

VaxSocial Learning Seminar #4

Sustainability and Cost Effectiveness

28th September 2026



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The VaxSocial Initiative is a **\$12 million** program focused on demonstrating how social media can help build vaccine confidence funded by **Gavi the Vaccine Alliance** and **Advancing Health Online (AHO)** – a fiscally sponsored project of Global Impact.

Aims of the Seminar



Understand

What VaxSocial tells us about the value for money and sustainability of integrated digital approaches.



Learn

Why some models, roles and partnerships are positioned to continue – and others are not.



Shape

How should integrated digital tools be scaled: what can be organised nationally, and what must remain local?

Today's seminar

- | | | |
|----|--|---------|
| 01 | The VaxSocial journey so far | 5 mins |
| 02 | Cost-effectiveness: what represents value? | 15 mins |
| 03 | How has VaxSocial strengthened local health systems? | 10 mins |
| 04 | How to scale integrated digital tools? | 10 mins |
| 05 | Grantee Spotlight: <i>Ghar Ghar Teeka</i> in India | 5 mins |
| 06 | Audience Q&A | 10 mins |
-



01. The VaxSocial Journey So Far...

Introducing VaxSocial

A program that supports country-driven projects that leverage social media and behavioral science to build confidence around routine immunizations and drive scale and replicability in approach across geographies.

