INTRODUCTION

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1.1 GEOGRAPHY AND POPULATION

Uzbekistan is a landlocked country located in Central Asia between two major rivers, the Amudarya and the Syrdarya. The territory of Uzbekistan covers 448,900 square kilometers and is bordered by Kazakhstan to the north, Kyrgyzstan and Tajikistan to the south and east, Afghanistan to the south, and Turkmenistan to the west.

Uzbekistan is a presidential democracy. The president is elected by popular vote for a seven-year term. The last election was held on 9 January 2000.

Uzbekistan consists of 12 administrative regions (oblasts), the Autonomous Republic of Karakalpakstan, and Tashkent City. Each region is further broken down into administrative areas called rayons. There are 162 rayons, and 118 cities and towns in Uzbekistan.

With a population in excess of 25 million, Uzbekistan is the third most populous country of the former Soviet Union after Russia and the Ukraine. Approximately 63 percent of the population resides in rural areas. The country is characterized by a high rate of population growth, mainly due to the high (although declining) birth rate (20 per 1,000 population in 2001 as opposed to 29 per 1,000 in 1995) and relatively low death rate (5.3 per 1,000 population in 2001). As a result of high fertility and population growth rates, Uzbekistan has a young population: 36 percent of the population are under 15 years of age, while the population over 65 years of age is relatively small at about 4 percent (State Department of Statistics, 2002).

Life expectancy in Uzbekistan has declined steadily since the collapse of the Soviet Union, especially among men. In 2001, life expectancy was 72.6 years for women and 67.6 years for men, a difference of five years. Uzbekistan has a double burden of diseases, with the majority of all deaths being due to cardiovascular diseases, but with respiratory, digestive, and infectious diseases also being prevalent, viral hepatitis, tuberculosis, and sexually transmitted infections are of particular concern.

The population density of Uzbekistan is 56 persons per square kilometer. However, the population is unevenly distributed among the regions. The population is mainly concentrated in the grasslands and in the industrialized urban areas. The capital of Uzbekistan, Tashkent City, with a population of more than two 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 are Uzbeks, constituting more than 80 percent of the population. Other significant ethnic groups are Russians, Tajiks, Kazakhs, and Tatars. The Uzbek language belongs to the Turkic 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 These statistics on life expectancy are based on data from the national registration system provided to the World Health Organization. The figures may be overestimated because the infant mortality rate (which is a primary determinant of life expectancy at birth) from the 2002 Uzbekistan Health Examination Survey data is significantly higher than the official infant mortality rate from the registration system (see Chapter 8).
1.2 HISTORY OF UZBEKISTAN

In ancient times, the people of Uzbekistan were mainly nomadic and involved in agriculture and cattle herding. As early as the fifth and sixth centuries B.C., centralized states were established throughout the territory of Uzbekistan. This early period also witnessed the rise of the great ancient cities of Samarkand, Kyuzelgir, and Kalagyr.

During the sixth century, the territory of Uzbekistan was conquered by Turkic tribes that introduced their language and culture. Arab invasions in the seventh and eighth centuries brought Islam, which unified many settled and seminomadic Turkic-speaking tribes and led to the formation of the Uzbek nation. The period from the ninth and thirteenth century was marked by a renaissance during which trade, craftsmanship, science, and poetry flourished in Uzbekistan.

In the beginning of the thirteenth century, Central Asia was invaded by Genghis Khan, who dominated Central Asia for several centuries. In 1370, Tamerlan (Timur), a descendent of Genghis Khan, came to power and created an empire that extended from the Middle East to India.

After the collapse of Tamerlan’s dynasty in the Eighteenth century, three states were established in the territory of Uzbekistan: Bukhara Emirate, Kokand Khanate, and Khiva Khanate. In the second half of the nineteenth century, the Russian Empire established a protectorate over Khiva Khanate and Bukhara Emirate, and incorporated Kokand Khanate as part of its Turkestan administrative unit. The Russian conquest played an important 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 strong political impact in the region, initiating nationalistic movements that later became a major force against Tsarist Russia. In 1924, the Soviet Government granted Uzbekistan the status of Soviet Socialist Republic, incorporating the Republic into the Soviet Union. This event led to industrial development, eradication of illiteracy, granting of women’s rights, and the introduction of a Western health care system. The system of compulsory secondary education, introduced during the Soviet era, has been a keystone of the Republic’s development.

