Microplanning SToT for 2025 Integrated SIAs

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Duration: 30 mins

Arrival and Registration

By:

All Participants

Duration: 30 mins

Opening Prayers/ Introductions

Duration: 5 mins

Goodwill Messages

By:

Representatives of all Partners

Duration: 5mins

Opening Remarks

By:
Executive Secretary

Duration: 10mins

Objectives and Expected Outcomes

Objectives of the Training

1. To update participants on the **current Measles and Rubella disease burden** with an **overview of 2025 integrated campaign** with high impact health interventions
2. To **guide participants** on steps in the **development of an integrated microplan** which includes verification and validation
3. To provide participants the opportunity to have **hands-on the micro plan template**, **daily implementation plan (DIP) and GIS maps for micro plan development**
4. To update participants on findings from **Measles Risk Analysis (MRAT)**
5. To acquaint **participants** with their **roles & responsibilities, and deliverables** for the microplanning process

Expected Outputs of the Workshop

- Participants are **updated on the current Measles and Rubella disease burden with an overview of 2025 integrated campaign** with high impact health interventions
- Participants are **guided on steps in the development of an integrated microplan which includes verification and validation**
- Participants are **provided the opportunity** to have **hands-on the micro plan template, daily implementation plan (DIP) and GIS maps for micro plan development**
- Participants are **updated on Findings from the Measles Risk Analysis (MRAT**
- Participants are **acquainted with** their **roles & responsibilities and deliverables** for the microplanning process

Duration: 20 mins

Link:

Pre-Test

Epidemiology of Measles and Rubella in Nigeria

Microplanning SToT for 2025 Integrated SIAs

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

A. Measles: Introduction

- Measles is a highly contagious viral disease characterized by fever, cough, conjunctivitis, and a distinctive maculopapular rash
- It can lead to **severe complications** such as **pneumonia, encephalitis, and death,** especially in young children and immunocompromised individuals
- Measles is a leading cause of death among young children worldwide
- Rubella, also known as ***German measles***, typically causes mild illness in children and adults
- Rubella infection during pregnancy can result in severe birth defects known as ***Congenital Rubella Syndrome*** (CRS)

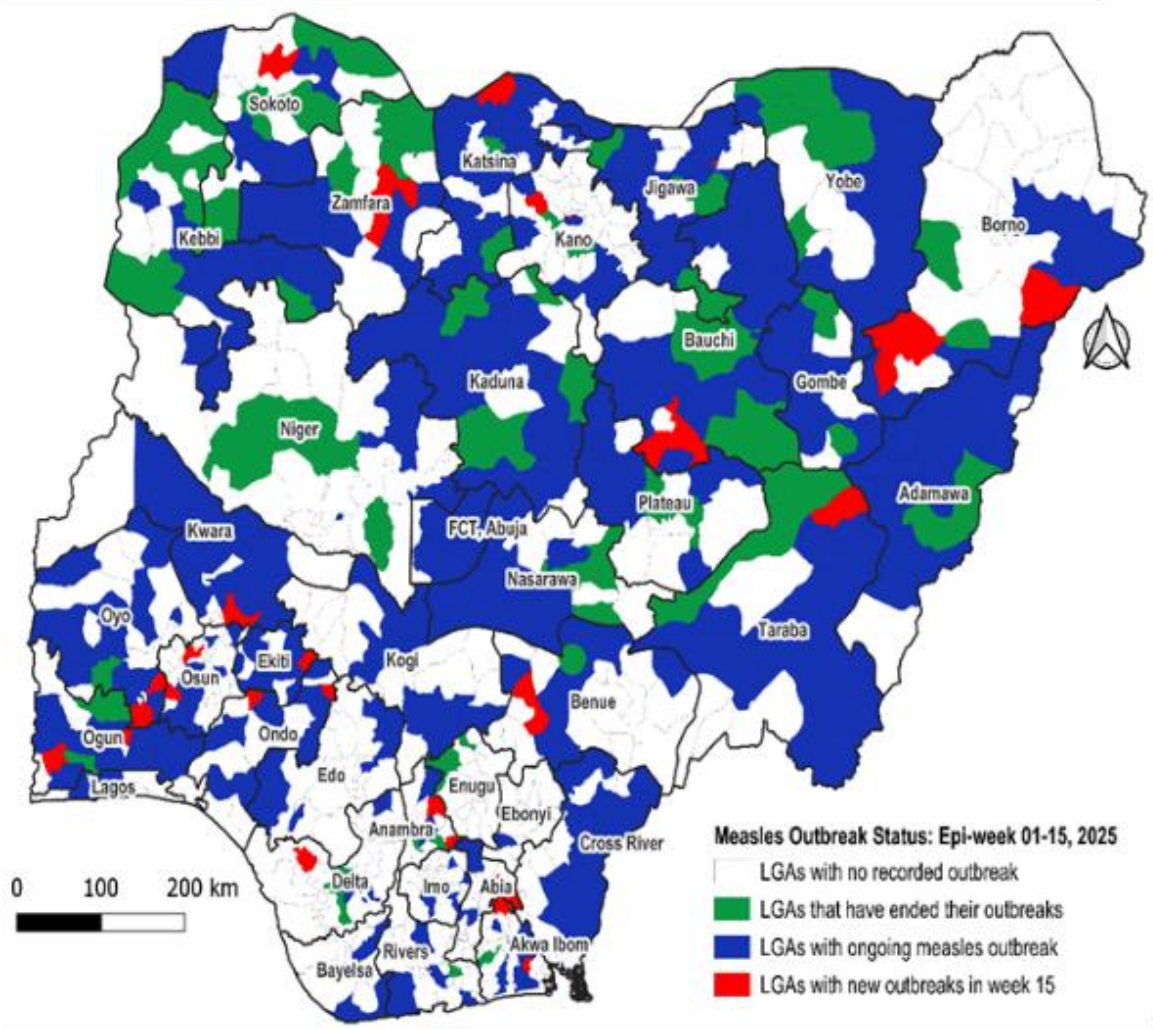
Image Source: ICIR Nigeria

Add State Measles Surveillance Data

- Not more than two slides

Measles Outbreak Status by states/LGAs:

2024: epi-week 01 – 15, 2025



Measles Outbreak Summary, Epi-week 01-15, 2025

- As at end of **epi-week 15** of **2025**, a total of **386 LGAs** across **37 States** have recorded a measles outbreak (more than 3 measles **IgM+** cases within **4wks** period).
- **Katsina State** had the highest number of **LGAs** (**27**) with record of measles outbreak, followed by **Jigawa** with **20 LGAs. Adamawa,** and **Kaduna** has **19 LGAs** each. While **Oyo has 18 LGAs. Bauchi** and **Kebbi** has **16** and **15 LGAs** respectively, while **Ogun State** has **13 LGAs**.
- A total of **295 LGAs** across **36 states** have **ongoing** measles outbreak, with **Katsina** State having the highest number (**24 LGAs**), followed by with **Adamawa** with **18 LGAs**. **Jigawa** and **Kaduna** has **15 LGAs** each. **Oyo State** has **14 LGAs**, while **Bauchi** and **Ondo** have **13 LGAs** and **11 LGAs** respectively.
- A total of **61 LGAs** across **24 States** have ended their measles out as at epi-week 15. **Kebbi** and **Sokoto** lead the pack with **7 LGAs** each that have **ended** their outbreak, followed by Yobe State with 5 LGAs, while **Jigawa, Kaduna**, and **Zamfara** have **4 LGAs** each
- Furthermore, **30 LGAs** across **19 states** recorded **new measles outbreak** in **epi-weeks 15**, 2025, with **Anambra, Borno and Oyo States** having the highest number (**3 LGAs** each with new measles outbreaks).

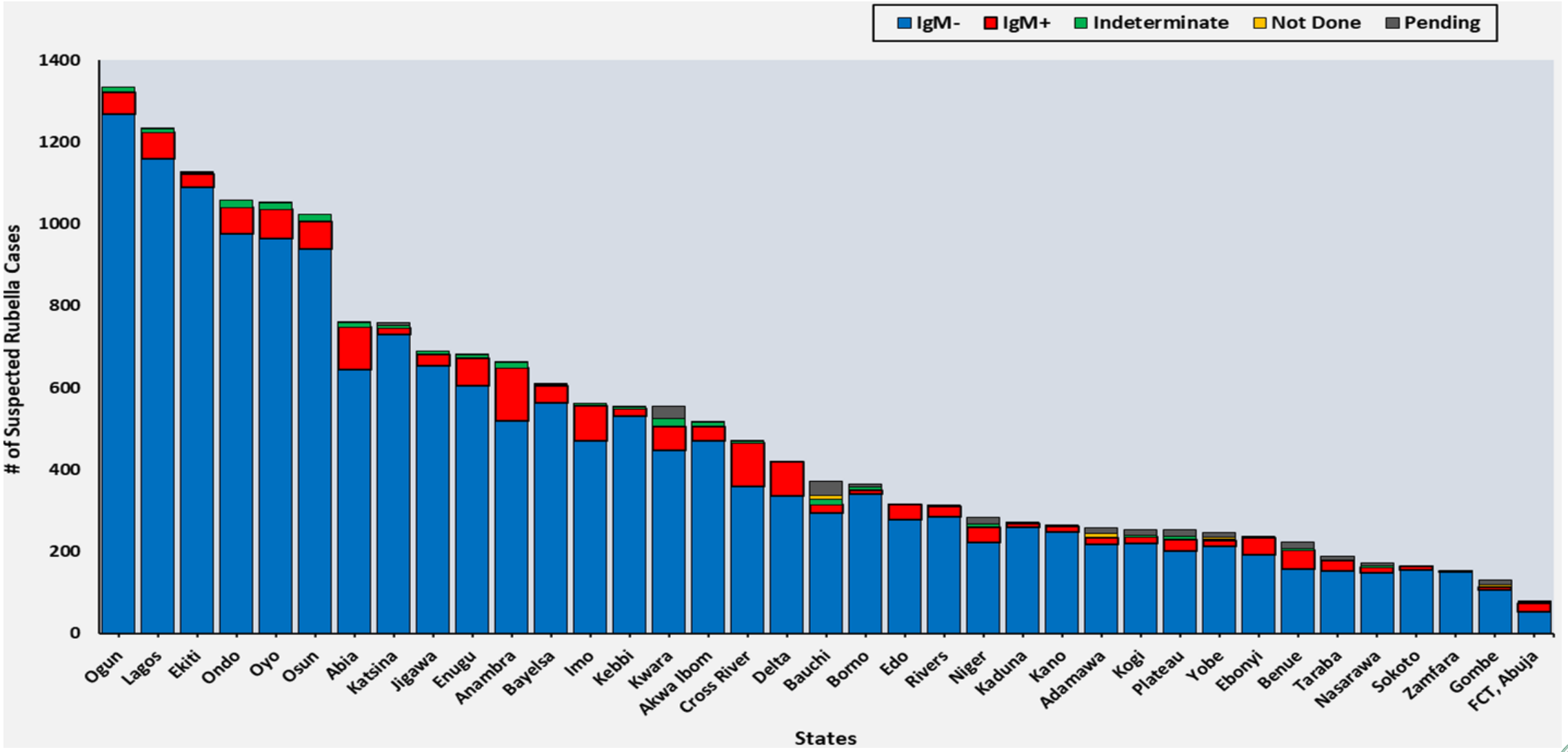
B. Overview of Rubella in Nigeria

Rubella:

- **Under-Reported Cases:** Rubella burden in Nigeria is under documented due to limited surveillance
- **High Susceptibility:** Seroprevalence studies many women of childbearing age remain unprotected
- **Congenital Rubella Syndrome (CRS):**
  - As of **2024, CRS remained a significant global public health concern**, with an estimated **100,000 babies born with CRS each year**
  - **High susceptibility of Rubella among women of childbearing age** contributes to the national CRS burden

Distribution of Rubella Cases by States in Nigeria:

epi-week 01 – 11, 2025



State Rubella Surveillance Data (by LGA)


Thank You

Overview of 2025 Integrated SIAs

Microplanning SToT for 2025 Integrated SIAs

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Rationale for Measles Rubella Vaccine Introduction

- Nigeria contributes significantly to the burden of measles, rubella and cVPV2 globally (in Africa, 54% for polio, second highest for measles after DRC)
- The campaign is being implemented to:
  - **Close immunity gaps**
    - MR vaccine has a better seroconversion than measles-only vaccine - >90% VS 85%
    - Protect a large cohort (9 months -14 years) and bridge the gaps in those who have never received Rubella
    - Starts the drive towards reducing the incidence of Congenital rubella syndrome (CRS)
  - **Interrupt transmission of Polio, Measles and Rubella infections**
  - **Strengthen Routine Immunisation**
    - 2YL activities and integration into broader PHC interventions for healthier communities
    - Addressing vaccine inequities
    - Strive towards elimination

Nigeria is striving for a future where no child dies or is limited by the harmful effects of measles and rubella infection; thus, is carrying out these measures

Measles vaccine is routinely given at **9 months & 15 months** since 2019 with the introduction of the measles second dose

Strengthening RI: outreach services, data quality, micro-planning at LGA/Ward /HF levels (Zero dose Reduction Plan)

Strengthening of case-based surveillance – integrated laboratory network including capacity building -MOBR

Prompt response to outbreaks (reactive vaccination)

Introduction of Measles Rubella vaccine into the RI

All in an effort to reduce measles & Rubella incidence to **< 1 case per million** and achieve elimination by 2030 in line with the National Measles Rubella Elimination plan

Aim and Objectives of the Integrated MR Campaign

AIM: To contribute to the reduction of measles and rubella incidence in Nigeria to < 5 cases/million by 2026 and 1 case/million in 2030 by increasing population immunity through vaccination

1. Achieve 95% measles-rubella vaccination post campaign coverage among children aged 9 months – <15years in all implementing states

2. Achieve greater than 85% coverage of measles zero dose children in all implementing states and at national levels

3. Strengthen the immunisation system by using the 2025 SIA microplanning to improve RI performance, 2YL and strengthen AEFI surveillance

4. Achieve 95% coverage with nOPV2 in states conducting polio campaign

2025 Measles- Rubella Catch-Up Campaign

- **Campaign Scope: Nationwide**
- **Target age group: 9 months -14 years**
- **Operational target population for the 36 + 1 States : 102,539,762**
- Will leverage **Health Campaign Effectiveness (HCE)** model to integrate high-impact interventions – (Oyo, Kano, Yobe) –**MR, NTDs, Polio, Malaria**
- RI implementation begins immediately (**MR switch using 5 dose vial)**
- Campaign will ride on lessons learned from previous SIAs
- Phase 1 states will integrate with Polio in October 2025

Phasing of Implementation

Phase	States	Start date of implementation
Phase 1 Stream 1	Kebbi, Sokoto, Zamfara, Katsina, Kano, Jigawa, Niger, Kwara, FCT, Kogi and Oyo	**4-13 October 2025**
Phase 1 Stream 2	Yobe, Borno*, Bauchi, Kaduna, Taraba, Plateau, Gombe,Adamawa Nasarawa, Benue	**18-27 October 2025**
Phase 2 Stream 1	Lagos,Osun, Ondo, Ekiti, Ogun, Edo, Delta and Bayelsa	**20-29 Jan 2026**
Phase 2 stream 2	Abia, Anambra, Ebonyi, Enugu, Imo, Akwa Ibom, Cross River and Rivers	**4-13 Feb 2026**

Strategies: vaccination will be carried out in ***10 days + 2 days mop-up*** at **Fixed posts** and **Temporary fixed (mobile) posts**