**6
Grantees**

**3
Countries**

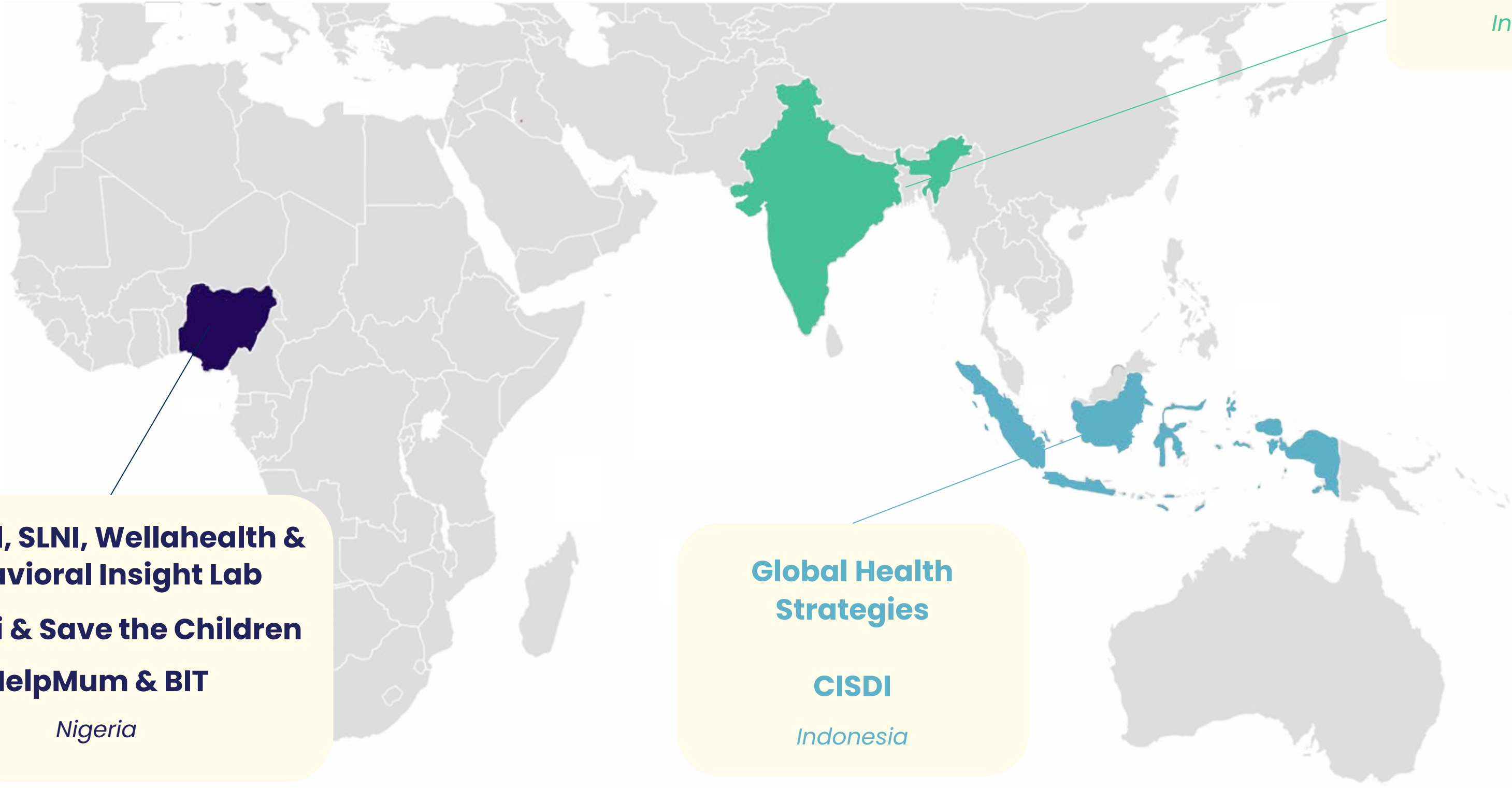
**Apr '24 –
Jun '26**

**Routine
Immunisation
& HPV**

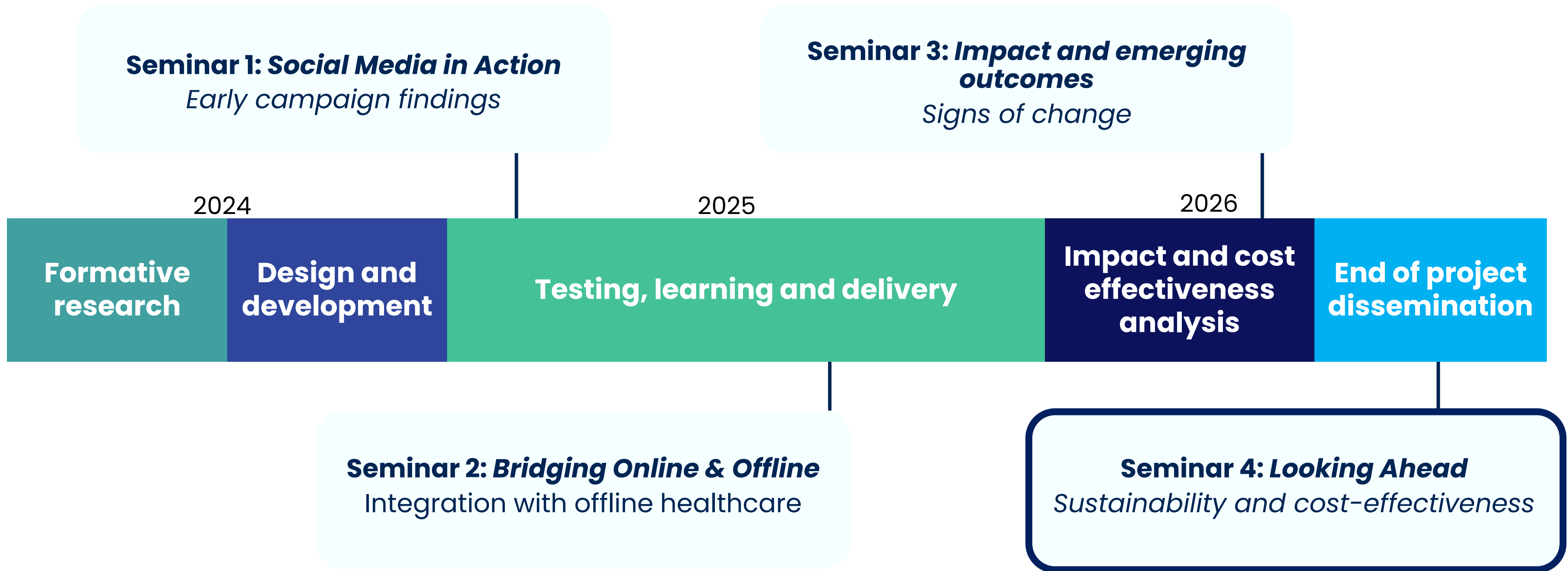
**Innovative
Integrated
Digital Tools**

We use the term
'Integrated Digital Tools'
to describe the whole
intervention: the online
and offline elements
fused together

The VaxSocial Portfolio



Today's session: Sustainability and cost-effectiveness



VaxSocial in Numbers

21m

actively engaged in
social media content
or a digital health
tool

3,000

health care workers
trained

370,800

onboarded to
interactive two-way
tools such as WhatsApp
support groups, hotlines
and chatbots

~47,100*

Estimated
additional
vaccinations



02. Cost-effectiveness: *How is value measured?*

Three key questions for cost-effectiveness....

1

Engagement

Which platforms / approaches are most cost effective at reaching and engaging audiences?

2

Influence

Do integrated digital tools provide value for money in preparation for getting a vaccine?

3

Impact

How cost-effective are integrated digital tools at increasing vaccine uptake?

The cost-effectiveness of integrated digital solutions always improves with greater scale and length of deployment

Across the VaxSocial projects, what percentage of the total budget do you think went to paid social media advertising?