During World War II, many industries were evacuated from Russia and European parts of the Soviet Union and brought to Uzbekistan. These industries were the basis for postwar economic development of Uzbekistan. As a Soviet Republic, Uzbekistan relied for many years on a planned economic system that was tightly controlled by the central Soviet Government.

With the collapse of the Soviet Union in 1991, Uzbekistan became a sovereign republic and joined the United Nations. Under transition from a centrally planned economy to a market economy, Uzbekistan is now experiencing rapid social and economic changes. This process has produced disruption in some sectors of the economy.

1.3 ECONOMY

Uzbekistan is self-sufficient in terms of agricultural products. However, during the Soviet era, cotton production was the number one priority for meeting the strategic objectives of the Soviet Government. In some areas of Uzbekistan, this policy required that 85 to 90 percent of the arable land be devoted to cotton production. This had a severe impact on the other sectors of agriculture. Currently, the Government of Uzbekistan is rectifying this imbalance and is promoting development in such areas as livestock farming, production of crops, grapes, melons, and silkworm breeding. However, cotton is still the main agricultural crop. With 42 percent of all arable land devoted to cotton, it is a main source of foreign exchange.
Uzbekistan is rich in mineral resources and has substantial energy reserves, both oil and gas. During the last two decades, Uzbekistan developed national industries in copper, machinery, chemical fertilizers, petroleum products, and hydroelectric plants. Under the new economic policy of attracting foreign investments, joint enterprises have been launched with Korean, Italian, Turkish, American, and other foreign firms.

1.4 Health Care System

1.4.1 Facilities and Human Resources

The health care system in Uzbekistan was developed as part of the Soviet system with the objective of providing adequate access to health services to all citizens. With these goals, a nationwide network of more than 6,000 primary, secondary, and tertiary health care facilities was created under the control of the Ministry of Health (MOH). The health care system in Uzbekistan is almost all state-owned. Throughout the country, health services are provided free of charge, including antenatal care, delivery assistance, neonatal and pediatric services, immunizations, family planning, and specialized health care. However, some health professionals offer private fee-for-service health care. Almost all hospitals have some beds operated on a self-financing basis through fee-for-service payments by patients (Ilkhamov and Jakubowski, 2001).

In Uzbekistan, almost all health professionals (81,400 physicians and 263,100 midlevel professionals in 2001) are government employees. However, the distribution of physicians is uneven between urban (47 per 10,000 population) and rural areas (23 per 10,000 population) (State Department of Statistics, 2002). Health professionals are paid on a salary basis. The average salary is low, and additional income is generated through informal payments made by patients, although there is no reliable data on this practice. It is estimated that in recent years 30,000 health professionals left the state health care system, including 7,000 physicians (Ilkhamov and Jakubowski, 2001).

1.4.2 Health Care Reforms

Since 1991, the Ministry of Health has undertaken targeted health care reforms. The 1991-1998 reform priorities were focused on the development of national policies, health care financing, resource allocation, and improvement of maternal and child health care services, including family planning. A new form of outpatient day-care treatment was introduced in 1992. Introduction of these services has led to the elimination of 104,200 hospital beds as of 2001 (Ilkhamov and Jakubowski, 2001). In 1997, Uzbekistan adopted a program on healthy lifestyle, which focuses on prevention of smoking and promotion of physical activity and healthy nutrition.

The 1998-2005 reform priorities include a plan and a timetable for establishment of a national network of emergency medical care centers; a plan for establishing of a network of rural medical centers (selsky vrachebny punkt [SVPs]), that will eventually replace feldsher-midwifery posts (feldshersko-accouchersky punkt [FAPs]), rural outpatient clinics, and rural hospitals; further development of the private health care sector; the introduction of high education for nurses; and provisions for monitoring the implementation of reforms. The Ministry of Health is developing a list of illnesses that will be covered by treatment under the State budget, including treatment protocols and a maximum length of stay in State health facilities. After 2005, health services not covered by the government package, such as elective procedures and specialized dental care, will be funded by the patient, his employer, or by insurance coverage.

