and 7) health data specified by type of medical services including medical care for patients with cancer, tuberculosis, mental disorders, drug abuse, and sexually transmitted diseases. These data are usually tabulated at the national and oblast levels, and for some categories, by the age groups 0-14 and 15 or more years.

1.7 Objectives and Organization of the Survey

The purpose of the 1996 Uzbekistan Demographic and Health Survey (UDHS) was to provide an information base to the Ministry of Health for the planning of policies and programs regarding the health of women and their children. The UDHS collected data on women’s reproductive histories, knowledge and use of contraception, breastfeeding practices, and the nutrition, vaccination coverage, and episodes of illness among children under the age of three. The survey also included, for all women of reproductive age and for children under the age of three, the measurement of the hemoglobin level in the blood to assess the prevalence of anemia and measurements of height and weight to assess nutritional status.

A secondary objective of the survey was to enhance the capabilities of institutions in Uzbekistan to collect, process and analyze population and health data so as to facilitate the implementation of future surveys of this type.

The 1996 UDHS was the first national-level population and health survey in Uzbekistan. It was implemented by the Research Institute of Obstetrics and Gynecology of the Ministry of Health of Uzbekistan. The 1996 UDHS was funded by the United States Agency for International development (USAID) and technical assistance was provided by Macro International Inc. (Calverton, Maryland USA) through its contract with USAID.

1.7.1 Sample Design and Implementation

The UDHS employed a nationally representative probability sample of women aged 15 to 49, representative of 98.7 percent of the country. Seven raions were excluded from the survey because they were considered too remote and sparsely inhabited. These raions are: Kungradskiyi, Muyinakskiyi, and Takhtakupyrskiyi in Karakalpakstan; Uchkudukskiyi, Tamdynskiyi, and Kanimekhskiyi in Navoiiskaya; and Romitanskiyi in Bukharaksya oblast. The remainder of the country was divided into five survey regions (Figure 1.1). Tashkent City constituted a survey region by itself while the remaining four survey regions consisted of groups of contiguous oblasts. The five survey regions were defined as follows:
Figure 1.1
OBLAST COMPOSITION OF REGIONS IN UZBEKISTAN, 1996

CITY OF TASHKENT

SURVEY REGION 1
Republic of Karakalpakstan and Khorezmskaya Oblast

SURVEY REGION 2
Navoiiskaya, Bukharskaya, Kashkadaryinskaya, and Surkhandaryinskaya Oblast

SURVEY REGION 3
Samarkandskaya, Dzhizakska, Syrdaryinskaya, and Tashkentskaya Oblast

SURVEY REGION 4
Namanganskaya, Ferganskaya, and Andizhanskaya Oblast
In the rural areas, the primary sampling units (PSUs) were the raions which were selected with probability proportional to size, the size being the population size as published by Gozkomprognozstat in 1994. At the second stage, one village was selected in each selected raion. This resulted in 64 rural sample clusters. A complete listing of households in the selected clusters was carried out. The lists of households served as the frame for third-stage sampling; i.e., the selection of the households to be visited by the UDHS interviewing teams. In each selected household, women age 15-49 were eligible to be interviewed.

In the urban areas, the PSUs were the cities and towns themselves. In the second stage, one health block was selected from each town except in self-representing cities (large cities that were selected with certainty), where more than one health block was selected. In total, 104 urban health blocks were selected. The selected health blocks were segmented prior to the household listing operation which provided the household lists for the third stage selection of households.

On average, 21 households were selected in each urban cluster, and 27 households in each rural cluster. It was expected that the sample would yield interviews with approximately 4,000 women between the ages of 15 and 49. Because of the non-proportional distribution of the sample to the different survey regions, sampling weights have been applied to the data in this report.

Details of the UDHS sample design are given in Appendix A and the estimation of sampling errors for selected variables is given in Appendix B.

### 1.7.2 Questionnaires

Two questionnaires were used for the UDHS: the Household Questionnaire and the Individual Questionnaire. The questionnaires were based on the model survey instruments developed in the DHS program. The questionnaires were adapted to the data needs of Uzbekistan during consultations with specialists in the areas of reproductive health and child health in Uzbekistan. Both questionnaires were developed in English and then translated into Russian and Uzbek. A pretest was conducted in March-April 1996. Based on the pretest experience, the questionnaires were further modified.

The Household Questionnaire was used to enumerate all usual members and visitors in a sample household and to collect information relating to the characteristics of the dwelling unit. In the first part of the Household Questionnaire, information was collected on age, sex, educational attainment, and relationship to the head of household of each person listed as a household member or visitor. The primary objective of collecting this information was to identify women who were eligible for the individual interview. In the second part of the Household Questionnaire, questions were included on the dwelling unit, such as number of rooms, flooring material, source of water, type of toilet facilities, and on the availability of a variety of consumer goods.