A Under 10%

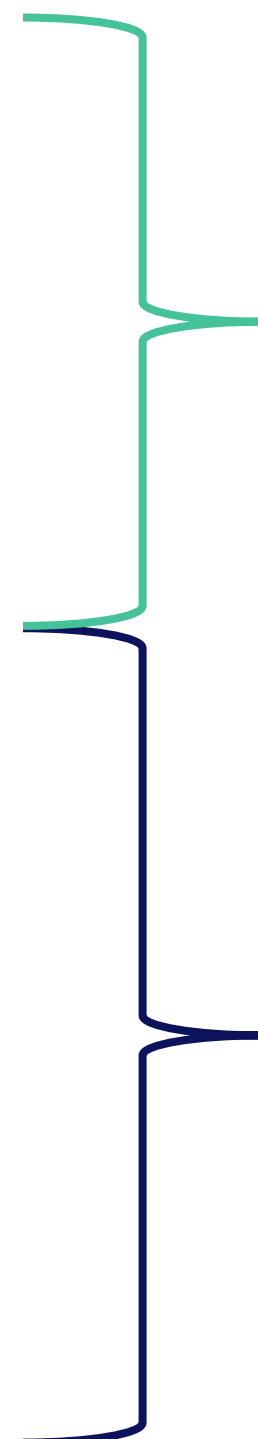
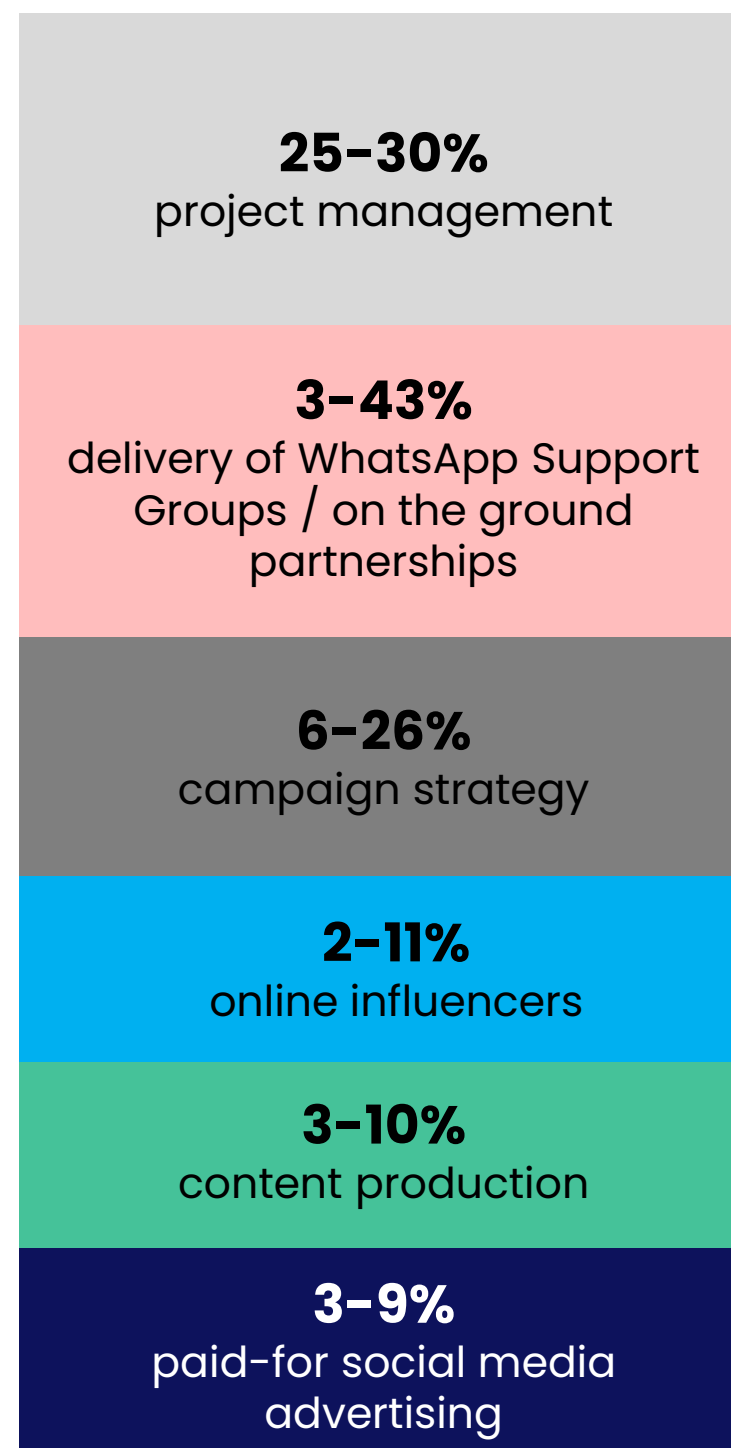
B 10 to 25%

C More than 25%

Please scan the QR code and follow the instruction on your phone screen to complete the short poll.



Integration of offline and online digital drives behavioural change – *what does this effectiveness cost?*



Additional investment to run integrated digital tools

This included partnerships with pharmacists, community health volunteers, and health professionals running WhatsApp Support Groups

Typical social media campaign costs

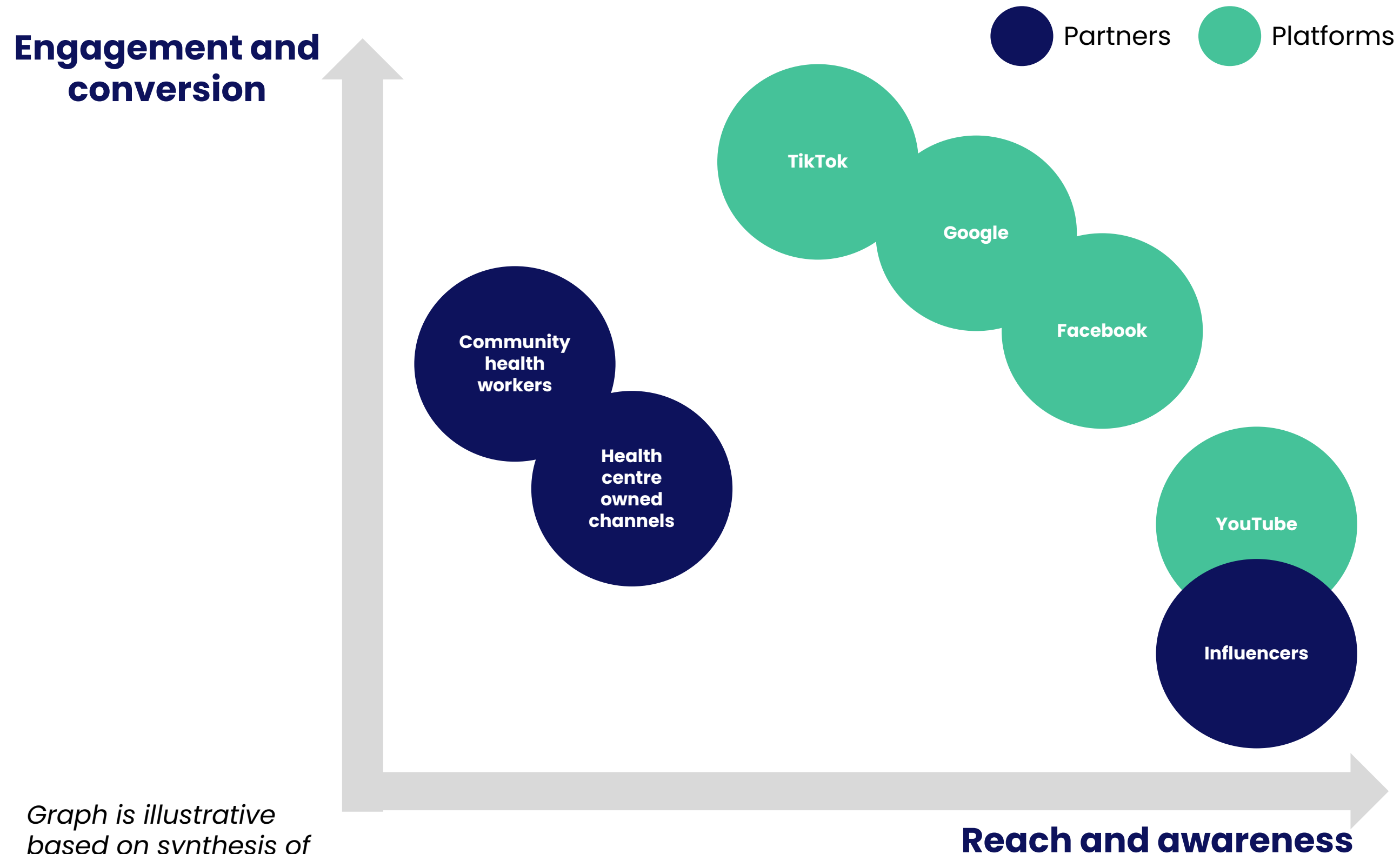
Though less went on paid for advertising, wider budget required to build campaign strategy, partner with online influencers and produce content

