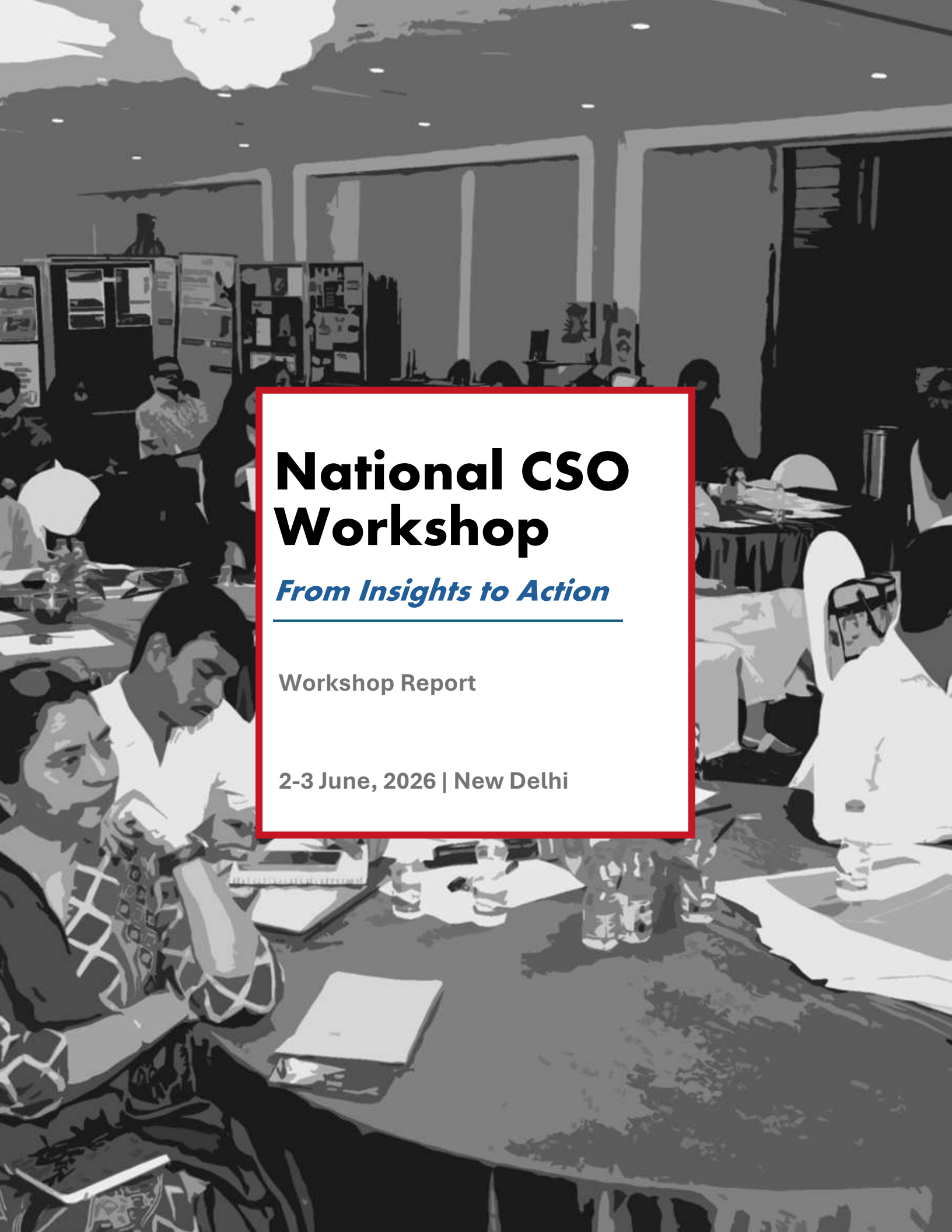




National CSO Workshop

From Insights to Action

Workshop Report

2-3 June, 2026 | New Delhi

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Executive Summary

Five patterns emerged consistently across UNICEF Led - CSOs experience in eleven states, spanning tribal, urban, migrant and geographically isolated contexts:

1. Behavioural diagnosis must precede communication design, not follow it. Organizations that mapped context-specific barriers before designing interventions consistently reported more targeted results than those using standardized materials.
2. Non-health community actors - Panchayati Raj Institutions, teachers, self-help groups, local volunteers - are an underused identification and referral channel that can extend reach without expanding the health workforce.
3. Trusted local messengers are critical in addressing vaccine doubts. Religious leaders, village elders, teachers and peer mothers consistently proved effective.
4. Household decision-making extends beyond mothers. Communication that targets mothers

exclusively risks missing fathers and grandparents as active decision-making nodes.