Phasing of MR vaccination Campaign –

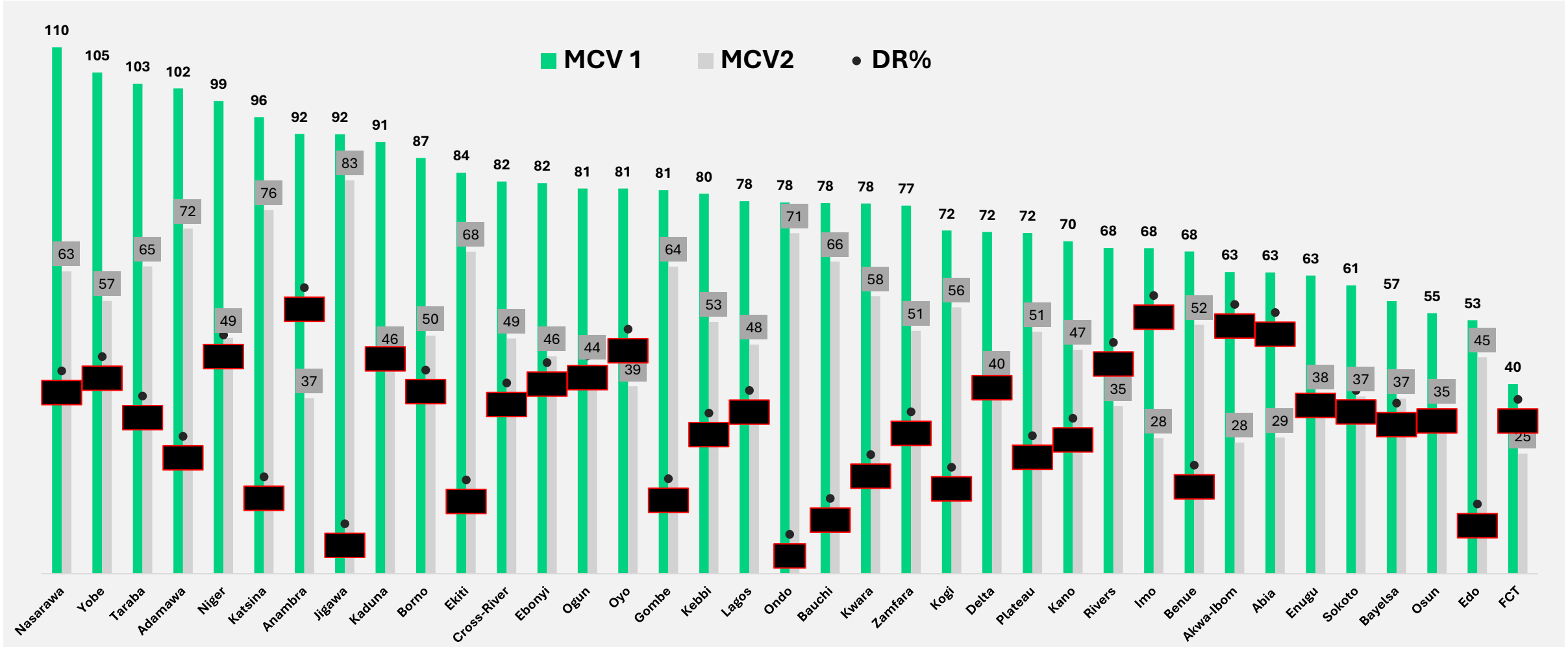
Bloc 1&2 will integrate with Polio, Bloc 3 & 4 Standalone

BLOC 1 **4-13 October 2025**	• Kebbi, Sokoto, Zamfara, Katsina, Kano, Jigawa, Niger, Kwara, FCT, Kogi and Oyo
BLOC 2 **18 -27 October 2025**	• Yobe, Borno, Bauchi, Kaduna, Taraba, Plateau, Gombe, Adamawa, Nasarawa, Benue
BLOC 3 **20 -29 January 2026**	• Lagos, Osun, Ondo, Ekiti, Ogun, Edo, Delta and Bayelsa
BLOC 4 **4 -13 February 2026**	• Abia, Anambra, Ebonyi, Enugu, Imo, Akwa Ibom, Cross River and Rivers

Strengthening Routine Immunization (RI) is important because

- **RI is crucial for maintaining herd immunity in the nation**
- **SIA** are **implemented to address immunity gaps** and **prevent potential outbreaks**
- **Coverage for RI is generally inadequate**, with the presence of **Zero Dose children posing a substantial risk**
- The **National Immunization Programme provides two doses of** Measles Containing Vaccine **(MCV) at 9 months** and **15 months of age**
- According to the National Immunization Coverage Survey **(NICS) 2021: MCV1 – 60%**
- Findings from the National Demographic Health Survey 2023 indicate: **MCV1 - 51%; MCV2 – 30%**
- Admin coverages **2024 (DHIS2)- MCV1- 77.9%, MCV2- 49.7%**

Trends in measles coverage by state for 2024- DHIS2



- **Ondo** State possesses the lowest DR (8%) while the remaining have more than 10%.
- All States to revisit the IPC during vaccination sessions as well as the knowledge of HCW of the immunization schedule

Strengthening the Routine Immunisation (RI) System

- **RI remains the bedrock of preventing VPDs**
- **RI stakeholders should be involved** in all aspects of the **SIA planning at States, LGA and community levels** to optimize opportunities to enhance RI
- **SIA micro plans** should be **developed to include delivery of RI antigens** by all fixed and temporary fixed posts and
- **Microplans should also be used to update REW microplans** addressing missed or underserved areas reached during campaigns
- **Integrated messages developed for the SIA should create demand for RI** and other PHC services
- To enable seamless switch, the **MR vaccine** will adopt the same **measles vaccine schedule**; the **1st dose at 9 months** of age and **2nd dose at 15 months**


Thank You

Findings from 2025 Measles Risk Assessment 2022-2024 Review Period

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Introduction

Risk Assessment: A systematic process to identify, evaluate and prioritize potential risks or threats that could negatively impact public health or program implementation

- Conducted **using an Excel-based tool developed by WHO**, which is **updated annually** and **reviewed quarterly at the LGA level** to track changes in risk
- Tool is **customized to country-specific needs** with the goal of categorizing each LGA by its attendant risk

Measles Risk Assessment: Is a process used to evaluate areas not meeting measles programmatic target

- Guides and strengthens measles elimination program activities
- Reduces the likelihood and potential impact of measles outbreaks in specific areas or populations
- Helps identify immunity gaps and improves population immunity
- Guides efforts to strengthen or expand immunization
- It has 4 category of indicators that have sub-indicators to which are assigned risk points

Populating the Measles Risk Analysis Template

1. POPULATION IMMUNITY	2. MEASLES CASE-BASED SURVEILLANCE	3. PROGRAM PERFORMANCE	4. THREAT ASSESSMENT/ VULNERABLE GROUPS
Some parameters in this category include: • Administrative Measles 1 Coverage • Administrative Measles 2 Coverage • Measles 1 Trend Compared to Previous Year • Measles 2 Trend Compared to Previous Year	**Some parameters in this category include:** • Non-measles Discarded Rate • Percentage with adequate investigation • Percentage with adequate blood specimen collection • Percentage with Timely availability of Lab results	**Some parameters in this category include:** • MCV 1 to MCV2 Drop-out rate • Cumulative Penta 1 Coverage • Cumulative Penta 3 Coverage • Penta Drop-out rate • MCV Stockout for > 3 years	**Some parameters in this category include:** • Evidence of confirmed measles cases in the last 12 months in ages <5years, 5-15 years and >15 years • Population Density • Bordering Previous measles outbreak • Presence of Vulnerable groups or inaccessible population

List of Moderate Risk LGAs by State

Zone	Name of State	Name of LGAs
NCZ	Benue	Buruku
	Benue	Gboko
	Benue	Kwande
	Benue	Oju
	Benue	Okpokwu
	Benue	Otukpo
	Benue	Ushongo
	Benue	Vandeikya

SN	Name of State	Number of LGAs
NCZ	Kwara	Ilorin East
	Kwara	Offa
	Nasarawa	Akwanga
	Niger	Chanchaga
	Niger	Gurara
	Niger	Mashegu
	Niger	Rafi
	Niger	Suleja
	Plateau	Jos North

List of Moderate Risk LGAs by State

SN	Name of State	Name of LGAs
NEZ	Borno	Askira/Uba
	Borno	Dikwa
	Borno	Gwoza
	Borno	Ngala
	Taraba	Wukari
NWZ	Jigawa	Kazaure
	Kaduna	Chikun
	Kaduna	Igabi
	Kaduna	Jema'a
	Kaduna	Kachia
	Kaduna	Lere

SN	Name of State	Number of LGAs
NWZ	Katsina	Dan Musa
	Katsina	Danja
	Katsina	Dutsi
	Katsina	Ingawa
	Katsina	Kafur
	Katsina	Kurfi
	Katsina	Mai'adua
	Katsina	Malumfashi
	Kebbi	Arewa Dandi
	Kebbi	Argungu
	Kebbi	Birnin Kebbi
	Kebbi	Gwandu

List of Moderate Risk LGAs by State

SN	Name of State	Number of LGAs
NWZ	Kebbi	Jega
	Sokoto	Binji
	Sokoto	Bodinga
	Sokoto	Sabon Birni
	Sokoto	Shagari
	Sokoto	Silame
	Sokoto	Wamakko
	Sokoto	Yabo
	Zamfara	Birnin Magaji/Kiyaw
	Zamfara	Bukkuyum
	Zamfara	Kaura Namoda
	Zamfara	Tsafe
	Zamfara	Zurmi

SN	Name of State	Number of LGAs
SWZ	Lagos	Alimosho
	Lagos	Badagry
	Lagos	Epe
	Lagos	Eti Osa
	Lagos	Ibeju Lekki
	Lagos	Ikorodu
	Lagos	Kosofe
	Ogun	Ado Odo/Ota
	Ogun	Ipokia
	Ondo	Akoko South West
	Ondo	Ondo East

List of Moderate Risk LGAs by State

SN	Name of State	Name of LGAs
SEZ	Abia	Aba South
	Abia	Bende
	Abia	Ukwa East
	Abia	Umuahia North
	Anambra	Anambra East
	Anambra	Dunukofia
	Anambra	Nnewi South
	Anambra	Oyi

SN	Name of State	Number of LGAs
SEZ	Enugu	Igbo-Eze-North
	Enugu	Igbo-Eze-South
	Enugu	Nsukka
	Imo	Mbatoli
	Imo	Njaba
	Imo	Owerri Municipal
	Imo	Owerri North

List of Moderate Risk LGAs by State

SN	Name of State	Number of LGAs
SSZ	Akwa Ibom	Okobo
	Akwa Ibom	Oron
	Akwa Ibom	Oruk Anam
	Bayelsa	Ekeremor
	Bayelsa	Kolokuma/Opokuma
	Bayelsa	Nembe
	Bayelsa	Ogbia
	Cross River	Obanliku
	Cross River	Obudu
	Delta	Patani
	Delta	Sapele

SN	Name of State	Number of LGAs
SSZ	Delta	Ughelli North
	Delta	Warri South
	Delta	Warri South-West
	Edo	Egor
	Edo	Esan West
	Edo	Orhionmwon
	Edo	Ovia South-West
	Edo	Owan East
	Rivers	Eleme
	Rivers	Khana

List of Moderate Risk LGAs by State

SN	Name of State	Number of LGAs
SWZ	Ondo	Owo
	Osun	Atakumosa West
	Osun	Boripe
	Osun	Egbedore
	Osun	Ife South
	Osun	Ifedayo
	Osun	Ila
	Osun	Irewole
	Osun	Isokan
	Osun	Obokun

SN	Name of State	Number of LGAs
SWZ	Osun	Ola Oluwa
	Osun	Olorunda
	Oyo	Atiba
	Oyo	Ibadan South West
	Oyo	Ibarapa North
	Oyo	Ido
	Oyo	Irepo
	Oyo	Lagelu
	Oyo	Saki West
	Oyo	Surulere

List of High Risk LGAs by State

SN	Name of State	Number of LGAs
1	Anambra	7
2	Bayelsa	4
3	Benue	2
4	Borno	10
5	Cross River	1
6	Delta	2
7	Enugu	2
8	FCT, Abuja	5
9	Gombe	2

SN	Name of State	Number of LGAs
10	Imo	1
11	Kaduna	2
12	Katsina	19
13	Kebbi	2
14	Niger	1
15	Osun	12
16	Rivers	1
17	Sokoto	9
18	Zamfara	4
TOTAL		84 (11%)

List of High Risk LGAs by State

SN	Name of State	Number of LGAs
1	Anambra	7
2	Bayelsa	4
3	Benue	2
4	Borno	10
5	Cross River	1
6	Delta	2
7	Enugu	2
8	FCT, Abuja	5
9	Gombe	2

SN	Name of State	Number of LGAs
10	Imo	1
11	Kaduna	2
12	Katsina	19
13	Kebbi	2
14	Niger	1
15	Osun	12
16	Rivers	1
17	Sokoto	9
18	Zamfara	4
TOTAL		84 (11%)

List of High Risk LGAs by State (2)

Zone	Name of State	Name of LGAs
NCZ	Benue	Guma
	Benue	Katsina-ala
	FCT, Abuja	Abaji
	FCT, Abuja	Bwari
	FCT, Abuja	Gwagwalada
	FCT, Abuja	Kwali
	FCT, Abuja	Municipal Area Council
	Niger	Bida

SN	Name of State	Number of LGAs
NEZ	Borno	Abadam
	Borno	Damboa
	Borno	Kaga
	Borno	Kala/Balge
	Borno	Kukawa
	Borno	Mafa
	Borno	Magumeri
	Borno	Maiduguri
	Borno	Marte
	Borno	Nganzai
	Gombe	Nafada
	Gombe	Shomgom

List of High Risk LGAs by State (4)

SN	Name of State	Name of LGAs
NWZ	Kaduna	Kaduna North
	Kaduna	Kaduna South
	Katsina	Batagarawa
	Katsina	Batsari
	Katsina	Baure
	Katsina	Bindawa
	Katsina	Charanchi
	Katsina	Daura
	Katsina	Faskari
	Katsina	Funtua
	Katsina	Jibia
	Katsina	Kaita

SN	Name of State	Number of LGAs
NWZ	Katsina	Kankara
	Katsina	Kankia
	Katsina	Katsina
	Katsina	Mani
	Katsina	Mashi
	Katsina	Musawa
	Katsina	Rimi
	Katsina	Sabuwa
	Katsina	Safana
	Kebbi	Augie
	Kebbi	Dandi
	Sokoto	Dange-shuni

List of High Risk LGAs by State (6)

SN	Name of State	Number of LGAs
NWZ	Sokoto	Gada
	Sokoto	Gudu
	Sokoto	Gwadabawa
	Sokoto	Kebbe
	Sokoto	Kware
	Sokoto	Sokoto North
	Sokoto	Sokoto South
	Sokoto	Tambuwal
	Zamfara	Bakura
	Zamfara	Gusau
	Zamfara	Maru
	Zamfara	Talata Mafara

SN	Name of State	Number of LGAs
SWZ	Osun	Ayedaade
	Osun	Ayedire
	Osun	Ede North
	Osun	Ede South
	Osun	Ejigbo
	Osun	Ife Central
	Osun	Ife North
	Osun	Ifelodun
	Osun	Ilesa East
	Osun	Ilesa West
	Osun	Iwo
	Osun	Oriade

List of High Risk LGAs by State (7)

SN	Name of State	Name of LGAs
SEZ	Anambra	Anambra West
	Anambra	Ayamelum
	Anambra	Idemili North
	Anambra	Njikoka
	Anambra	Ogbaru
	Anambra	Orumba North
	Anambra	Orumba South
	Enugu	Aninri
	Enugu	Igbo-Etiti
	Imo	Aboh Mbaise

SN	Name of State	Number of LGAs
SSZ	Akwa Ibom	Ibiono Ibom
	Bayelsa	Brass
	Bayelsa	Sagbama
	Bayelsa	Southern Ijaw
	Bayelsa	Yenegoa
	Cross River	Ogoja
	Delta	Burutu
	Delta	Udu
	Rivers	Port-Harcourt
	Akwa Ibom	Ibiono Ibom

Application of Measles Risk Assessment

- **Measles risk assessment** identifies **areas vulnerable to outbreaks** by classifying risk level and analyzing **immunity trends, program performance, surveillance performance**, and areas that have ongoing or **recent outbreaks** of the disease. Guides public health decisions and interventions, including:

1

IDENTIFYING HIGH-RISK AREAS

- Using population immunity, surveillance quality, program performance, & threat assessment

2

GUIDE INTERVENTION STRATEGIES

- Informs targeted interventions like vaccination campaigns, enhanced surveillance, & program strengthening in high-risk or underperforming areas

3

MONITOR PROGRESS TOWARDS ELIMINATION

- Tracks measles elimination progress & highlights areas needing intensified efforts

4

PRIORITIZE RESOURCES

- Ensures limited resources are directed to the most vulnerable areas

5

INCORPORATE LESSONS LEARNED

- Uses past outbreak analysis to improve future prevention; emphasizes the need for frequent LGA-level risk assessments in Nigeria


Thank You

Presentation – Microplanning process step-by-step

By:
Duration: 30 minutes

Introduction

Microplanning is a detailed planning process that focuses on specific, localized aspects of a program. It involves:

Key Aspects

- **Bottom-up approach**: Microplanning starts with local-level data and insights to inform planning decisions.
- **Specific goals and objectives**: Clearly defined targets and outcomes for a specific area or community.
- **Detailed resource allocation**: Allocation of resources, such as personnel, equipment, and budget, to achieve specific objectives.