Key takeout for funders

Don't budget only for an online social media campaign. Choose partnerships that maximise community engagement, authenticity and sustainability.

Partnerships with online influencers also need to demonstrate good value for money – additional reach doesn't always translate into additional engagement.

Platforms and partnerships represent different strengths: some are better for reach, others help maximise engagement



Graph is illustrative
based on synthesis of
project findings

Key takeout for funders

A blend is likely the best approach.

Social media can't do it alone

Social media can be more than a broadcast tool that seeks to alter attitudes towards vaccination or counter misinformation.

Social media should promote an immediate call to action (e.g. join a chatbot, attend an outreach event) to help maximise engagement.

Health professionals do generate higher quality engagement when referring directly to another digital service such as a WhatsApp Support Group.

Reach looks cost effective, but to what extent should it be the priority outcome?



Social media
reach



Chatbot
reach

#1 Recall of campaign material was high

- **GHS** endline survey of caregivers found **92.5%** had at least some recall of the campaign assets
- **CISDI**: recall of **65.7%** among caregivers in the monitoring survey
- **Upswell**: approximately **55%** of caregivers in treatment areas reported having seen or heard a pharmacist talking about the HPV vaccine on Facebook or Instagram

#2 Increased reach and recall doesn't always translate to increase change

- **CISDI** found improved knowledge, awareness and attitudes among those who recalled seeing the campaign
- **Upswell and WPP** also found correlation between recall and HPV vaccination status
- **But...** this may show success in reaching an already receptive audience
- **GHS** found a potential ceiling effect where 'practice' (intent) dipped among those with the highest exposure to the campaign materials.

#3 Social media can't do everything

- Further analysis needed to understand which groups are more/less likely to be reached by social media.
- NIVI RCT recruitment showed that social media recruitment alone struggles to reach zero dose families
- Opportunity to link with other regular communications channels to promote digital services (e.g. chatbots or WhatsApp Support Groups)

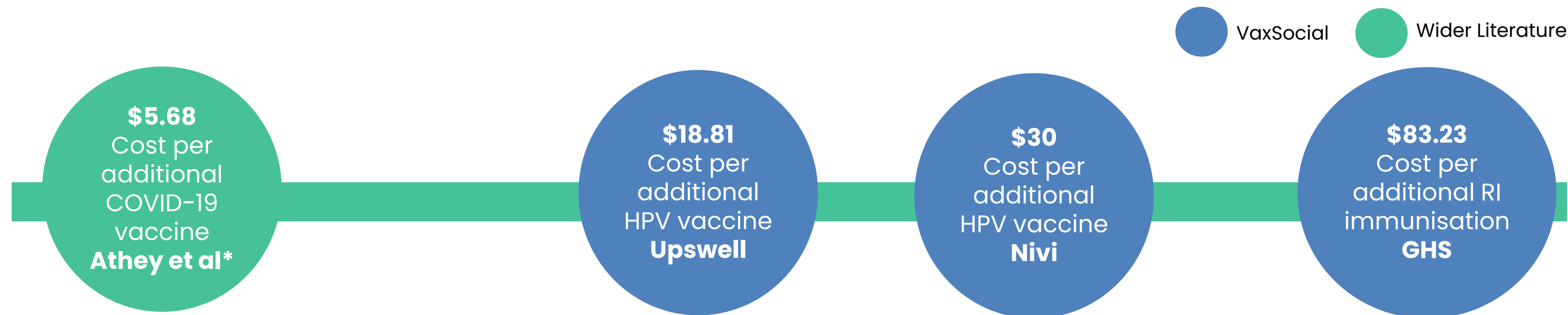
\$0.29
Cost per
person
reached
GHS

\$1.61
Cost per
girl aged 9-
14 reached
Upswell

\$4.01
Cost per
chatbot
user
Nivi

Costs per additional vaccination can reduce with scale, but this is not universal

Integrated digital tools to promote HPV appear more cost effective, but account for fewer rounds of vaccination. All approaches would be more cost effective with greater scale, but there are trade-offs and considerations when deciding how best to connect with local communities.



Elements that can scale for greater efficiency

- Content creation across a wider geography / audience
- Co-ordinated social media campaigns
- Intermediaries and partners that have a wide reach across multiple geographies
- Infrastructure and tech development (e.g. Chatbots)
- Use of national comms channels to onboard / signpost to digital tools



Elements that are proven but will remain more resource intensive

- Local content creation
- Hyper-local or micro-targeting within social media campaign
- Training and ongoing support
- Local trusted messengers and partnerships
- Day-to-day investment from front line workers to engage and respond to caregivers

* Based on advertising spend only
Findings are based on Preliminary Data

Key Takeaways

01

Don't budget only for an online social media campaign

Integrated digital tools are so much more, and are most effective when they are delivered with trusted partners on the ground

02

Blend reach and engagement, tailored to the need

Don't chase 'reach' for its own sake. Use the platforms and partnerships most likely to close the intention-to-action gap in that community.