5. Tracking mobile and migrant children is a shared, cross-state system gap and is currently being solved independently and repeatedly by individual organizations.

Across all five patterns, gains were sustained where CSOs strengthened existing government systems like frontline worker capacity, supportive supervision, microplanning. This indicates that coverage numbers alone do not capture the success of CSOs; institutionalisation should be assessed as a distinct criterion.

The recommendations in Section 5 are organised by what they require: immediate low-cost action within the current programme cycle, cross-state coordination, and structural or institutional commitment with a suggested owner for each.

1. Background and Context

Despite sustained progress under India's Universal Immunization Programme (UIP), ensuring that every child completes the full immunization schedule remains a significant implementation challenge. National survey estimates indicate that immunization coverage has improved substantially, although important inequities remain among vulnerable populations. Demand-side barriers-including vaccine hesitancy, migration, weak household engagement, misinformation, social exclusion and geographic inaccessibility-continue to limit equitable immunization coverage.

India has committed to strengthening equitable immunization coverage in line with the Sustainable Development Goals and WHO's Immunization Agenda 2030, which aims to reduce the number of zero-dose children by 50% by 2030 compared with the 2019 baseline (WHO Immunization Agenda 2030; Gurnani et al., 2024). Zero-dose and under-immunized children remain concentrated in a small number of states, several represented at this workshop, and are disproportionately affected by the barriers this report examines.

Civil Society Organizations (CSOs) have emerged as important partners in addressing these last-

mile challenges by working closely with communities, strengthening trust, supporting frontline workers and developing locally responsive solutions. Behavioural and human-centred design evidence suggests that demand generation is most effective when interventions are grounded in local context, community insights and iterative learning. Across different implementation settings, UNICEF led CSOs have demonstrated that improving routine immunization requires approaches rooted in community realities and supported by strong collaboration between government systems and local institutions.

Against this backdrop, the **National CSO Workshop: From Insights to Action** brought together representatives from government, development partners and CSOs from across India to consolidate field experience, share evidence-based practices and identify practical strategies for strengthening routine immunization demand. Rather than documenting individual projects, the workshop focused on distilling implementation lessons that could inform programme planning, policy development and cross-state learning.

2. Workshop at a Glance

Workshop Objectives

- Consolidate implementation experiences from UNICEF led- CSOs working across diverse socio-cultural and geographic contexts.
- Identify practical approaches for addressing behavioural and social barriers to routine immunization.
- Strengthen knowledge exchange between government, development partners and implementing organizations.
- Translate field experience into actionable recommendations for strengthening routine immunization demand at scale.

Participating Organizations

The workshop under the overall leadership of the Ministry of Health and Family Welfare (MoHFW), brought together representatives from UNICEF, WHO, UNDP, the Community of Practice-

Demand (CoP-D), and Civil Society Organizations working across Rajasthan, Uttar Pradesh, Bihar, Maharashtra, Jharkhand, Madhya Pradesh, Arunachal Pradesh, Haryana, Meghalaya, Mizoram and Nagaland. The complete list of participating organizations is provided in Appendix.

Workshop Approach

The workshop combined technical presentations, evidence sharing, field demonstrations and peer learning to examine routine immunization from both behavioural and implementation perspectives. Discussions

moved beyond identifying barriers to exploring scalable solutions that have demonstrated success across different contexts, with emphasis on translating implementation experience into practical recommendations that can strengthen programme design and support state-level action. A dedicated Marketplace session gave CSO partners a hands-on platform to demonstrate field-tested tools and innovations directly to government and development partner representatives, complementing the plenary discussions with practical, on-the-ground exchange.

3. Key Insights from Technical Sessions

This section summarises the four technical sessions held during the workshop, along with the presenters and key insights from each.

3.1 From Insights to Action: The CoP-D Demand Generation Approach

This session focused on how the CoP-D playbooks were developed through a participatory design process combining human-centred design, behavioural research and cross-state consultations. Each playbook is organised around three elements for a given context: a) the barriers identified; b) the behavioural or solution design direction; c) corresponding communication strategies and tools. Discussion centred on how this barrier-direction-solution architecture could be adapted to different state and district contexts, with participants contributing feedback to further strengthen the playbooks. The playbooks are designed to be adapted rather than adopted, they provide states with a structured framework that can be tailored to local realities while drawing on shared learning from across the CoP-D network.

Key Insights

- Built through a participatory design process, the playbooks combine human-centred design, behavioural research and cross-state consultations to ground recommendations in frontline implementation experience.
- Each playbook links context-specific barriers to tailored behavioural directions and communication solutions, supporting adaptation rather than a one-size-fits-all approach.
- Playbooks are designed as living resources. Participant feedback will inform further iterations, while the CoP-D Microsite- <https://communityofpractice-immunizationdemand.com/> be used to share the communication assets, and strategies shared across states.