Applications

- **Healthcare**: Microplanning is used to allocate resources, such as vaccines, personnel, and equipment, to specific areas or communities.
- **Development**: Microplanning helps identify specific needs and develop targeted interventions.

Introduction

Benefits

- **Improved resource allocation**: Microplanning ensures resources are allocated efficiently and effectively.
- **Enhanced community engagement**: Microplanning involves local stakeholders and communities in the planning process.
- **Increased precision**: Microplanning allows for more precise targeting of interventions and resources.

By focusing on specific, localized aspects of the programme, microplanning can help achieve more effective and efficient outcomes.

Overview of Microplanning Steps

- Community profile
- Line listing schools, health facilities, health care workers, worshiping places (mosques, churches, etc.), marketplaces, motor parks, etc.
- Identifying existing resources such as local influencers, CBOs, cold chain equipment
- Verification
- Review and Validation

Step 1: Situation Analysis

Purpose: Understand the local context and realities.

Activities:

- ***Review previous SIA data*:** Analyse data from past campaigns to identify gaps, successful strategies, and challenges encountered.
- ***Identify and map high-risk areas*:** Use high risk analysis should be used during health facility routine immunization microplanning to determine outreach and mobile delivery strategies. Community maps, records, and discussions with local leaders to pinpoint areas with high dropout rates or access challenges.
- ***Engage community leaders and stakeholders*:** Conduct meetings with traditional rulers, religious leaders, local associations, and health facility heads to gain buy-in and local insights.

Step 2: Target Population Estimation

Purpose: Know the specific groups to reach

Activities:

- ✓ ***Use updated data*:** Gather the most recent demographic figures data (population, names and list of settlements etc.) from local government records, survey data, or household enumeration exercises
- ✓ ***Adjust for new settlements or migration*:** Account for temporary settlements, nomadic populations, urban slums, and migration trends that affect population distribution
- ✓ ***Break down by age group, risk factors, and location*:** Disaggregate the population by key indicators such as children under five, pregnant women, people living in hard-to-reach areas, and underserved groups

Step 3: Team Composition and Deployment

- **Purpose**: Form effective vaccination teams

- **Activities:**
  - ***Assign clear roles***: Define specific responsibilities for each team member. Typically, this includes a vaccinator who administers the vaccine, a recorder who keeps track of data and forms, and a supervisor who oversees quality and coordination.
  - ***Ensure team training***: Each team member must be trained not only in their tasks but also in interpersonal communication, basic troubleshooting, and safety practices.
  - ***Plan daily team routes and targets***: Develop route maps and assign coverage areas that are realistic, geographically efficient, and equitable. Teams should have specific daily target numbers based on population size and accessibility.
  - ***Balance team workload***: Avoid overburdening teams by factoring in distance, terrain, and population density while assigning locations and targets.
  - ***Coordinate with local guides or community leaders***: Pair each team with someone familiar with the local area to improve access, safety, and community cooperation.

Step 4: Logistics and Supplies Planning

- Purpose: Ensure uninterrupted supply chain.
- Activities:
  - ***Calculate vaccine and material needs*:** Estimate the quantity of vaccines, syringes, safety boxes, cotton swabs, and other consumables required based on target population plus buffer stock (usually 10%).
  - ***Plan cold chain logistics*:** Ensure that adequate cold chain equipment (refrigerators, cold boxes, vaccine carriers as well as icepacks) is available and functional. Map out the vaccine distribution route from the central store to each team.
  - ***Check availability of logistics materials*:** Confirm that all essential items including tally sheets, pens, PPE, and waste disposal materials are quantified.
  - ***Coordinate with supply stakeholders*:** Work closely with logisticians, LGA cold chain officers, and state stores to schedule timely deliveries and resolve bottlenecks.

Step 5: Social Mobilization Planning

Microplanning enhances community engagement in several ways:

Community Involvement

1. ***Local participation***: Microplanning involves local stakeholders, community leaders, and residents in the planning process, ensuring their needs and concerns are addressed.
2. ***Needs assessment***: Microplanning helps identify specific community needs, allowing for targeted interventions that resonate with the local population.
3. ***Culturally sensitive approaches***: By engaging with local communities, microplanning can incorporate culturally sensitive approaches that are more likely to be effective.

Building Trust

- ***Community ownership***: Microplanning fosters a sense of community ownership and responsibility, as local stakeholders are involved in decision-making processes.
- ***Transparency and accountability***: Microplanning promotes transparency and accountability, as community members are informed about plans and progress.

Community Engagement Process

Advocate to the community leaders

State clear objective of meeting

Make it open and inclusive

Make it Participatory

Show interest in other issues raised by the community

Use data to guide engagement and decision making

Empower Community members to identify key issues and collectively proffer solutions

Community engagement for microplanning: Step by Step

At the ward level, the Ward Focal Person should;

- Pay advocacy visits to the community leaders. (WDC platform where functional). Especially areas with non-compliance
- Organize a sensitization meeting, introduce yourself, and state the clear objective of the engagement.
- Emphasize the importance of the microplanning process and what the community seeks to achieve from the campaign.
- Explain the need to mobilize the target population and the health benefits of the campaign to the community
- Make the engagement open and inclusive, encourage questions, and respond professionally and respectfully
- Work with the community leaders to fill some of the requirements in the micro plan template at residence of the community leaders
- They can also identify Community members who can serve as vaccination team members (esp., mobilizers, town announcers), and help resolve non-compliance.

As all microplanning processes are concluded;

- Review all the activities and ensure all relevant information is obtained and accurate.
- Conduct a feedback meeting on findings, this provides the community with a sense of ownership.
- Use data to guide all engagements and decision-making (DIP)
- The engagement outputs with the community/ village heads should include the correct names of settlements, updated lists of schools, mosques, churches, markets, potential vaccination sites, and other special areas

Step 6: Data Collection Tools Preparation

Purpose: Gather accurate field data

Activities:

- ***Identify required data tools*:** Determine the exact data tools needed for daily activity recording, such as tally sheets, AEFI forms, summary forms etc
- ***Train health teams on proper usage*:** Provide hands-on training to vaccinators and recorders on accurately filling out each data tool, including date, location, doses administered, refusals, and adverse events.
- ***Include supervisory tools and checklists*:** Prepare tools for supervisors to monitor team performance, data consistency, and overall compliance with microplans.

Step 7: Review and Verification

Purpose: Ensure accuracy and adaptability in microplanning.

Activities:

Conduct review meetings: Regularly meet with team leaders and key stakeholders to assess progress, identify bottlenecks, and make adjustments to plans as necessary.

Verify data in real-time: Cross-check data collected by teams with local health records to ensure consistency and correct any discrepancies immediately.

Adapt strategies based on feedback: Be flexible and ready to adapt the plan based on feedback from the ground. Micro plans should be flexible enough to accommodate changing circumstances, such as outbreaks or natural disasters. If new challenges arise, respond quickly to find solutions and reallocate resources as needed.

- ***Verify vaccine coverage and quality***: Assess the effectiveness of vaccination coverage, ensuring that no groups are missed and that all vaccination teams are adhering to safety protocols.
- Conduct desk review
- Validate microplans in the field

View of the MP template

State	LGA	Ward name	Choose Vaccination Post Type (F/TF)	No. of Private HF	No. of Public HF	Total No. of Heath facility	No. of Health Facilities to serve as Vaccination post	Number of Nurses/ Midwives	Number of CHOs	Number of CHEWs	Number of Retired Health Workers	Others (student of SHT)	Total of Qualified Available Vaccinators	Doctors (No.)	Private school	Public school	Total Number of schools
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0
						0							0				0

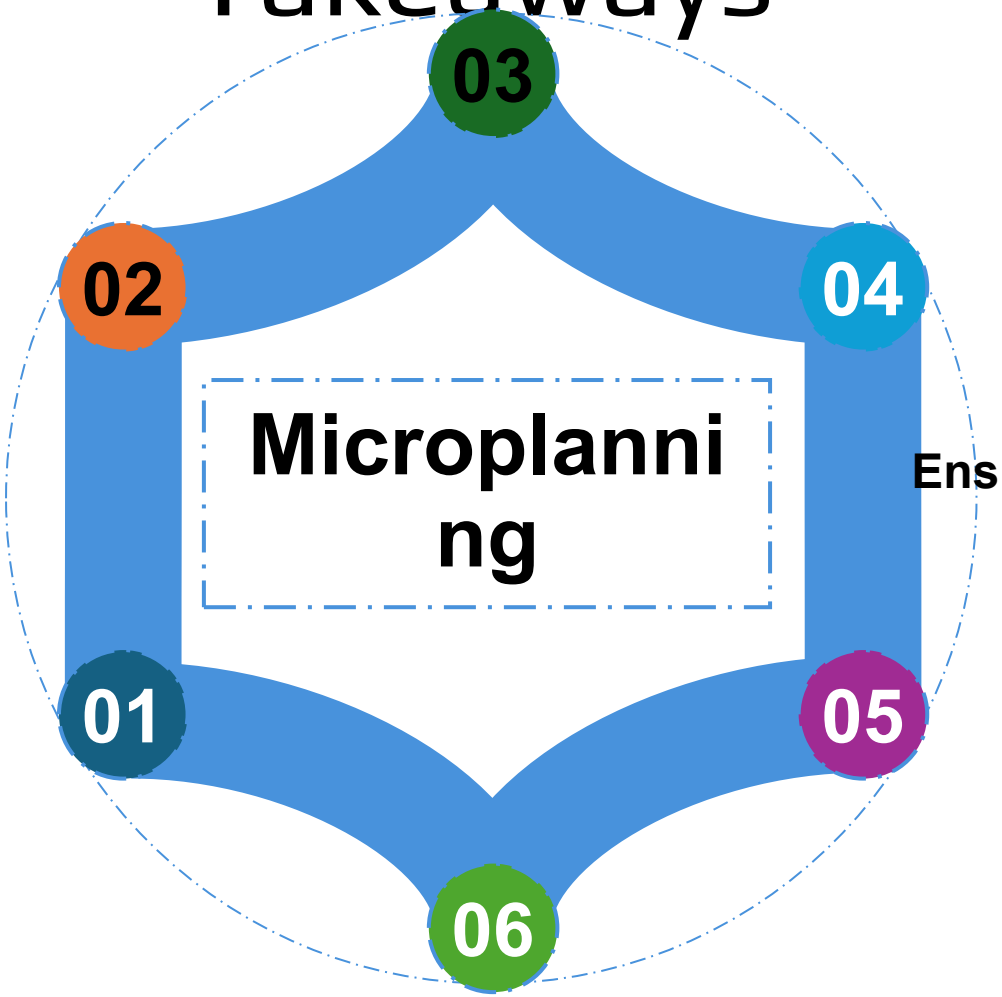
State	LGA	Ward name	Total Number of schools	Number of schools with eligible populations	Creches/ Day-care	Number Nurseries	Number Primary schools	Number Secondary schools	Number Tertiary Institutions	Number of Quranic Schools	Others	No. of Mosques	No. of Churches	No. of Markets	No. Special (Banks,Malls, Boarders, Water point, Transit points, Motor Parks etc)	Special (Transit points, Motor Parks etc)
			0													
			0													
			0													
			0													
			0													
			0													
			0													
			0													
			0													
			0													
			0													

View of the MP template

State	LGA	Ward name	Polio Vaccine =tp x 1.18	MR Vaccine =tp x 1.05	YF Vaccine =tp x 1.05	Td Vaccine =tp x 1.05	HPV Vaccine =tp x 1.05	MR AD Syringes= vaccine doses	YF AD Syringes=vaccine doses	Td AD Syringes=vaccine doses	HPV AD Syringes=vaccine doses	Reconstitution Syringes =total # vials	Safety Boxes((Number of AD + Reconstitution syringes) / 100)x1.05 (round up)	Total No of vaccination cards = Vaccine doses	Cotton WoolTwo 500 gm rolls of cotton wool per vaccination team	Tally sheet No. teams x 1.1
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
			#VALUE!	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A

State	LGA	Ward name	AEFI Line listing FormNo. teams x 1 x 1.1	AEFI Reporting FormNo. teams x 1 x 1.1	AEFI investigation FormNo. teams x 1 x 1.1	No. of AEFI KitsNo. of AEFI Kits = no. Vaccination Teams*	Cold Box RCW 25	Vaccine Carrier Gio'Style	Vaccine Carrier RUSH	Total Vaccine Carrier (BT + BU)	0.6L Icepacks	0.3/0.4L Icepacks	Refrigerator/Freezers	Refrigerator/ Freezers # Non Functional .	Refrigerator/ Freezers # Functional.	Total functional vaccine storage vol avail in litres (Refrigerator). ***Check back of the equipment*
										0						
										0						
										0						
										0						
										0						
										0						
										0						
										0						
										0						
										0						
										0						

Takeaways



Ensures that

01 all communities are reached and that no one is missed

02 Every step matters

03 Everyone is involved (teams as well as communities)

04 All steps are fully covered

05 All data recorded are accurate

06 Inter-connectivity will easily be set-up for real-time involvement and feedback


Thank You

Microplanning in Insecure Settlements

National Primary Health Care Development Agency

Accessibility for health teams

- Accessibility simply means access to communities for PEI services.

