VaxSocial

VaxSocial Global Learning Symposium

From reach to action



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4 November 2026

Aims of the symposium



Understand

What the final VaxSocial evidence shows about using integrated digital tools to increase vaccination uptake.



Learn

Which design choices worked, for whom and why, from the evidence and from the grantees themselves.



Shape

How to design cost-effective models that last beyond the grant.

Today’s session

01 **Welcome and opening remarks**

The Gavi and AHO partnership behind VaxSocial

02 **Programme overview and headline findings**

What grantees did on the ground, and what VaxSocial showed

03 **Five best-practice takeaways**

Five design choices, and where the balance sits

04 **Cost-effective and sustainable models**

What it costs, what lasted, and how to design for both

05 **Practitioner panel**

Lessons from Ghar Ghar Teeka, askNivi and Keluarga Berimun

06 **Open Q&A and close**

What confirmed or surprised you?

Opening Remarks

WARM-UP

Before we start: over to you

ACTIVITY

Design a program to generate demand and increase vaccination uptake:
What features of the design would you prioritise?

A **National vs local**

B **Reach vs engagement**

C **Knowledge vs action**

D **Targeted push vs routine immunisation**

E **Online vs offline**

Open the poll in the Teams chat.

For each pair, choose where you would place greater emphasis in your design.

We will come back to your answers at the end.

02. Programme overview
and headline findings

Introducing VaxSocial

VaxSocial was a $12M initiative, supported by Gavi and Advancing Health Online, to understand whether social media and online platforms can be used to increase vaccine uptake.

Ipsos and M&C Saatchi World Services were the global evaluation partners, supporting monitoring, evaluation and learning across the six grantees.

6
grantees

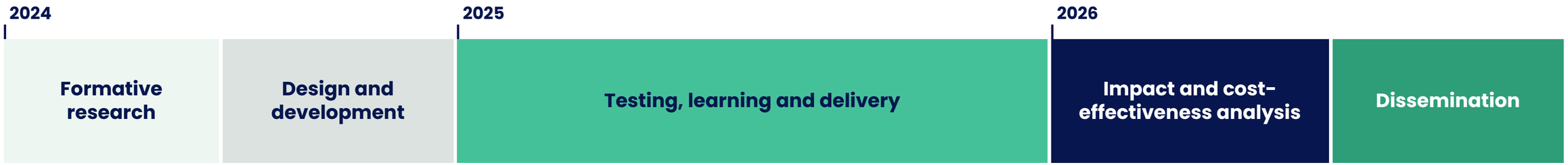
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countries