3.2 Key Evidence and Hyperlocal Insights

This session drew on evidence from field engagement, behavioural research and implementation experience across states. It highlighted that the remaining immunization gap is concentrated among children facing overlapping vulnerabilities, including migrant

families, geographically isolated populations, tribal communities and other socially marginalised groups, who often remain invisible within routine systems. A recurring theme was hyperlocal variation: barriers differ not only across states, but also across districts and communities. As a result, approaches that work in one context may not transfer to another.

Key Insights

- Many under-immunized children are missed through mobility, exclusion and weak system linkages rather than active refusal.
- Trust in last-mile health workers, local influencers and health services remains central to vaccine confidence and completion.
- Hyperlocal behavioural diagnosis enables communication and engagement strategies to reflect local realities.

Behavioural evidence is most valuable when it informs programme design, not just programme reporting.

3.3 Understanding Gender and Household Decision-Making

This session explored how gender norms and household decision-making shape immunization. While mothers are expected to ensure children are vaccinated, they do not always make the final decision. Fathers, grandparents and other family members often influence whether a child is vaccinated, making immunization a household behaviour rather than an individual one. Participants discussed how gender roles affect access to information, mobility and healthcare, and the challenges faced by last-mile health workers, who are expected to influence household decisions while communication efforts continue to focus primarily on mothers. The session highlighted the value of family-centred approaches that engage all key decision-makers.

Current Approaches

- **Papa Ki Pehal** - engaging fathers as active partners in child health and immunization.
- **Tika Tayyar Parivar** - promoting household preparedness and shared responsibility for vaccination.
- **Household Engagement Tools for Last-Mile Health Workers** - supporting ASHAs and other community health workers to engage multiple household decision-makers.

Key Insights

- Mothers often carry responsibility for vaccination without having the final say.
- Fathers and grandparents remain influential but are often overlooked in immunization communication.
- Last-mile health workers need practical tools to navigate household dynamics and behavioural barriers.
- Family-centred engagement can strengthen confidence, preparedness and continuity of care.

3.4 Sustainability and Systems Strengthening

This session explored how successful demand generation approaches can be sustained beyond project timelines and integrated into routine immunization systems. Drawing on implementation experience across states, participants noted that community engagement approaches are more likely to endure when they are embedded within routine planning, supervision and review processes rather than implemented as standalone activities. The discussion also highlighted the importance of linking community engagement with last-mile health worker capacity, district leadership and local ownership to support continuity, learning and scale.

Key Areas of Focus

- Strengthening the capacity and support systems of last-mile health workers.
- Embedding demand generation within routine immunization planning and review
- Fostering community ownership and participation.
- Strengthening district- and block-level leadership.
- Documenting and institutionalising effective practices.
- Promoting continuous learning and adaptation.
- Building programme sustainability through stronger health systems.



4. Learning from the Field: What CSO Experience Tells Us About Strengthening Routine Immunization

Technical sessions and presentations by UNICEF Led - CSOs converged on the same underlying finding: demand generation cannot rely on awareness campaigns or standardized materials alone. Vaccination decisions are shaped by a combination of behavioural, social and practical factors including vaccine confidence, social norms, family influence and access, that interact differently across communities. From the workshop it also emerged that behavioural

evidence is most useful when it informs planning, service delivery and monitoring, not only communication content.

Seventeen CSO partners shared implementation experience spanning tribal, urban, peri-urban, migrant and geographically isolated contexts. The table below summarises the problem each organization addressed and the learning it generated.

Organization	Key Problem Identified	Key Learning
Manjari Sansthan (Rajasthan)	Seasonal migration, dispersed settlements and families residing in RIICO industrial areas frequently remain outside routine beneficiary identification and follow-up systems. Weak convergence between community institutions and frontline workers further limits continuity of immunization services among vulnerable populations.	- Strengthen community ownership by integrating Gram Panchayats, PRI members, Self-Help Groups (SHGs), Village Health Sanitation and Nutrition Committees (VHSNCs), ASHAs, ANMs and Anganwadi Workers (AWWs) into routine immunization planning, beneficiary identification and follow-up. - Develop district-specific convergence and communication plans that bring together government departments, frontline workers and community institutions to sustain engagement with migrant and underserved families beyond routine immunization sessions.
IPE Centre for Knowledge & Development (UP)	Community beliefs and fear of side effects often carry more weight than official messaging, especially when grievances go unresolved. Migrant children are frequently missed because records are fragmented and registrations are incomplete, while overstretched frontline workers struggle to track the most vulnerable families.	Household-level data helps prioritise high-risk families, while ASHAs are supported to improve VHIR and U-WIN reporting. Zero-dose children are tracked through structured follow-up, community engagement is tailored to local contexts, and issues like vacancies, U-WIN gaps, and access barriers are escalated through block and district reviews. VHSNCs and mothers' meetings are strengthened to sustain community ownership.
RCDSSS (Rajasthan)	Migration, dispersed populations and limited community ownership continue to reduce routine immunization coverage among brick kiln workers, RIICO industrial labour colonies and other underserved communities where routine outreach remains inconsistent.	- Strengthen local accountability by engaging Gram Panchayats, PRI members, VHSNCs, schoolteachers, ASHAs, ANMs, religious leaders and community volunteers in household tracking and immunization mobilization. - Adapt communication and service delivery through locally relevant platforms such as <i>Mamta Express</i>, <i>Amavasya meetings</i> and RIICO outreach to improve access among migrant and vulnerable populations.