  - **Inaccessibility:** is when there is a complete access denial to reach communities by AGO for vaccination and surveillance activities (Meaning AGO occupied territory) eg Boko Haram, Ansaru, Lukarawa, Darul Salam.
  - **Partially accessibility**:
    - When an LGA or ward has more than 1 accessibility categorization.
    - When there are threats to reach or work in a particular settlement (Meaning no AGO in the settlement but along the road/while working).
  - **Fully accessibility:** When the access is not denied or no threats

Insecure Settlements

Factors affecting settlement inaccessibility

- Security crisis/situation related to insurgency.
  - Bandit, Lakurawa, Herdsmen, Al-Shabaab, Taliban, ISIS, etc.
- Population movement and displacement related to abandonment of settlements.
  - IDPs, Refugees, Nomads, Fishermen
- Geographical nature of the area.
  - Sandy, Rocky, waterlogged, etc.
- Political differences.
  - Party “A” or “B”
- Religious crisis.
  - Religion “A” or “B”

Micro planning for insecure communities

Responsible Persons

- State team ensure plans are developed by each LGAs to capture scattered and insecure settlements
  - –Adequate logistics, training and data tools
- LGA teams are to guide respective WFPs in the process of developing DIPs for insecure settlements.
- WFP are responsible for developing ward level DIPs, including insecure areas.

Requirements for Development the Micro plan

The WFP under the guide of the LGA team

- Use the updated harmonized state MLoS
- Identify insecure areas from the MLoS (categorization)
- Line list the traditional leaders/community leaders from insecure areas
- During planning meetings, meet with community leaders and security personnels from underserved communities to harmonize and update the settlement lists
- You can use GIS Maps where available
- Adopt a uniform template for data collection (ODK)
- Disaggregate small settlements into individual communities on the MP
- Validation of the MLoS settlement list by the WFP before the commencement of the exercise.

Developing plans & DIPs to reach security compromised areas.

- During ward level development of DIP, ensure the development of DIP for each of the team
- Ensure rational team workloads for each day, considering scattered and insecure nature of the settlements
- Recruit team members and supervisors from those areas
- Use vigilantes/security escorts where possible to support teams
- Review/update during ERM to identify any unreached, new settlements for revisit
- Provide enough detail to guide team members to each settlements
  - Security tips
  - Nature of terrain
  - Appropriate means of transport
  - Communication devices
- **LGA should inform/engaged security agencies while planning**


Thank You

Development of Daily Implementation Plan and Team Movement Plan including Catchment Area Map

Microplanning SToT for 2025 Integrated SIAs

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Outline

- Definition
- Benefits of DIP
- Components of DIP
- Development of DIP
- Using Maps to populate the DIP template
- Qualities of a good catchment area map
- Conclusion
- Integrated MR DIP Template

Definition of Daily Implementation Plan (DIP)

- **Daily Implementation Plan** serves as a **framework for organizing daily activities during a campaign**
  - It details the **specific steps and actions necessary** to ensure the **successful execution of immunization programs**
- For an effective reach, a DIP should focus on vaccination plans, data collection process, and monitoring plans
- Team supervisors and Ward Focal persons are responsible for developing/ updating DIPs
- Other persons involved in developing/updating of DIPs include:
  - Community leader
  - Other stakeholders

Benefits of DIP

- **The daily implementation work plan ensures:**
  - ✓Proper implementation of workload rationalization
  - ✓Tracking of teams and daily performance by all supervisors
  - ✓Achievement of vaccination target
  - ✓Vaccine logistics is made easy
  - ✓Work schedule is adhered to and reduces missed opportunities for vaccination
- **Plans** should **prioritize vaccination efforts**, **active community engagement**, and **robust monitoring and evaluation** mechanisms

Components of a DIP

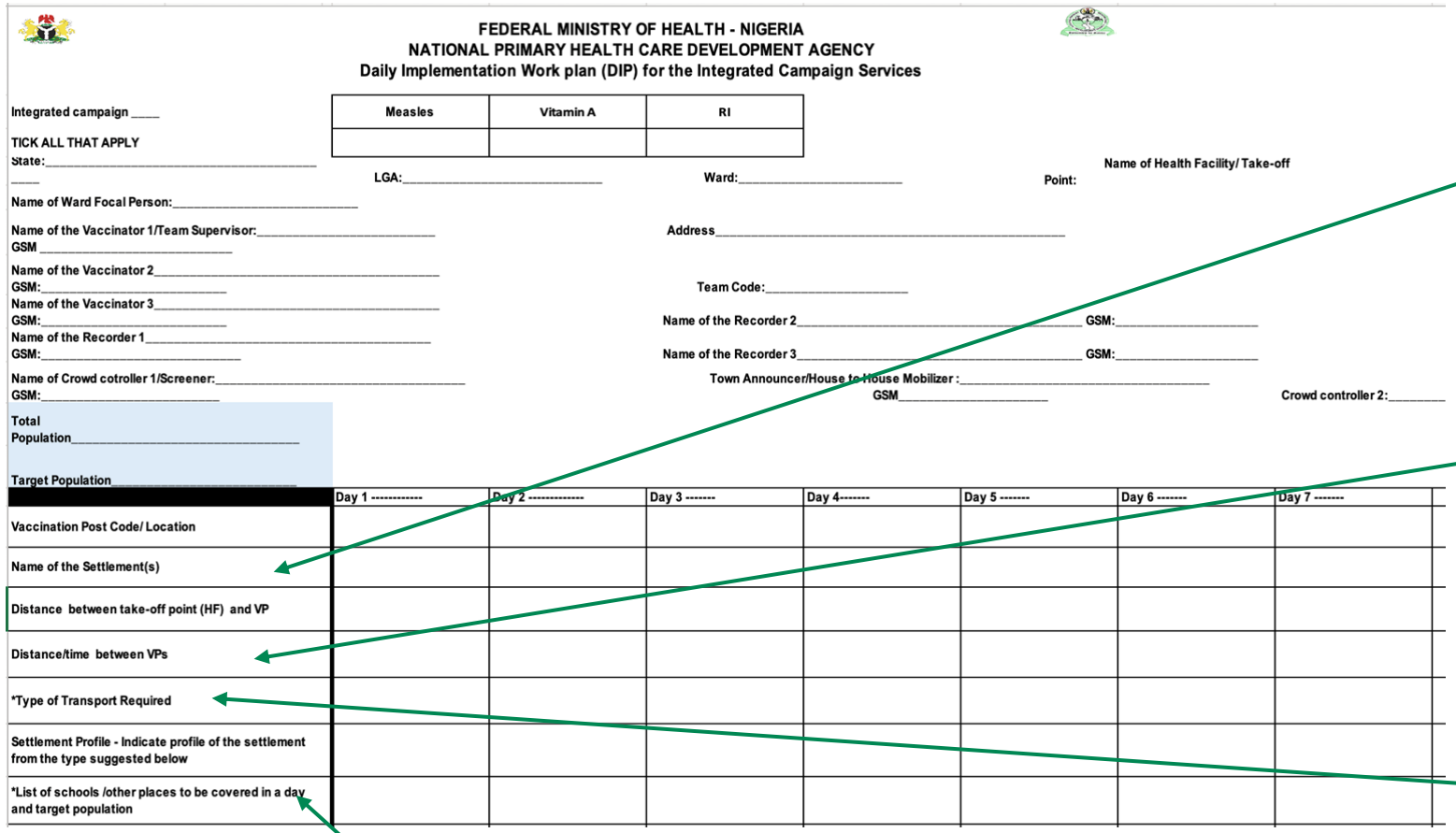
1	Catchment area profile (List of Settlements and their target population, Boundaries of catchment areas, Name of Health Facility and its location, Areas of special population etc.)
2	Team composition and designation
3	List of all settlements, their target population and settlements to be covered per day
4	List of schools,(nursery, primary, secondary and Tertiary institutions) viewing centers, mosques, banks, churches, markets, motor parks and any other place with eligible persons
5	List of border settlements, nomads and hard to reach settlements to be visited
6	Vaccines and logistics (transportation and distribution)required per day
7	Catchment Area Map/a hand drawn map

Development of Daily Implementation Plan (DIP)

Team Supervisors, with the support of **WFPs, traditional leaders, and other influential leaders in the settlement/community**, should:

Conduct a planning meeting to	• Update the list of settlements, schools, mosques, churches, markets, and motor parks • Identify a central and accessible location to serve as the vaccination post • Determine the location and approximate distance of each settlement from the vaccination post
Map and organize the catchment area	• Draw a catchment area map clearly showing the boundaries and key locations • Use the map to guide planning and ensure adequate coverage
Develop a vaccination schedule	• Collaborate with community to agree on specific date each settlement will come for vaccination • Divide the settlements over the required number of days for the MR campaign • Coordinate with school heads to schedule times for school-based vaccinations
Disseminate the plan	• Share the finalized plan with the town announcer and all influential community members to ensure wide awareness and participation

Using Maps to Populate the DIP template



FEDERAL MINISTRY OF HEALTH - NIGERIA
NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY
Daily Implementation Work plan (DIP) for the Integrated Campaign Services

Integrated campaign ____	Measles	Vitamin A	RI
TICK ALL THAT APPLY			

State:_____ LGA:_____ Ward:_____ Name of Health Facility/ Take-off Point:

Name of Ward Focal Person:_____

Name of the Vaccinator 1/Team Supervisor:_____ Address_____
GSM _____

Name of the Vaccinator 2_____
GSM:_____ Team Code:_____

Name of the Vaccinator 3_____
GSM:_____ Name of the Recorder 2_____ GSM:_____

Name of the Recorder 1_____
GSM:_____ Name of the Recorder 3_____ GSM:_____

Name of Crowd cotroller 1/Screener:_____ Town Announcer/House to House Mobilizer :_____
GSM:_____ GSM_____ Crowd controller 2:_____

Total Population_____

Target Population_____

	Day 1 ----------	Day 2 ----------	Day 3 -------	Day 4-------	Day 5 -------	Day 6 -------	Day 7 -------
Vaccination Post Code/ Location							
Name of the Settlement(s)							
Distance between take-off point (HF) and VP							
Distance/time between VPs							
*Type of Transport Required							
Settlement Profile - Indicate profile of the settlement from the type suggested below							
*List of schools /other places to be covered in a day and target population							

Settlements to be visited each day, can be verified based on their geographic distribution

Distances between take-off point (HF) and VP, as well as distances between VPs can be determined by using the scale bar

Type of transport can be verified by observing road network and distances visualized on the maps

Schools and POIs visualized on the maps can be used to verify if their locations are in close proximity to target populations

Using Maps to Populate the DIP template (2)

During DIP development, the team Supervisors should ensure a GIS map is available to guide the team during the process

- Understand the legend and ensure you are able to identify settlements, POIs, operational boundaries and health facilities on your ward level map
- Divide the ward area on the map into clusters/catchments based on the number of teams allocated to a ward
- Determine the number of days per cluster. Based on the total number of days planned for the implementation, circle the settlements that will be visited each day
- Make sure that each team has a relatively equal number of settlements and children to vaccinate within their catchment areas to ensure fairness and equitable distribution of the vaccination efforts
- Identify temporary vaccination post location for each day by referring to POIs on the map and your local knowledge
- Record the vaccination point on the DIP where the team will operate during each campaign day
- Keep in mind that on certain days the vaccination team might work at multiple vaccination points

Qualities of a Good Catchment Area Map

Team supervisors and their team members are responsible for developing their catchment Area Map. The map is drawn at the back of DIP template of the vaccination teams and must have:

A title
- Name of the area or location or settlement

North arrow
- Showing the four-cardinal point of the area

Legends
- Keys explaining map symbols and colors. E.g. + for Health Facility(ies), which are Fixed/Temporary FP) and add a scale bar for distance

List of Settlement and their target population
- Including neighboring areas, major roads and landmarks

Boundaries of catchment area

Clear labelling of catchment boundaries, landmarks and relevant features

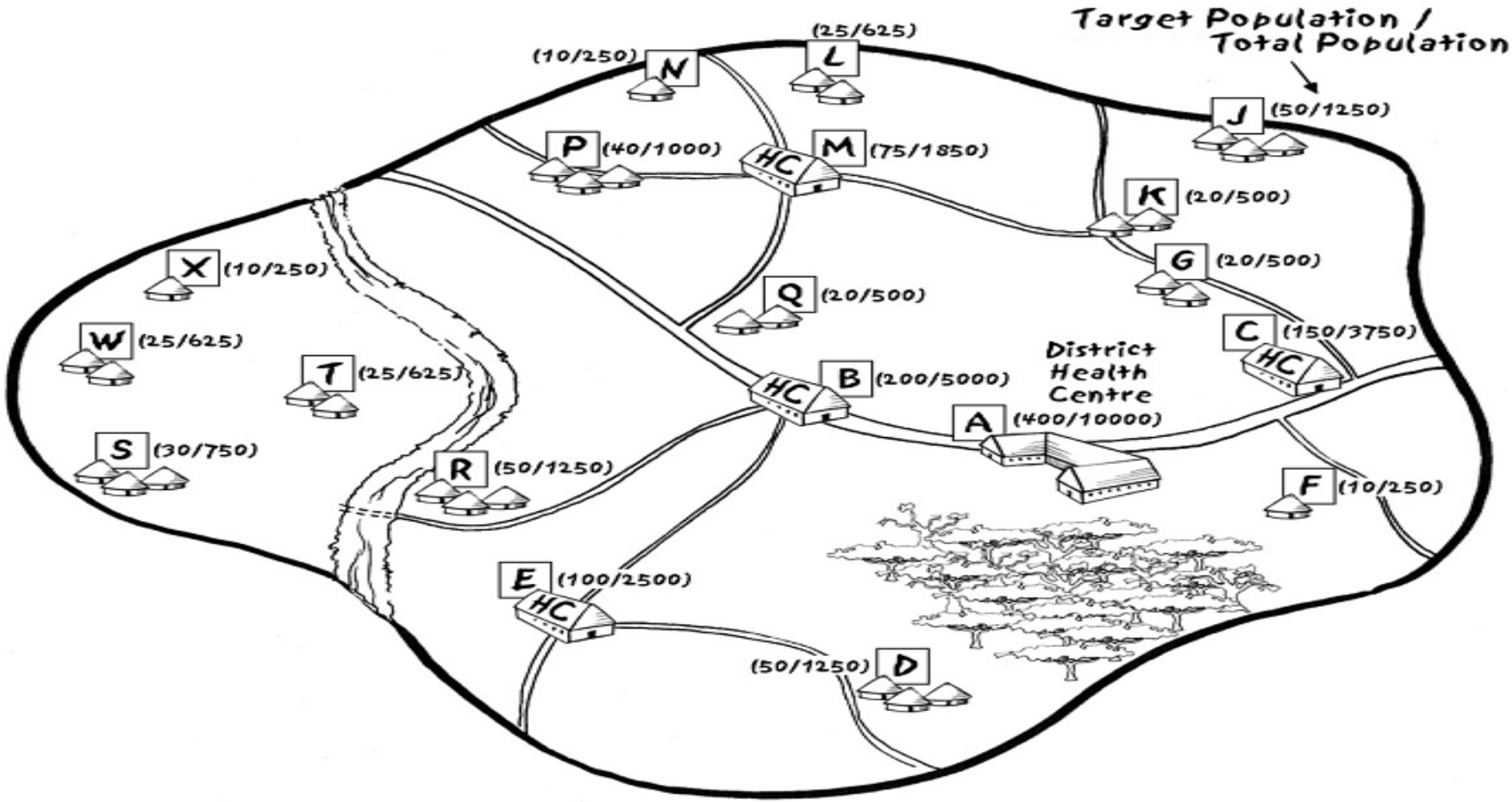
Name of Health Facility and its location

Names/Location of Churches, Mosques, Schools & Markets

Areas of special population (mobile population, Refugee camps etc.)

