

The 8  
Millennium  
Development  
Goals



# THE MILLENNIUM DEVELOPMENT GOALS PERFORMANCE TRACKING SURVEY 2015 REPORT



NATIONAL BUREAU OF STATISTICS



THE FEDERAL REPUBLIC  
OF NIGERIA

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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndromes
DPRS	Department of Planning, Research, and Statistics
CFR	Commander of the Federal Republic
DHS	Demographic Health Survey
DPT	Diphtheria, Pertussis, and tetanus
EAs	Enumeration Areas
EdData	Education Data
FCT	Federal Capital Territory
HIV	Human Immune Virus
Hep B	Hepatitis-B
ITNS	Insecticide Treated Net
LGAS	Local Government Areas
MDAs	Ministries, Departments, and Agencies
MDGs	Millennium Development Goals
NBS	National Bureau of Statistics
NISH	National Integrated Survey of Households
NpopCs	National Population Commission
NSS	National Statistics System (NSS)
SSA	Senior Special Assistant

# INTRODUCTION

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It will be recalled that the MDGs 2012 Performance Tracking Survey was the first attempt by Nigeria to objectively and specifically estimate MDG indicators. By 2014, two years would have elapsed from 2012 and many activities and programs would have taken place, particularly with the latest introduction of the MDGs Acceleration Frame Work (MAF). As a result it was necessary to carry out another tracking exercise to check the impact of these programs and activities as coordinated by the Office of the Senior Special Assistant to the President on MDGs. The 2014 Millennium Development Goals' Survey not only has served this purpose but is an update of the 2012 version. A lot of changes have taken place as several successes recorded in the 2012 version ignited interest from governments at all levels, particularly those states in the lime light. It is very necessary to harvest the new developments and use them as input in strengthening the MDG framework upon which the 2015 successor agenda would be built. The 2012 MDGs Survey was born out of the keen interest of the government to know the level of achievement of Nigeria goal by goal, and target by target. The survey canvassed for data from the 36 states of the Federation and the FCT. Twenty one indicators cutting across the poverty, education, health and environment goals were estimated. The indices fast tracked the establishing of an achievement spectrum of the MDGs, and at the same time served as input in projecting MDGs to 2015.

The 2014 survey is an improvement on the 2012 survey as a result of lessons learnt from the 2012 exercise. The first major improvement was the sample size of the survey. In the 2012 exercise, twenty two thousand households were selected, this was however increased to thirty three and a half thousand in this round to make the results more representative. Another enhancement was in the timeline for the survey. By the convention and statistical operation standard of the National Bureau of Statistics, the 2012 MDGs Survey would have taken a minimum of six months for completion; however due to the urgency it was completed in 3 months. Also recognized was the limited role or even absence of some major stakeholders whose inputs would have added to the strengthening and more successful completion and ownership. However, this round of the survey was encompassing, as more stakeholders were involved in the process which is expected to increase the ownership and acceptability of the results.

# EXECUTIVE SUMMARY

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As the 2015 deadline for the Millennium Development Goals (MDGs) approaches, the United Nations and the international community at large have started work on a new development framework. Equally as important to drafting a new development framework, is the need to assess the impact and effectiveness of the MDGs on the lives of people. In the year 2000, over 148 countries signed up to the Millennium Declaration, which articulated a bold vision and established concrete targets for improving and saving the lives of those threatened by diseases and hunger. Many countries, particularly in Sub-Sahara Africa have seen important progress across all goals, though uneven. In Nigeria, this has been no different as results from the MDGs Performance Tracking Survey in 2012 indicate that Goal 3. Gender Parity has already been achieved ahead of the 2015 deadline; while Goals 4 and 5 have strong prospects of being met by 2015. The importance of using statistical data to corroborate progress or otherwise in the MDGs cannot be over emphasized. Though this critical role of data in monitoring the implementation and progress of the MDGs was not acknowledged at the inception, it is now being increasingly recognized and supported.

It is in recognition of this important role of data and in demonstration of the commitment of the federal government to meeting the targets of the MDGs, that National Bureau of Statistics (NBS) commissioned the 2014 MDGs Performance Tracking Survey. This is the second round of the survey and it is designed to generate specific indicators to monitor progress of the MDGs across the goals. These findings will also help policy makers identify gaps and challenges to the realization of the goals and proffer solutions to ultimately achieve a successful completion of the MDGs targets by 2015. The survey generated several indicators across seven of the eight MDG goals to track progress.

## PROGRESS INDICATORS:

- **ERADICATION OF EXTREME POVERTY AND HUNGER:**

Extreme poverty and hunger has been prevalent in the African continent for decades. In view of this, the MDGs sought to halve between 1990 and 2015, the proportion of people who suffer from hunger. For this report, the prevalence of underweight in under-five children was measured. In 2014, the percentage of underweight prevalence was 25.50 per cent which is a positive decrease by 6.9 per cent in comparison with 27.40 per cent in 2012. This shows that there is a lower prevalence of underweight children in 2014.

- **ACHIEVING UNIVERSAL PRIMARY EDUCATION:**

The target is that by 2015, all children (boys and girls) would have completed a full course of primary schooling. The indicator for this target is the net attendance rate. In 2014, the net attendance rate for primary school was 68.70 per cent which represents a 3.2 per cent decrease from 71.00 per cent recorded in 2012. Secondary school net attendance ratio was 57.4 per cent in 2014, recording a minimal increase of 4.7 per cent from 54.80 in 2012. Primary 6 (six) completion rate was about 74.00 per cent in 2014 which dropped by 15.6 per cent when compared to the 2012 figure. There was also a slight increase in literacy among young women by 0.15 per cent from 2012 to 2014. The survey revealed that the proportion of boys and girls attending primary school declined in 2014, while those attending secondary schools increased minimally. However, primary 6 completion rate recorded a slight decline in 2014.

- **PROMOTING GENDER EQUALITY AND EMPOWERING WOMEN:**

The goal aimed at eliminating gender disparity in primary and secondary education preferably by 2005, and at all levels by 2015. The indicator used for monitoring the target is the Gender Parity Index (GPI). In primary schools, the GPI in 2012 was 1.00 per cent which increased in 2014 to 1.02 per cent. In secondary schools, the GPI



ratio was 1.02 per cent in 2012 and decreased by barely 1 per cent in 2014 to 1.01 per cent. This indicates that for every male, there is a female being enrolled into schools. With this, Nigeria has achieved the target.

- **REDUCUCTION IN CHILD MORTALITY:**

The target is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. Under-five mortality rate, Infant mortality rate and immunization coverage are the indicators for this target. Under-five mortality rate in 2012 was 94 (per 1000 live births) which positively reduced to 89 (per 1000 live births). Infant mortality rate stood at 61 (per 1000 live births) in 2012 which decreased to 58 (per 1000 live births) in 2014. To further combat infant mortality, incentives such as full immunizations against killer diseases such as Polio (1, 2&3), Diphtheria, Pertussis & Tetanus (DPT 1, 2&3), Measles, Hepatitis B (1, 2&3) and Yellow fever were administered. Babies immunized with Polio at birth in 2014 were 52.8 per cent, Polio (1,2&3) averaged at 57.6 per cent in 2012 and 63.5 per cent in 2014, DPT 1,2&3 averaged at 53.1 per cent in 2012 and slightly increased to an average of 57.2 per cent in 2014. Measles immunization coverage was 63.1 per cent in 2014 which shows an increase of 13.1 per cent compared to the figure in 2012.

- **IMPROVEMENT IN MATERNAL HEALTH:**

The target is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and to achieve by 2015, universal access to reproductive health. In 2014, the proportion of women who die from pregnancy related problems, child birth and six weeks after delivery, reduced to 243 (per 100,000 live births) as compared to 350 recorded in 2012. Skilled attendance at delivery increased by 9.3 per cent in 2014 as compared to the figure in 2012. Contraceptive prevalence rate increased by 6.9per cent to 18.5 per cent in 2014 as compared to the 2012 figure,

which could indicate that women have increased their dependence on contraceptives as a method of family planning.

Adolescent fertility rate (15-19) stood at 74 (per 1000 live births) in 2014 which was a decrease from 79 (per 1000 live births) recorded in 2012. About 68.8 percent of ante natal visits at least once by skilled personnel were recorded; this was an increase when compared to the 2012 figure. Ante natal coverage at least 4 times by any provider also increased to 60.6 per cent from 57.40 in 2012. This shows that the number of women being attended to by skilled personnel or by any provider while on an ante natal visit increased which positively influenced the decline recorded from Maternal mortality rate.

- **EFFECTIVELY COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES:**

The goals are to have; halted by 2015 and begun to reverse the spread of HIV/AIDS; achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it; have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. The percentage of the population (15-49) with comprehensive knowledge about HIV prevention increased to 32.10 per cent from the previous year. The percentage of women (15-24) with comprehensive correct knowledge of HIV was also significantly low at 32.80 per cent, a decline by 0.6 per cent from the previous year. Interestingly, the acceptance attitude towards people living with HIV dropped to 11.00 per cent from the previous year, implying that stigmatization of people living with AIDS is still an issue to be tackled. The proportion of women who knew a place to be tested for HIV increased to 69.20 per cent from the previous year. But a significant decline of 56.7 per cent was observed in the percentage of women who have been tested for HIV and know the result. Consequently, there is a need to enlighten the population on the importance of knowing their HIV status.

On Malaria, there was a decline in the number of household with at least one ITN to 38.9 per cent. The proportion of pregnant women and children (under-five) sleeping under ITN reduced to 28.50 per cent and 34.70 per cent respectively. The percentage of people who are aware of anti malaria treatment also reduced to 53.50 per cent. Consequently, there is a need for more awareness on the use of ITNs especially for pregnant women and children and on the treatment for malaria.

- **ENSURING ENVIRONMENTAL SUSTAINABILITY:**

The main target is to halve by 2015, the proportion of the population without access to sustainable safe drinking water and basic sanitation. The survey shows that the number of people with access to a improved source and use of improved drinking water stood at 62.20 per cent which is 14.8 per cent less than the MDG's benchmark of 77 per cent. This reveals that there is an improvement from the 57.80 per cent recorded in 2012. People with access to and use of improved sanitation facilities stood at 33.30 per cent, a decline by 1.2 per cent as compared to 2012.

