



University  
of Manitoba

# Targeted Interventions on Routine Immunization with a Gender Integrated Approach



## Design Overview: Targeted Intervention on Routine Immunisation with a Gender Integrated Approach

### 1. Introduction

Despite gains in overall immunisation coverage, NFHS-5 data show that children who miss vaccinations in Uttar Pradesh are systematically concentrated within specific socio-economic and household contexts. Zero-dose prevalence is higher in urban areas (11.6%) than rural areas (8.1%) in NFHS-5 (UP). However, disaggregation shows that urban poor children have much higher zero-dose prevalence (15.7%) compared to urban non-poor (9.6%), suggesting that proximity to services alone does not ensure access and that socio-economic barriers and intersecting inequalities within urban populations play a significant role. Strong gradients are evident by mother's education, with zero-dose prevalence highest among children of mothers with no education (12.4%) and declining steadily with increasing educational attainment. Household structure and caregiving dynamics further shape exclusion: children in nuclear families (11.1%) face higher zero-dose prevalence than those in non-nuclear households, reflecting greater caregiving burdens and limited support for women. Birth order also matters, with higher-order births (third and above) showing elevated zero-dose prevalence, suggesting cumulative constraints on time, resources, and attention. These risks are compounded by economic disadvantage, as zero-dose prevalence is highest among children from the poorest households (12.9%) and declines across wealth quintiles. Together, these intersecting patterns demonstrate that children who miss vaccinations are not randomly distributed, but are shaped by structural conditions linked to poverty, education, family composition, and caregiving responsibilities. Achieving universal RI coverage and addressing zero-dose therefore requires approaches that account for socio-economic realities and respond to gender inequities influencing immunisation access.

Reaching the last mile therefore requires moving beyond uniform, supply-driven strategies towards tailored approaches that respond to the specific barriers experienced by excluded communities. Recognising immunisation inequities as structurally produced—rather than solely demand- or awareness-related—enables programmes to design context-specific solutions that factor in, gender inequalities. Such approaches prioritise identifying who is left behind, understanding the power relations and constraints shaping access, and adapting service delivery accordingly, thereby advancing more equitable and sustainable immunisation coverage (WHO, 2019).

Understanding the structural drivers of last-mile exclusion necessitates closer attention to gender norms and power relations that influence immunisation access at multiple levels. Harmful gender norms and unequal power relations restrict women's mobility, decision-making authority, and access to resources, directly influencing children's vaccination outcomes. Evidence shows that these gender-related barriers persist across multiple ecological levels—individual, household, community, service delivery platforms, and health systems—and are embedded within broader structures of social inequality (GAVI, 2022; Jones et al., 2022; Thorpe et al., 2016; UNICEF, 2019). Gender intersects with caste, class, religion, and disability, compounding exclusion and reinforcing patterns of disadvantage. Addressing immunisation gaps therefore requires explicitly recognising and responding to gendered power dynamics across the ecology to achieve equitable outcomes (IHAT, 2024).

Globally, immunisation programmes have demonstrated that gender-responsive strategies can effectively address both demand- and supply-side barriers. Approaches such as male engagement, gender-responsive communication, and participatory community models have contributed to shifts in household norms, shared decision-making, and improved immunisation uptake (UNICEF, 2022). On the supply side, unexamined gender biases among health workers can deter service use, particularly among marginalised families, underscoring the need for provider-focused capacity strengthening. Evidence highlights that participatory, adult-learning approaches—supported by practical tools and continuous mentoring—enhance providers’ ability to identify left-out families, understand intersecting barriers, and adapt service delivery, resulting in more equitable and effective routine immunisation outcomes (Jeff et al., 2024; UNICEF, 2024; Ward et al., 2019).

These findings illustrate how gendered barriers to immunisation operate across multiple levels of the socio-ecological framework, shaping influence families’ ability to seek immunisation services for their children, while shaping women’s roles and constraints as primary caregivers. Rather than stemming from individual choice alone, immunisation gaps emerge from intersecting constraints related to caregiving burdens, household power relations, community norms, and health system practices. Together, these layered barriers reinforce exclusion and disproportionately affect women as primary caregivers, particularly those from marginalised contexts. Understanding these dynamics is essential for designing tailored, gender-responsive strategies, cognizant of socio economic and cultural factors that address last-mile inequities in routine immunisation.