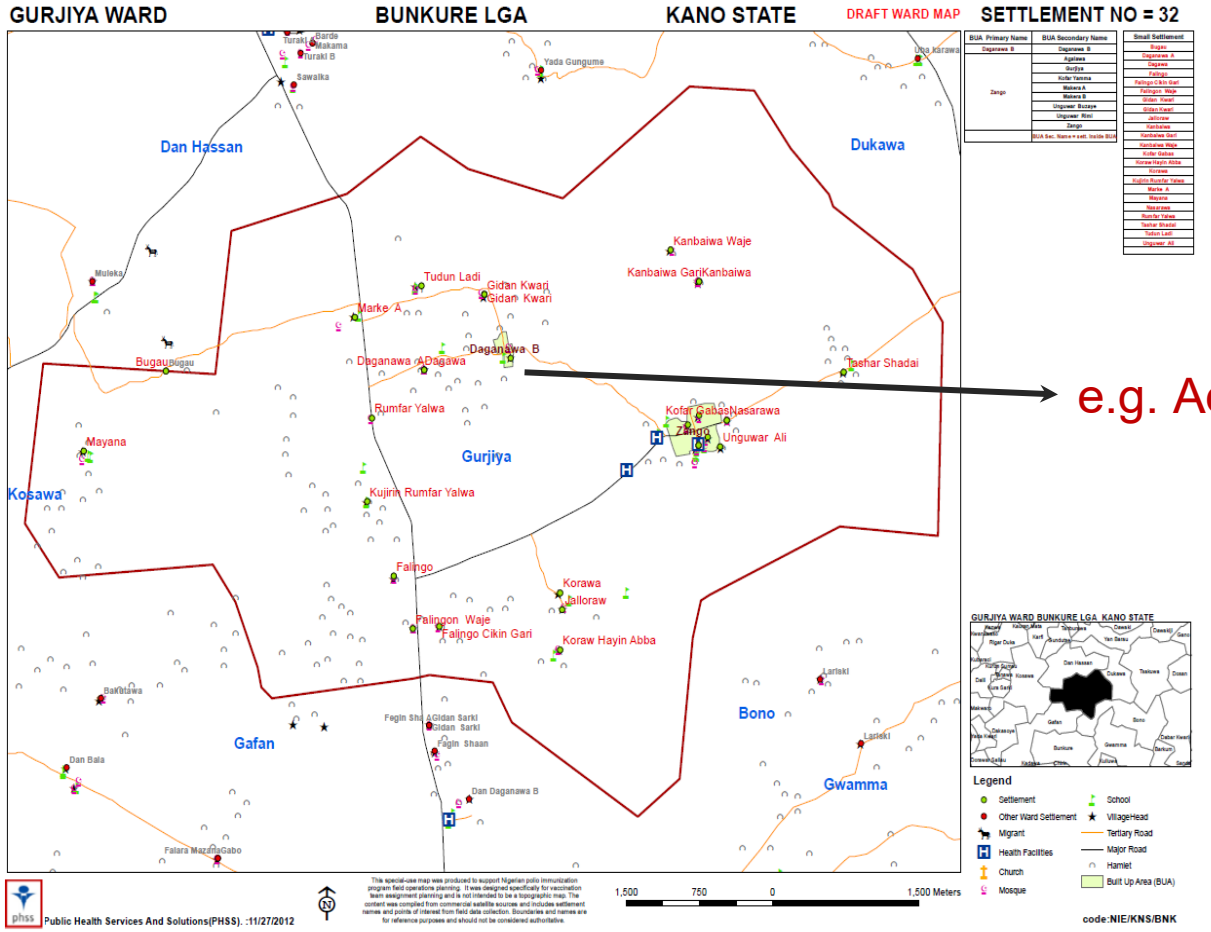
Hard to reach areas and convenience of communication

Hand drawn Catchment Area Map



Navigate the Ward Map

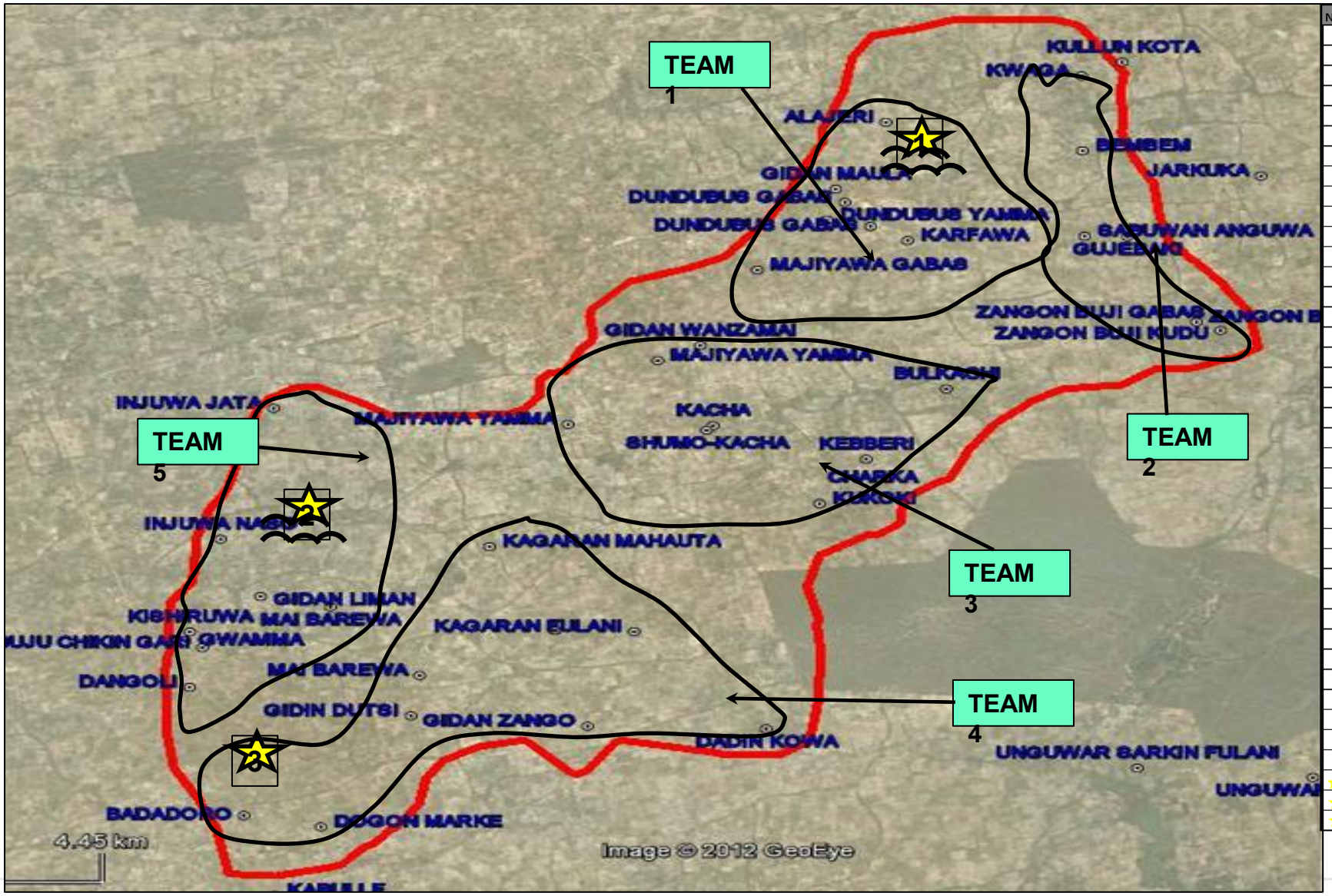
Indicate local names of important landmarks to guide & enhance understanding of the map



e.g. Ado's camp

- Confirm all settlements on the ward list
- Provide local names for unnamed HAs, important landmarks like mountains, valleys & rivers
- Profile the settlements; densely populated are BUAs & HAs will be classified as H2R & settlements more than 5km from ward headquarters

Revise Team Areas to include all settlements, minimize travel time, and balance team workloads



NEW	SETTLEMENT	Team	Day
	ALAJERI		
	BADADORO		
	BEMBEM		
	BUJU CHIKIN GARI		
	BULKACHI		
	CHARKA		
	DADIN KOWA		
	DANGOLI		
	DIGAWA		
	DOGON MARKE		
	DUNDUBUS GABAS		
	DUNDUBUS YAMMA		
	GIDAN LIMAN		
	GIDAN MAULA		
	GIDAN WANZAMAI		
	GIDAN ZANGO		
	GIDIN DUTSI		
	GUJEBAKI		
	GWAMMA		
	INJUWA JATA		
	INJUWA NASO		
	KACHA		
	KAGARAN FULANI		
	KAGARAN MAHAUTA		
	KARFAWA		
	KEBBERI		
	KISHIRUWA		
	KUKOKI		
	KWAGA		
	MAI BAREWA		
	MAJIYAWA GABAS		
	MAJIYAWA YAMMA		
	SABUWAN ANGUWA		
	SHUMO-KACHA		
	ZANGON BUJI GABAS		
	ZANGON BUJI KUDU		
	ZANGON BUJI YAMMA		
★1			
★2			
★3			

Digawa
Fulani

Gidan

Steps to Success

This is the bedrock of the micro-planning process:-

1. Use **existing catchment area map and settlement list** to locate team coverage areas on new map
2. **Identify settlements not assigned** to any team
3. **Identify risk, evaluate and minimize** risks
4. **Re-draw team coverage areas** to **include all settlements, minimize distances traveled, and balance workloads**

Conclusion

- A **good DIP guides teams during implementation** by e**nsuring they reach all eligible clients with potent vaccine**
  - ✓Makes monitoring and supervision easy
  - ✓Facilitate community mobilization
  - ✓Maintain a balanced workload for the vaccination team
  - ✓Shows movement pattern of vaccination teams
  - ✓Estimate distance of travel from one settlement to the vaccination post
  - ✓Assist the ward focal person and supervisors on Cold chain and logistics requirement and distribution
- A **draft DIP should be developed on day five**, immediately **after the micro planning process**

Integrated DIP Template

FEDERAL MINISTRY OF HEALTH - NIGERIA
NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY
Integrated Daily Implementation Work plan

Antigen Administered_____

Name of Health Facility/ Take-off Point:_____

State:_____ LGA:_____ Ward:_____

Name of Ward Focal Person:_____ Phone #_____

Team Code:_____

Name of the Vaccinator 1/Team Supervisor:_____
Phone # _____

Name of the Vaccinator 2_____
Phone #:_____

Name of the Vaccinator 3_____
Phone #:_____

Name of the Recorder 1_____
Phone #:_____

Name of the Recorder 2_____
Phone #:_____

Name of the Recorder 3_____Phone #:_____

Name of Community Leader/Crowd Controller 1:_____
Phone #:_____

House to House Mobilizer :_____ Phone #_____

Row No		Day 1 (Date)-----	Day 2 (date)------	Day 3 (date)	Day 4 (date)	Day 5 (date)	Day 6 (date)	Day 7 (date)	Day 8 (date)	Day 9 (date)	Day 10 (date)	Mop Up Day 1 (date)	Mop Up Day 2 (date)
11	A	B	C	D	E	F	G	H	I	J	K	L	M
12	Location/Landmark												
13	Name of the Settlement(s)												
14	Settlement Profile - Indicate profile of the settlement from the type suggested below												
15	Distance/time between take-off point and VP [Km or Hour(s)]												

Integrated DIP Template (2)

16	*Type of Transport Required												
17	*List of schools /other places to be covered in a day and target population												
18	Social Events												
19	Total Population												
20	Measles-Rubella Target Population to be covered (42% of total population) *=C19*42%*	0	0	0	0	0	0	0	0	0	0	0	0
21	Measles -RubellaVaccine Doses Required *=C20*42%*	0	0	0	0	0	0	0	0	0	0	0	0
22	Measles-Rubella Vials required *=(C21*42%)/10*	0	0	0	0	0	0	0	0	0	0	0	0
23	Reconstitution syringes (5ml) required *=C22*	0	0	0	0	0	0	0	0	0	0	0	0
24	AD (0.5ml) syringes required *=C21*	0	0	0	0	0	0	0	0	0	0	0	0
25	Safety boxes (AD syringes + reconstitution required) *=(C24+C23)/100*	0	0	0	0	0	0	0	0	0	0	0	0
26	Polio Target Population to be covered (20% of total population) *=C25*20%*	0	0	0	0	0	0	0	0	0	0	0	0
27	nOPV2 Doses Required *=C26*20%*	0	0	0	0	0	0	0	0	0	0	0	0
28	nOPV2 Vials required *=C27/50*	0	0	0	0	0	0	0	0	0	0	0	0

Profile the settlements as urban, rural, scattered, Border Settlement, Nomadic, Fulani, Riverine/desert

List of schools/other places to include Quaranic, Islamic, Nursery, Primary, market/Mosque/Church/Motor park/Playground/Water Point/Private & Government Clinic/ Farms

*Type of Transport Required - Walk, Motorcycle, Keke NAPEP, Jeep, Boat


Thank You

Use of GIS Maps for Microplanning and DIP Development

Microplanning SToT for 2025 Integrated SIAs

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Learning Objectives

- **At the end of this session, participants will be able to understand:**
  - ✓GIS-Based Microplanning Compared to Traditional Approaches
  - ✓Benefits of GIS-Based Microplanning
  - ✓GIS Microplanning Impact
  - ✓Core Spatial Data for GIS Microplanning
  - ✓Map Overview, Map Elements, Settlement Tables
  - ✓Using Maps for Developing Microplans and DIPs

GIS-Based Microplanning Compared to Traditional Approaches

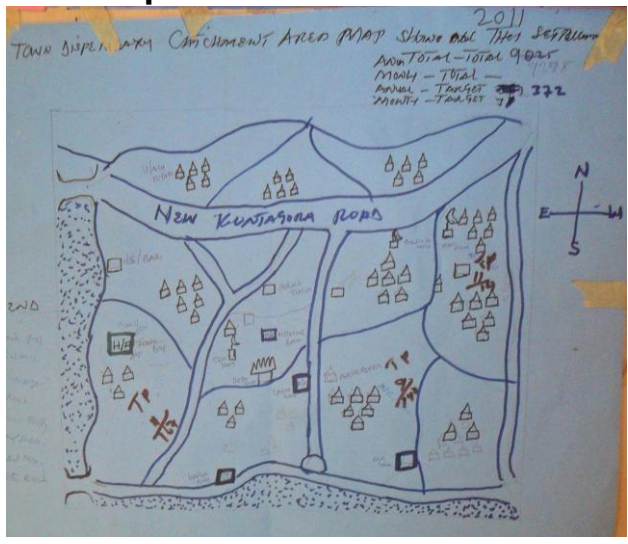
GIS Based Microplanning

- Utilizes geospatial analysis to identify all settled areas/communities
- Allows for more accurate distance measurements between a community and health facilities
- Determine optimal locations for outreaches to ensure all settlements within a specified catchment area have access to care
- Leverages existing road networks, topography, and water bodies that may serve as natural barriers in defining catchment areas

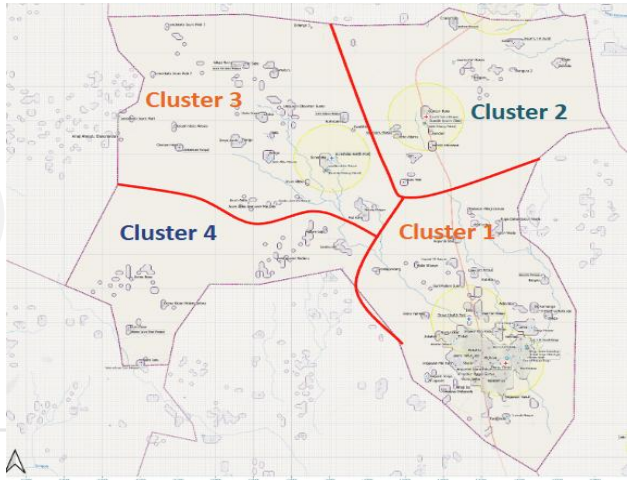
Traditional Microplanning

- Settlements are identified manually, which may result in some being missed
- Calculation of travel times between a community and health facilities using local knowledge
- Identification of outreaches without spatial proximity
- Catchment areas are determined based on local knowledge and estimated distances

