CREATING PATHWAYS

to Full Immunization Coverage through Social and Behaviour Change

Where we stand

The Universal Immunization Programme (UIP) in India is one of the largest public health programmes worldwide. It has achieved several milestones during its journey of nearly four decades.

To provide an impetus to UIP, the Ministry of Health and Family Welfare (MoHFW), Government of India (GoI), launched its flagship programme "Mission Indradhanush"[1], in December 2014. The aim was to take the percentage of full immunization coverage (FIC) among children to at least 90 percent by 2020, and sustain this increase in immunization.

In 2018, Intensified Mission Indradhanush (IMI) was launched to bring all children under the age of two and pregnant women in the ambit of immunization, not covered earlier under the UIP. But the setback caused due to the COVID-19 pandemic led to a considerable spike in the number of zero dose children[2], taking the number up to 2.7 million by 2021.

IMI 4.0 was launched in February 2022 to address this setback, and succeeded in substantially reducing the number of zero dose children to 1.1 million[3].

UNIVERSAL IMMUNIZATION PROGRAMME: SOME KEY MILESTONES

India became free of Poliomyelitis in 2014

Between 2000 and 2017, under-five mortality from vaccine preventable diseases (VPDs) decreased by 73 percent, against 61 percent for all causes

Maternal and neonatal tetanus was eliminated in 2016

The number of under-immunized and zero-dose children came down by 80 percent between 2000 and 2019

As of 2019-20, 92.8 percent of Indian children received full immunization coverage (FIC), a key success metric for UIP, which stood at just 42 percent at the turn of the century

---

[1] *Under the programme, Government of India identified 216 high focus districts across the country. The states of Uttar Pradesh (55 high focus districts) and Bihar (19 high focus districts) account for 38% and 10%, respectively, of the total missed children.*

[2] *Children who have not received any basic vaccine. For operational and reporting purposes, "zero-dose children" are defined as children who have not received a first dose of Pentavalent vaccine, till one year of age.*

[3] *WHO/UNICEF Estimates of National Immunization Coverage (WUENIC), July 2023 release; figures calculated using number of surviving infants from UN World Population Prospects (UN WPP)*

Prerequisites for achieving full immunization coverage

Past experience suggests that a combination of factors related to perception/awareness among communities about vaccinations and lack of information on service availability plague sustained uptake of routine immunization (RI) services.

This suggests a linkage between accurate information and awareness, and achieving FIC, denoting that building awareness about the benefits of vaccines, and enhancing trust and confidence among the communities, would eventually lead to a demand for vaccinations.

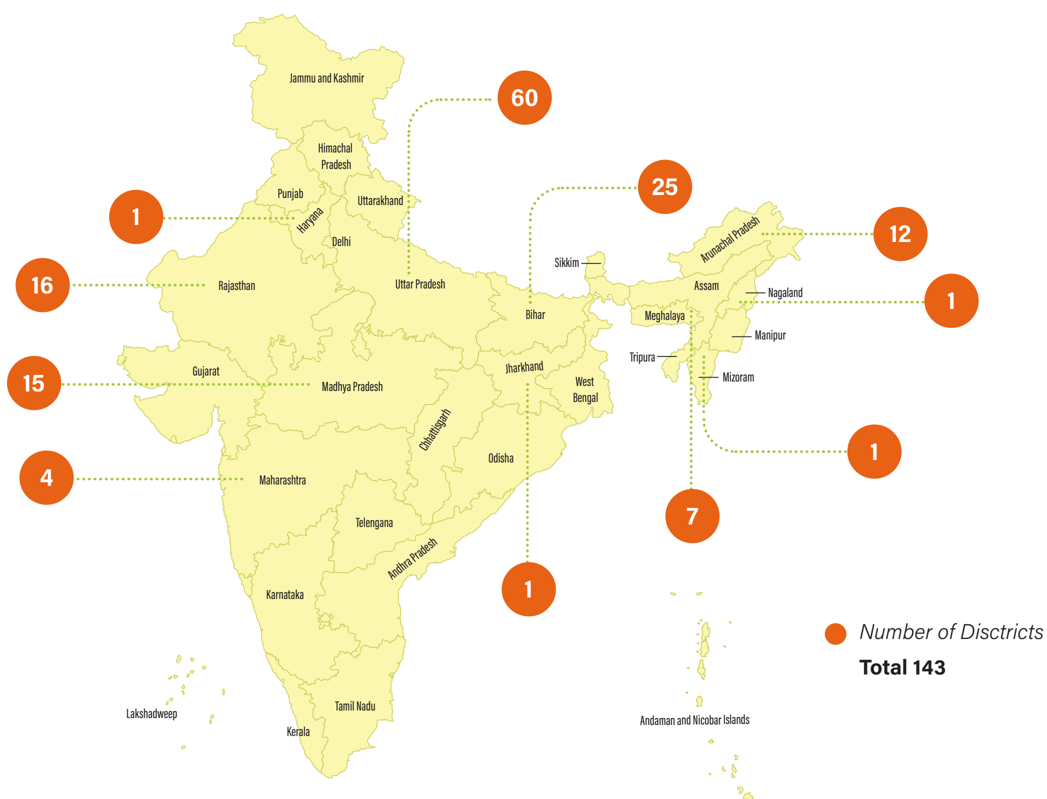
Building capacities to ensure full immunization coverage