- **Individual level:** Women’s heavy caregiving and work burdens, combined with limited decision-making power, fears of vaccine side effects, and restricted access to reliable information, contribute to immunisation hesitancy despite their role as primary caregivers.
- **Family level:** Gendered household norms restrict women’s mobility and authority over child health decisions, with husbands and elders often controlling finances, time, and approval for immunisation, resulting in inconsistent vaccine uptake.
- **Community level:** Community gender norms prioritise women’s unpaid labour over health-seeking, limit their public participation, and normalise unsafe travel and infrastructural barriers, making immunisation access an invisible but routine burden for women.
- **Service delivery level:** Limited counselling and support to manage post-immunisation effects, alongside long waits and overcrowding can heighten caregivers’ anxiety, reduce trust in public facilities, and increase reliance on private providers, affecting completion of immunisation schedules.

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## **2. Problem Statement**

Building on the gendered, multi-level barriers outlined above, the immunisation challenge in Uttar Pradesh reflects a gap not in service availability, but in the system's ability to respond to structural inequities shaping uptake. While the state has made steady progress, routine immunisation is delivered through a robust frontline architecture comprising Ayushman Aarogya Mandir (AAM/SC) teams comprising of Community Health Officers (CHOs), Accredited Social Health Activists (ASHAs), ASHA Sanginis, Auxiliary Nurse Midwives (ANMs), and Aganwadi Workers (AWWs) and platforms such as the Village Health Sanitation and Nutrition Day (VHSND) (Varma et al., 2023). Understanding children who miss vaccinations requires moving beyond labels to examine the correlated socio-economic, educational, and household factors that shape immunisation uptake. Social and gender-related factors continue to shape last-mile access, indicating the need to strengthen how contextual barriers are identified and addressed at the frontline.

Two key capacity gaps remain:

- **Identifying barriers:** Scope exists to strengthen AAM/SC teams' ability to identify families who are not fully reached and understand the structural and gender-related factors affecting service utilisation.
- **Responding to barriers:** Additional support can enable teams to design and implement context-specific, gender-responsive solutions beyond routine service delivery.

Focused, participatory capacity strengthening can complement existing efforts and support more equitable immunisation uptake.

## **3. Intervention**

The gender-integrated targeted interventions will be implemented in geographies as a part of the Zero Dose Learning Agenda (ZDLA). UPTSU block staff will lead the intervention, adopting a structured approach to identify and address structural barriers and root causes of inequity influencing immunisation uptake. UPTSU staff will continue active participation in AAA+C meetings and facilitate seven structured capacity strengthening sessions grounded in IHAT's Gender Analysis Framework (IHAT, 2024). The intervention will use participatory, reflective, adult-learning methodologies, supported by ongoing mentoring and field-based support to enable continuous learning and sustainability. The state gender team, with support from the UPTSU RI Team, will lead documentation, knowledge sharing, and advocacy to inform scale-up.

### ***3.1 Geography Selection***

The intervention will be implemented in four blocks - Manda (Prayagraj), Baberu (Banda), Ambiapur (Budaun), and Rampur Maniharan (Saharanpur). These geographies were selected to reflect the geographic and socio-economic diversity of Uttar Pradesh, informed by CiVHSND observation data, and NFHS-5 (2019–20).

AAM/SC teams are the primary service providers at the community level and receive routine technical training; however, existing capacity-building does not adequately equip them to identify and address structural and gendered barriers affecting immunisation uptake, particularly among zero-dose and underserved populations. The intervention focuses on

strengthening the teams' ability to analyse root causes of inequity and co-create context-responsive solutions with women, families, and community stakeholders.

### 3.2 Strengthening Capacity of AAM/SC teams to Address Structural Barriers

AAM/SC teams are the primary service providers and receive routine training; however, some households remain unreached due to underlying barriers. Current trainings offer limited support to identify and analyse these barriers through a gender and equity lens, constraining effective response. Strengthening teams' capacity to address structural root causes is essential to improve service uptake among underserved populations. In order to achieve this, following activities will be undertaken:

- Developing Training Curriculum and Methodology:** Seven interactive sessions will be designed using adult-learning and Participatory Learning and Action (PLA) principles (fig.1). Drawing on IHAT's Gender Analysis Framework and organised around a cyclical session flow (fig.1) that moves from root cause analysis to solution design and reflection, sessions will examine how gender roles, access to resources, social norms, decision-making, and power dynamics across individual, household, community, and health system levels shape immunisation uptake. Each session will align with a level of the socio-ecological model and will be anchored in participatory learning and action (PLA) principles to analyse intersecting inequities and solutioning with a gender responsive lens.