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2 A feldsher is the health professional trained in nursing and midwifery with extended training in diagnosis and pharmacology. Feldshers are authorized to provide basic treatment and to prescribe a restricted number of drugs at FAPs with no assigned doctor.
The new SVPs are currently being introduced throughout Uzbekistan. SVPs are designed to serve a population of between 4,000 and 6,000 people and are staffed with one to five physicians (specialized in internal medicine, gynecology, and pediatrics) and four to eight nurses and auxiliary personnel. These facilities provide primary health care, vaccination, reproductive health care, surveillance of people at special risk, and education on a healthy lifestyle.

1.4.3 Primary, Secondary, and Tertiary Health Care

Primary health care in Uzbekistan is provided by outpatient polyclinics, the recently introduced SVPs, primary health facilities at large enterprises, women’s consulting centers (a primary source of family planning services in urban areas), and delivery hospitals. The main focus of these institutions is disease prevention, 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, dispensaries, and clinical research institutes. The clinical treatment offered at these facilities is aimed at minimizing the effect of disease and disability.

1.4.4 Maternal and Child Health Care

Maternal and child health services in Uzbekistan are mostly provided through primary and secondary health care institutions. Almost all deliveries occur at the delivery hospitals and, in rare cases, at regular hospitals or at SVPs or FAPs in rural areas. Antenatal care is provided mainly by doctors at the women’s consulting centers (a department of urban polyclinics), rural hospitals and rural ambulatories, SVPs, and FAPs. Antenatal care starts early in pregnancy (usually during the first trimester) and continues on a monthly basis throughout the pregnancy.

Child health care is initially provided during the first week following delivery, while a woman and her newborn stay in the delivery hospital. After discharge from the delivery hospital, a child is visited at home by a nurse who conducts a physical examination of the child and provides counseling on child care to the mother. Additional pediatric services are mainly provided by primary health care facilities. A mother is required to take her child for regular checkups and vaccination at the polyclinic or outpatient clinic several times during the first two years of life. Doctors at the polyclinic can refer children to a specialized pediatrician and for hospitalization, as necessary.

The child vaccination schedule in Uzbekistan requires that BCG and oral polio vaccines be given in the delivery hospital during the first few days of life. Revaccination with oral polio vaccine is usually done at 2, 3, 4, 16, and 18 months and 6-7 years of age. The vaccination schedule for diphtheria, pertussis, and tetanus toxoid (DPT) is similar to the schedule for the polio vaccination, except that the first DPT vaccine is given at 2 months of age. Measles vaccinations are given at 9 and 16 months of age. In 1991, hepatitis B vaccination was introduced throughout the country. The first dose is given at birth; the second and third doses are given at 2 and 9 months (Ministry of Health, 1993).

1.4.5 Family Planning Services

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, and to reduce complications due to closely spaced pregnancies and pathological conditions 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. The Ministry of Health considers family planning as part of maternal health care and requires counseling on the selection and use of contraceptive methods by health professionals with skills in obstetrics and gynecology. For the past decade, women in Uzbekistan have relied primarily on the intrauterine device for contraception, almost to the exclusion of other methods.

Induced abortion is legal in Uzbekistan if done during the first 12 weeks of pregnancy. These procedures are typically performed at the outpatient departments of general hospitals or delivery hospitals. Abortion services may be free of charge, but lately fee-for-service facilities offering mini-abortions by the vacuum aspiration technique have become available. However, since the mid-1990s, the Ministry of Health has promoted the use of family planning methods as a substitute for reliance on induced abortion.

1.4.6 Tuberculosis DOTS Program

The Western region of Uzbekistan (Autonomous Republic of Karakalpakstan and Khorezm Oblast) became the pilot area for treating tuberculosis patients according to the WHO protocol known as DOTS (Directly Observed Treatment Short Course). The DOTS-Plus program is a strategy for the treatment of multi-drug-resistant tuberculosis (MDRTB). In October 2003, a new tuberculosis hospital opened in the city of Nukus (Karakalpakstan) to serve MDRTB patients in the region.

1.4.7 HIV/AIDS Program

In 1998, a new vertical infrastructure for prevention and treatment of HIV infection and AIDS was established in Uzbekistan. The Republican HIV/AIDS Prevention Center was open in Tashkent and branches throughout the country. The center has an immunodiagnostic laboratory and treatment facilities. The center’s primary aim is prevention, monitoring, and treatment, and it offers anonymous voluntary testing and counseling.