Apr 2024 to Jun 2026
programme period

RI and HPV
routine immunisation and HPV vaccination

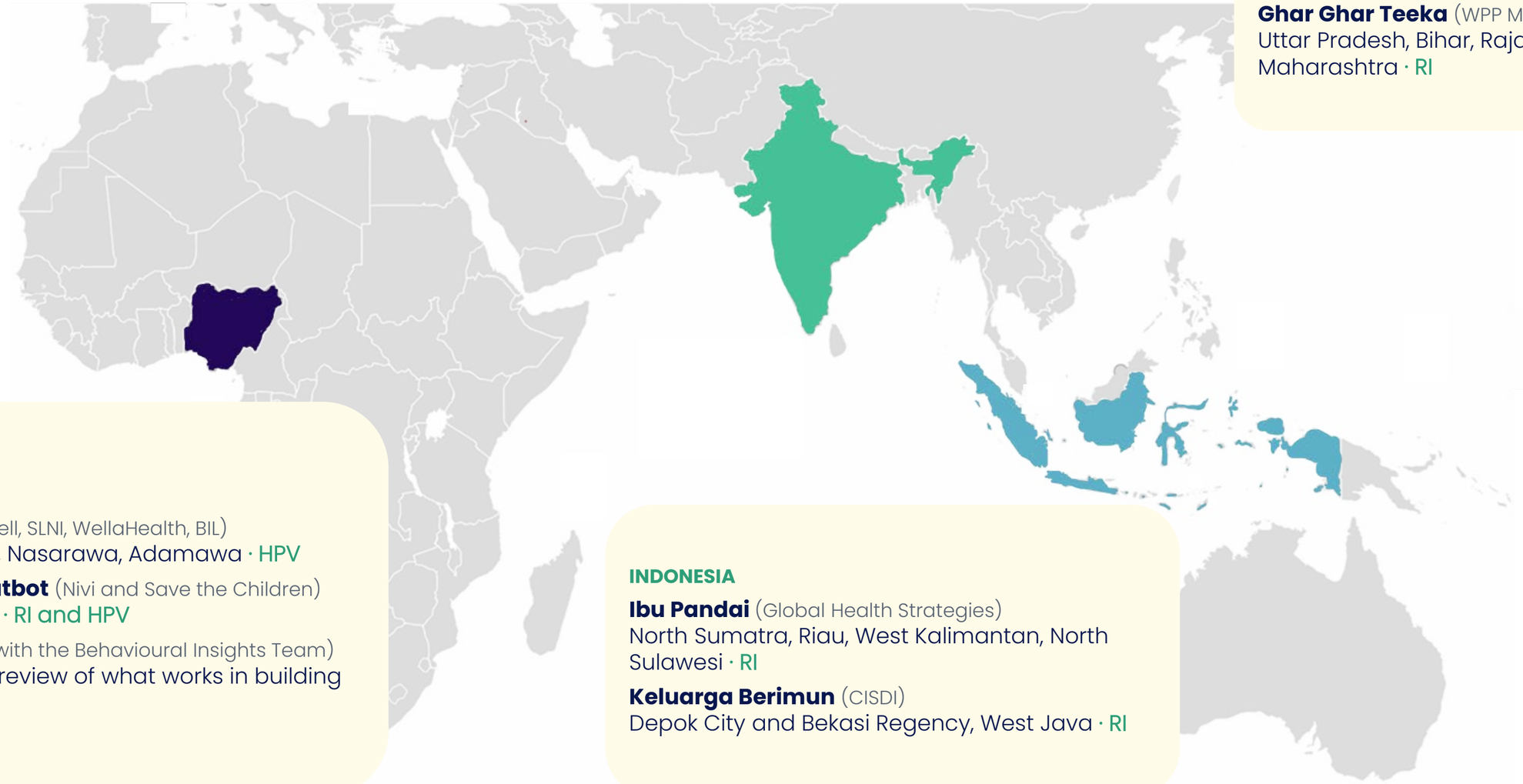
Integrated Digital Tools
online and offline delivery

PROGRAMME TIMELINE



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The VaxSocial Portfolio



INDIA

Ghar Ghar Teeka (WPP Media)
Uttar Pradesh, Bihar, Rajasthan, Maharashtra · RI

NIGERIA

VITAL (Upswell, SLNI, WellaHealth, BIL)
Abuja (FCT), Nasarawa, Adamawa · HPV

askNivi chatbot (Nivi and Save the Children)
Lagos State · RI and HPV

HelpMum (with the Behavioural Insights Team)
Systematic review of what works in building chatbots

INDONESIA

Ibu Pandai (Global Health Strategies)
North Sumatra, Riau, West Kalimantan, North Sulawesi · RI

Keluarga Berimun (CISDI)
Depok City and Bekasi Regency, West Java · RI

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Three main digital tools, multiple messengers

As an innovation programme, VaxSocial grantees explored different ways using digital tools to reach and engage caregivers.

Each programme had a different combination of tools and messengers.

Tools

Messengers

01 Social media campaigns

02 Facilitated WhatsApp groups

03 Chatbots

01 Frontline Health workers

- Pharmacists
- Community health volunteers
- Accredited Social Health Activists
- Local health centre staff

02 Key Opinion Leaders

- Religious leaders
- Community leaders
- Social workers
- Shopkeepers
- Journalists

03 Online Influencers

- Regional and local
- Family and parenting
- Humour-led
- Lifestyle

04 Owned Channels

- Local Health Centre channels
- Ministry of Health channels

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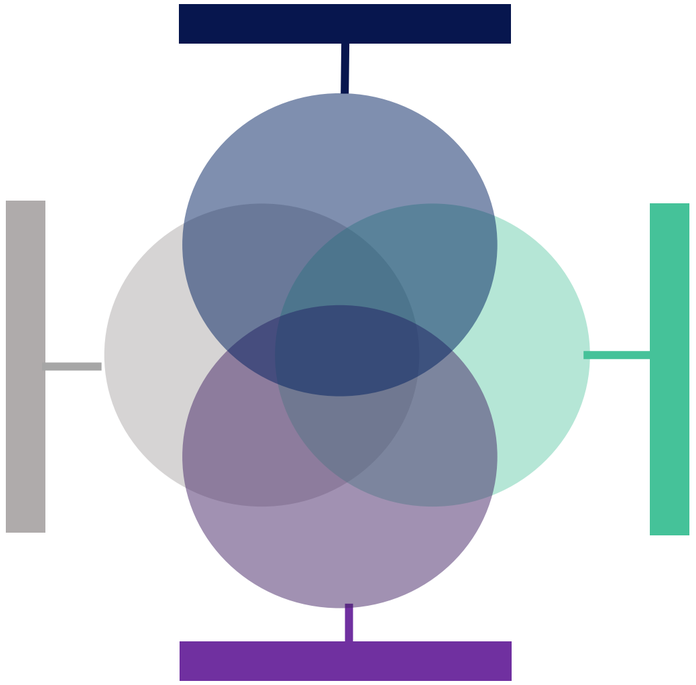
The purpose of integration:
4 x models