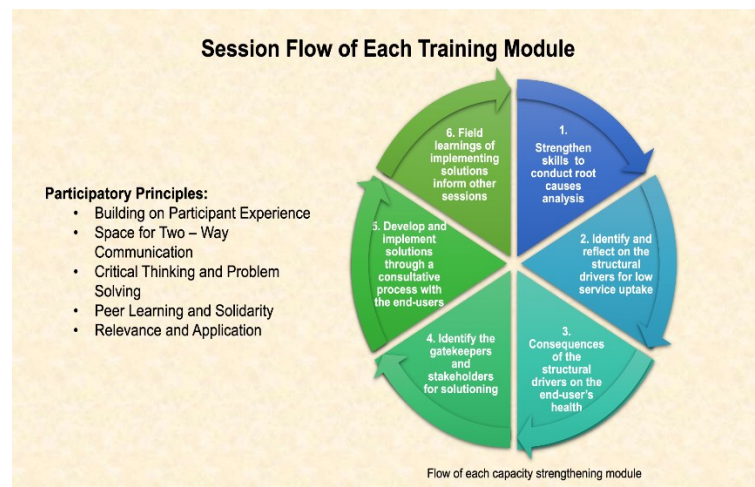


Fig.01: Principles and Session Flow

- Sessions Sequencing and Delivery:** The first session will orient participants to the intervention purpose and six-month plan, followed by six interconnected sessions that build progressively on insights and conclude with implications for access and uptake (refer Fig 2). Sessions will be conducted monthly during AAA+C meetings to allow reflection and application. Audio-visual tools and examples of positive deviant families will be used to support practical learning. Sessions will be pilot-tested, with feedback incorporated to enhance relevance and quality.

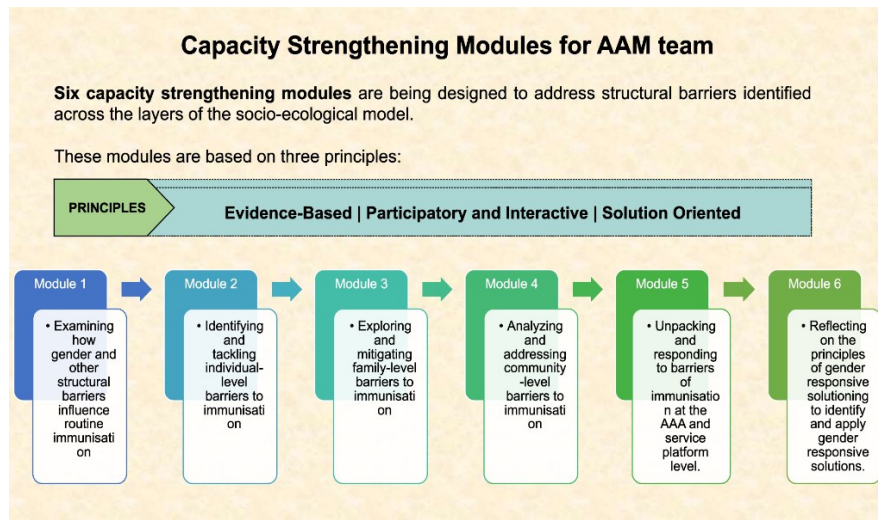


Fig.02: Module outline

- *Capacity Strengthening of UPTSU facilitators:* Facilitators will be trained on gender inequality, structural barriers to health, PLA facilitation, community engagement, documentation, and advocacy. They will lead session facilitation, mentor AAM/SC teams, and support knowledge sharing for sustainability.
- *Strengthening AMM/SC teams Capacity to Identify Structural Drivers and Drive Gender Responsive Solutioning:* AAM/SC teams will be strengthened to identify left-out families, analyse underlying structural barriers with focus on gender, engage key gatekeepers, and co-create gender-responsive, ‘Do No Harm’ solutions with women caregivers. Teams will also be supported to identify and leverage positive deviants and other stakeholders in the community to support implementation and norm change.

### 3.3 Ongoing Mentorship and Support to the AAM/SC Teams

Following the initial capacity-building sessions, UPTSU facilitators with support from the state teams will provide continued mentoring and handholding to support to AAM/SC teams for integration of skills into routine mobilisation and service delivery. This will include field-

- Reinforce learning through continuous discussions
- Use field-based case discussions to reflect and develop solutions
- Provide post-session support at other available platforms in the community
- Encourage Cross-Application of Skills
- Promote reflection and peer learning

### 3.4 Capture Implementation Processes, learnings, and Disseminate Best Practices

Systematic documentation and knowledge sharing are essential to capture implementation processes, generate learning, and inform future scale-up of the intervention. A structured approach will enable timely reflection, course correction, and dissemination of effective practices. This will support institutional learning and integration of the approach within existing health system platforms. Following are some key steps to the process:

- Regular documentation through monthly reports and case studies capturing the progress, challenges, successes, and innovations.
- Compilation of a comprehensive knowledge package that includes the refined training sessions, best practices, and successful strategies as learnings from the implementation process. These will inform future adaptation and scale-up of the approach for sharing with the health system as a resource.
- Sharing insights through community platforms, government review forums, and relevant stakeholder meetings, with opportunities explored for wider dissemination across UPTSU programmes and external platforms.

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