Organization	Key Problem Identified	Key Learning
MP Voluntary Health Association	Low male engagement, persistent misconceptions and limited community ownership continue to reduce vaccine confidence among tribal communities, where routine communication often fails to engage influential household and community decision-makers.	- Build trusted community ecosystems by engaging tribal leaders, traditional healers, Gram Panchayats, PRI members, fathers, ASHAs, ANMs and community volunteers in routine immunization planning, counselling and follow-up. - Strengthen community-led planning through Participatory Rural Appraisal (PRA), Choupals and communication micro plans that promote shared ownership and improve beneficiary tracking.
Arpan Seva Sansthan (Rajasthan)	Denotified Tribes (DNTs), nomadic communities and migrant families frequently remain excluded from routine immunization due to high mobility, lack of documentation and limited engagement with formal health services.	- Strengthen inclusion by engaging Bhopas, Gram Panchayat representatives, PRI members, ASHAs, ANMs, community volunteers and local leaders to identify and mobilize nomadic and migrant families. - Adapt service delivery through Chalta Firta Teeka Samvad, migration tracking and flexible vaccination approaches that ensure children are vaccinated regardless of documentation status
Doctors For You (Maharashtra)	In the urban context, misinformation spreads faster than counter-messaging. Social exclusion is structural, densely packed slums and settlements are hard to reach and harder to sustain outreach in. Vaccination decisions rest with unavailable male family members, leaving willing mothers with no agency to act. Frequent supervisory transfers disrupt momentum.	Misinformation was countered on the same channels it spreads; through WhatsApp and local trusted voices including doctors and community leaders. ZDC camps were directly taken into high-resistant pockets, instead of expecting families to travel to sessions. Male engagement was structured through Father Meetings, Juma Meetings, and tele-counselling. At the system level, community influencers were embedded into CTFI and ward-level planning meetings, and migrant families tracked through construction supervisors.
JSI R&T Foundation India (UP)	Vaccine myths, fear of side effects, and distrust of health workers keep many families away from immunization. For daily-wage earners and migrant households, even when the willingness exists, time, distance, and mobility leave many zero-dose children outside the system.	Reaching zero-dose children begins with identifying them through household surveys and social mapping, followed by regular home visits to build trust. Local leaders should be active partners in mobilization, while migrant families need to stay connected to immunization services through tools like WhatsApp tracking and U-WIN. Sustained progress depends on strong coordination, regular reviews, and a well-supported frontline workforce.
Public Health Foundation of India (UP)	Vaccination decisions are often controlled by elderly family members, leaving mothers with no autonomy, while poor recall of missed doses and immunization schedules leads to further drop-offs. Seasonal migration interrupts children's vaccination cycles. Limited counselling skills and weak zero-dose identification make it harder for frontline workers to reach those most at risk.	Social maps were used as live planning tools, updated regularly to track zero-dose, migrant, and missed children. Community engagement was built into existing platforms through influencers, SHGs, and Pradhans, with frontline workers trained on counselling and zero-dose identification rather than awareness alone. The defining feature was a planned transition from CSO-led mobilisation to government ownership, with block review structures and community platforms expected to sustain demand beyond the project.
SCHOOL (Jharkhand)	Tribal communities remain underserved as geographic isolation, gender inequities and cultural distance continue to limit meaningful	Build trusted community ecosystems by embedding local influencers, faith leaders, Teeka Mitras, youth groups and village institutions into