Direct Broadcast

Mass-reach campaigns to build awareness, confidence and trust

Using blends of platforms (Facebook, Instagram, TikTok, YouTube)

Partnerships with influencers and local trusted voices



Engage caregivers

Digital tools that facilitate a two-way dialogue with caregivers

Via WhatsApp Support Groups and chatbots

Moderated by health workers

Responsive to caregiver questions and concerns

Extends the reach and presence of health workers in their communities

Signpost Support

Using social media ads and in person recommendations to direct people to other services and conversations

Signpost to digital services such as chatbots, websites and helplines

Or in person services such as pharmacists

Empower trusted voices

Digital peer-to-peer networks for training, advice and best practice

Delivered through WhatsApp with frontline workers and key opinion leaders

Supports better in-person interactions in existing communities

We use the term **‘Integrated Digital Tools’** to describe the whole intervention: both online and offline elements fused together

Four key evaluation questions

1

Integration

Can digital tools be integrated into existing health systems?

2

Reach & Engagement

Can they reach and engage intended audiences?

3

Impact

Can they impact attitudes and behaviours towards vaccination?

4

Cost-effectiveness & Sustainability

Can they be sustained and scaled?

LEARNING QUESTION 1 OF 4: INTEGRATION

Can digital tools be integrated into existing health systems?

YES **Digital tools were successfully built into existing health systems**

Integration worked best when it was:

1. **‘Phygital’**
   Integration of digital tools with local trusted voices to blend online and offline delivery.

2. **Localised**
   Tailored design and delivery to local needs and contexts.

3. **Connected to supply**
   Using digital tools to link caregivers directly to immediate opportunities to get vaccinated.

4. **Motivating for partners**
   Use of recognition, financial rewards and peer mentoring to boost frontline health worker performance.



EVIDENCE FROM THE FIELD

NIGERIA · VITAL
40 pharmacists featured in the campaign held **20,317** in-person conversations with caregivers.

INDONESIA · GHS
Health centre staff ran ‘Ibu Pandai’ WhatsApp groups, answering **92%** of questions in 33 minutes on average.

INDIA · WPP MEDIA
More than **nine in ten** messages in frontline worker WhatsApp groups were started by ASHAs themselves.

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LEARNING QUESTION 2 OF 4: REACH AND ENGAGEMENT

Can integrated digital tools reach and engage intended audiences?

YES **... but only when online and offline touchpoints work together.**

The most effective projects had:

1. **Deeper engagement at scale**
   Chatbots and digital peer networks delivered both breadth and depth of access to caregivers.

2. **Authentic partnerships with in-person contact**
   Offline conversations could signpost digital tools and better reach underserved communities.

3. **Tailored content**
   Content was designed around local audience realities, decision-makers and motivational drivers.

4. **Narrative-led video content**
   Authentic storytelling and video consistently outperformed more static, formal communications.



EVIDENCE FROM THE FIELD

INDIA · WPP MEDIA
A network of 7,500 frontline workers connected through peer-to-peer WhatsApp support group and reached a total of 63,200 households.

NIGERIA · NIVI
Community health volunteers recruited **35%** of chatbot users; **98%** of them finished onboarding, against 55% from ads.

ACROSS PROGRAMMES
Evidence that we reached the **hardest-to-reach** is limited.

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Can integrated digital tools impact vaccine attitudes and behaviours?

YES **Vaccination rates improved for HPV, but not consistently for routine immunization.**

Closing the intention to action gap required integrated digital tools that:

1. **Move beyond knowledge**
   Gains in factual knowledge alone were not enough to change behaviour.

2. **Make vaccination easy**
   Giving clear information on where, when and how to get vaccinated.

3. **Deliver sustained interaction at scale**
   Building infrastructure and partnerships that support deep conversations with large numbers of caregivers.



EVIDENCE FROM THE FIELD

NIGERIA · VITAL
Pharmacist and social media model: **+8.9pp** HPV vaccination against control areas.