## Summary of Performance Indicators

MDGs Indicator Number	MDGs indicator	MDGs 2012	MDGs 2014
	<b>Goal 1 - Eradicate extreme poverty and hunger</b>		
	Prevalence of underweight children under-five years of age		
1.8	<b>Underweight prevalence: Moderate</b>	27.40%	25.50%
	Stunting prevalence: Moderate (-2SD)	41.30%	37.40%
	Wasting prevalence: Moderate	12.00%	16.40%
	<b>Goal 2 - Achieve universal primary education</b>		
2.1	<b>Primary school net attendance rate (Proxy)</b>	71.00%	68.70%
	Secondary school net attended rate (Proxy)	54.80%	57.40%
2.2b	<b>Primary 6 Completion Rate</b>	87.70%	74.00%
2.3	<b>Literacy rate of 15-24 year-olds (Women)</b>	66.00%	66.70%
	<b>Goal 3- Promote gender equality and empower women</b>		
	Ratios of girls to boys in primary, secondary and tertiary education		
3.1a	<b>Ratios of girls to boys in primary,</b>	1.00	1.02
3.1b	<b>Ratios of girls to boys in secondary school</b>	1.02	1.01
	<b>Goal 4 - Reduce child mortality</b>		
4.1	<b>Under-five mortality rate</b>	94 (per 1000)	89 (per 1000)
4.2	<b>infant mortality rate</b>	61 (per 1000)	58(per 1000)
	<i>Polio immunization coverage</i>		
	<i>polio at Birth</i>		52.80%
	polio 1	71.90%	78.80%
	Polio 2	62.40%	68.60%
	Polio 3	38.60%	43.20%
	<i>Immunization coverage for Diphtheria, Pertussis and Tetanus (DPT)</i>		
	DPT 1	61.30%	64.70%
	DPT 2	55.10%	58.80%
	DPT 3	42.80%	48.10%
4.3	<b>Proportion of 1 year-old children immunised against measles</b>	55.80%	63.10%
	<i>Hepatitis B Immunization coverage</i>		
	<i>Hep B at Birth</i>		44.60%
	Hep B 1	55.30%	58.40%
	Hep B 2	44.70%	49.80%
	Hep B 3	28.60%	31.70%
	Yellow fever	53.50%	60.10%
	<b>Goal 5- Improve Maternal Health</b>		
5.1	<b>Maternal mortality</b>	350 (per 100,000)	243 (per 100,000)
5.2	<b>Proportion of births attended by skilled health personnel</b>	53.60%	58.60%
5.3	<b>Contraceptive prevalence rate</b>	17.30%	18.50%
5.4	<b>Adolescent birth rate</b>	79(per 1000)	74(per 1000)
5.5a	<b>Antenatal care coverage with at least once by skilled personnel</b>	66.30%	68.80%
5.5b	<b>Antenatal care coverage at least four times by any provider</b>	57.40%	60.60%
	Early childbearing	23.00%	28.10%
5.6	<b>Unmet need for family planning</b>	25.10%	22.20%
	<b>Goal 6 - Combat HIV/AIDS, Malaria and Other Diseases</b>		
	Comprehensive knowledge about HIV prevention (15-49)	31.50%	32.10%
6.3	<b>Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS</b>	33%	32.80%
	comprehensive correct knowledge of HIV/AIDS		
	Knowledge of mother-to-child transmission of HIV	73.90%	76.00%
	Accepting attitudes towards people living with HIV	12.70%	11.00%
	Women who know a place where to be tested	66.10%	69.20%
	Women who have been tested for HIV and know the result	32.80%	14.20%
	<i>Malaria</i>		
	Household with at least one ITN	43.80%	38.90%
	Proportion of children under 5 sleeping under insecticide-treated bed nets	34.60%	34.70%
	Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	54.80%	53.50%
	Pregnant women sleeping under Insecticide-treated net (ITNs)	30.30%	28.50%
7.8	<b>Proportion of population using an improved drinking water source</b>	57.80%	62.20%
7.9	<b>Proportion of population using an improved sanitation facility</b>	33.70%	33.30%

# SURVEY RESULTS

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## **GOAL 1: TO ERADICATE EXTREME POVERTY AND HUNGER**

**Target 1c:** Halve between 1990 and 2015, the proportion of people who suffer from hunger.

*Indicator 1.8: Prevalence underweight children under five year of age.*

The ultimate goal of the MDGs is to lift and rescue nations from the scourge of poverty and hunger. Several studies have confirmed that children are more vulnerable to diseases, epidemic and some other socio-economic problems, than adults. Economic hard times are easily expressed in them. This underscores the inclusion of underweight children indicator in the poverty and hunger eradication goal. Underweight in children is fundamentally caused by undernourishment. Undernourishment itself is very characteristic of a hunger – ravaged community. Underweight children indicator is an auxiliary variable that can be used to gauge the hunger situation of a country.

In the year 2008, the proportion of underweight children going by the national average was 23.1%. It went up to 27.4% in 2012 but declined to 25.5% in 2014. For lack of data, concrete trend cannot be established with this report. Although Nigeria has attained the hunger target according to other reports, yet more interventions are needed not only for the under-five children but for their mothers in order to alleviate them completely from the scourge of hunger.

## **GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION**

Civilization and Development are intertwined. Both of them leverage very much on education. Education is a weapon for liberation from ignorance and diseases. Hence, it cannot be isolated from any development agenda as it is the pivot upon which several other programs rotate. Although the emphasis is on achieving primary education, but it has to be realized that to sustain progress towards other goals such as full employment, poverty reduction, health related programs, etc, attention should be extended beyond primary education.

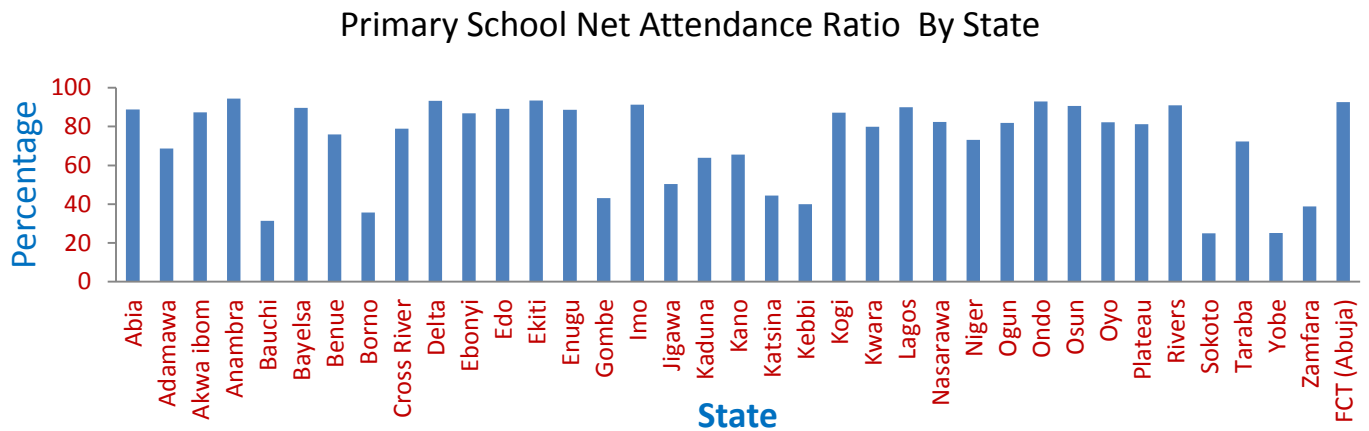
**Target 2A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.**

**Indicator 2.1: Net enrolment in primary education.**

At the inception of the MDGs, countries were advised to domesticate the indicators to suit their experience. Thus, each country had the privilege of identifying the indicators whose content and estimation procedure were either not applicable to them or completely out of context. In Nigeria, the computation of the primary school net enrolment ratio has faced some challenges because it involves a complete census of both private and public primary schools. Consequent upon this, the net attendance ratio estimated from household survey is adopted as a proxy in this report.

In 2014, fig. 2.1 below shows the net attendance ratio according to their distribution by state. The states with very high attendance ratios included. Anambra (94%), Delta (92.8), Imo (90.7), Lagos (92), Ondo (92.4), Osun (91.6), Edo (91.0), Ekiti (93.6) and FTC (94.1) while the least were Bauchi (29.9), Sokoto (24.8), Yobe (23.7), Zamfara (37.8).

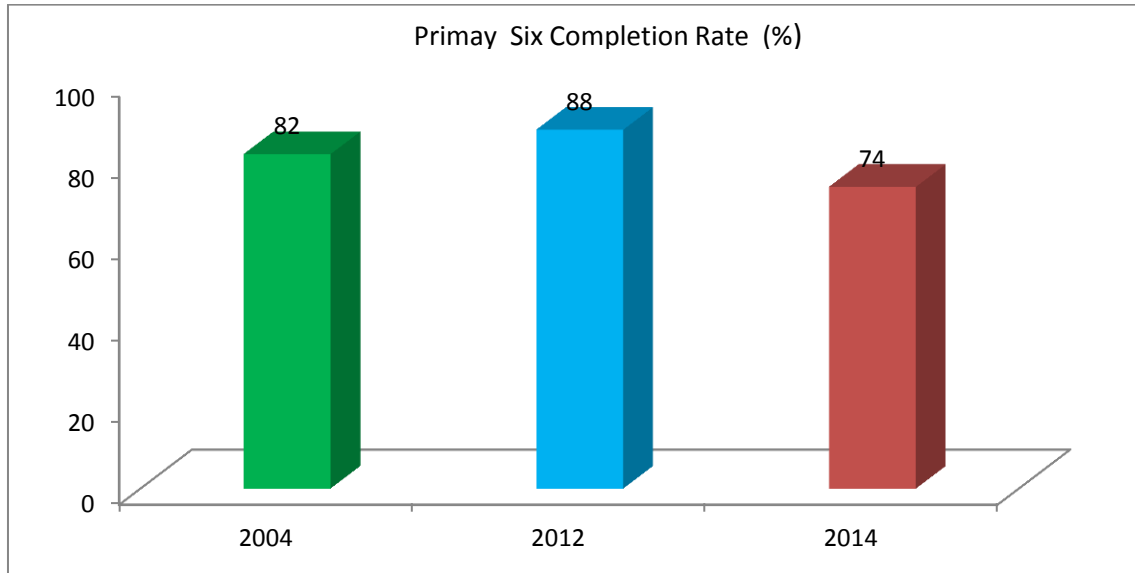
**Fig 2.1**



At the national level, the net attendance ratio was 61% in 2008 and it increased to 71% in 2012. In 2014, there was a shortfall of 2.3% and the net attendance for 2014 thus dropped to 68.7%. When classified by sectors, net attendance in the urban (84.3%) was much higher than in the rural areas (62.2%). Across the geopolitical zones, it was very encouraging in the South East (90.5%), South South (88.1%), South West (87%) and North Central (80.2%). But in the North West (50.5%) and particularly North East (42.5%) net attendance was not impressive. Although one

hundred per cent enrolment and attendance are expected of children within this cohort, the achievement within the sub regions shows that Nigeria is on track of meeting the target.

**Indicator 2.2:**

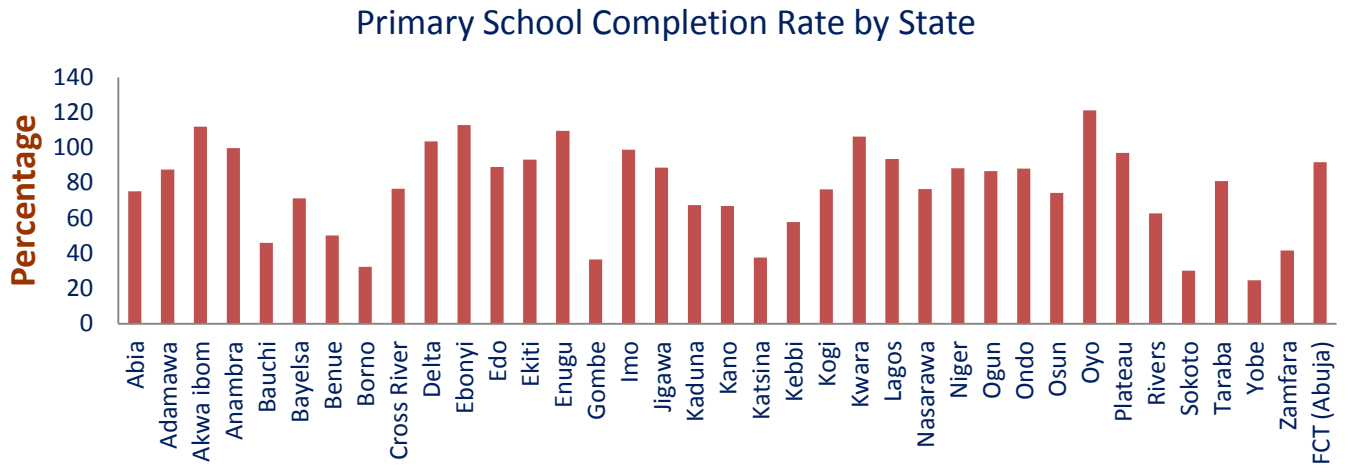


Completion rate is very important in Primary School education as it marks the beginning of transition to secondary school. Children often enroll without attending due to one challenge or the other. Those of them who eventually commence attending may withdraw or drop out without completing. This underpins the education indicator defined as ‘Proportion of pupils starting grade one and reaching final grade’. Final grade in this context is the completion grade.

