INTEGRATING GENDER INTO ROUTINE IMMUNISATION DELIVERY AND FRONTLINE PRACTICE

Gender norms in India shape who seeks immunisation, who supports the decision and how services are delivered, influencing coverage, continuity and equity.

INDIA | ROUTINE IMMUNISATION | PROGRAMME IMPLEMENTATION

CONTEXT

Routine Immunisation (RI) in Uttar Pradesh is delivered largely by female frontline workers, including Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs). These workers face gendered challenges such as safety concerns during travel, expectations of availability at all times and workloads that limit time for outreach and counselling.

Mothers often carry the primary responsibility for child immunisation. However, their mobility, decision-making power and ability to take time away from household duties are constrained. Fathers, though influential in household decisions, frequently remain disengaged from immunisation due to norms around gender roles.

Household practices, social expectations and community dynamics influence children's vaccine completion. Immunisation microplans typically do not account for gender-specific barriers. These include women's mobility restrictions, fathers' limited involvement, or the locations where families spend most of their time. These gaps contribute to missed last-mile delivery, low completion rates and persistent pockets of zero-dose or under-immunised children.

To address these barriers, the India Health Action Trust (IHAT) and the Institute for Global Public Health, University of Manitoba (IGPH-UoM) developed and piloted a gender-responsive approach to strengthen the frontline teams and improve community engagement.

STRATEGY IN ACTION

The India country card illustrates the Programme Implementation sphere of Programme Science. It applies a gender lens to adapt service delivery, strengthen provider practices and improve last-mile reach.

Capacity Strengthening of Frontline Workers

- Introduced six interactive modules based on IHAT and IGPH-UoM's Gender Analysis Framework to build reflective and participatory learning.
- Shifted sessions from basic barrier analysis to root-cause examination using a gender lens to identify restrictive norms, unequal power relations and women's limited agency.
- Supported frontline teams to develop solutions for these root causes using a gender-responsive approach.
- Used the socio-ecological model to show how gender roles, social norms, resource control and power dynamics influence immunisation practices at different levels.
- Identified which levels of the ecology required action to address these gender-related barriers.
- Integrated adult learning methods and Participatory Learning and Action (PLA) tools to support intersectional analysis and inclusive problem-solving.
- Built reflective practice into routine work to make service delivery more gender-responsive, equitable and aligned with women's lived realities.

Engaged Communities, Families and Partners

- Used PLA tools to help frontline workers identify and engage key influencers and relevant stakeholders across families, communities and facilities .
- Facilitated context-specific discussions that encouraged reflection on gender norms limiting women's mobility and decision-making.
- Strengthened shared responsibility and collective ownership for child immunisation within families and communities.

Allocated Dedicated Resources

- Allocated resources for developing the training module in consultation with affected women and frontline workers.
- Provided dedicated training and mentoring through IHAT districts facilitators and state-level gender and immunisation teams.
- Developed monitoring tools to track progress of the interventions.
- Documented lessons learned and captured best practices for advocacy and scale-up.

WHAT CHANGED

Clearer understanding of gender norms: Frontline teams recognised how entrenched gender norms limit women's mobility, decision-making and access to immunisation services.

Stronger focus on women's agency: Teams began centring women's experiences in their engagement, supporting confidence-building and negotiation within households.

Shift in communication practices: Frontline workers reported prioritising direct communication with mothers and affected women instead of relying only on household gatekeepers.

More enabling environments for women: Teams made conscious efforts to create spaces that support women's voices in immunisation decisions.

Recognition of intersecting inequalities: Teams identified how caste, age, education and physical ability compound gender barriers, prompting nuanced approaches to reach marginalised women and families.

INDIA

TIPS FOR APPLICATION

- Use existing frontline team meetings to introduce the modules.
- Allow sufficient time for reflection sessions so facilitators and participants can absorb content and apply learning.
- Offer hands-on mentoring in the first two to three sessions to help facilitators gain confidence and stay aligned with the design.
- Increase touchpoints during rollout with refresher meetings, online discussions and in-person check-ins to sustain engagement and address challenges in real time.
- Offer post-training support to frontline workers to ensure they feel confident applying the learning.
- Ensure data collection for monitoring remains focused, manageable and consistent with core objectives.

TOOLS USED

- Interactive Training Modules
- Pre- and Post-Test Questions to Assess Changes
- Post-Session Feedback Form
- Mentoring and Observation Checklist
- Monitoring Tools

In Programme Science, Programme Implementation focuses on adapting services, strengthening provider practices and improving last-mile reach. The India case shows how applying a gender lens at this stage helps frontline teams recognise gendered barriers, adjust their practices and deliver immunisation services that reflect the lived realities of women and families.