NIGERIA · NIVI
Tailored chatbot journey: **+7.7pp** HPV vaccination; but no change in routine immunization, where most families were already on schedule.

INDIA · WPP MEDIA
Frontline worker groups **+12pp** and WhatsApp bot **+5.8pp** full immunisation; both involved deep engagement, the other three approaches showed no significant change.

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LEARNING QUESTION 4 OF 4: SUSTAINABILITY AND SCALE

Can integrated digital tools be sustained and scaled?

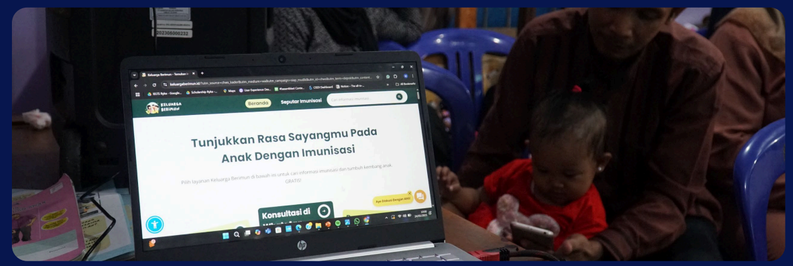
POTENTIALLY **No programme was sustained in full, but some promising signs for continuation of low-cost elements built into existing roles.**

Future models should:

1. **Design and budget for engagement**
   Blend designs for both reach and direct engagement with caregivers, and build national digital infrastructure that facilitates local communication and action.

2. **Budget for local adaptation from the outset**
   Scale where it makes sense, and keep local the elements that depend on authenticity and engagement.

3. **Embed for continuity**
   Name owners early, build into existing routines and plan for sustainability from day one.



EVIDENCE FROM THE FIELD

ACROSS PROGRAMMES
Cost per additional vaccination varied greatly where it could be costs: **$18 to $83**.

INDIA AND INDONESIA
WhatsApp groups carried on: peer networks in India, caregiver groups in Indonesia.

NIGERIA
Local partnerships with pharmacist and community health volunteers did not continue after the project

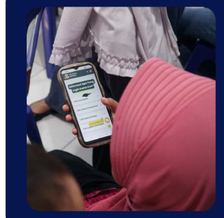
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03. Five best-practice takeaways

Five design choices, one answer to each

BEST-PRACTICE TAKEAWAYS: WHICH TOOL, WHEN

Each tool suits a different task, so start from what people need to do next.

	Social media campaigns Reach, motivate and signpost	Facilitated WhatsApp groups Reassure and sustain support	Chatbots Guide, remind and refer
THE TOOL AND ITS JOB			
BEST FOR	**Targeted reach**, social norms and signposting to a next step	**Trusted peer support** for caregivers or frontline workers	**Personalised guidance**, reminders and referrals at scale
USE IT WHEN	The audience is online, speed matters and services can respond	Members can be recruited and moderation can be sustained	The journey is structured and service information is kept current
DON'T ASK IT TO	Resolve complex individual barriers or reach groups less visible online	Deliver anonymous mass reach or run without active human stewardship	Build trust from scratch or shift firmly held hesitancy without human support

Let the behavioural task decide the tool, then plan the human support and services each one depends on.

BEST-PRACTICE TAKEAWAYS: FIVE DESIGN CHOICES

Across all five choices, integrated digital tools worked best when it connected people to trusted support and a service they could reach.



		WHERE THE BALANCE SITS	
1	**National vs local**	Local — National	The balance depends on the model and its context. A good rule: **share platforms nationally, and keep delivery, trust and ownership local.**
2	**Reach vs engagement**	Reach — Engagement	Reach builds awareness at low cost; **trusted, two-way engagement moved people towards vaccination.**
3	**Knowledge vs action**	Knowledge — Action	Knowledge is the foundation from which action can develop; **knowing where to go and finding it easy drove vaccination.**
4	**Targeted push vs routine**	Targeted — Routine	Some vaccines need a targeted push with one clear action and a date; others need a schedule sustained by human support. **Align the tool to the cause from the start.**
5	**Online vs offline**	Online — Offline	Both are needed, **with a deliberate handover between them.**

DESIGN CHOICE 1: NATIONAL vs LOCAL

Each model needs its own balance: platforms can be shared nationally, while delivery, trust and ownership sit locally.

WHERE THE BALANCE SITS

Local — National

The more human support a model needs, the further towards local it sits.