Nationally completion rate according to fig. 2.2 in 2004 was 82%. It increased to 87.7% in 2012 and dropped to 74.0 in 2014. Within the 2014, the completion rate was higher in the urban (84.4%) when compared with the rural (69.7). In the zones, completion rate was highest in South East (98.7%) zone, followed by South West (94.1%). Primary six completion rate was poorest in the North East (49.5%) zone. Nigeria is also on track.

Fig. 2.2a shows the distribution of completion rate by states in 2014

Fig. 2.2a



Indicator 2.3: Literacy rate of 15 – 24 years, women definition.

Figure 2.3

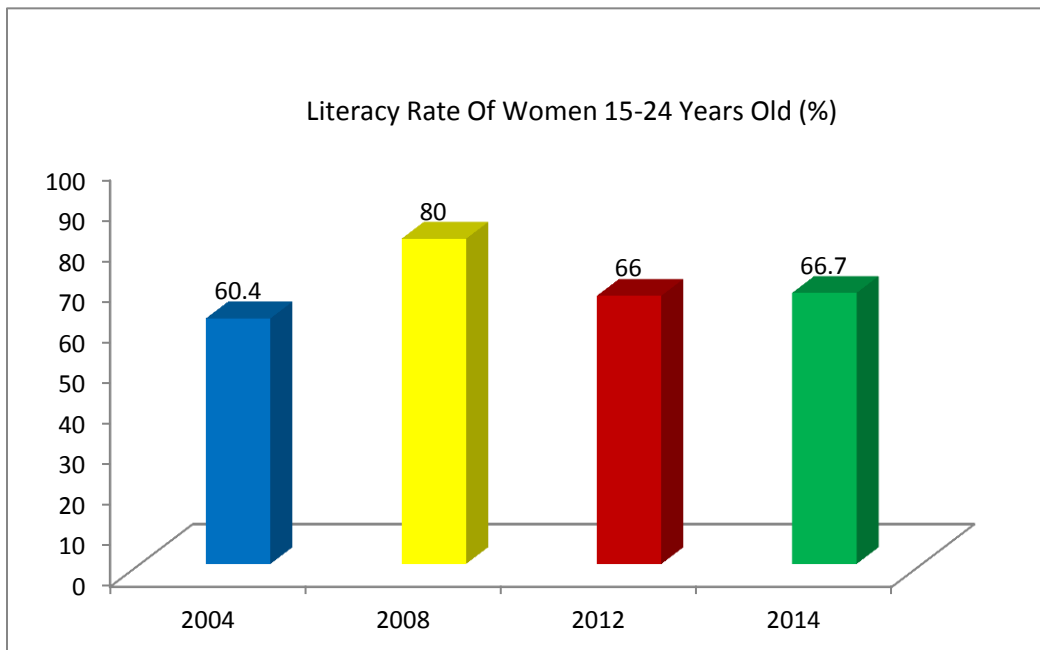
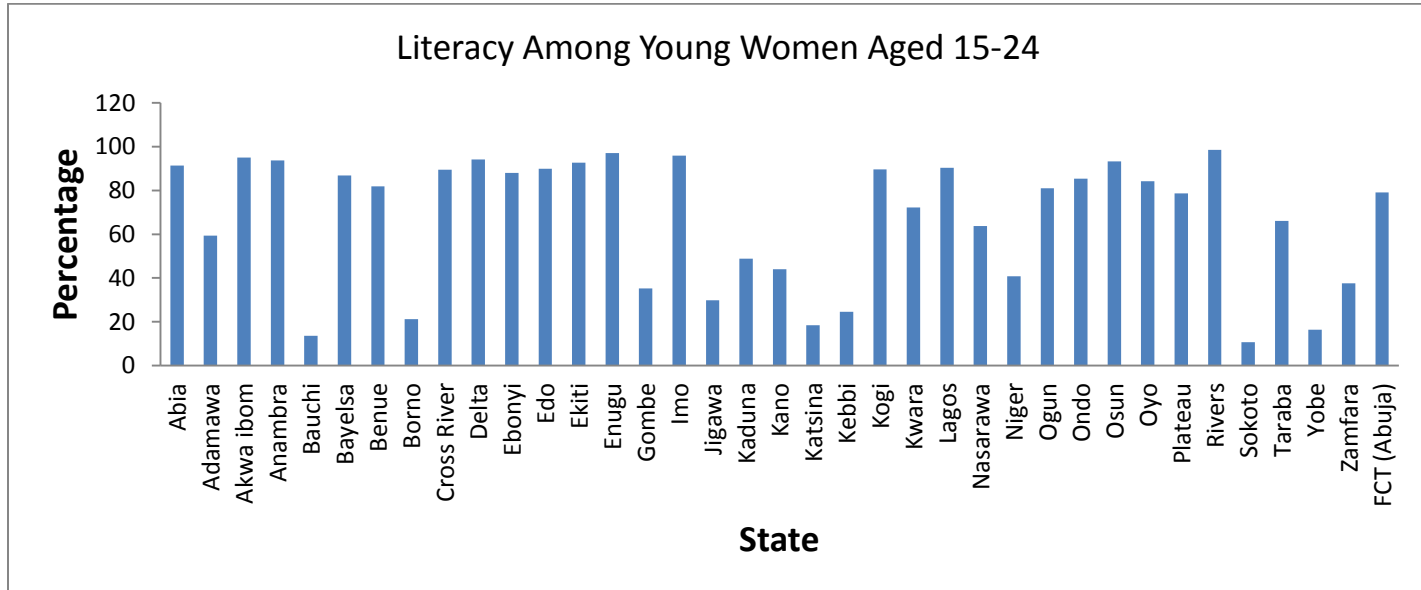


Fig. 2.3 shows the literacy rate of youth women between 2004 and 2014 at the national level. It increased from 60.4% in 2004 to 80% in 2008. In 2012, it declined to 66%. Although it slightly appreciated in 2014 (66.7%), but that is insignificant. At



the state level, literacy of youth women aged 15 – 24 was very encouraging in states like Rivers (98%), Enugu (97%), Imo (95%), Akwa Ibom (95%), Delta (94.1%), Anambra (93%), Ekiti (92.7%), Abia (91.3%). Conversely, literacy rate among woman of age 15 – 24 was poor in Sokoto (10.7%), Bauchi (13%), Yobe (16%) etc.

**Fig 2.3a**



Sectorally, the survey showed that there were more literate youth women (85.3%) in the urban as against the 57.8% recorded in the rural areas. In the zones the literate youth women in the South East (93.5%) were much higher than the rest of the zones. North East (33.0%) and North West (35%) had the lowest percentage of literate youth women in 2014.

**GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN**

**Target 3.A: Eliminate gender disparity in primary and secondary education preferably by 2005, and at all levels of education no later than 2015.**

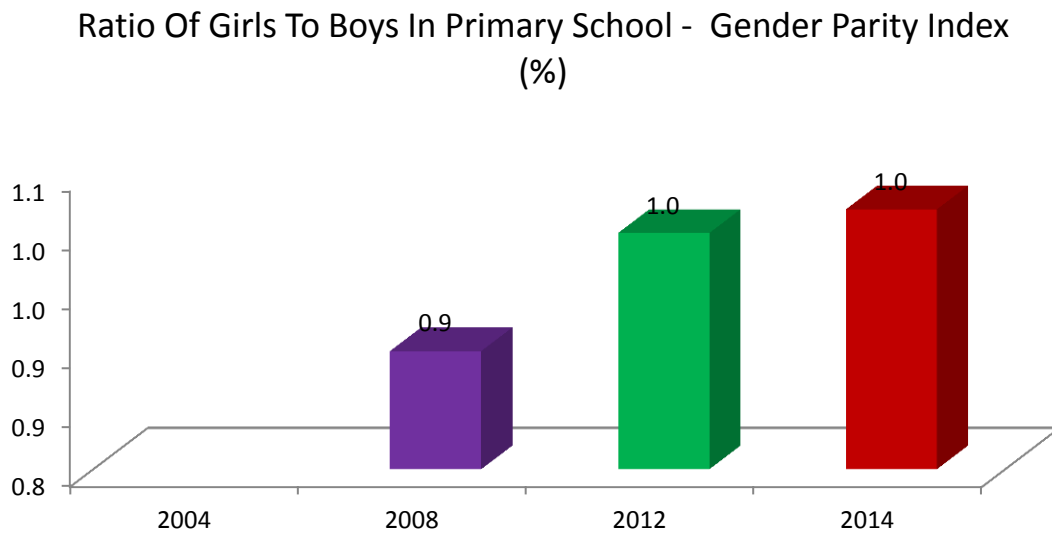
In the days of old and based on outdated cultural and tradition norms, the place of a woman ended in the kitchen. A woman had no rights to contribute to the family decisions. She was not entitled to inheritance. In the interest of the family, she was

given out in marriage even earlier than necessary in order not to bring shame to the family through an unwanted pregnancy.

The target on gender equality and women empowerment seeks for the elimination of this disparity by encouraging and supporting equal educational opportunities in both primary and secondary schools. Hence the monitoring indicator tagged ratio of girls to boys in primary, secondary and tertiary education. This is also called gender parity index. The target also uses a second indicator – share of women in wage employment in the non-agricultural sector, for the monitoring of the redress on gender disparity. However, this particular indicator was not estimated in this survey.

*Indictor 3.1: Ratio of girls to boys in Primary and Secondary education*

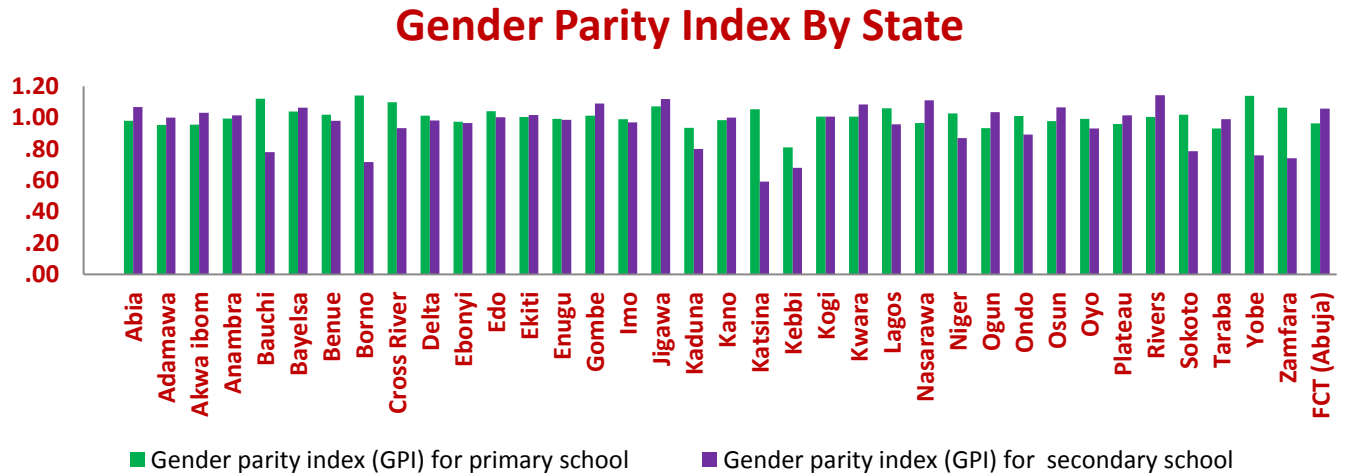
*Fig.3.1 Gender Parity Index*



Nationally, the gender parity in the primary school in 2008 was 0.9. The interpretation is that in every 9 girls in primary school in 2008, there were 10 boys. It increased to 1.0 in 2012 implying 10 girls in every 10 boys. The parity index increased to 1.02 in 2014. The rural (1.01) and urban (1.01) were equal. The GDIs across the zones were exceedingly encouraging. In the secondary schools in 2012, the gender parity index was 1.02. The decline to 1.01 in 2014 was insignificant.