Organization	Key Problem Identified	Key Learning
	engagement and access. The PVTGs remain specially disadvantaged due to spatial and relational distance from the mainstream.	routine immunization planning, mobilization and follow-up. Strengthen last-mile delivery through hyperlocal planning, intensive use of the One Week-One CHC approach to intensify planning, supervision and community engagement at the local level. By concentrating resources and follow-up within a defined geography, the approach improves accountability while reaching zero-dose, left-out and migrant children more effectively.
CACR (Maharashtra)	Urban minority communities often experience persistent vaccine hesitancy driven by misinformation, limited trust in formal health systems and inadequate engagement of influential community leaders.	- Build trust by engaging Unani doctors, Imams, Hajis, loom owners, religious leaders, ASHAs, ANMs and community volunteers as credible messengers for routine immunization. - Use existing community platforms and interpersonal dialogue to address misconceptions while strengthening household confidence in vaccination.
Shiv Shiksha Samiti (Rajasthan)	Children from mining communities, brick kiln settlements and socially marginalized populations frequently remain underserved due to population mobility, difficult access and weak community engagement within routine immunization planning.	- Strengthen community participation by engaging Teeka Mitras, PRI members, school teachers, mine owners, brick kiln representatives, ASHAs, ANMs and community volunteers in beneficiary identification and mobilization. - Use locally developed communication approaches and village-level dialogue platforms to improve household engagement and sustain routine immunization demand.
JSI Foundation (Nuh, Haryana)	Routine immunization decisions are strongly influenced by fathers, religious leaders and senior family members, yet communication efforts frequently focus only on mothers, limiting their effectiveness in addressing vaccine hesitancy.	- Promote household-centred communication by engaging fathers, Imams, Maulvis, Gram Pradhans, PRI members, ASHAs, ANMs and community champions in counselling and routine immunization planning. - Strengthen beneficiary identification through high-quality headcount surveys, social mapping and regular engagement with influential community institutions.
Tattva Foundation (Meghalaya, Mizoram and Nagaland)	Remote tribal communities continue to experience low routine immunization uptake due to difficult terrain, deep-rooted cultural beliefs, fear of adverse events following immunization (AEFI) and limited trust in formal health systems. Conventional communication approaches often fail to resonate within indigenous community structures.	- Apply Human-Centred Design (HCD) to understand community-specific behavioural barriers and co-create locally relevant solutions with caregivers, frontline workers and tribal institutions. - Build trusted community ecosystems by engaging Buddy Mothers, Gaon Buras, Nokmas, Church leaders, Village Health Councils (VHCs), ASHAs, ANMs and mothers' groups to strengthen confidence, improve household engagement and sustain immunization demand
PCI (Uttar Pradesh)	Vaccine hesitancy, weak community ownership and limited engagement of influential local actors reduced the effectiveness of routine immunization efforts, particularly among zero-dose, migrant and resistant populations.	Institutionalize Community Engagement Teams (CETs) by integrating barbers, Kotedars, shopkeepers, Gram Pradhans, Ward Members, PRI representatives, religious leaders, traditional healers, ASHAs, ANMs and Anganwadi Workers into routine immunization micro plans.

Organization	Key Problem Identified	Key Learning
		Strengthen community ownership through structured orientation, due-list verification, household counselling and session-level support that complements the work of frontline health workers.
PCI & Wadhvani AI (Bihar)	Routine communication strategies often failed to address the diverse behavioural, social and service delivery barriers influencing zero-dose and under-immunized children, resulting in generalized interventions with limited local relevance.	- Use Differential Diagnosis and social mapping to identify the underlying causes of missed vaccinations before designing communication and service delivery interventions. - Strengthen local planning through household segmentation, frontline worker engagement, community mapping and data-driven prioritization to ensure that interventions respond to specific barriers rather than assumptions.
VHAI (Arunachal Pradesh)	Left-out, drop-out and resistant children are difficult to identify across remote terrain. Even where immunization sessions are available, uptake remains low due to limited awareness, deep trust in traditional remedies, and cultural hesitancy further compounded by rumours.	LODOR moves beyond treating missed children as a single backlog by classifying them as Left-Out, Drop-Out or Resistant, enabling responses tailored to the underlying barrier. Children are jointly identified and verified through community mapping and household visits before being added to due lists. Mobilization is then led by trusted local actors like CBOs, influencers and Buddy Mothers who support families before and after immunization.
ADRA India (Uttar Pradesh)	Persistent misinformation, low male participation and limited opportunities for community dialogue continued to reinforce vaccine hesitancy among resistant communities, particularly where routine communication failed to reach key household decision-makers.	- Create trusted platforms for dialogue through Night Choupals, fathers' meetings and community discussions involving teachers, religious leaders, Gram Pradhans, PRI members, ASHAs, ANMs and village elders to address misconceptions and build confidence in routine immunization. - Strengthen community ownership by integrating local influencers into household counselling, routine microplanning and follow-up of zero-dose and vaccine-avoidant families.