1.5 SYSTEMS FOR COLLECTING DEMOGRAPHIC AND HEALTH DATA

The State Department of Statistics of the Ministry of Macroeconomics and Statistics is responsible for maintaining the national registration system and conducting censuses. Births, deaths, marriages, and divorces are registered at the local administrative level, and aggregated statistics are forwarded through the rayon and oblast level statistical offices to the State Department of Statistics. The last census in Uzbekistan was conducted in 1989, and results were published in 1990. A census was originally scheduled for 2000 but has been postponed due to financial constraints.

Collection of health data is primarily the 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 rayon and oblast level health departments. The Statistical Department of the MOH 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 annually published by the Statistical Department of the MOH consist of the following major categories: 1) morbidity specified by type of disease; 2) mortality specified by causes of death; 3) infant deaths, including perinatal and early neonatal deaths; 4) maternal mortality specified by

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3 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).

4 As of August 2003, the DOTS program was considered fully implemented in only these two areas.
cause of death; 5) data on maternal and child health services; and 6) the number of health facilities, medical personnel, hospital beds, and length of the average hospital stay. These data are tabulated at the national and oblast levels. These data, at the national level, are also available at the WHO website, Health for All DataBase.

1.6 Objectives and Sponsorship of the UHES

In 1996, a Demographic and Health Survey (DHS) was conducted in Uzbekistan with emphasis on maternal and child health, and family planning issues. In 2000, a national-level Multiple Indicator Cluster Survey (MICS) was conducted in Uzbekistan with emphasis on the reproductive health of women and the health and education of children.

During the planning phase of the 2002 Uzbekistan Health Examination Survey (UHES), the Ministry of Health indicated a particular need for information pertaining to adult health issues. Accordingly, the content of the current survey differs considerably from that of the 1996 DHS or 2000 MICS. Data on maternal and child health were collected, but to a lesser extent than in the earlier surveys, while much more information on adult health issues was collected (e.g., risk factors for cardiovascular disease, respiratory disease, tuberculosis, and lifestyle issues [physical activity, smoking, and alcohol usage]).

The 2002 UHES also collected an extensive set of biomarker data for women, men, and children. Section 1.8.1 has a complete listing of the types of biomarker data collected.

An important purpose of the collection of biodata in the 2002 UHES was to provide health data representative of the general population as opposed to clinic-based data.

The 2002 UHES was implemented by the Analytical and Information Center of the Ministry of Health. The sampling design was developed by the State Department of Statistics of the Ministry of Macroeconomics and Statistics. The Institute of Dermatological and Venereal Diseases in Tashkent, Uzbekistan, and the Institute of Nutrition in Almaty, Kazakhstan, provided laboratory analysis of the biodata collected. The U.S. Agency for International Development and UNICEF/Uzbekistan provided funding for the survey. UNDP/Uzbekistan provided administrative support. The MEASURE DHS+ project of ORC Macro provided technical support for the survey.

1.7 Sample Design

The sample was designed to provide demographic and health indicators, including fertility and childhood mortality rates, at the national level and for urban and rural areas. The sample design specified a target of 800 female respondents in each of the five sampling regions. In addition, on request of the Ministry of Health and UNICEF, the Autonomous Republic of Karakalpakstan and Fergana Oblast were over sampled to provide approximately 800 women in each, yielding a target sample size of approximately 5,600 women. Fertility rates and other indicators were estimated for the following five regions:

Western: The Autonomous Republic of Karakalpakstan and Khorezm Oblast
Central: Navoi, Bukhara, Kashkadarya, and Surkhandarya Oblasts
East-Central: Samarkhand, Jizzakh, Syrdarya, and Tashkent Oblasts
Eastern: Namangan, Fergana and Andizhan Oblasts
Tashkent City
OBLAST COMPOSITION OF REGIONS IN UZBEKISTAN, 2002

- **WESTERN REGION**
  - The Autonomous Republic of Karakalpakstan and Khorezm Oblast