There were no disparity in both the rural (1.0) and urban (90.98) in 2012. Nigeria has already achieved gender parity index as illustrated in fig 3.1a, being a chart of gender parity in both primary and secondary schools distributed by state in 2014.

Fig 3.1a



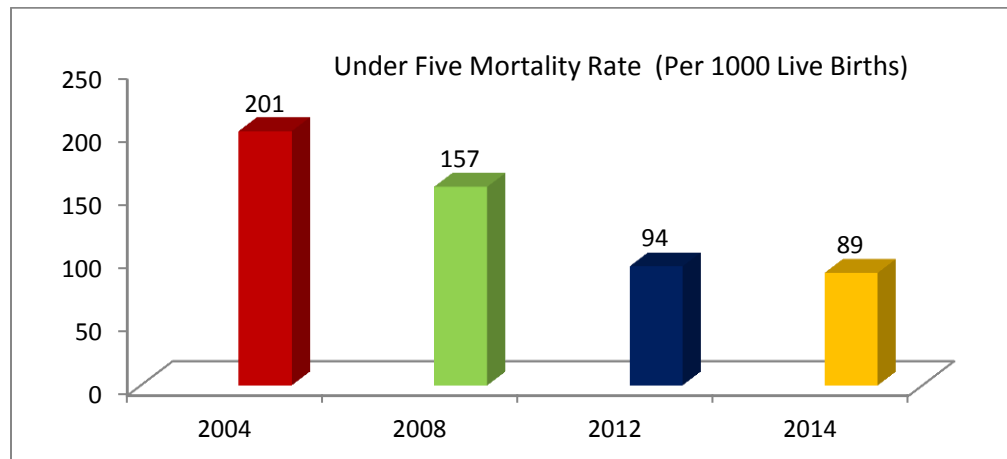
## GOAL 4: REDUCED CHILD MORTALITY

**Target: Reduce by two thirds between 1990 and 2015, the mortality rate among children under five years old.**

Early care for new born, infants and young children can help in preventing their death. Such care ranges from feeding programs, vaccines administration, and protection from mosquito bites and other measures of prevention from infections.

*Indicator 4.1: Under five Mortality Rate (U5MR)*

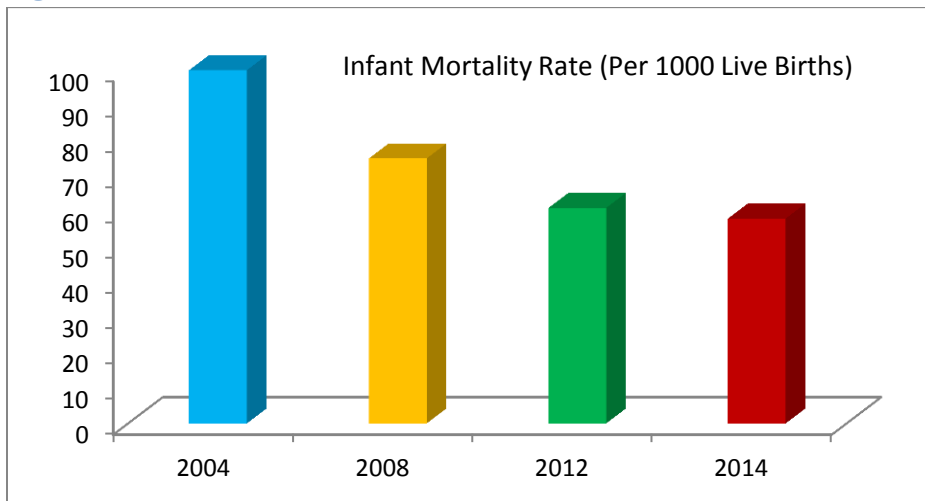
Fig 4.1



About ten years ago specifically 2004 (201), Nigeria’s average under five mortality rate was very high. But right from then, there has been a steady decrease till 2014 when there was a record of only 89 children dying before their fifth birthday in every 1000 live births. See Fig4.1. Although the national average in 2014 was 89, yet some states had numbers much higher than the national average. The states include Kogi (169), Katsina (155), Kaduna (167) etc. The death prevalence in 2014 however was much more in the rural areas with 98 deaths against the 66 in the urban. North West zone with 121 and North East zone with 78 had the highest under five mortality rate than the other zones. South West zone had 45 as the least. If the rate in 2004 is adopted as the base value, it implies that some zones and states would have met the MDGs target on under five mortality before 2015.

**Indicator 4.2: Infant Mortality Rate (IMR)**

*Fig 4.2*



The deaths of infants under one year per 1,000 live births in Nigeria was also very high in 2004 where 100 children died without seeing their first birth day in every 1,000 live births. The deaths of infants have been on the decrease since 2008 in which 75 infants died per 1000 till 2014 with a record of 58. The prevalence of infant mortality in 2014 was more prominent in the rural areas with a record of 63 deaths than the urban with a record of 46 deaths per 1000 live births.

Across the zones, the North West with 77%, followed by South East with 69, had more infants dying without seeing their first birth day in every 1000 live births. Fig is a graphical illustration of the under-five mortality prevalence in 2014.

Fig. 4.2a

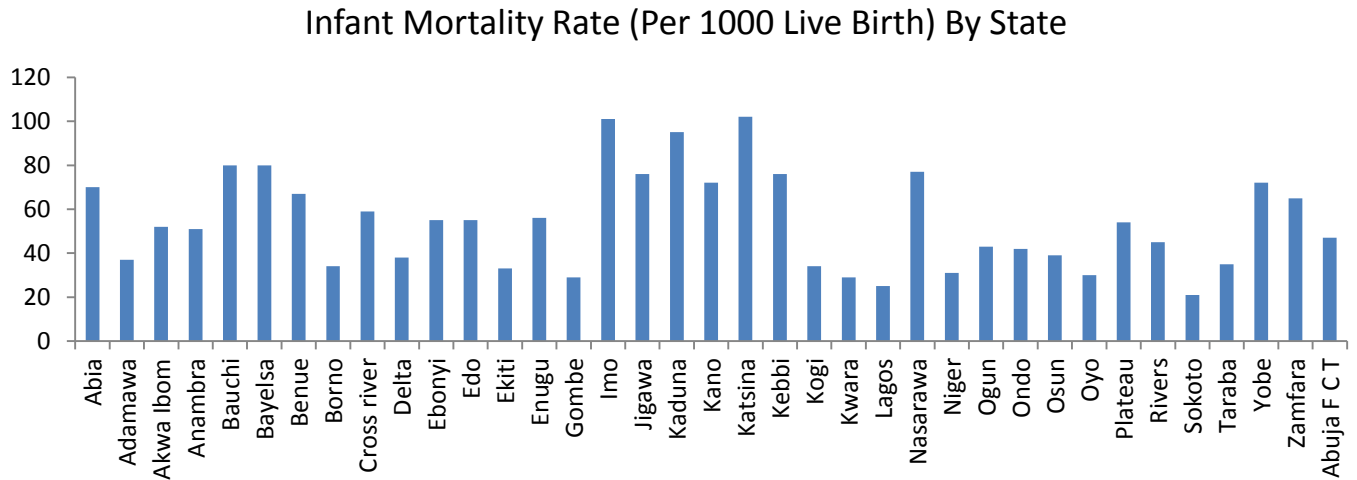
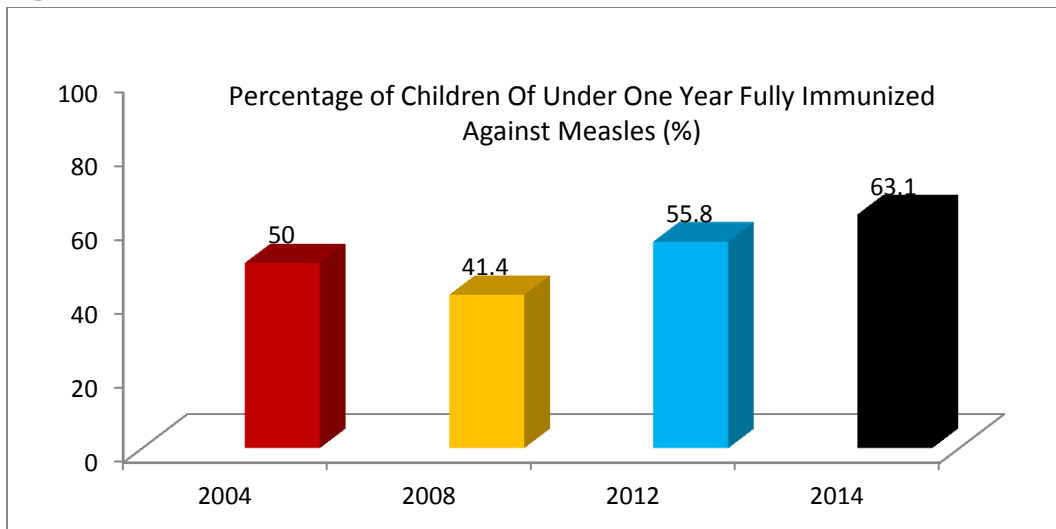


Fig 4.2a is a graphical illustration of infant mortality by state.

**Indicator 4.3 – Proportion of one year old children immunized against measles.**

Fig.3



Measles vaccination is becoming popular and the coverage is improving though slowly. Fig4.3 shows that between 2004 and 2012, the measles vaccination of children under one year of age staggered between 50% and 55.8%.

In 2004, there was a record of 50%. It went down to 41.4% in 2008 and appreciated again to 55.8% in 2012. There was a significant increase in 2014 in which 63.1% of children under one year were immunized against measles.

The analysis of the survey result by geo-political zones showed that over 80% of one year old children were immunized in South East (82.4%), South West (81.2%) and South South (80.3%). Although North Central (77.0) was not bad, yet North East (42.4) and North West (35.4%) were not encouraging. One year old children were predominantly immunized in the urban areas (56.2%) than the rural areas (39.95).

## **GOAL 5: IMPROVED MATERNAL HEALTH**

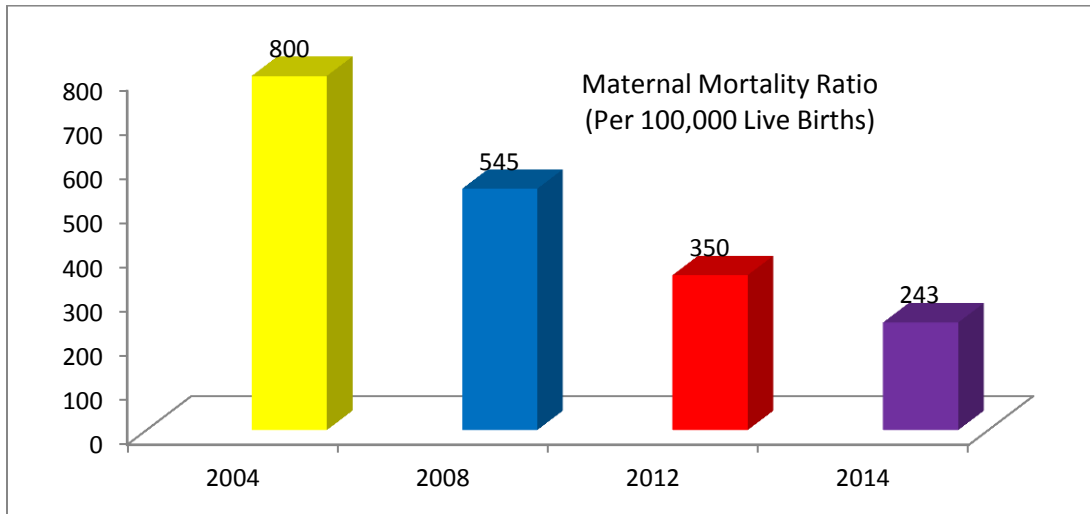
### **Target 5.A. Reduce by three quarters, between 1990 and 2015, the Maternal Mortality Ratio.**

Maternal health in Nigeria has been a general concern because of the mortality rate. While some aspects of maternal death are man-made in the sense that they are more of tradition/culture rather than natural experience, others are inexplicable. By the definition of maternal mortality, it is not just the natural or accidental death of women that are pregnant, rather death arising through pregnancy related complications, child delivery complications and other problems within six weeks after delivery.