03

Incorporate contextualisation costs from onset

Scale solutions where appropriate, but consider which elements will be best delivered locally to retain authenticity and engagement



03. How has VaxSocial strengthened local health systems?

Project legacy

Four building blocks pointing to sustainability

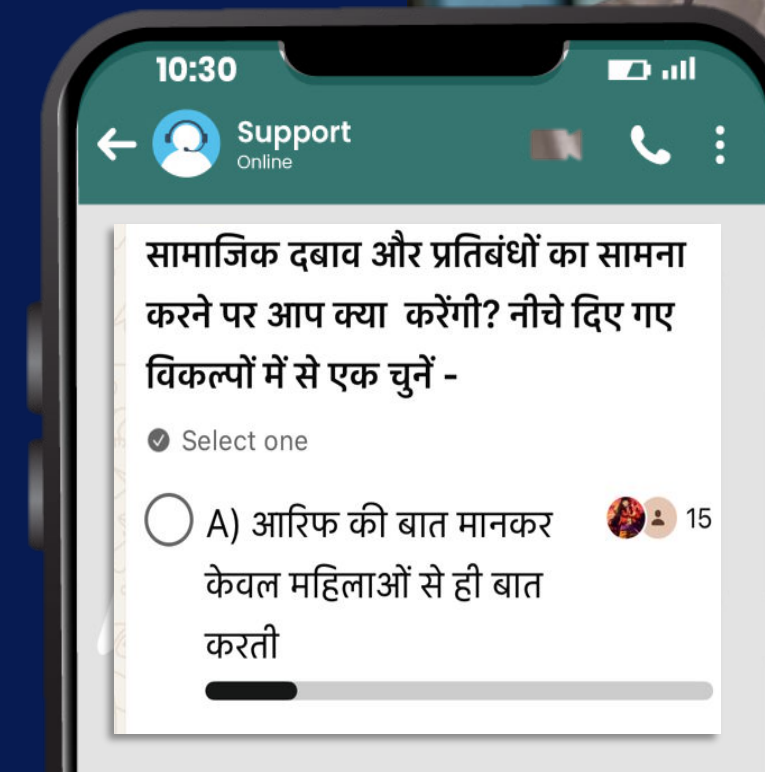
Partners created a lasting legacy of evidence, practical capability, reusable tools and stronger relationships with local delivery systems. The extent to which future immunisation initiatives can build on these assets— is a key measure of VaxSocial's enduring success.

SKILLS &
CAPABILITY

PARTNERSHIPS &
OWNERSHIP

EVIDENCE &
LEARNING

TOOLS &
INFRASTRUCTURE



Bapak-bapak Antar
Imunisasi Gini, Wak?

Facilitated WhatsApp groups provide the clearest evidence of continuation, while other routes remain emerging

The WhatsApp Group model uses existing roles rather than requiring a new workforce, while active caregiver and peer groups provide an ongoing reason to maintain it. This also creates a credible route into existing health-system infrastructure.



INDIA | WPP MEDIA

Continuation embedded in existing roles

- The WhatsApp Support Groups were integrated locally and became active working spaces. Local actors were equipped to manage even after the intervention ended.
- 18 Accredited Social Health Activist champions developed content-creation, facilitation and group-management skills to sustain activity.



INDONESIA | CISDI + GHS

Continuation through local health infrastructure

- District Health Offices formally committed to continue CISDI's WhatsApp Support Group model.
- GHS groups were administered by Puskesmas teams through familiar WhatsApp channels within existing primary-care structures.



NIGERIA | askNivi + VITAL

Emerging route to sustainability

- askNivi's integration route and VITAL's approved formats are promising, but long-term ownership and resourcing are not yet confirmed.

VaxSocial built frontline capability and extended advocacy through trusted local actors

1 Capacity building among health workers

- Create and adapt local digital content
- Manage social media and WhatsApp groups
- Respond to misinformation; link caregivers to services

1,904

frontline workers trained

WPP Media

2,357

examples of learning applied

WPP Media

500+

health and community workers supported

CISDI

236

health staff and community leaders trained

GHS

FOR PRACTITIONERS: Start with trusted actors who have a mandate, audience and routine.

2 Partnership and ownership

Wider online vaccination advocacy through trusted actors outside frontline delivery

India

Key opinion leaders and influencers

Relatable vaccine content

Indonesia

Journalists

Accurate immunisation reporting

Nigeria

Pharmacists

Advocacy online and in communities

FOR FUNDERS: Budget for staff time, coordination and continuing support.

Digital tools require an owner and route to use; evidence requires validation in the current setting.

3

Evidence and learning

A starting point for future investment and design



Formative research

Trusted sources, hidden decision-makers, barriers and information pathways



Global MEL

Reach, outcomes, cost-effectiveness across models

CONSIDERATION

Starting point only: it does not replace fresh primary research in each new setting.

FOR PRACTITIONERS

Use VaxSocial evidence to frame questions, then test current local barriers, decision-makers and channel use.

4

Digital tools

Reuse is clearest through channels partners already own



Social media content

CISDI: 9 of 12 Puskesmas plan to reuse social media content through their own digital channels.



Open-source training resources

GHS: open-source training and reporting resources remain available for adaptation.



Chatbot journeys

askNivi: developed reusable chatbot journeys, repointable to new settings

CONSIDERATION

Ownership matters: paid or centrally-run content has no local owner, so no route to reuse it.

FOR FUNDERS

Fund primary research in each new setting and provide clear ownership of reused tools.