India's zero dose implementation plan, supported by GAVI, the Vaccine Alliance's Health System Strengthening – Phase 3 (HSS-3), is being executed in 143 identified districts of 11 states in India (Figure).

The zero dose implementation plan recognizes the challenges associated with the inability to reach FIC. To translate the vision of FIC into a realistic and comprehensive strategy, the plan has identified the need for a focused and specifically tailored social and behaviour change communication (SBCC) strategy, which builds awareness among communities, helps generate demand for vaccinations and enhances public confidence in the benefits of vaccinations, for the general well-being of their children.

UNICEF is working with the MoHFW and several state governments to increase equitable coverage of RI through community engagement for awareness building and demand generation. To fulfil the recognized need, UNICEF has designed a comprehensive capacity development programme to bolster capacities of Civil Society Organizations (CSOs), Non-government Organizations (NGOs), state and district-level government programme managers and community-based groups.

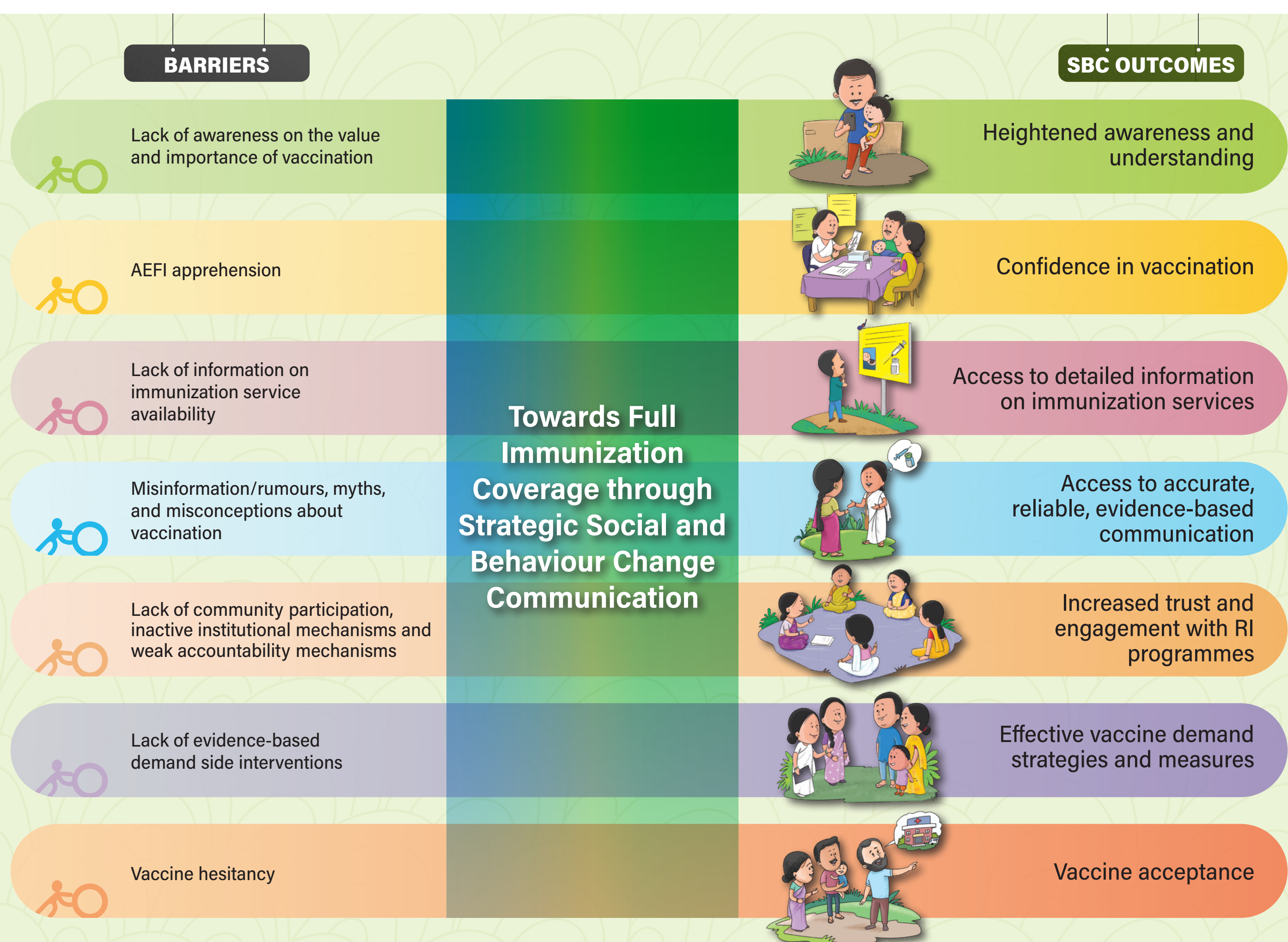
FIGURE : GAVI HSS-3 IMPLEMENTATION STATES