If a woman is given care by way of antenatal services right from the day she is confirmed pregnant to the day of delivery, many problems would be nipped in the bud. But aversion to medical innovation and the lack of access to these important services has claimed lives of many mothers. However, in recent time, many women have started embracing antenatal care. The maternal mortality ratio has been on the decline in recent years.

## Indicator 5.1 Maternal Mortality Ratio (MMR)

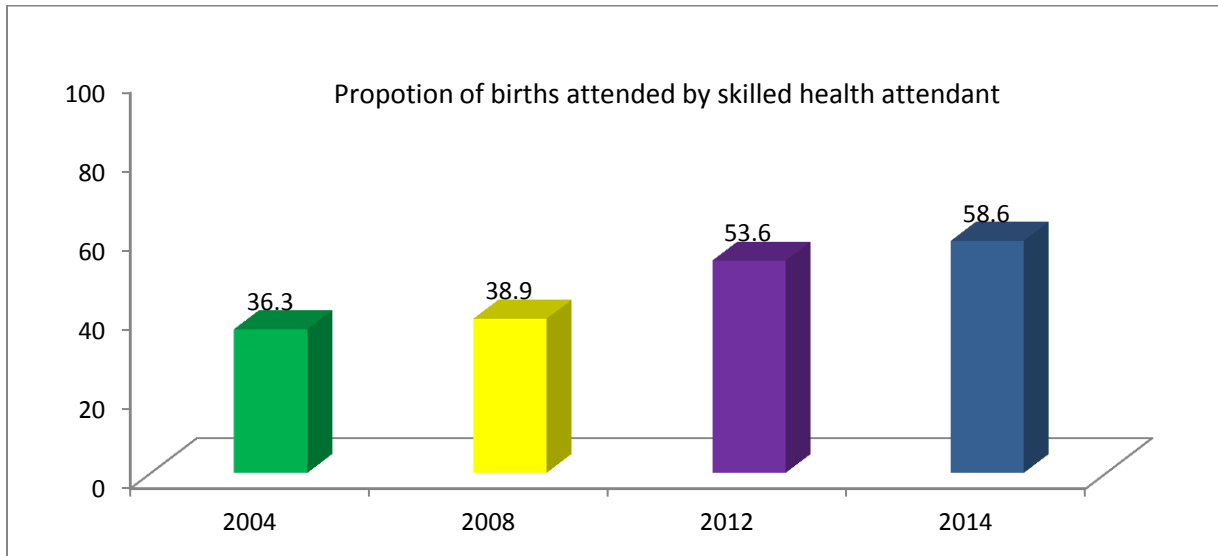
Fig 5.1



The 2004 Maternal Mortality ratio of 800 in every 100,000 live births crashed to 545 in 2008. The performance tracking survey of 2012 recorded a further decrease to 350 per 100,000 live births and the downward trend consistently maintained its course to 2014 with a record of 243 per 100,000 live births. As a remark, the 2014 estimation was strictly based on women within the age bracket of 15 to 49 years, as opposed to the 2012 age bracket of 15 to infinity. The rationale behind this is that the child bearing age for women is within that bracket. Based on this, Nigeria is at the verge of meeting the target on maternal mortality.

**Indicator 5.2: Proportion of Births attended by skilled health care attendants.**

**Fig5.2**



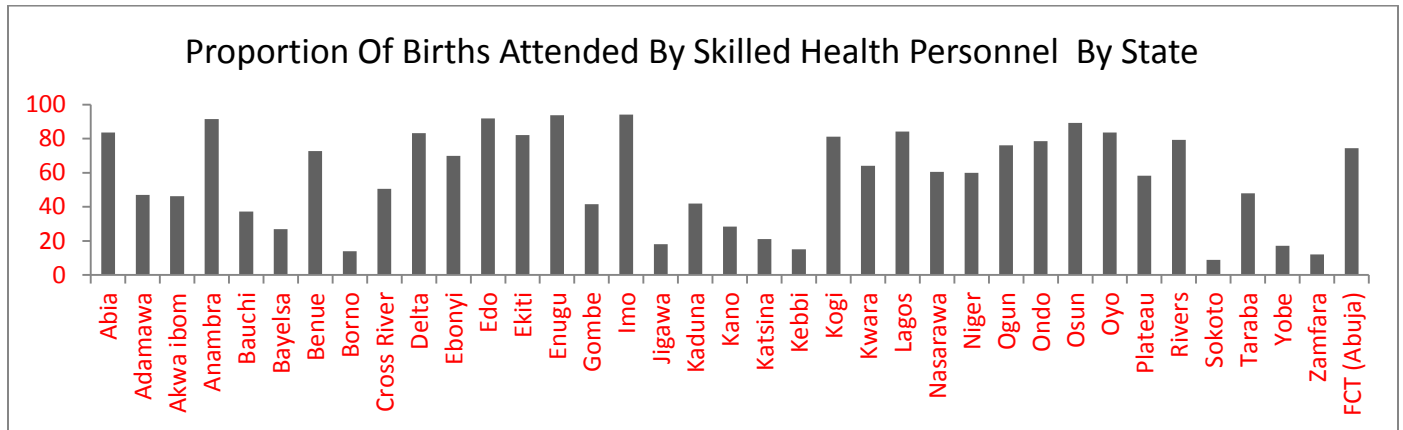
Assistance during child birth has a lot of influence on the birth outcome. It also determines the health and life of both the mother and child after delivery. The assistance of highly skilled birth personnel is imperative to guarantee successful delivery and life after such delivery.

Fig... shows the national trend of the proportion of births attended by skilled attendants. The proportion increased in 2008 (38.9%) from 36.3% recorded in 2004 while 53.6% was recorded in 2012. The situation improved further in 2014 (58.6%). A zonal disaggregation of this trend shows that of the children born within the period of reference, South East (89.1%) had the highest record of delivery assisted by skilled birth attendant. Eighty three percent was recorded in South West. North Central and South South zones respectively had a record of 67.2% and 64.4%. The least were in North East (30.8%) and North West (24.8%).

Sectorally, the urban areas with 79.2 had higher proportion of deliveries assisted by trained personnel's while the rural areas had 46.6%.



Fig 5.2a



**Target 5B: Achieve universal access to reproductive health by 2015**

This section concerns programmes and exercises that are of fundamental importance to the health of women as they manage their health as mothers or potential mothers. Within these components, indicators estimated include as follows.

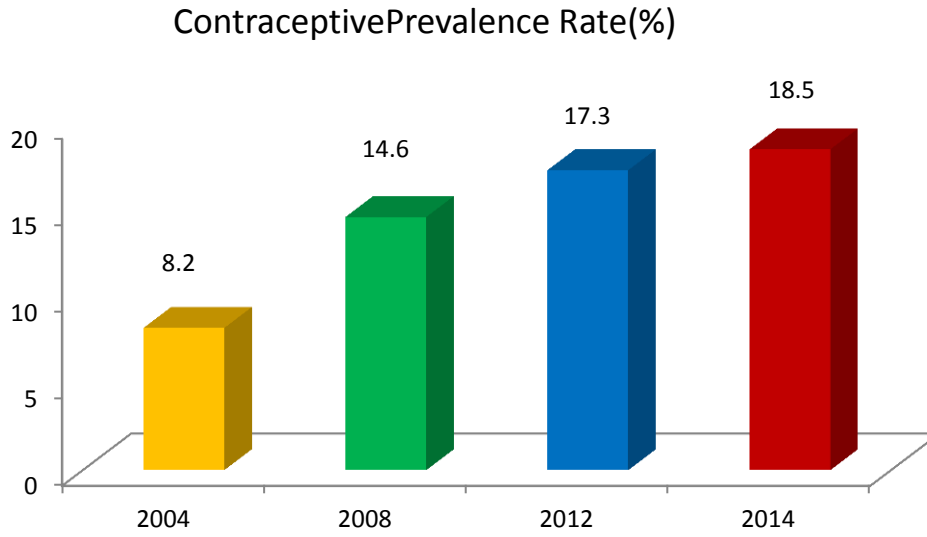
- Contraceptive prevalence rates
- Adolescent pregnancy rates
- Antenatal care coverage
- Unmet needs for family planning.

These indicators usually are surrounded by uncertainties as they concern some aspects of the private lives of women. Apart from the role that culture plays in this assessment, confidentiality and trust also influence the answers that are usually given. Notwithstanding these challenges, these are the reports.

**Indicator 5.3: Contraceptive Prevalence Rates:**

This is the percentage of women aged 15 – 49 years that use any method of family planning. The use of contraceptive is gradually gaining general acceptance.

**Fig 5.3**



In 2004, only 8.2% of women within the stated age bracket used contraceptive measures for family planning. The percentage increased to 14.6% (about 78% increases) in 2008. It appreciated further in both 2012 (17.3%) and 2014 (18.5%). Contraceptive prevalence was highest in South East zone with a of 43%, followed by South West (24.0%). The prevalence in the urban areas (16.7%) was higher than that of the rural (9.7%).

**Indicator 5.5: Antenatal Care Coverage.**

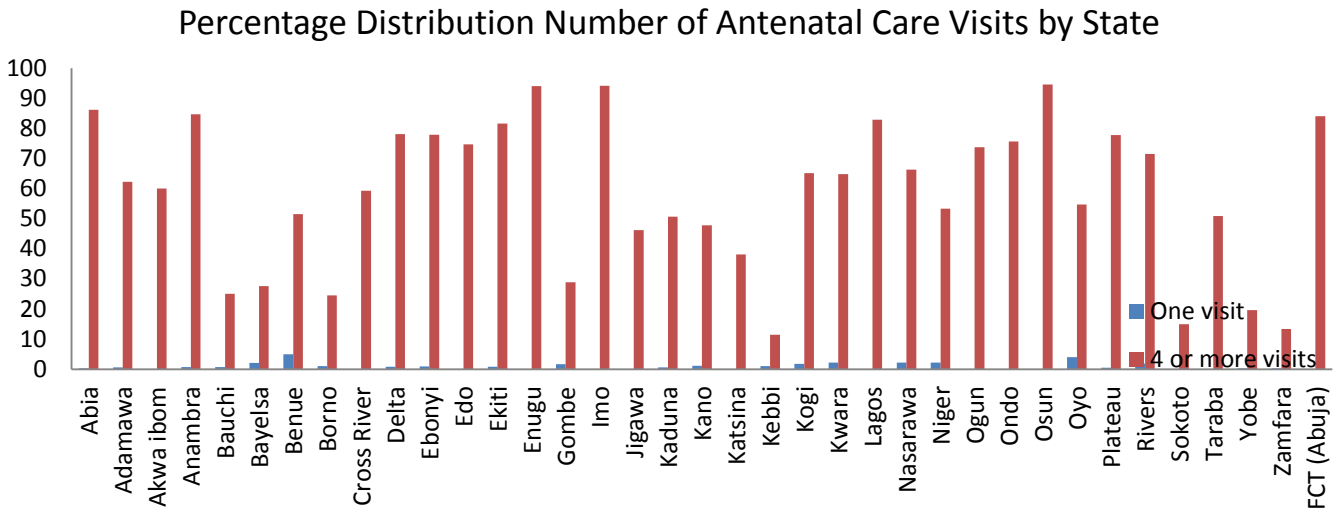
Antenatal Care avails much in preventing pregnancy complications, when it is sought early and continued through to delivery. Early antenatal care reveals impending dangers and makes referrals timely. It is a direct approach to reducing maternal mortality.