Three conditions separate a sustainable asset from a project output

01

Embed for continuity

- **Name an owner** within the health system or delivery organisation.
- **Build into routines** such as SOPs, supervision, reporting and budgets.
- **Build for handover** from day one, ensuring continuity after programme ends.

02

Invest in people

- **Equip trusted actors** with the skills and mandate to keep using the approach.
- **Support application** through coaching, facilitation and peer networks.
- **Fund frontline staff time, not just training** to keep digital delivery responsive

03

Reuse, then adapt

- **Reuse evidence and assets** to reduce the cost of starting again.
- **Adapt content and delivery** to local barriers, language and services.
- **Keep learning** so the model remains useful as conditions change.

The strongest legacy combines an owner, capable people, reusable assets and the resources to keep them working.



04. How to scale integrated digital tools?

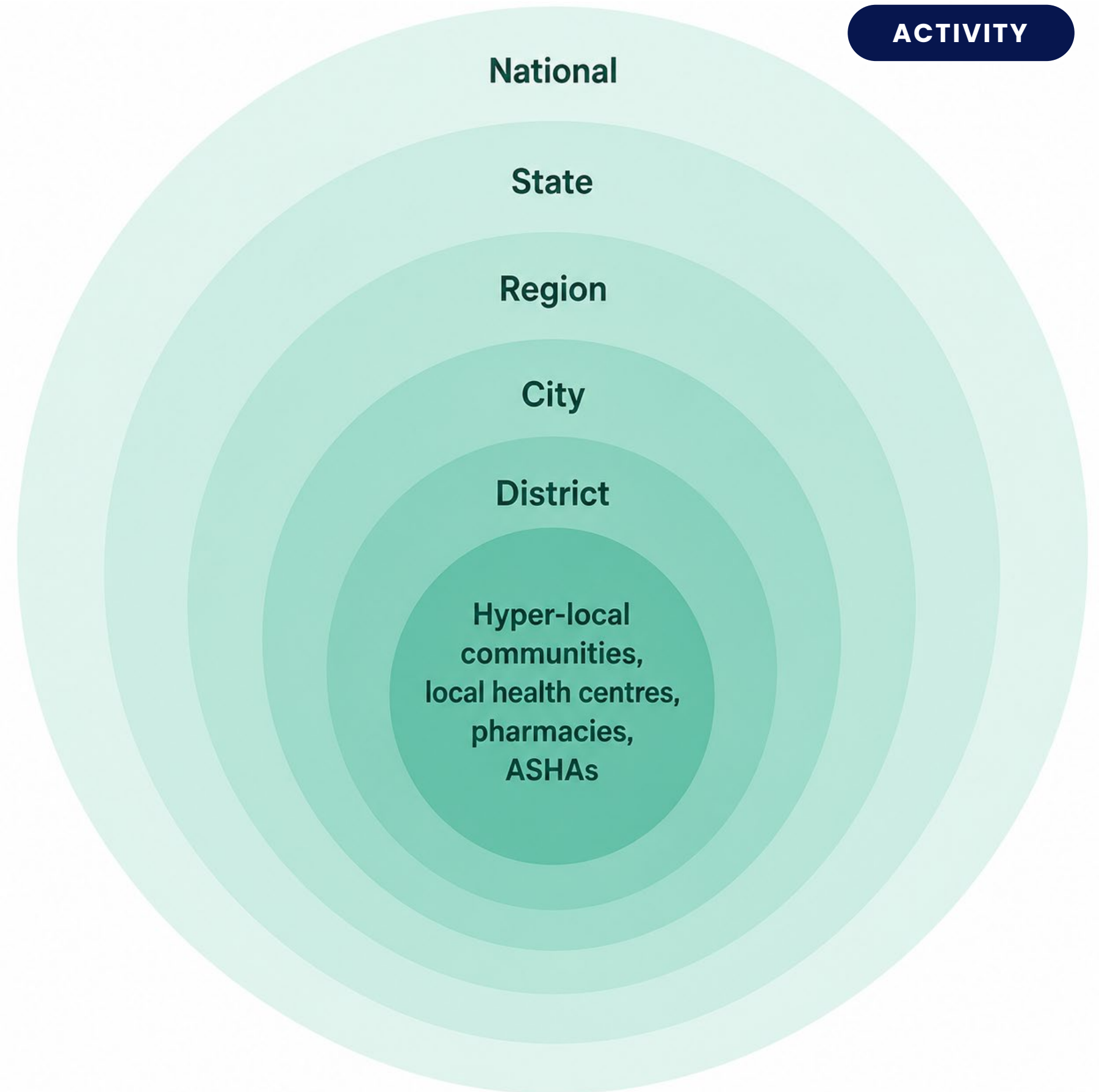
– And what must stay local?

What is the best level for delivering integrated digital tools that change immunisation behaviour?

Please scan the QR code and follow the instruction on your phone screen.



ACTIVITY



Step 1: Choose the right intervention or combination of integrated digital tools

	01 Social media campaigns 	02 Facilitated WhatsApp groups 	03 Chatbots 
 BEST PLACED TO	Generate targeted reach, shape salience and social norms, and signpost to a live next step.	Build sustained, trusted peer support for a defined cohort of caregivers or frontline workers.	Offer private, consistent and personalised guidance, reminders and referrals at scale.
 CHOOSE IT WHEN	The audience is active on-platform, rapid reach matters and services can respond.	Members can be recruited and trusted facilitation, moderation and escalation can be sustained.	The journey can be structured and content, service information and escalation can stay current.
 DO NOT ASK IT TO	Resolve complex individual barriers or reach priority groups less visible online.	Deliver anonymous mass reach, or operate without active human stewardship.	Build trust from scratch or shift firmly held hesitancy without human support.