1) Original hand drawn map for microplan



2) GIS map showing coverage of ward with teams

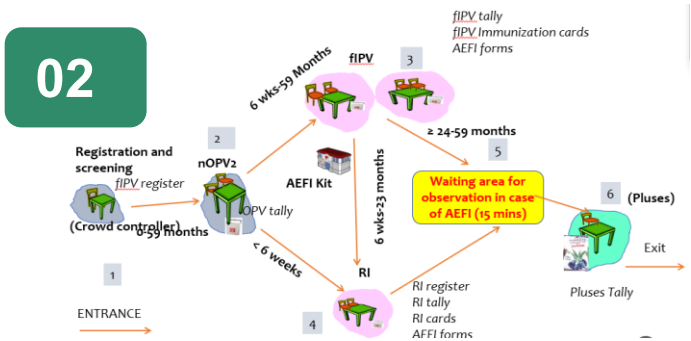


Benefits of GIS-Based Microplanning

01

Estimating number of settlements within a target area

02

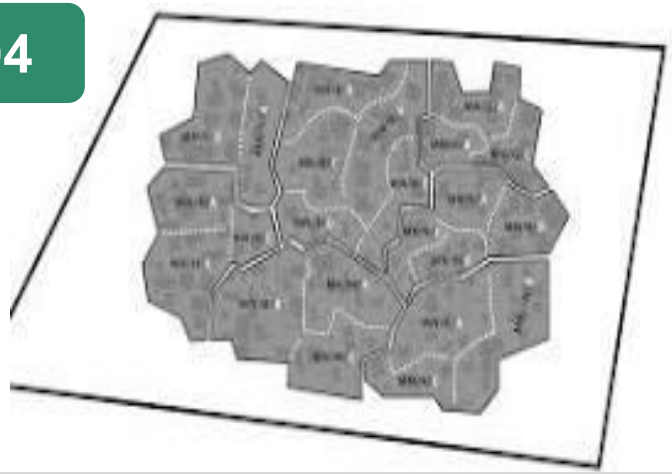


Estimation of number of fixed vaccination posts required & suggested locations for posts

03

Estimation of number of teams required

04

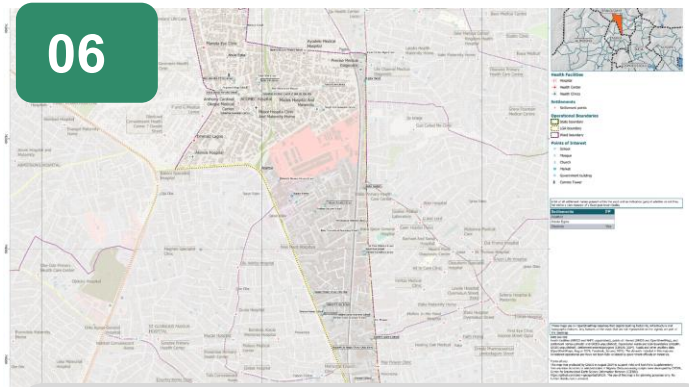


Settlement clustering and ward maps

05

Ensuring that immunization services reach all segments of the population

06



Geographical distribution of settlements, HFs, schools, churches, mosques, & markets

Updates to 2025 Maps

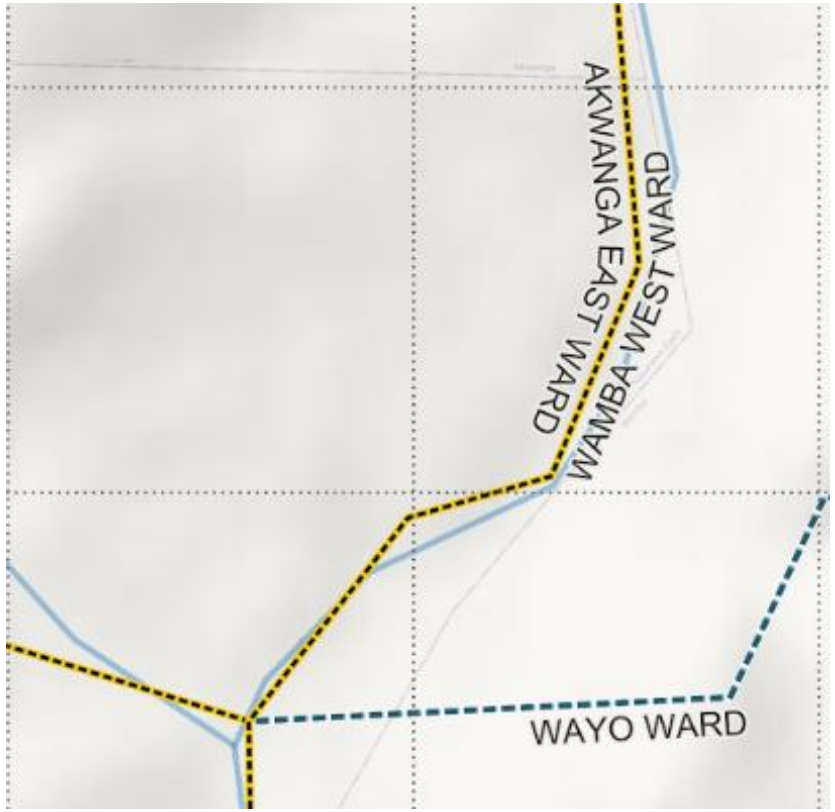
Based on lessons learned from 2024 the following adjustment were made to the 2025 maps:

- ✓Removed 1km buffer around health facilities due to changing fixed posts
- ✓Addition of dots representing building count per settled areas to estimate areas of settlements that might be most densely populated
- ✓Larger labels
- ✓Improved scale bar
- ✓Latest road data from OpenStreetMap

Data updates

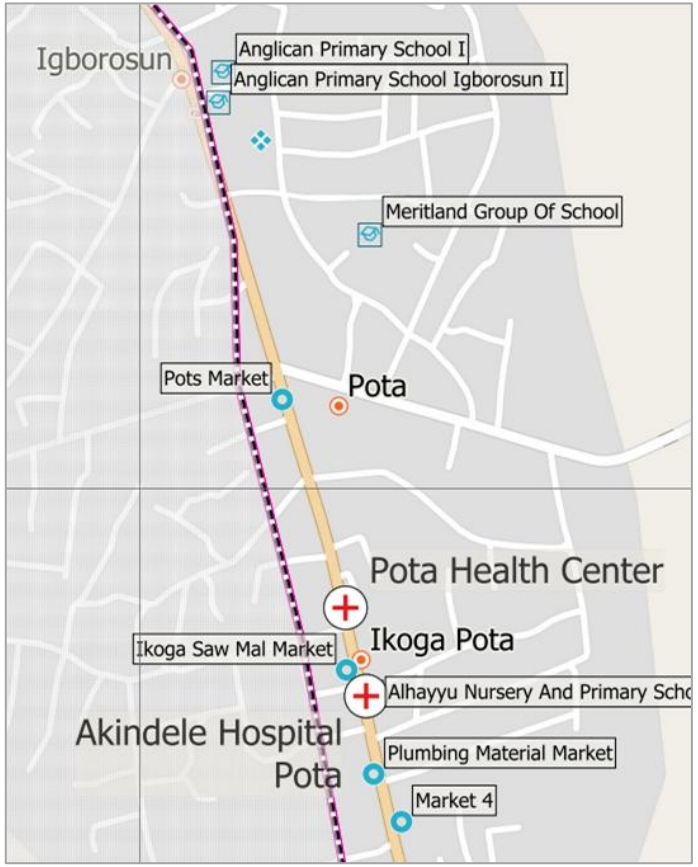
- ✓Updated operational ward boundaries for northern states
- ✓Updated settlement names (with GPS coordinates)
- ✓Updated health facility based on latest National Health Facility Registry (NHFR)

Core Spatial Data for GIS Microplanning



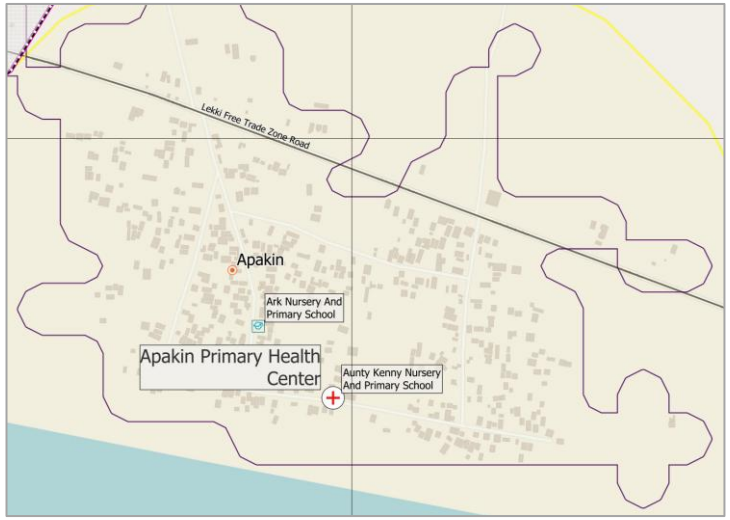
Operational Boundaries

- Ward boundary
- LGA boundary
- State boundary



Points of Interest

- POI's such as schools, religious buildings and markets are used to help the map users orientate themselves
- Combined from existing open sources, including OpenStreetMap



Health Facilities

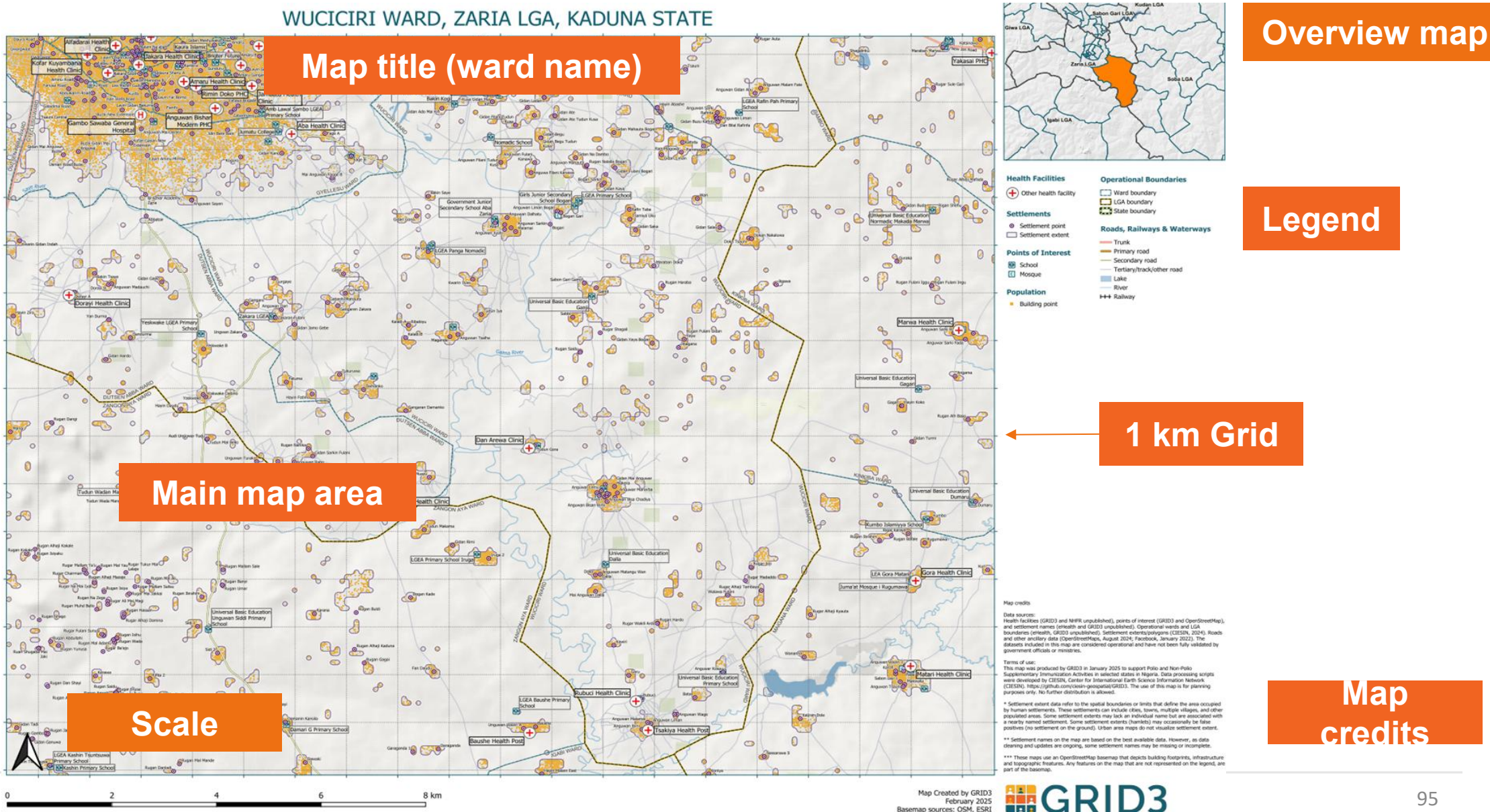
Health Facility

- Health facilities with GPS coordinates, including those listed in the National Health Facility Registry (NHFR), are included on the maps
- However, if new facilities have recently opened or existing ones have relocated, they may not be reflected on the maps

Map Overview

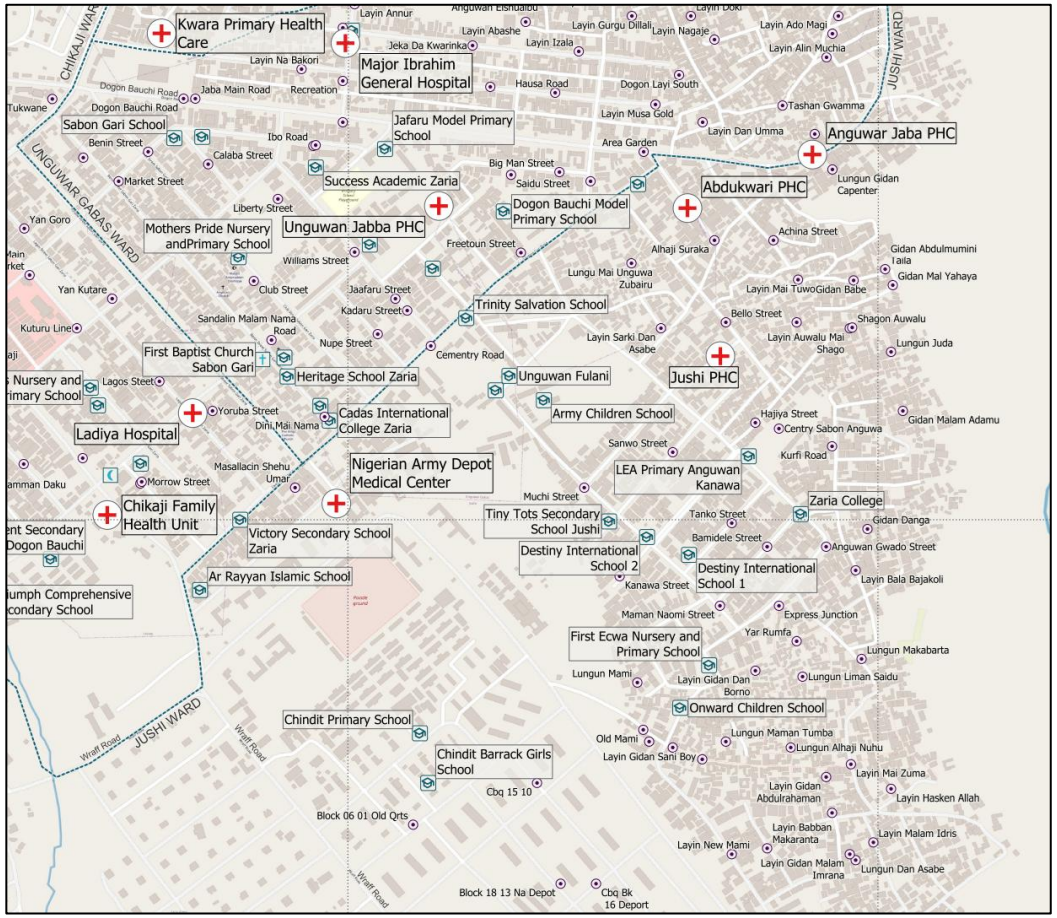
- **Maps enhance microplanning** and **Daily Implementation Planning** (DIP) for the integrated campaign
- **Integration of maps improves the planning process** without disrupting traditional microplanning
- **Maps developed at the ward level** and aggregated to LGA, State, and National levels **for effective planning**
- **Maps identify** settlements within 1km of health facilities and **critical outreach points**
- **Maps assist with navigation** through difficult terrains and help locate hard-to-reach settlements