In 2008, only 8.2% of the pregnant women attended antenatal for one visit while 44.8% attended for at least 4 visits. In 2012 66.3% of them attended for at least one visit and 57.8% for at least four visits. The record in 2014 was that about 25% of the women that were pregnant never attended antenatal visits. At the same time, 68.9% attended at least once while 60.6% attended for four times and over.

The number of visits for antenatal was encouraging in the urban where 75.9% of pregnant women had at least four visits. The rural rears were no exception as 51.6% of the pregnant women visited over four times. With regard to the zones, South East

(88.3%) had the highest number of visits. South West (78%), South South (64.1) and North Central (65.8) had encouraging number of antenatal visits. But very few pregnant women in North West (38.1%) and North East (32.9%) attended antenatal up to four times.

Fig 5.5



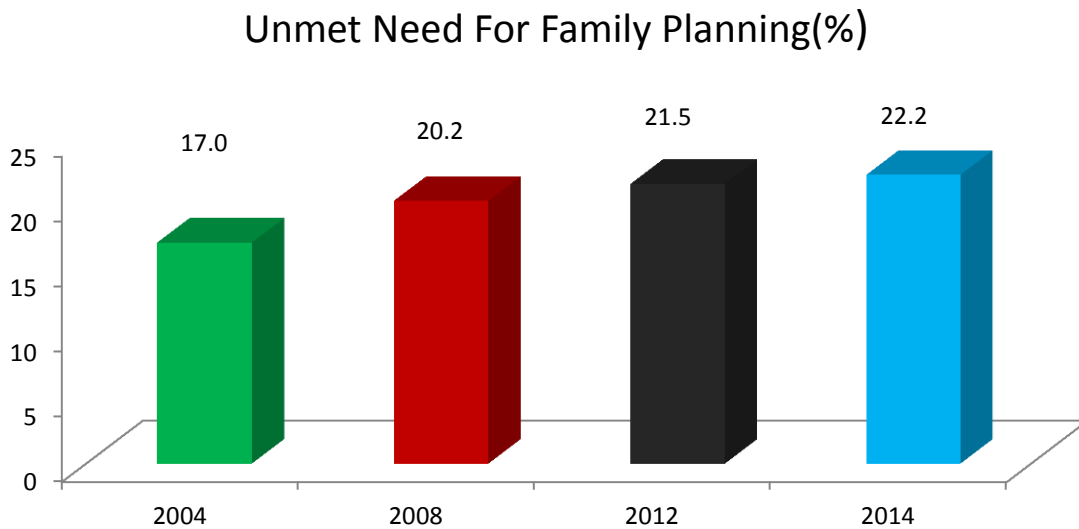
**Indicator 5.6: Unmet Needs for Family Planning**

In Nigeria and almost the whole of Africa, there is the cultural belief that the strength of a family lies in the number of children. Unfortunately, the population of the country is rapidly increasing and considering its multiplier effect on the economy, health, education and other social phenomenon, many families are giving a second thought to the concept of large families; the pride in having large number of children is gradually fading away.

As women in most cases bear the burden of large families, majority of them are now interested in birth control and family planning. This is particularly true with women that are sexually active and within the child bearing age. Maybe due to ignorance, poor education, lack of access and general poverty, some women in this category meet their spouses without any method of contraception. They are said to have unmet need.

Thus, women who wish to delay giving birth for two or more years or who want to avoid pregnancy altogether, but are not using a contraceptive method are said to have an unmet need for family planning.

*Fig 5.6*



In 2004, there were about 17% of women in this category. They increased to 20.2% in 2008 and 21.5% in 2012. However, there was a marginal increase in 2014 (22.2%).

The prevalence of unmet need was more in the rural sector (22.4%) than the urban (21.8%). Across the zones, there were higher incidences of unmet need in North West (27.4) and North East (25.8) than the rest of the zones. The experience was very low in the South East (11.4%).

## **GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER MAJOR DISEASES**

**Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**

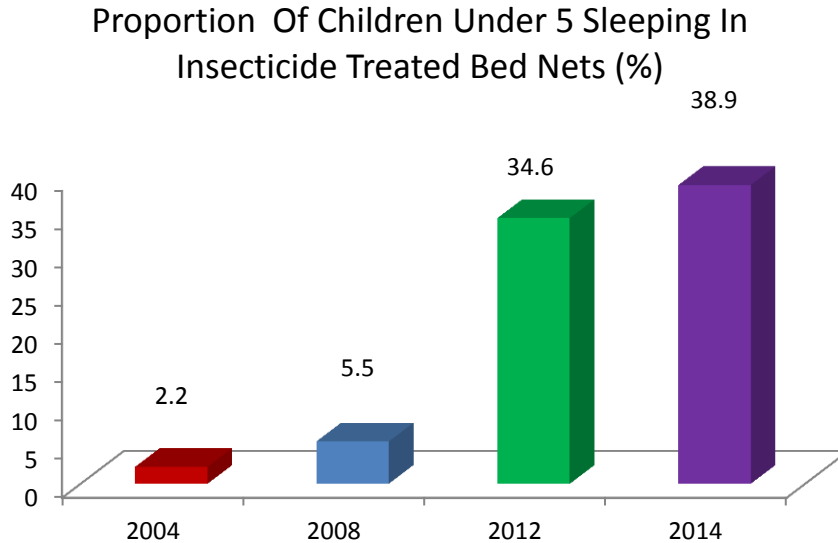
**Indicator 6.3: Percentage of Young Women aged 15 – 24 years with comprehensive knowledge of HIV/AIDs**

Knowledge of HIV/AIDS and related diseases among the young women is increasing. There is a general consciousness that HIV/AIDS is real. In 2004, only 18.3% of the young ladies within age 15 – 24 years had comprehensive and correct knowledge about HIV/AIDS prevention, and transmission and others. There was a rise in this percentage in 2012 (33%). There was not much difference in the record for 2014 (32.8%). Thus the trend remained at the national level. But in the sectors, the urban areas with 37.8% showed that there were more young women with comprehensive knowledge than the 30.5% in the rural.

At the level of the zones, a large percentage of the young ladies in North Central had comprehensive knowledge. Besides the North Central zone were the South East (37.3%), South West (34.3%) and South South zone (33.2%). Both the North West (26.5%) and particularly North East (23.2%) had little proportion of young ladies with comprehensive knowledge about HIV/AIDs.

## Indicator 6.7: Proportion of children under 5 sleeping in insecticide – treated bed nets

**Fig 6.7**



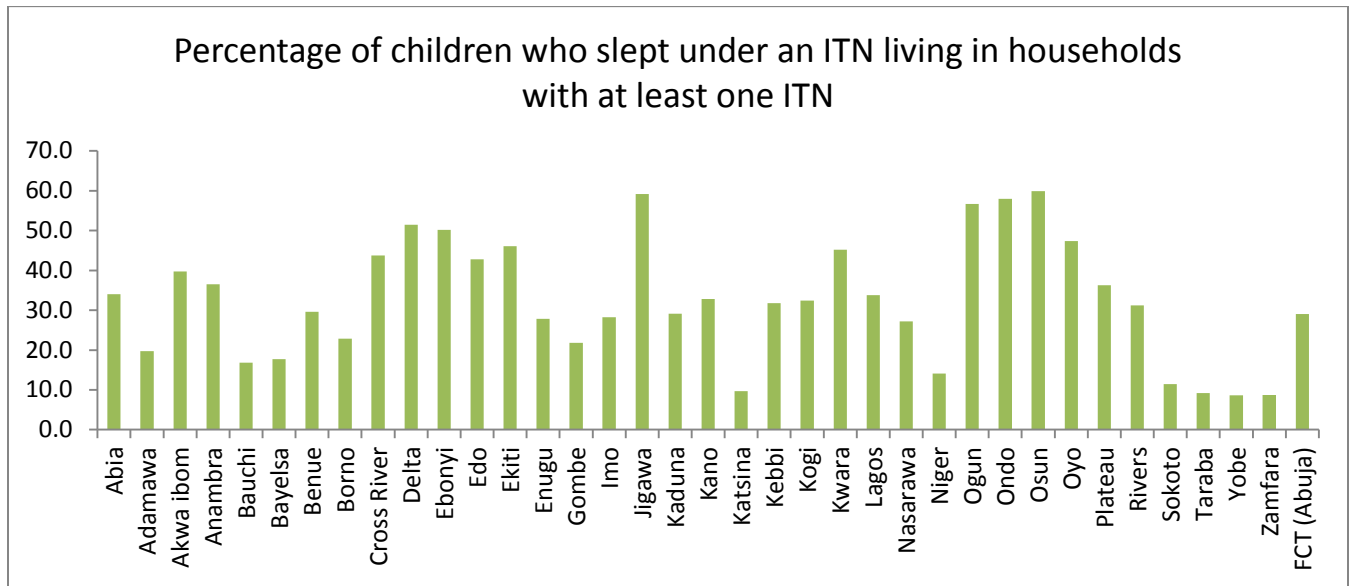
Malaria sickness is principally caused by mosquito bite. Households and individuals are urged to use insecticide treated nets (ITNs) in order to repel mosquitoes and at the same time, protect oneself against their bite. The survey result of 2014 showed that 38.9% of the household owned ITNs.

It has to be recalled that only 2.2% of children in 2003 slept in insecticide treated nets. The percentage went up to 34.6% in 2012. The trend showed no difference in 2014 as 34.7% of the children slept in insecticide treated bed nets in the night preceding the survey. Across the sectors showed that the urban areas (41.7%) had more children who slept in insecticide treated bed nets than the rural with a record of 31.2%.

In the zone the percentage of children sleeping in insecticide treated bed nets lingered between 47% and 17.8%.

Similarly, 28.5% of pregnant women slept in insecticide treated bed nets in 2014 against the 30.3% record of 2012. Majority of the pregnant women were from the South West (45.3%) zone as compared to the least in North East (16%) zone.

Fig 6.7a



While 36.5% were urban dwellers, twenty six percent of them were rural dwellers.

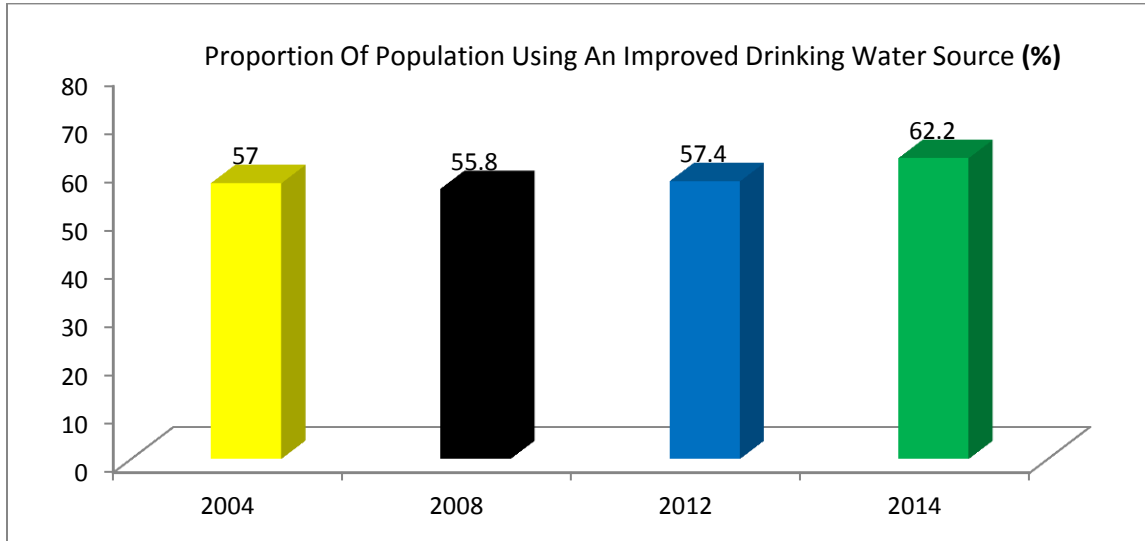
Fig 6.7a is a graph illustrating the state distribution of children who slept in an ITN in households with at least one ITN.

## GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

**Target 7.C: Halve by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation**

**Indicator 7.8: Proportion of population using an improved drinking water source**

*Fig.7.8*

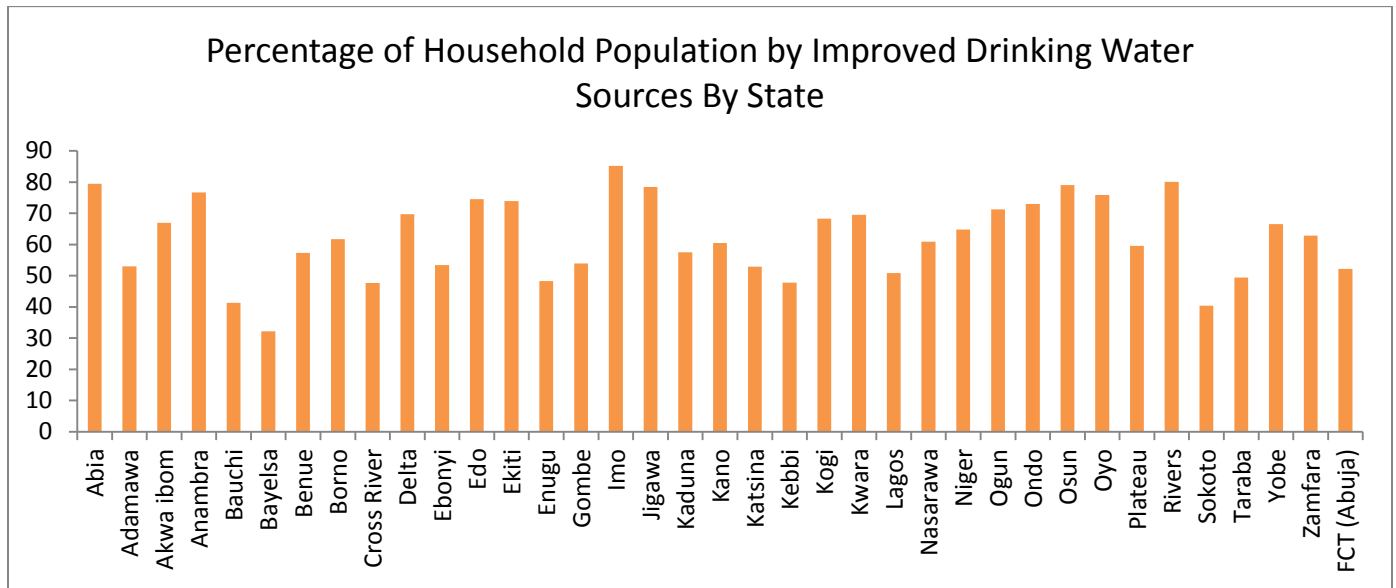


The role of water in human life cannot be over emphasized. At the same time several diseases are borne by water. Hence the emphasis on improved drinking water source. Fifty seven percent of Nigeria households had access to improved water source in 2004. In 2008, there was a slight decrease to 55.8 percent. Fifty seven percent was recorded again in 2012 while in 2014 there was an increase to 62.2%.

Access to improved sources of drinking water has been unstable in Nigeria. Although in 2014, the urban areas recorded about 74.6% against the 57.6% of the rural, yet access within the zones showed that it was only in South West that a 70.6% access to improved sources was recorded. The rest of the zones lingered between 68% and 53%.

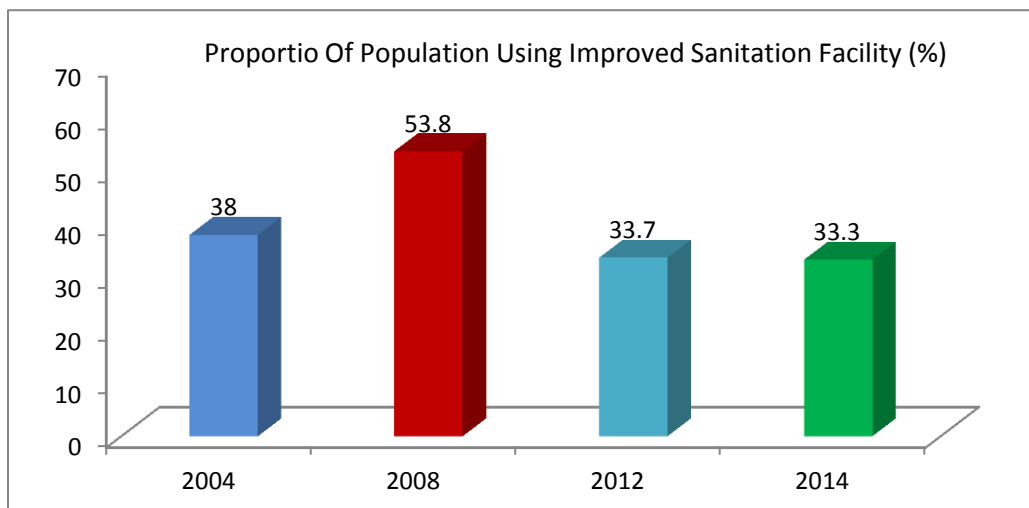


Fig. 7.8a



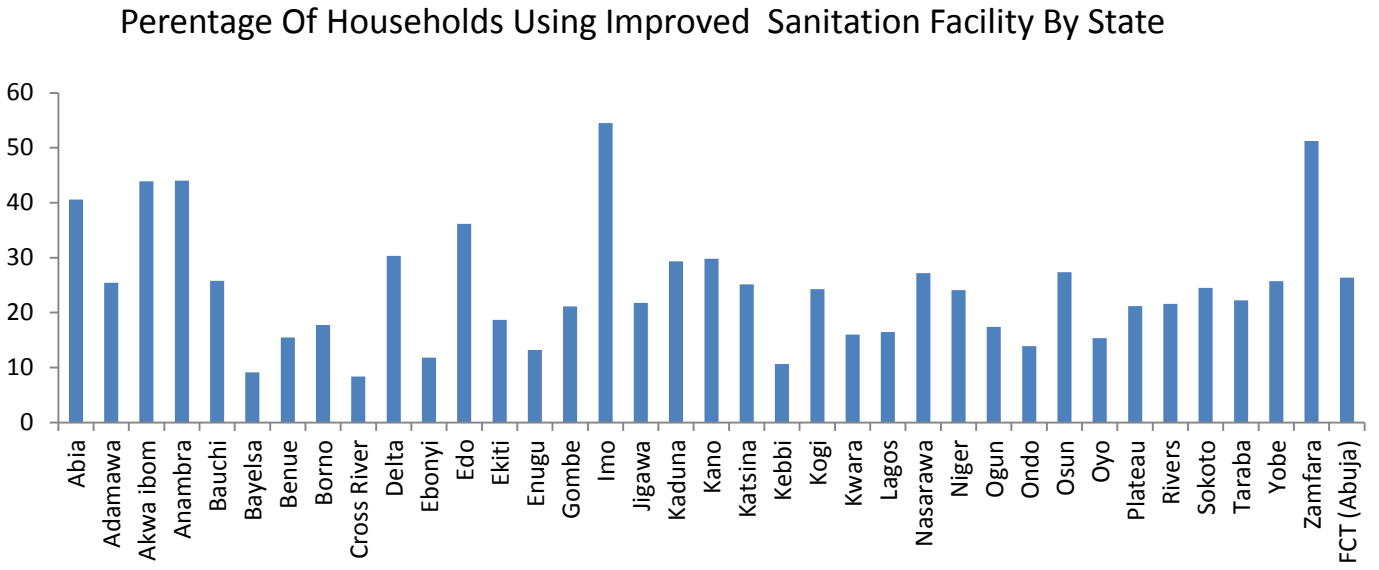
**Indicator 7.9: Proportion of population using an improved sanitation facility**

Fig 7.9



The use of improved sanitation facilities is generally low in Nigeria. The thirty eight percent of households with improved sanitation recorded in 2004 appreciated to 53.8% in 2008. Regrettably, the assessment of 2012 showed a significant decline to 33.7%. Even in 2014 (33.3%), there had not been any record of improvement in the proportion of population using an improved sanitation facility in Nigeria. Sectorally, the urban areas have an estimated proportion of 42.9% against the 29.9% recorded in the rural. The graph of fig 7.9a shows distribution of sanitation access by state.

Fig.7.9a



# SURVEY METHODOLOGY

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## **OBJECTIVE:**

- The whole essence of a survey is to provide numerical information. As remarked earlier, new developments would have taken place within the elapsing two years and they might be favorable or unfavorable. But as Nigeria along with other countries of Africa and the World in general match towards 2015, the creed is 'Sustainable and Inclusive Development'. Amidst the numerous achievements, there are embedded challenges and deficiencies capable of undermining the successes. That underscored another round of the assignment in order to have concrete indices for structural economic transformation for inclusive growth.
- It was also in fulfillment of the directive of Mr. President that the MDGs should be monitored using data from one source - NBS data precisely.
- To provide data for a comparative evaluation with previous years.

## **COVERAGE OF THE SURVEY:**

The survey was carried out in all the thirty six (36) states of the Federation and FCT, Abuja. It covered both urban and rural areas.

## **SCOPE OF THE SURVEY:**

The general subject areas that were covered within the households were; household information panel, household roster, household demographic characteristics, Education, Water and sanitation. Others were Housing characteristics, Insecticide treated nets, Child Orphan & vulnerable children, HIV/AIDS, Child health and immunization, maternal mortality etc.

For the Individual Women aged 15-49 years, the variables that were captured included women's information panel, background, child mortality, desire for last birth, maternal and newborn health, illness symptoms, contraception, unmet needs, and HIV/AIDS etc.

The subject areas for children were under-five information panel, age, birth registration, early child development and breastfeeding, care of illness, malaria, immunization, anthropometry etc.

## **SURVEY INSTRUMENTS:**

The survey instruments used were: MDG questionnaire, household listing form, instruction manual, EA line maps and selection sheets. In addition to the survey instruments were the following equipment required to be used for measurement; mother and child scale (for weights), and measuring board (for heights).

## **SAMPLE DESIGN:**

The frame of Enumeration Areas (EAs) for 2006 Housing and population Census conducted by National Population Commission (NPopC) was used. However, the National Integrated Survey of Households (NISH) which is the vehicle for conducting all household based surveys in NBS, the 2007/2012 edition, was also used for the survey.

There are over 662,000 EAs in the country from which NBS had selected 23,280 EAs for all its household based surveys. These EAs were selected based on 30 EAs per LGA and 40 EAs per 6 FCT LGAs and pooled together after which 200 EAs were selected per state and FCT-Abuja, to form the NISH 2007/2012 edition master sample. These 200 EAs are put into 20 independent replicates of 10 EA each.

The NISH sample design is a 2-stage, replicated and rotatable design where Enumeration Areas (EAs) serve as the Primary Sampling Units and households as the secondary or ultimate sampling units.