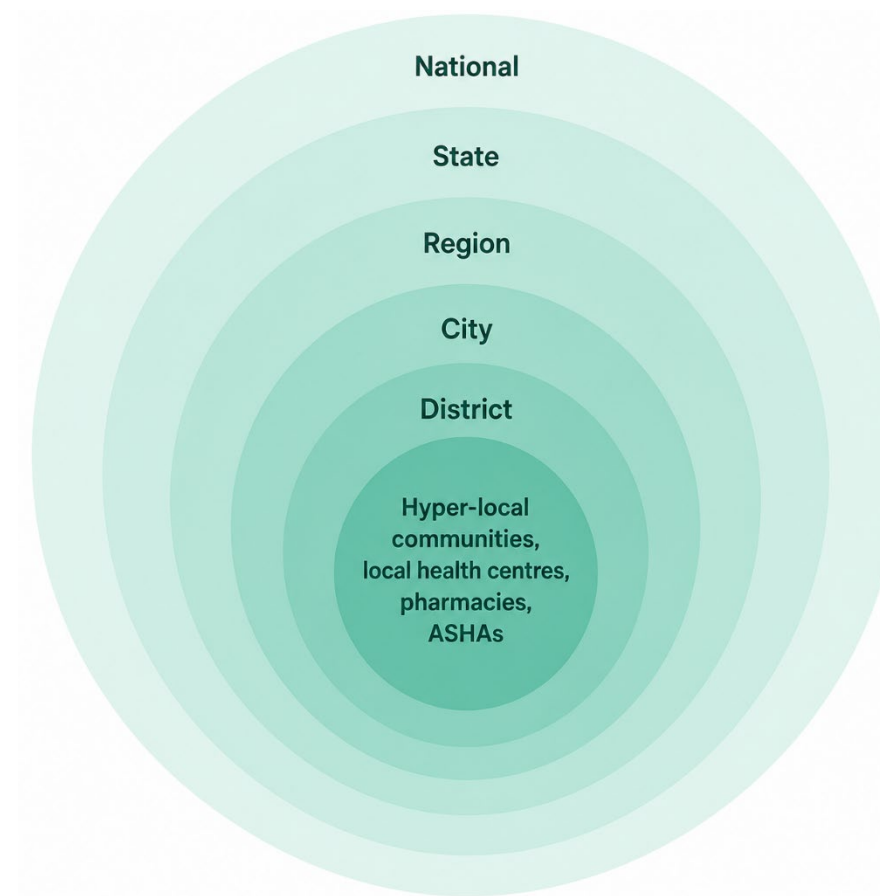
Step 2: Build a hyper-local design at national scale

01

Scaling national infrastructure

The common operating model:

- WhatsApp peer-learning groups
- A frontline champion model
- Reusable bots, training modules and content libraries
- SOPs for facilitation, escalation and handover
- Social listening to guide adaptation



02

What must remain local

The who, what and how:

- Who delivers the message
- What is discussed
- How it is expressed
- How people act
- How engagement is sustained

Different delivery models require a different balance of national infrastructure and local capacity

Digital components can often be reused nationally, but human-supported models depend more heavily on local delivery capacity, service connections and ownership.

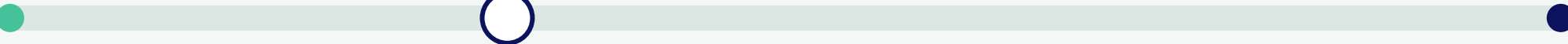


HUMAN-SUPPORTED CHATBOT

INDIA | WPP Media

1,275 frontline workers trained to support the WhatsApp bot

LEANS LOCAL



LOCALLY REQUIRED

Frontline-worker coverage, caregiver onboarding and follow-up; trusted relationships, mobilisation and supervision

SHARED FOUNDATION

Bot infrastructure, core caregiver journeys and training materials



DIGITAL-FIRST CHATBOT

NIGERIA | askNivi

115,330 chatbot journeys initiated through digital advertising

MORE SHAREABLE NATIONALLY

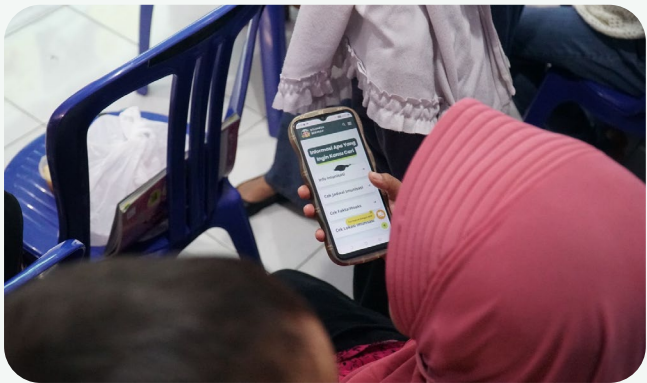


LOCALLY REQUIRED

Media spend and optimisation; local targeting, current provider information and ready referral services

SHARED FOUNDATION

Chatbot platform, core journey architecture and measurement framework

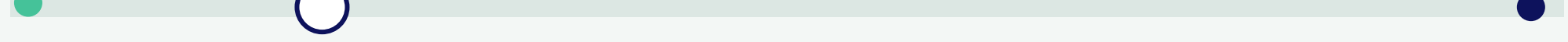


HEALTH-SYSTEM WHATSAPP GROUPS

INDONESIA | CISDI + GHS

Continuation commitments in Depok and Bekasi

STRONGLY LOCAL



LOCALLY REQUIRED

Facilitator capacity, supervision and quality assurance; district ownership, service and community connections, staff time and operating budget

SHARED FOUNDATION

Core facilitation model, standard operating procedures, performance measures and content templates



Grantee Spotlight: *Ghar Ghar Teeka in India*

WPP Media: What lasts depends on what we scale, adapt or stop

01 WHAT WOULD YOU DIAL UP OR DOWN?

DEPTH OVER REACH

Invest more in direct engagement with families through ASHAs, supported by digital tools. The FLW model reached all caregivers of children under 2 (63,200 households) in the district, with 2,357 instances of digital content translating into field-level action. This suggests value in using digital channels to enable conversations and action, rather than focusing only on scale of reach.