Map Elements

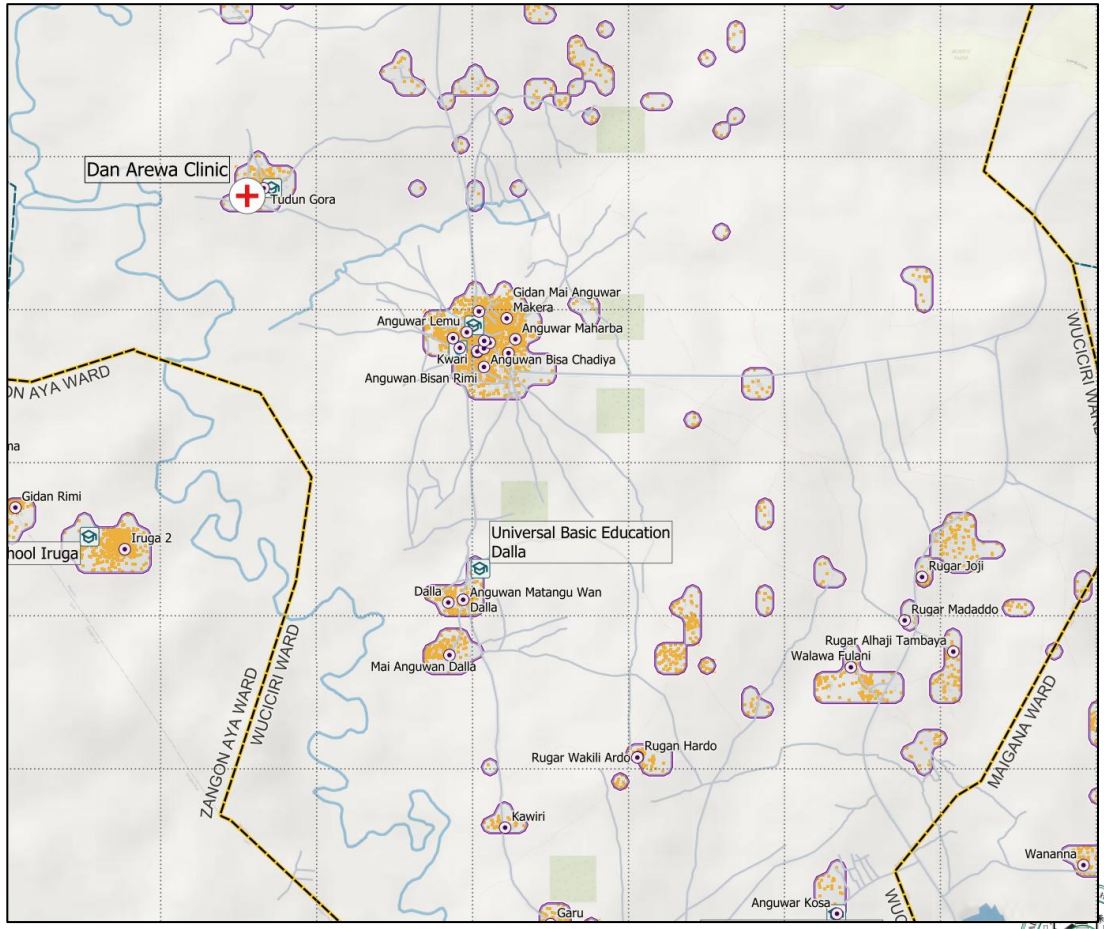


Examples of Urban and Rural GIS maps

Example map of an urban ward
Sabon Gari Ward, Jushi LGA, Kaduna State



Example map of a rural ward
Zaria Ward, Wuciciri LGA, Kaduna State



Settlements Tables (Spatial Data)

- **Each ward map** is accompanied by a **table listing all settlements** within the ward that **have GPS coordinates**
- A **settlement might not be listed** on the table **if it doesn't have a GPS coordinate** in the GIS repository
- In **densely populated areas**, **not all settlements may be visible** on the map, **but are included in the accompanying table**

AMEJO WARD, OKPOKWU LGA, BENUE STATE

GRID3

* This settlement is part of the ward but was excluded from the map to keep the labels easy to read and avoid overcrowding

SN	Settlement
1	Abode Aikpla
2	Ai Abba
3	Ai Abba Eefficho Edumoga
4	Ai Abba Effoyo Edumoga
5	Ai Abba Ehaje
6	Ai Oko Okpudo
7	Ai Okoko Effoyo
8	Akpali Ichakwu
9	Akpeke Aikpla
10	Akpeke Akpali
11	Ateikpo Okpafie
12	*Effoyo
13	*Effoyo Edumoga
14	Eficho Okpafie Edumoga
15	Efu Okpafie
16	Enyibokwu Effoyo
17	Ichakwu
18	Ijege
19	Ikpogo Effoyo
20	Ipole Okpafie
21	*Obekpa
22	Odessasa Ugbokolo
23	Odessassa
24	Ogokwuei Okpafie Edumoga
25	Ohaji Okpafie
26	Okpafie
27	Okpafie Edumoga
28	Okpudo
29	Okpudo Olanyega
30	Okwudo Amejo
31	Okwungaga Ugbokolo
32	Omadewu
33	Omadewu Effoyo
34	*Omulonye Ehaje
35	Omulonye Ehicho
36	Oyilawu Okpafye
37	Ugbokolo
38	Ugbokolo

SN	Settlement

SN	Settlement

Using Maps for Microplanning

- ✓**Understand the map legend** to identify settlements, POIs, operational boundaries, and health facilities
- ✓**Identify hard-to-reach settlements** due to geographic isolation, challenging terrain, or inadequate road infrastructure
- ✓**Cross-check map features** against your list, adding missing data with markers based on local knowledge
- ✓**Prioritize areas beyond 1 km from fixed posts**; identify potential temporary or outreach sites (e.g., health facilities, schools, mosques, churches) based on proximity and access
- ✓**Ensure settlements within catchment areas of outreach sites are 1 km apart**, using scale bars or grid overlays for reference

Using Maps to Populate Integrated Microplanning Template

WARD INTEGRATED IMMUNIZATION MICRO PLANNING TEMPLATE

Part A1: List of Settlements, Target Population and proposed Number of Vaccination Posts and Teams

State: **LGA** **WARD**

Manually input DATA for columns A to J, P, Q, AE to AH
Columns "K to O, R to AD' are Automated; Do not input DATA

S/N	Settlement Name	Type of Settlement		Hard to reach Yes / NO	Security Threat Yes / NO	IDP Camps and other special Population	Total Population	Is the special population part of the total population Yes / NO	Special Places Total Population	Measles	Number of vaccination posts	
		Urban Settlement Yes / NO	Rural Settlement Yes / NO						Special Places (IDPs, Nomadic)	Measles TP 17% Total Population	Fixed vacc post at Health facility (A)	Temporary vaccination post (B)
1								Yes		-		
2										-		
3										-		
4										-		
5										-		
6										-		
7										-		
8										-		
9										-		
10										-		
11										-		
12										-		
13										-		
14										-		
15										-		
16										-		
17										-		
18										-		
19										-		
20										-		

Must READ | Health Facilities | Schools | Part A1 | Part A2 | Part A3 | ... 6 | Part A7 | Part A8 | Part

Maps help ensure all settlements are accounted for

Schools and POIs visualized on the maps can be used to verify locations of temporary vaccination points, ensure close proximity to target populations

Vaccination post Strategy (Numbers)		
Fixed Post	Temporary FP	Mobile / Outreach/Transit

Based on geographic distribution of settlements and their proximity to health facilities, vaccination post strategy can be determined for each settlement

Map Use: Hands - on Exercise Session

Using Map for Team Allocations and DIP development

STEP 1

Identify all settlements, HFs & POIs that can serve as vaccination posts on the map

STEP 2

Divide the area of a ward into clusters/catchments based on number of teams allocated

STEP 3

Cluster settlements based on distance, considering total number of days planned for implementation

STEP 4

Allocate days to each sub-cluster based on the estimated implementation days & assigned team

STEP 5

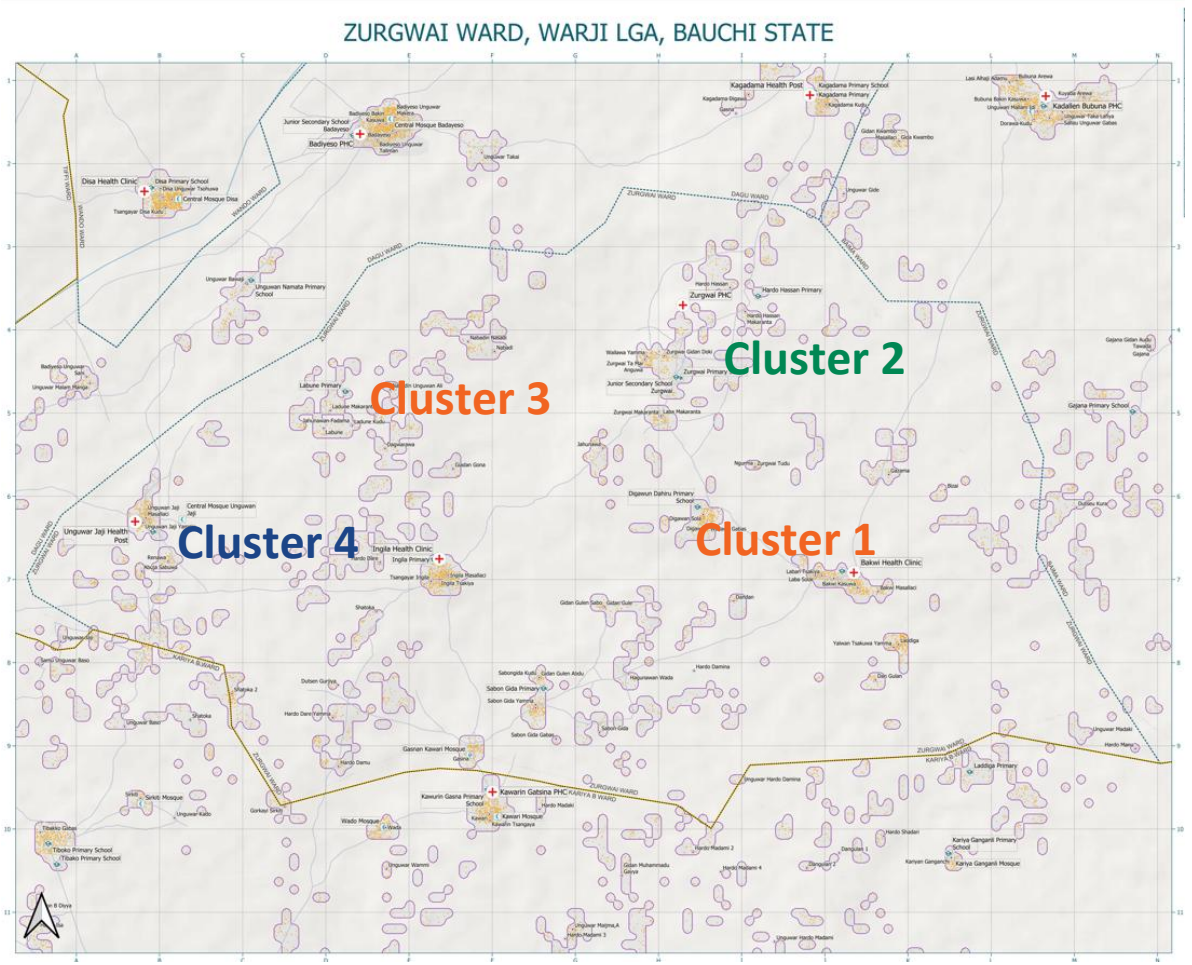
Using scale bar & 1 km grid, **create catchment areas for vaccination posts**

STEP 6

Record vaccination posts, settlement(s), & vital POIs allocated to team & respective days on DIP

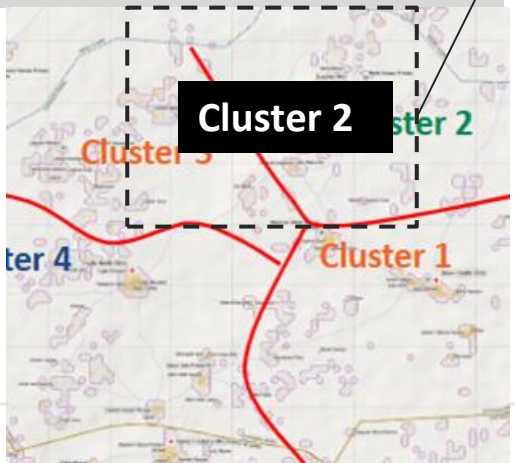
Settlement clustering/catchment and team daily work plan