- **CENTRAL REGION**
  - Navoi, Bukhara, Kashkadarya, and Surkhandarya Oblasts

- **EAST-CENTRAL REGION**
  - Samarkhand, Jizzakh, Syrdarya, and Tashkent Oblasts

- **EASTERN REGION**
  - Namangan, Ferghana, and Andizhan Oblasts

**TASHKENT CITY**
A weighted, multistage, stratified, cluster sampling design was employed. In total, 219 sample clusters were selected for the sample (101 in urban areas and 118 in rural areas). Then, a household listing operation was conducted in each sample cluster. The final selection of approximately 20 households per cluster was made at survey headquarters in Tashkent using systematic random sampling. The selected sample consisted of 4,385 households. Appendix A provides more information on the sample design.

All selected households that were occupied were eligible for the Household Questionnaire. In all regions, all women age 15-49 in the selected households were eligible for the Women’s Questionnaire. Eligibility for the Men’s Questionnaire differed between Tashkent City and the other four regions. In Tashkent City, all men age 15-59 in the selected households were eligible respondents, while in the four remaining regions only men age 15-59 in every third household were eligible respondents. The rationale for a larger sample of men from Tashkent City was to ensure a sufficient number of observations to permit gender comparisons of the biodata collected only in Tashkent City.

1.8 SURVEY IMPLEMENTATION

1.8.1 Questionnaires

The UHES employed three survey instruments: a Household Questionnaire, a Women’s Questionnaire, and a Men’s Questionnaire. The survey instruments were based on the model questionnaires developed by the MEASURE DHS+ project augmented by modules on topics related to adult health. The data collection instruments were reviewed and approved by an Advisory Committee of subject matter experts appointed by the Minister of Health during the summer of 2001.

The 2002 Household Questionnaire consisted of three sections. In the first section, all usual members and visitors in the sampled households were listed, and for each listed person, information was collected on age, sex, educational attainment, and relationship to the head of household. A second section of the Household Questionnaire included questions on the characteristics of the dwelling unit (e.g., the number of rooms, flooring material, source of water). The third section included the forms for recording information on the biodata collected.

Some biodata specimens were collected in the sample households in all survey regions (height and weight measurements, blood pressure and capillary blood for determining anemia status of children). In Tashkent City and in Ferghana Oblast, additional biodata specimens were collected (venous blood and vaginal swabs). The additional biodata collection was restricted in terms of the areas covered because of financial constraints. Table 1.1 summarizes information on the biodata collected, eligible donors, and the health indicators derived.

The Women’s Questionnaire was more extensive than the Men’s Questionnaire, although there was considerable overlap in the subject matter covered by each. The topics included in the two questionnaires are summarized in Table 1.2.
1.8.2 Pretest of Survey Instruments

The survey instruments, including biodata collection, were pretested in November 2001. Uzbek and Russian language versions of the questionnaires were used. The pretest lasted four weeks. The first week was devoted to orientation to the survey and lectures. The second week focused on practice interviewing in the classroom. The third and fourth weeks were devoted to fieldwork. The fieldwork was conducted in two urban and two rural locations. About 100 persons were interviewed, and biodata samples were obtained from 52 respondents.

1.8.3 Organization of the Survey Teams

Seven teams of interviewers conducted data collection for the main survey. Each team consisted of eight field staff: a team supervisor, a field editor, five interviewers (four female and one male), and a
health technician. The female and male interviewers in each team were responsible for: administering the questionnaires to respondents and blood pressure measurement of men and women.

The health technicians were responsible for:

- Height and weight measurement of women, men, and children
- Capillary blood testing for anemia in children
- Capillary blood testing for lead levels in children (Tashkent City only)
- Venous blood collection (fasting) from men and women (Tashkent City only), and
- Vaginal swab, self-administered, from ever-married women (Tashkent City only)
- Venous blood collection from children (Ferghana Oblast only)

Measurements of height, weight, and blood pressure were recorded in the questionnaires while the interviewing team was at the respondent’s house, and recorded immediately in the questionnaires. Anemia testing and measurement of lead levels in children’s capillary blood were conducted at the time of the interview, and the results were recorded immediately in the questionnaires.

The analysis of venous blood (for hepatitis B diabetes, lipids profile, and vitamin A testing) and analysis of vaginal swabs (for chlamydia) required laboratory analysis, and the specimens were sent from the field to Tashkent and Almaty, Kazakhstan. The results of these analyses were added to the data set during data processing.