Capacity building approach

The capacity building programme employs human centric design principles by developing an understanding of the capacity deficits through capacity needs analysis and setting shared goals of desired shifts in knowledge, skills, attitudes and practices based on a needs analysis. Curriculum frameworks and training modules have been designed keeping in mind adult learning principles[4] and building a mechanism of handholding support to trainers.

The trainees will gain upgraded communication skills and practical inputs on how strategic SBCC could help enhance the efficacy and acceptance of RI among communities.



The capacity building plan includes two trainee groups:

- Direct trainees: State, district, and block-level staff members of CSOs including national and state-level NGOs, Mother NGOs, and some local Community-based Organizations (CBOs) engaged by UNICEF for programme implementation.
- Training by trainees:
  - Community-based groups including Self-help Groups (SHGs), Mahila Arogya Samitis (MAS), Village Health Committees, among others
  - Panchayat bodies in rural areas and urban local bodies in urban areas of Maharashtra
  - State, district and block-level programme managers and supervisory cadre of health department
  - Officials from district administration, Community Health Officers of Health and Wellness Centres, officials from ICDS, State Rural Livelihood Missions etc.

---

[4] *Adult Learning principles refer to experiential learning in a problem-solving approach. Adults learn better when they are self-motivated and find the content is relevant and practical. Demonstration is a key component of adult learning principles.*

Key elements of training design

The capacity building programme has been designed with a specific focus on time efficiency and high recall. Innovative learning approaches are employed with built-in mechanisms for handholding support of trainees and functionaries at different levels. Day-long field demonstrations and practice for both the trainee groups will help the participants employ the learned principles on ground.

Digital technology has been used to create user-friendly applications such as reminders for vaccinations and awareness building quizzes, which could be disseminated through WhatsApp.

Two training modules have been developed – Induction Training Module and Programme Implementation Training Module for direct trainees and training of trainees respectively. The training modules will be pre-tested with the actual intended audience groups by the trainers who will conduct the trainings, and finalized with incorporation of participant feedback. Regional context is a prime consideration in keeping the content relevant for all regions and states.

Initially developed in Hindi, the modules have been translated into English, Marathi, Khasi and Panar.

To ensure and facilitate wider use of the training modules through online learning, they will be converted into e-learning modules.

HIGHLIGHTS OF TRAINING DESIGN

- Focus on time efficiency and high recall
- Participatory learning
- Informed by evidence and data on community behaviours and perceptions regarding immunization
- A focus on gender and equity lens
- Specific to context of implementation states
- Day-long field demonstration and practice
- Handholding support to trainers and functionaries
- Adaptation of modules as interactive e-learning courses
- Innovative learning approaches
- Use of digital technology
- In-built quality assurance mechanisms
  - Pre and post assessments
  - Participants' feedback and ratings

TRAINING MODULES

- In five languages – Hindi, English, Marathi, Khasi and Panar
- Include:
  - A trainers' manual
  - Participants' handouts, and job-aids, reporting formats
  - A list of pre-reads, course content and additional reads
  - Demonstrations, experiential learning, field visits and digital tools
  - RI specific case studies and best practices specific to India and state context
  - A list of optional/advanced readings for self-paced learning

What will be achieved?

In keeping with the scale of the capacity building programme, the trainings will be taken up in a phased manner in the 11 implementation states, starting with Uttar Pradesh, Bihar and Madhya Pradesh – states with the highest number of districts where trainings need to be taken up.

A team of two trainers – a Lead Trainer and a Co-facilitator – will lead the trainings. A total of 35 batches will be conducted for the Induction Training Module comprising direct trainees and the Programme Implementation Training Module will be undertaken in 25 batches. The trainings across the 143 districts will be undertaken in a span of 12 months.