What's Moving the Needle:

Across these seventeen experiences, five actionable patterns recur consistently.

1. Diagnosis before intervention

Organizations that invested in identifying context-specific barriers before designing communication saw more targeted results than those applying standardized approaches.

PCI & Wadhvani AI (Bihar) used **Differential Diagnosis**, social mapping and household segmentation to distinguish behavioural, access and service-related barriers before planning interventions. ASHAs, ANMs, community

volunteers and local leaders jointly validated household information, enabling frontline workers to tailor communication and follow-up according to the specific reason a child had missed vaccination rather than treating all zero-dose children alike.

Tattva Foundation (Meghalaya, Mizoram & Nagaland) applied **Human-Centred Design** to understand why families delayed or avoided vaccination before designing interventions. Through repeated engagement with **Buddy Mothers, Gaon Buras, Nokmas, Church leaders, Village Health Councils, ASHAs and ANMs**, the programme co-created culturally appropriate communication that reflected tribal

traditions, local beliefs and community decision-making processes, making routine immunization more acceptable and trusted.

In **Arunachal Pradesh**, **VHAI** implemented the **LODOR (Left-Out, Drop-Out and Resistant) framework** to identify children at different stages of immunization risk - distinguishing those never reached from those who lapsed, and those whose families actively hesitate on cultural grounds. This allowed frontline workers to prioritize follow-up by cause, track households across some of the region's most inaccessible terrain (six of twelve districts sit on international borders, some reachable only by a two-day walk), and counsel families based on the actual reason a child had missed vaccination.

Public Health Foundation of India (PHFI) emphasized using **programme data, behavioural evidence and implementation research** to understand local barriers before designing interventions. Strengthening evidence-informed planning enables district teams and frontline workers to develop more targeted and responsive routine immunization strategies.

Policy implication

Pre-intervention diagnostic tools like social mapping, risk categorization can be resourced as a standard first step, not an optional add-on, in state-level RI planning.

2. Non-health community actors are an underused delivery channel

Manjari Sansthan (Rajasthan) strengthened routine immunization by engaging **Gram Panchayat representatives, PRI members, SHGs, VHSNC members, ASHAs, ANMs, AWWs, religious leaders and local volunteers** to identify vulnerable children and support follow-up in RIICO industrial areas and migrant settlements. Their involvement strengthened community ownership while improving household tracking and routine immunization continuity.

RCDSSS (Rajasthan) mobilized **Gram Pradhans, PRI members, VHSNCs, school teachers, ASHAs, ANMs, brick kiln owners, religious leaders and community volunteers** to strengthen accountability for routine immunization. Community platforms such as **Mamta Express, Amavasya meetings** and **RIICO** outreach helped identify missed children, mobilize migrant families and sustain engagement beyond routine vaccination sessions.

Arpan Seva Sansthan (Rajasthan) engaged **Bhopas, Gram Panchayat representatives, PRI members, ASHAs, ANMs, community volunteers and local leaders** through **Chalta Firta Teeka Samvad** to reach Denotified Tribes and migrant families. Community-led migration tracking and flexible outreach ensured that highly mobile children remained connected to routine immunization services despite frequent movement.

MP Voluntary Health Association (Madhya Pradesh) engaged **tribal leaders, traditional healers, Gram Panchayat members, PRI representatives, ASHAs, ANMs, fathers and community volunteers** through **Teekakaran Choupals** and participatory rural appraisal exercises. These local actors strengthened community dialogue, supported household tracking and created locally owned solutions that improved trust and participation in routine immunization.

PCI (Uttar Pradesh) formalized the role of non-health actors through **Community Engagement Teams**, bringing together **barbers, Kotedars, shopkeepers, Gram Pradhans, Ward Members, PRI representatives, religious leaders, traditional healers, ASHAs, ANMs and AWWs** within RI microplans. These community actors supported household visits, due-list verification, migrant tracking and family counselling, extending the reach of the health system while strengthening community trust.

Shiv Shiksha Samiti (Rajasthan) strengthened routine immunization by engaging **Teeka Mitras, PRI members, school teachers, mine owners,**

brick kiln representatives, ASHAs, ANMs and community volunteers to identify missed children and mobilize vulnerable families. Community-led dialogue and localized communication strengthened trust while improving beneficiary follow-up across difficult-to-reach settlements.

Policy implication

Formal recognition and light-touch training of non-health community actors could extend identification and referral capacity without expanding the health workforce.

3. Trusted local messengers outperform new messaging

Doctors For You (Maharashtra) built trust by working through respected community representatives and integrating interpersonal communication within existing community outreach activities. The approach prioritised trusted relationships over mass awareness campaigns.