02 WHAT MAKES SUSTAINABILITY REAL?

BUILT INTO EXISTING WORK

The approach was integrated into ASHAs' existing immunisation work, rather than creating a separate role. The WhatsApp groups provided content and support that ASHAs could continue to use in their regular interactions with families. This existing network and role are what make continuation more realistic.



03 WHAT SHOULD SCALE—AND WHAT MUST STAY LOCAL?

CENTRAL TOOLS, LOCAL ACTION

The WhatsApp model, core content, training and tools can be developed and supported centrally. The actual engagement should remain local — language, examples, local concerns and the way ASHAs engage families need to be adapted to the context.



Final takeaways

The strongest integrated digital investments extend the health system – linking a clear behavioural need to trusted delivery, local ownership and services that can respond.

01

Invest against outcomes— not reach

Start with the behaviour and local barrier. Compare channels against the full delivery cost, then treat reach as an input – not the outcome.

02

Build digital around trust and access

Pair digital touchpoints with trusted people, two-way support and clear routes to vaccination. Budget for facilitation, moderation and follow-up.

03

Design sustainability in from the start

Name the owner early. Build local capability, embed the model in routines and budgets, and leave reusable tools and evidence that can be adapted.

04

Scale shared infrastructure; keep delivery local

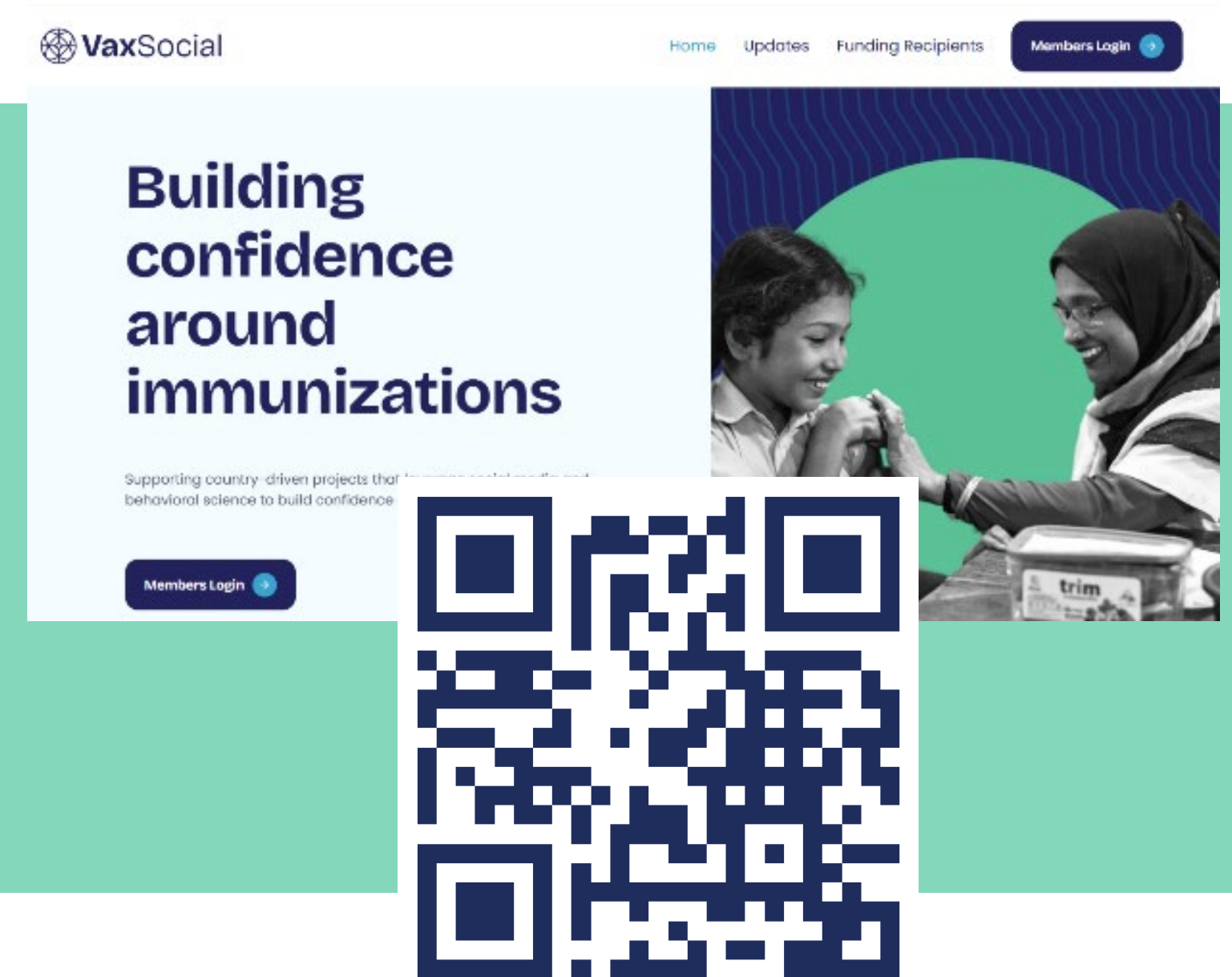
Standardise platforms, SOPs and shared content where useful. Keep messengers, language, service links and delivery decisions rooted in local context.

Q&A



Stay in the Loop

- Evaluation and Learning reports will be shared on the **VaxSocial website**.
- **Global Learning Symposium** showcasing key insights, best practices, and lessons learned from the implementing campaigns in October 2026.



Thank you

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