### 1.8.4 Main Survey Training and Fieldwork

Sixty-five medical personnel, mostly physicians, were recruited and trained to be staff for the interviewing teams. Training, which started on August 12 and continued for four weeks, was conducted in Uzbek and Russian and consisted of lectures, demonstrations, and practice interviewing. Two physicians from the MOH who had participated in the pretest conducted the training. Staff from the Demographic and Health Surveys program assisted with the training. The fourth week of training consisted of field practice conducted on a team basis.

On September 9, data collection started in Tashkent City and within a few days in the four remaining regions. By December 15, all interviewing teams had completed data collection in their regions.

### 1.8.5 Laboratory Testing in Tashkent and Almaty

Venous blood specimens and vaginal swabs obtained from respondents in Tashkent City were sent to the Institute of Dermatological and Venereal Diseases in Tashkent for laboratory analysis. Two distinct laboratories were established at the Institute: one to test blood specimens for hepatitis B, diabetes, and lipids profile, and a second to test vaginal swabs for chlamydia. Staff at the Institute received refresher training in testing procedures over a period of three weeks. ORC Macro staff and a consultant from the Centers for Disease Control and Prevention conducted the training.

Venous blood specimens from children in Ferghana Oblast for the determination of vitamin A status were sent to the Institute of Nutrition in Almaty, Kazakhstan, which contained the only laboratory in the region with the equipment for conducting the required analysis.

### 1.8.6 Data Processing

Data processing took place at the Analytical and Information Center of the Ministry of Health. The office editing staff checked to confirm that questionnaires for all selected households and all eligible respondents were returned from the field. The few questions that had not been precoded (e.g., occupa-
tion) were coded at this time. The data were then entered and edited on computers using the ISSA (Integrated System for Survey Analysis) package, with the data entry software translated into Russian. Office editing and data entry activities were conducted between September 2002 and February 2003.

1.9 RESPONSE RATES

Table 1.3 shows the response rates for the 2002 UHES. A total of 4,385 households were selected for the women’s sample and 2,094 for the men’s sample. The overall household response rate was 99 percent for both household samples.

<table>
<thead>
<tr>
<th>Table 1.3 Results of the household and individual interviews</th>
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<tbody>
<tr>
<td>Unweighted number of households, number of eligible female and male respondents, and response rates, according to residence, Uzbekistan 2002</td>
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<table>
<thead>
<tr>
<th></th>
<th>Women’s sample</th>
<th>Men’s sample</th>
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<tbody>
<tr>
<td></td>
<td>Residence</td>
<td></td>
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<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td><strong>Household interviews</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Households selected</td>
<td>2,021</td>
<td>2,364</td>
</tr>
<tr>
<td>Households occupied</td>
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</tr>
<tr>
<td>Households interviewed</td>
<td>1,865</td>
<td>2,303</td>
</tr>
<tr>
<td><strong>Household response rate</strong></td>
<td>98.4</td>
<td>99.7</td>
</tr>
<tr>
<td><strong>Individual interviews</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number eligible</td>
<td>2,240</td>
<td>3,348</td>
</tr>
<tr>
<td>Number interviewed</td>
<td>2,200</td>
<td>3,263</td>
</tr>
<tr>
<td><strong>Individual response rate</strong></td>
<td>98.2</td>
<td>97.5</td>
</tr>
<tr>
<td><strong>Overall response rate</strong></td>
<td>96.6</td>
<td>97.1</td>
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1 Overall response rate = (household rate)* (individual rate)

In the interviewed households, 5,588 women were eligible for the Women’s Questionnaire (i.e., women age 15-49 who were usual residents or visitors and who had spent the previous night in the household), and 2,447 men were eligible for the Men’s Questionnaire (i.e., men age 15-59 in all sample households in Tashkent City and in one-third of sample households outside of Tashkent).

Interviews were completed with 5,463 women and 2,333 men, yielding response rates of 98 percent for women and 95 percent for men. The principal reason for nonresponse was a failure to find an eligible respondent at home after repeated visits to the household.

The overall response rates (the product of the household and the individual response rates) were 97 percent for women and 94 percent for men.