The Individual Questionnaire was used to collect information from women age 15-49. These women were asked questions on the following major topics:

- Background characteristics
One of the major efforts of the UDHS was testing women and children for anemia. Testing was done by measuring hemoglobin levels in the blood, using a portable machine called a Hemocue. Before collecting the blood sample, women were asked to sign a consent form, giving permission for the collection of a blood droplet from herself and her children. Results of anemia testing were kept confidential (as are all UDHS data); however, strictly with the consent of respondents, local health care facilities were informed of women who had severely low levels of hemoglobin (less than 7 g/dl).

1.7.3 Training and Fieldwork

The UDHS questionnaires were pretested in March-April 1996. Eight interviewers were trained over a two-week period at the Institute of Obstetrics and Gynecology. The pretest included one week of interviewing in an urban area (Tashkent City) and one week in a rural area. A total of 120 women were interviewed. Pretest interviewers were retained to serve as supervisors and field editors for the main survey.

Staff members of the Institute of Obstetrics and Gynecology and female nursing students of the National Medical College were recruited as field supervisors, editors, interviewers and medical technicians for the main survey. A total of 50 people were trained for three weeks during June 1996. Training consisted of in-class lectures and practice, as well as conducting practice interviewing in the field. Interviewers were selected based on their performance during the training period.

The UDHS data collection was carried out by five teams. Each team consisted of eight members: the team supervisor, one editor, one household interviewer, four individual women interviewers, and one medical technician (responsible for height and weight measurement and anemia testing). All interviewers were female, while most of the supervisors and technicians were males.

All five interviewing teams began work in Region 5 (Tashkent City) on June 24. After three weeks of interviewing in Tashkent City, four survey teams were assigned to the remaining survey regions and fieldwork started in Regions 1 through 4 on July 14. One team continued data collection in Tashkent City. Data collection was completed on October 12, 1996.

1.7.4 Data Processing

Questionnaires were returned to the Institute of Obstetrics and Gynecology in Tashkent for data processing. The office editing staff checked that questionnaires for all selected households and eligible respondents were returned from the field. The few questions which had not been precoded (e.g., occupation, type of chronic disease) were coded at this time. Data were then entered and edited on microcomputers using the ISSA (Integrated System for Survey Analysis) package, with the data entry software translated into Russian. Office editing and data entry activities began on August 5, and were completed on October 31, 1996.
1.7.5 Response Rates

Table 1.1 presents information on the coverage of the UDHS sample including household and individual response rates. A total of 3,945 households were selected in the sample, of which 3,763 were occupied at the time of conducting fieldwork. The main reason for the difference was that some dwelling units which were occupied at the time of the household listing operation were either vacant or members of the household were away for an extended period at the time of interviewing. Of the 3,763 occupied households, 3,703 were interviewed, yielding a household response rate of 98 percent.

In the interviewed households, 4,544 women were eligible for the individual interview (i.e., all women 15-49 years of age who were either usual residents or visitors who had spent the previous night in the household). Interviews were completed with 4,415 of these women, yielding a response rate of 97 percent. The principal reason for nonresponse was a failure to find an eligible woman at home after repeated visits to the household. The overall response rate for the survey, the product of the household and the individual response rates, was 96 percent.

| Table 1.1. Results of the household and individual interviews |
| Number of households, number of interviews and response rates, Uzbekistan 1996 |

<table>
<thead>
<tr>
<th>Residence</th>
<th>Result</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household interviews</strong></td>
<td><strong>Households sampled</strong></td>
<td>2,228</td>
<td>1,717</td>
<td>3,945</td>
</tr>
<tr>
<td></td>
<td><strong>Households found</strong></td>
<td>2,099</td>
<td>1,664</td>
<td>3,763</td>
</tr>
<tr>
<td></td>
<td><strong>Households interviewed</strong></td>
<td>2,062</td>
<td>1,641</td>
<td>3,703</td>
</tr>
<tr>
<td></td>
<td><strong>Household response rate</strong></td>
<td>98.2</td>
<td>98.6</td>
<td>98.4</td>
</tr>
<tr>
<td><strong>Individual interviews</strong></td>
<td><strong>Number of eligible women</strong></td>
<td>2,388</td>
<td>2,156</td>
<td>4,544</td>
</tr>
<tr>
<td></td>
<td><strong>Number of eligible women interviewed</strong></td>
<td>2,306</td>
<td>2,109</td>
<td>4,415</td>
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<tr>
<td></td>
<td><strong>Eligible woman response rate</strong></td>
<td>96.6</td>
<td>97.8</td>
<td>97.2</td>
</tr>
</tbody>
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