Centre for Advocacy and Research (CACR) strengthened vaccine confidence by identifying influential local voices and continuously adapting communication based on community feedback. The emphasis was on dialogue and locally relevant messaging rather than standard IEC dissemination.

SCHOOL (Jharkhand) designed culturally rooted communication like *teeka ki diwar* by working with tribal leaders, teachers and community elders. Messages were delivered through locally accepted platforms like Night Chapuals and reflected tribal traditions, language and social practices. Teeka Mitras, faith leaders, Hajis, PRI members and other community influencers were integrated into RI microplans to strengthen mobilization, household tracking, advocacy and trust-building.

ADRA India (Uttar Pradesh) repositioned **Night Choupals** as trusted community dialogue platforms where **teachers, religious leaders, Gram Pradhans, PRI members, ASHAs, ANMs,**

fathers and village elders could openly discuss vaccine concerns before immunization sessions. By strengthening trusted local platforms instead of relying solely on campaign messaging, the programme improved confidence, household engagement and follow-up among vaccine-avoidant families

Tattva Foundation complemented Human-Centred Design with **Buddy Mothers** and respected community members who acted as trusted intermediaries between health workers and caregivers. Their lived experience and community acceptance helped improve confidence in routine immunization.

Policy implication

SBCC budgets may benefit from weighting investment toward messenger identification and platform access, alongside content development, rather than treating content as the primary spend.

4. Household decision-making extends beyond mothers

JSI Foundation (Nuh, Haryana) strengthened routine immunization by engaging **fathers, Imams, Maulvis, Gram Pradhans, PRI representatives, ASHAs, ANMs and community champions** through household counselling and community meetings. Recognizing fathers and religious leaders as key decision-makers helped improve family support for vaccination while strengthening follow-up among hesitant households.

MP Voluntary Health Association organised male engagement sessions and community meetings to encourage fathers and senior family members to actively participate in immunization decisions. This reduced the burden placed solely on mothers and improved household support.

VHAI (Arunachal Pradesh) encouraged family-based counselling during follow-up visits, ensuring that fathers, grandparents and other caregivers understood vaccination schedules and the importance of completing immunization.

ADRA India (Uttar Pradesh) used **Night Choupals** and household counselling to engage fathers and influential family members directly, creating opportunities for collective discussion and informed decision-making around vaccination.

Policy implication

Caregiver-facing RI communication that targets mothers exclusively may be missing a decision-making node; household-level engagement models merit wider piloting.

5. Tracking systems for mobile populations are a common gap

IPE UP strengthens household-level tracking and community-led follow-up by enabling ASHAs to prioritise high-risk families, improve VHIR and U-WIN reporting, systematically track zero-dose children, tailor engagement to local needs, and escalate service delivery gaps through block and district review mechanisms. Community ownership is reinforced through strengthened VHSNCs and mothers' meetings to sustain demand for routine immunisation.

PCI (Uttar Pradesh) integrated beneficiary tracking into Community Engagement Team activities, enabling community actors to identify migrant families, update beneficiary lists and support continuity of immunization during population movement.

PCI & Wadhwani AI (Bihar) combined Differential Diagnosis with digital social mapping to identify migration-related barriers and prioritize follow-up of children at greatest risk of becoming zero-dose or under-immunized.

VHAI (Arunachal Pradesh) used the LODOR framework alongside community-based tracking registers to monitor left-out and drop-out children living in remote and geographically

inaccessible villages, enabling more systematic follow-up by frontline workers.

Doctors For You Maharashtra counters misinformation through trusted local voices and the same digital channels where it spreads, while bringing Zero-Dose Child (ZDC) camps closer to high-resistance communities. The organisation strengthens demand through Father Meetings, Juma Meetings, and tele-counselling, embeds community influencers into CTFI and ward-level planning, and tracks migrant families through construction supervisors to ensure continuous immunisation access.

MP Voluntary Health Association supported village-level tracking through community volunteers and local institutions, helping frontline workers identify families that had migrated or missed vaccination sessions and facilitating timely follow-up.

Policy implication

This is a cross-cutting system gap rather than a state-specific one; a shared, interoperable tracking mechanism could reduce duplicated effort across implementing organizations.

Sustainability

Across all five patterns, organizations reported that gains held only where they strengthened existing government systems like last-mile public health worker capacity, supportive supervision, microplanning, institutional coordination. However, the CSOs pointed out that coverage measures outputs, not sustainability. Indicators of institutionalisation e.g. government ownership, embedded training, and continued tool use after programme exit, should be built into programme design from the outset, and used alongside coverage numbers as a basis for assessment.