For this round of MDGs survey, a total of ninety (90) Enumeration Areas (EAs) were drawn from replicates 02- 09 per state. In each EA, twelve (12) households (HHs) were selected for study using systematic random selection procedure. However, as an updated list of HHs was required; there was the need to update the listing earlier before the survey.

## **SAMPLE SIZE:**

A total of Ninety (90) EAs and Nine Hundred and Sixty (960) households were covered per state and FCT, Abuja. At the national level, a total of Two Thousand, Nine Hundred and Sixty (2,960) Enumeration Areas (EAs) and Thirty Five Thousand, Five Hundred and Twenty (35,520) households (HHs) were covered.

### **TARGET POPULATION:**

From the household roster and the information collected, access to the target population which was mostly Women aged 15 – 49 years and Children under 5 years was carried out.

### **DATA COLLECTION TECHNIQUE:**

Personal Interview method was used to collect information from eligible respondents in the households, with the aid of the prescribed format (Questionnaire). In addition, physical measurement of the weight and height of the children under age 5 years was taken and recorded in the appropriate schedule.

### **TRAINING FOR FIELDWORK:**

The training was more of a refresher exercise as the same set of officers who were trained for 18 days and used for the Multiple Indicator Cluster Survey was recycled for the survey. Two levels of training were arranged. The first level being training of trainer (TOT) was done at NBS corporate headquarters, Abuja. At this Level, fifty five officers comprising of trainers, monitors, coordinators, and MDG officials participated. The training lasted for three (3) days.

The 2<sup>nd</sup> level training took place at the zonal 6 Zonal Headquarters of North Central (Niger-Minna), North East (Gombe-Gombe), North West (Kaduna-Kaduna), South East (Enugu-Enugu), South South (Cross River-Calabar) and South West (Oyo-Ibadan). The training lasted for four (4) days.

### **TRAINING VENUES:**

For effective training, efficient management and quality, there were two (2) training centres in South West, North Central, North West and North East zones. One (1) training centre was used in South South and one also in South East zones.

Each centre was manned by two (2) trainers from the headquarters and a zonal controller. There was one female among the trainers in each centre. In all, ten (10) training centres were put in place throughout the country while 15 officers were trained per state.

## **TRAINING ARRANGEMENT:**

**North Central :** Niger, FCT, Benue, Plateau, Kogi, Kwara, and Nasarawa.

**North East:** Gombe, Borno, Adamawa, Yobe, Taraba, and Bauchi while

**North West:** Kaduna Kebbi, Sokoto, Jigawa, Katsina, Zamfara, and Kano.

**South West:** Oyo, Ondo, Osun, Ekiti, Lagos, Ogun, and Edo, while South East will receive Enugu, Abia, Anambra, Ebonyi, Imo and Delta.

**South South:** Cross River, Rivers, Bayelsa, and Akwa-Ibom

## **FIELD ARRANGEMENT FOR DATA COLLECTION:**

Three (3) roving teams were used in each state and FCT, Abuja. Each roving team comprised of one (1) supervisor, who could either be male or female (NBS permanent staff with experience, and familiar with the local terrain) and five (5) interviewers – mostly Females where possible. One of the interviewers perceived to be more physically strong and intelligent served as the measurer. Each team moved in a roving manner, completing data collection in an EA before moving to another one. On the average, an interviewer covered 4 HHs per day.

## **LOGISTICS:**

To ensure a smooth take off of the survey, all materials and equipment needed for the data collection were provided on time and made available to the state officers at the training venue for delivery to their respective states at the end of the training.

*Distribution of field personnel by state*

The table below shows the distribution of field personnel by states:

Zone	S/n	State	No of EAs	No of HHs	No of Interviewer	No of Supervisor
North Central	1	Niger	80	960	15	3
	2	FCT	80	960	15	3
	3	Benue	80	960	15	3
	4	Plateau	80	960	15	3
	5	Kogi	80	960	15	3
	6	Kwara	80	960	15	3
	7	Nasarawa	80	960	15	3
<b>Sub-Total</b>			<b>560</b>	<b>6,720</b>	<b>105</b>	<b>21</b>
North East	1	Gombe	80	960	15	3
	2	Borno	80	960	15	3
	3	Adamawa	80	960	15	3
	4	Yobe	80	960	15	3
	5	Taraba	80	960	15	3
	6	Bauchi	80	960	15	3
<b>Sub-Total</b>			<b>480</b>	<b>5,760</b>	<b>90</b>	<b>18</b>
North	1	Kaduna	80	960	15	3
	2	Kebbi	80	960	15	3
	3	Sokoto	80	960	15	3
	4	Jigawa	80	960	15	3

West	5	Katsina	80	960	15	3
	6	Zamfara	80	960	15	3
	7	Kano	80	960	15	3
<b>Sub-Total</b>			<b>560</b>	<b>6,720</b>	<b>105</b>	<b>21</b>

Zone	S/n	State	No of EAs	No of HHs	No of Interviewer	No of Supervisor
South West	1	Oyo	80	960	15	3
	2	Ondo	80	960	15	3
	3	Osun	80	960	15	3
	4	Ekiti	80	960	15	3
	5	Lagos	80	960	15	3
	6	Ogun	80	960	15	3
<b>Sub-Total</b>			<b>480</b>	<b>5,760</b>	<b>90</b>	<b>18</b>
South East	1	Enugu	80	960	15	3
	2	Abia	80	960	15	3
	3	Anambra	80	960	15	3
	4	Ebonyi	80	960	15	3
	5	Imo	80	960	15	3
<b>Sub-Total</b>			<b>400</b>	<b>4,800</b>	<b>75</b>	<b>15</b>
	1	Cross River	80	960	15	3



South South	2	Delta	80	960	15	3
	3	Rivers	80	960	15	3
	4	Bayelsa	80	960	15	3
	5	Akwa Ibom	80	960	15	3
	6	Edo	80	960	15	3
<b>Sub-Total</b>			<b>480</b>	<b>5,760</b>	<b>90</b>	<b>18</b>
<b>Grand- Total</b>			<b>2,960</b>	<b>35,520</b>	<b>555</b>	<b>111</b>

### QUALITY ASSURANCE MEASURES:

In order to ensure quality data, the following quality assurance measures were put in place: The resource persons during the training at both levels were competent senior staff of the Bureau. There were series of classroom lectures, mock interviews, role play, field practical etc., in order to prepare the interviewers and the supervisors for a good work.

### MONITORING PROCEDURE FOR FIELDWORK:

This is one of the quality control measures used for quality data collection. Those involved in the monitoring exercise included thirty seven (37) NBS headquarters staff, six (6) NBS Zonal Controllers and thirty seven (37) NBS State Officers. Also to be involved are MDG officials and Independent Monitors.

However, the trainers will form part of the Headquarters team for the monitoring exercise. Monitoring guidelines and instruments were presented and discussed before the commencement of the exercise. The monitoring commenced 5 days from the beginning of data collection, so that monitors could come back with the first batch of retrieval.

The exercise lasted for 5 days for Headquarter monitors and 5 days for Zonal-Controllers while for NBS State Officers, it lasted throughout the survey period.

### **COORDINATION:**

Directorate members of staff of NBS coordinated the survey. The activities coordinated included among others; planning and preparation, state trainings, fieldwork, data processing/analysis and report writing. Activities coordination lasted throughout the survey period.

### **RETRIEVAL OF RECORDS:**

All the completed questionnaires were properly edited by each team and submitted to the supervisors, who in turn submitted to the state officer. After being batched EA by EA they were forwarded to the NBS headquarters for processing.

### **DATA PROCESSING AND ANALYSIS:**

Data processing was centrally done in NBS, headquarters, Abuja. It was planned to commence shortly after the data entry training. The data processing comprised of the following interrelated operations as follows:

### **SCREEN DEVELOPMENT:**

Data capture format screen was developed and test run for efficiency and accuracy in preparation for data entry. It had automatic inbuilt quality check programme to fast track error minimization.

### **MANUAL EDITING:**

As part of the data preparation, the collected data was firstly checked and manually edited by a team of editors before entry, to ensure accuracy and consistency.

### **DATA ENTRY AND VERIFICATION:**

A data entry screen was developed using CSpro software. This data management software displays the questionnaire on the screen to be filled out by the data entry operators, with the data just as they appear in the completed survey questionnaires.

The screen was designed in a way that the data entry operators could key in the data at a high production rate without loss of data quality. Aside this, the data entry program in addition had in built range checks that format and correct skip and filter errors at the point of entry.

### **COMPUTER EDITING AND CORRECTION:**

To be very sure that data entry was done with minimum errors, a verification exercise was carried out after the data entry to detect and correct errors that frequently entered the data at the point of entry. Among such errors included wrong figures because the responses in the questionnaires were not properly entered or as a result of pressing a wrong key during entry operation.

However, not minding the range and consistency check, record duplication and omission could also be detected. This stage of the operation to edit and correct errors was to ensure that all codes were within the specified ranges and all consistency errors effectively and correctly affected.

### **COMPUTER TABULATION/DATA ANALYSIS:**

To further give the data a reasonable meaning, a tabulation plan was done, and statistical table generated using CS pro or SPSS software packages.

### **REPORT WRITING:**

Report writing was done by senior and experienced report writers from NBS and Stakeholders in such a way that it would be useful to all users like policy makers, Planners, Researchers and Students.

### **DOCUMENTATION/DISSEMINATION/ARCHIVING:**

Data Management toolkit will be used to document and disseminate the data. The results may also be published on CD and hosted on NBS and MDGs websites for further dissemination

**TIME-LINE FOR DOCUMENTATION:**

<b>S/No</b>	<b>Activity</b>	<b>Date/Period</b>
1	Planning & Preparation ✓ Meeting within NBS ✓ Stakeholders meeting ✓ Instrument development ✓ Strengthening of questionnaire	November 2013 – January 2014
2	Selection of EA Maps	Feb 3 <sup>rd</sup> - Feb 14 <sup>th</sup> 2014
3	Re-listing of Households	Feb 17 <sup>th</sup> –Feb 28 <sup>th</sup> 2014***
4	Training of Trainers (TOT)- Headquarters	May 26 <sup>th</sup> - May 30 <sup>th</sup> 2014.
5	Zonal Training	June 2 <sup>nd</sup> - June 8 <sup>th</sup> 2014
6	Field Work	June 9 <sup>th</sup> -June 30 <sup>th</sup> 2014
7	State Officers Monitoring	June 9 <sup>th</sup> – June 30 <sup>th</sup>
8	Zonal Controllers	June 9 <sup>th</sup> – June 19 <sup>th</sup>
9	Headquarters Monitoring 1 <sup>st</sup> Round	June 9 <sup>th</sup> -June 13 <sup>th</sup> 2014
10.	Headquarters Monitoring 2 <sup>nd</sup> Round	June 30 <sup>th</sup> –July 4 <sup>th</sup> 2014
9	Retrieval 1 <sup>st</sup> Round	July 4 <sup>th</sup> -July 7 <sup>th</sup> 2014
10	Retrieval 2 <sup>nd</sup> Round	July 8 <sup>th</sup> –July 14 <sup>th</sup> 2014
11	Headquarters' training for data processing	July 28 <sup>th</sup> -August 1 <sup>st</sup> 2014
12	Data Entry	August 4 <sup>th</sup> -August 16 <sup>th</sup> 2014

13	Data Processing	August 18 <sup>th</sup> -August 30 <sup>th</sup> 2014
14	Data Cleaning/Table generation Begins	September 1 <sup>st</sup> - September 12 <sup>th</sup> 2014
15	Data Validation	13 <sup>th</sup> September – 31 <sup>st</sup> September 2014
16	Report writing	1 <sup>st</sup> October – 30 <sup>th</sup> October 2014
17	Data Archiving/Dissemination	