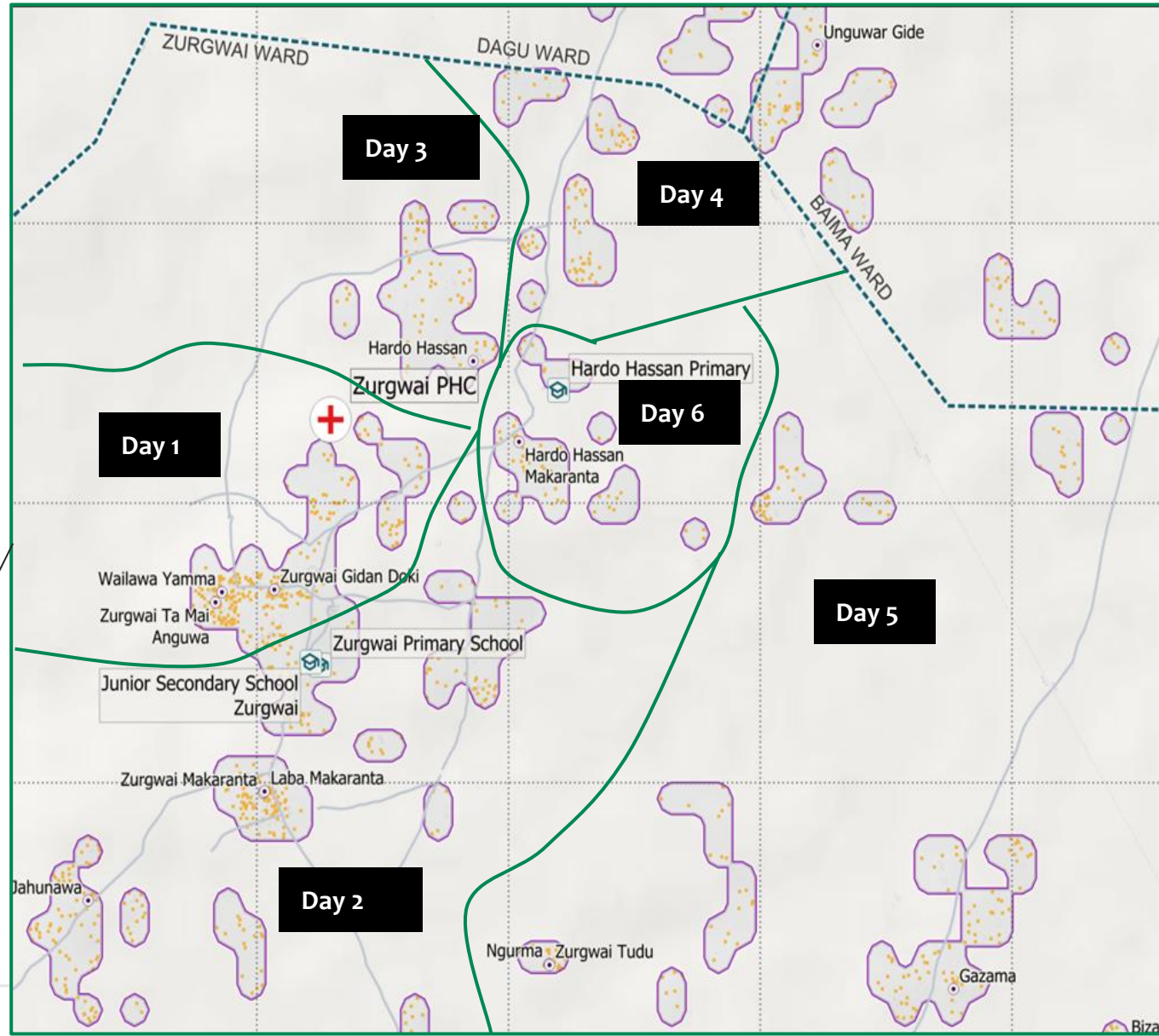
- **Step 1:** Refer to the map, to identify settlements, health facilities, and POIs
- **Step 2:** Divide the ward area on the map into clusters/catchments based on the number of teams allocated to a ward
  - In this example a ward has 4 teams. Each cluster/catchment represent where the vaccination teams will operate
  - Each cluster/catchment should have at least one fixed or temporary vaccination post
  - **Aim for relatively uniform population sizes within each catchment/cluster to ensure equitable coverage**



Settlement clustering/catchment and team daily work plan (2)

- **Step 3: Determine the number of days per cluster**
  - Based on the total number of days planned for the implementation, circle the settlements that will be visited each day
- **Step 4: Ensure Equal Distribution**
  - Make sure that each team has a relatively equal number of settlements and children to vaccinate within their catchment areas
  - This helps ensure fairness and equitable distribution of the vaccination efforts

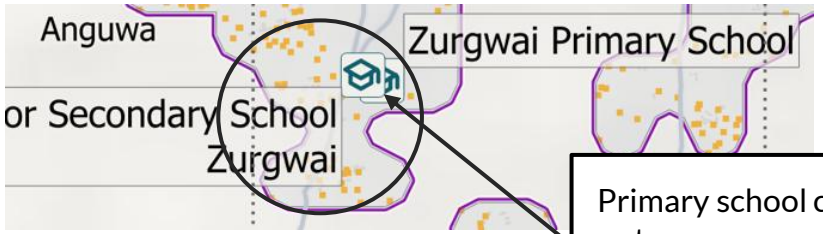




Settlement clustering/catchment and team daily work plan (3)

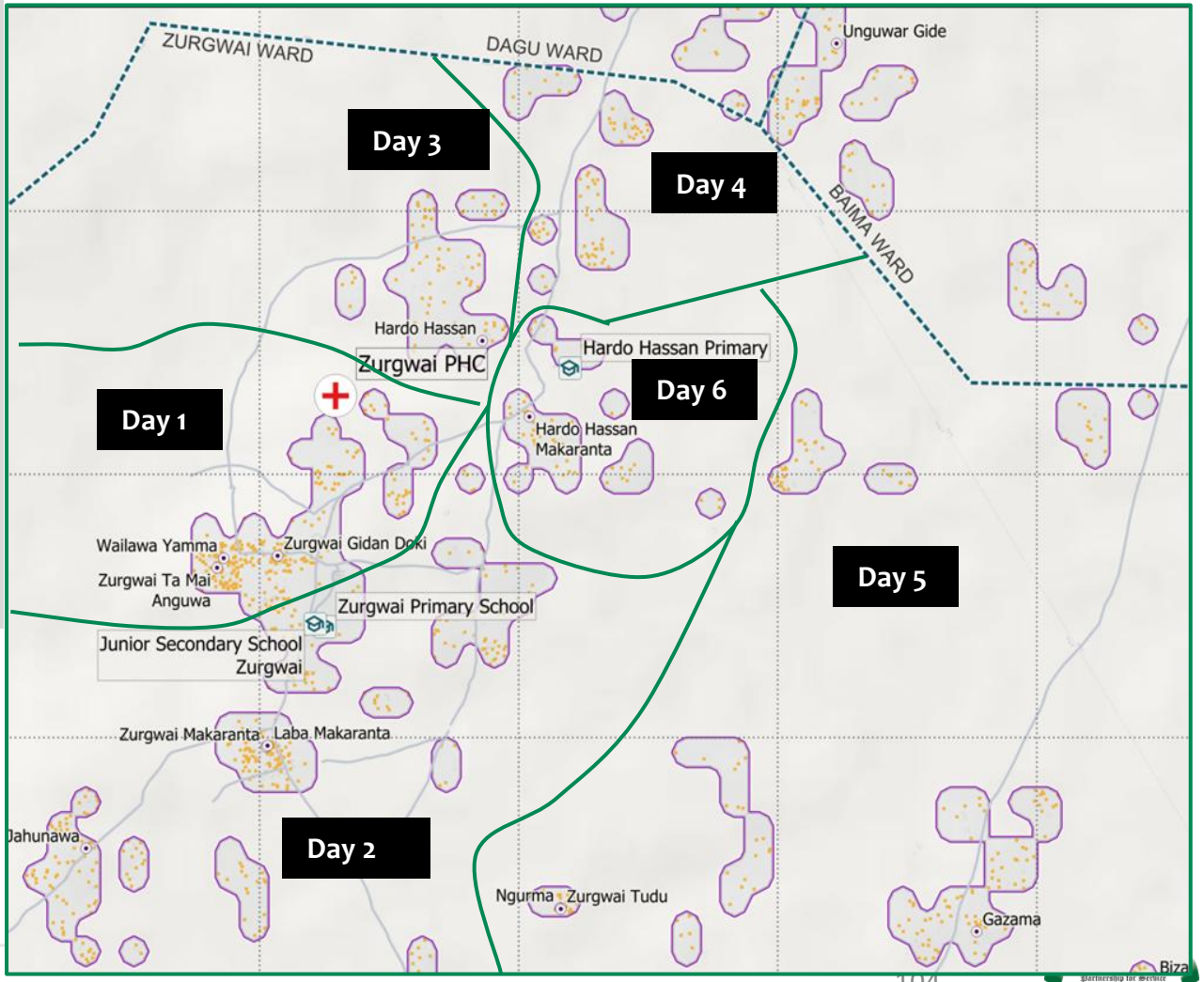
- **Step 5: Draw a buffer around temporary vaccination post**. Use 1 km grid on the map to identify how many vaccination points are needed to ensure every 1 sq km is covered

- **Step 6: Identify temporary vaccination post location for each day** by referring to POIs on the map and your local knowledge. Consider the locations of settlements, population density, and logistics for efficient vaccination coverage
  - Record the vaccination point on the DIP where the team will operate during each campaign day. Keep in mind that on certain days, the vaccination team might work at multiple vaccination points

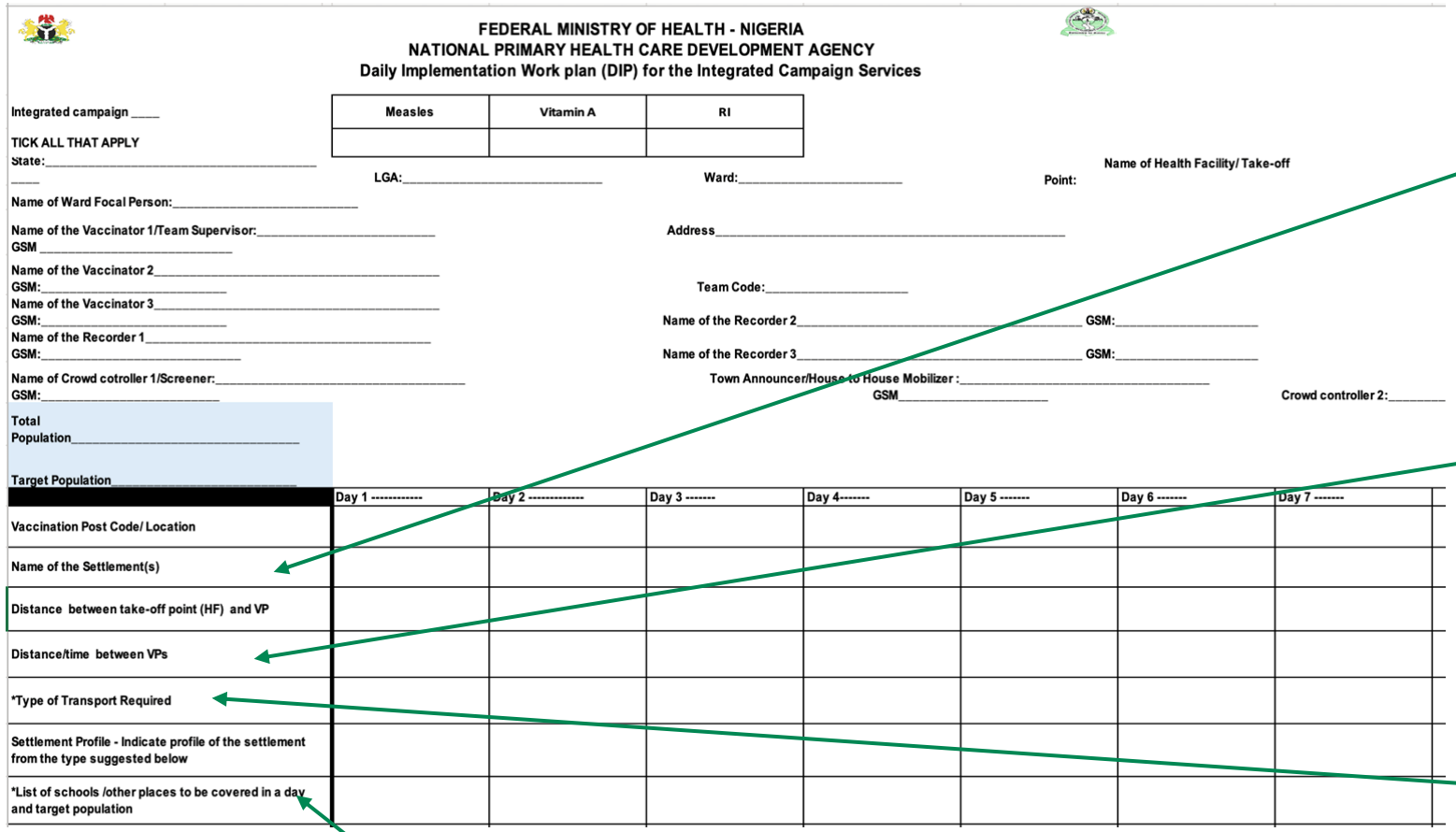


Primary school can serve as temporary vaccination post

Team 02 daily mapping plan



Using Maps to Populate the DIP template



FEDERAL MINISTRY OF HEALTH - NIGERIA
NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY
Daily Implementation Work plan (DIP) for the Integrated Campaign Services

Integrated campaign ____	Measles	Vitamin A	RI
TICK ALL THAT APPLY			

State:_____ LGA:_____ Ward:_____ Name of Health Facility/ Take-off Point:

Name of Ward Focal Person:_____

Name of the Vaccinator 1/Team Supervisor:_____ Address_____
GSM _____

Name of the Vaccinator 2_____
GSM:_____ Team Code:_____

Name of the Vaccinator 3_____
GSM:_____ Name of the Recorder 2_____ GSM:_____

Name of the Recorder 1_____
GSM:_____ Name of the Recorder 3_____ GSM:_____

Name of Crowd cotroller 1/Screener:_____ Town Announcer/House to House Mobilizer :_____
GSM:_____ GSM_____ Crowd controller 2:_____

Total Population_____

Target Population_____

	Day 1 ----------	Day 2 ----------	Day 3 -------	Day 4-------	Day 5 -------	Day 6 -------	Day 7 -------
Vaccination Post Code/ Location							
Name of the Settlement(s)							
Distance between take-off point (HF) and VP							
Distance/time between VPs							
*Type of Transport Required							
Settlement Profile - Indicate profile of the settlement from the type suggested below							
*List of schools /other places to be covered in a day and target population							

Settlements to be visited each day, can be verified based on their geographic distribution

Distances between take-off point (HF) and VP, as well as distances between VPs can be determined by using the scale bar

Type of transport can be verified by observing road network and distances visualized on the maps

Schools and POIs visualized on the maps can be used to verify if their locations are in close proximity to target populations


Thank You


Thank You

Presentation – Summary of microplanning process from data collation to verification

By:
Yazeed/Dahiru/Mashin/Dieng

Duration: 15 minutes

Level 1 Verification of Microplan

State Verification

- SIO and M&E to collate all folders from LGAs contained in the ward template
- Verify the completeness and correctness of the information provided in the template
- Verify data entered via desk review process
- Extract information such as linelist of school, cold chain gaps, number of HCWs etc.
- Using the validation template, constitute a validation process by randomly selecting (30%, 25%, or 15%) wards to be validated

Level 2 Verification of Microplan

National Verification

- Using the template
- Select the LGAs and wards to be verified based on criteria such as RA, previous performance and inconsistencies on the submitted MP
- Select Ward in the LGAs where the verification exercise will be conducted where necessary
- Verify the population and coldchain information of the MP by comparing what is physically seen and available
- Share feedback with the state to update the microplan and reshare where discrepancies have been noticed


Thank You

Next Steps

Microplanning SToT for 2025 Integrated MR SIAs

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Next Steps for SToT

S/N	Activity	Timeline/ Date	Person responsible
1	Planning meeting for LGA-level training		LIO
2	Micro plan training		LIO
3	Conduct of microplanning process		team
4	Electronic data entry of the hard copies		WFP/LIO/STF
5	Submission of the collated ward microplan to the State		LIO
	Microplan verification		SIO/LIO

Emails to send collated ward microplan

- LIOs should send collated microplans to:

---------- and

cc ----------

Next Steps for LGA level training for WFPs

S/N	Activity	Timeline/ Date	Responsible Person
1	Planning meeting for MP		WFP
2	Advocacy to Traditional leader for microplanning		WFP/STF
3	Microplanning process		Ward team
4.	Submission of hard copies of completed microplan to LGA		WFP


Thank You