5. Marketplace: Field Innovations

The Marketplace gave UNICEF led- CSO partners an interactive platform to demonstrate practical innovations developed through field implementation, and for participants to engage directly with approaches tested in diverse settings and discuss their applicability across states.



Exhibits went beyond communication materials. They included tools for end-user identification, community mobilisation, behaviour change, frontline worker support and programme monitoring.

These ranged from locally adapted communication materials and participatory engagement models to social mapping tools, household tracking systems, gender-responsive engagement approaches and mechanisms for mobilising trusted community influencers.



6. Strategic Recommendations

The recommendations below consolidate the cross-cutting policy lessons and strategic priorities raised across technical sessions, UNICEF Led - CSOs presentations and closing discussion. Each recommendation is grouped according to the type of action it requires, rather than the session in which it was raised.

Tier 1: Immediate opportunities within the current programme cycle

Institutionalising behavioural evidence as a standard planning step.

Programme planning could benefit from treating behavioural evidence, social mapping and community profiling as routine, adequately resourced inputs to communication design rather than optional add-ons.

Formal recognition of non-health community actors.

Light-touch training and formal recognition of PRIs, teachers, self-help groups and local volunteers, building on the Community Engagement Team model, could strengthen identification and referral capacity without expanding the health workforce.

Rebalancing SBCC investment towards messenger identification alongside content.

Future SBCC investments may benefit from placing greater emphasis on identifying and equipping trusted local messengers and platforms, including religious leaders, elders and peer mothers, alongside content development.

Tier 2: Cross-state coordination

Exploring a shared, interoperable tracking mechanism for mobile and left-out children.

Several UNICEF Led - CSOs partners independently developed similar approaches to tracking migrant,

undocumented and geographically isolated children. This points to a common system gap that could potentially be addressed through a shared, interoperable mechanism rather than parallel efforts across states.

Sustaining structured cross-state knowledge exchange.

Continued sharing of communication tools, implementation playbooks and field-tested assets through the CoP-D Microsite may help governments and UNICEF Led - CSOs partners adapt successful approaches across diverse contexts.

Tier 3: Structural and institutional opportunities

Strengthening household-centred communication within national SBCC guidance.

National guidance could increasingly encourage communication approaches that engage fathers, grandparents and other household decision-makers alongside mothers, recognising vaccination as a shared household decision.

Considering institutionalisation within funding and assessment frameworks.

Assessment frameworks may be strengthened by considering government ownership, integration into frontline worker training and continued use of tools after programme completion alongside programme coverage indicators.

Sustaining structured cross-state knowledge exchange, with a focus on urban immunisation and migration.

Urban immunisation remains a key challenge, with migrant children frequently becoming zero-dose. Doctors For You, CACR and PCI are testing effective approaches that should be shared through structured cross-state exchanges rather than replicated independently.

7. Way Forward

The tools and approaches developed by CoP-D will be scaled through regional-level trainings of master trainers of Civil Society Organizations (CSOs) across the Gavi program states. Trained CSO master trainers will, in turn, apply, share, and cascade CoP-D's training modules, knowledge products and communication tools within their respective intervention areas and catchments by training CSO frontline workers and health workers to extend the reach and uptake of these resources at the community level.

8. Conclusion

The workshop demonstrated the value of bringing together government representatives, development partners, technical experts and civil society organisations to collectively reflect on the challenges and opportunities associated with strengthening immunization demand.

Across sessions, participants repeatedly emphasized that the remaining immunization challenge is not solely about service delivery, but it is increasingly about ensuring that every child remains visible, supported and connected throughout the immunization journey.

The experiences shared by participating organisations highlighted the power of trust, community ownership and local adaptation in reaching vulnerable populations.

The practical solutions described in this report already exist across states and implementation contexts. The task ahead is to strengthen, adapt and scale them while preserving their relevance to local communities through the tiered actions set out in Section 5, with clear ownership at each level.



Appendix

Participating Organizations

Partners

- UNICEF
- World Health Organization (WHO)
- United Nations Development Programme (UNDP)
- Community of Practice - Demand (CoP-D)
- WPP Media
- Behavioural Insights Architecture & Strategy (BIAS)

Civil Society Organizations

- Manjari Sansthan
- IPE Centre for Knowledge & Development
- RCDSSS
- Madhya Pradesh Voluntary Health Association
- Arpan Seva Sansthan
- Doctors For You
- JSI R&T Foundation India
- Public Health Foundation of India
- SCHOOL
- Centre for Advocacy and Research (CACR)
- Shiv Shiksha Samiti
- Tattva Foundation
- PCI
- Wadhwani AI
- Voluntary Health Association of Arunachal Pradesh (VHAI)
- ADRA India