SHARE NATIONALLY

The common operating model

- Reusable bots, training modules and content libraries
- Standard operating procedures for facilitation, escalation and handover
- WhatsApp peer-learning groups
- Social listening to guide adaptation

KEEP LOCAL

The who, what and how

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

TOP TIP: Build a hyper-local design at national scale.

Example: in Indonesia, District Health Offices committed to the model and 9 of 12 health centres will reuse shared content.

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DESIGN CHOICE 2: REACH vs ENGAGEMENT

Wide reach rarely changed behaviour on its own; depth and trusted local voices did more of the work.

WHERE THE BALANCE SITS

Reach **Engagement**

Across grantees, in-person conversations, WhatsApp groups, hotlines and chatbots generated the deepest engagement.



Case study: India

	REACH	CHANGE IN FULL COVERAGE
General social media messaging	**14.5m people**	**No significant change**
Social media influencers Creator-led content	**1.6m people**	**No significant change**
FLW WhatsApp groups ASHAs, peer learning	**63,200 households**	**+12pp** against control districts
WhatsApp bot Personalised reminders	**32,738 households**	**+5.8pp** against control districts
KOL WhatsApp group Community influencers	**20,800 households**	**No significant change**

Difference-in-differences against control districts, parent-reported. Social media reach counts people; other reach counts households. Sources: India end-of-project evaluation, October 2026 (left); VaxSocial final MEL report and grantee evaluation summaries, 2026 (right).

TOP TIP: Judge reach by whether it leads people to a trusted conversation and a service.

HOW?

1. Blend reach and engagement: low-cost reach builds awareness; two-way contact moves people to act
2. Partner with existing networks: work with people and groups who already reach caregivers
3. Choose credible voices: local creators often engaged more deeply than bigger influencers

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DESIGN CHOICE 3: KNOWLEDGE vs ACTION

Vaccination rose where people knew where to go and found it easy, even when knowledge didn't change.

WHERE THE BALANCE SITS

Knowledge **Action**

Knowledge matters most where it is low. Where it is already high, gains came from making action easier.



Case study: Nigeria and India

	KNOWLEDGE	VACCINATION
Pharmacist and social media model Nigeria · HPV	**No measurable change** in knowing the right age for HPV vaccination	**+8.9pp** HPV vaccination against control areas
KOL WhatsApp group India · routine immunisation	**+34pp** knowledge of the vaccination schedule	**No measurable change** coverage fell in treatment and control districts alike

Difference-in-differences against control areas. Community leader coverage -5.7pp, not significant. Measures differ between the two models, so the grid compares direction of change only. Sources: final evaluations, Nigeria (2025) and India (2026).

TOP TIP: Design for the next step: clear details of where to go, easy access and a timely prompt.

HOW?

1. **Make direct referrals**: promote outreach events and share the nearest vaccination site
2. **Align with campaigns**: time content to national campaigns or local outreach events
3. **Keep moderators updated**: give them current supply information so they can answer queries

BEST-PRACTICE TAKEAWAYS: FIVE DESIGN CHOICES

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DESIGN CHOICE 4: TARGETED PUSH vs ROUTINE

A targeted push worked for HPV, while routine immunisation needed sustained support from trusted people.

WHERE THE BALANCE SITS

Targeted push **Routine support**

The right balance depends on whether there is a single action to take or a schedule to follow.



Case study: HPV and routine immunisation

HPV

Girls aged 9 to 14

One moment to act on

+7.7pp
Tailored chatbot journey, Nigeria (caregiver-reported)

+8.9pp
Pharmacist and social media model, Nigeria

Routine immunisation

Repeated visits from birth to age five

Seven visits by age five in India

No measurable effect
Same chatbot, routine trial; most families already on schedule

+12pp
FLW WhatsApp groups, India

Chatbot: two parallel randomised trials in Lagos; the routine trial mostly enrolled families already on schedule (about 84% reported a visit in both arms). Other results: difference-in-differences against control areas.

TOP TIP: Match the approach to the vaccine: a targeted push for one dated action, and sustained, trusted follow-up for routine schedules.

HOW?

1. **Anchor HPV campaigns to a date**: promote outreach or school vaccination days
2. **Reach caregivers early**: start in pregnancy, before doses are missed
3. **Keep health workers in the loop**: pair reminders with frontline follow-up between visits

BEST-PRACTICE TAKEAWAYS: FIVE DESIGN CHOICES

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DESIGN CHOICE 5: ONLINE vs OFFLINE

Online and offline played different roles, and the strongest models moved people between them deliberately.

WHERE THE BALANCE SITS

Online **Offline**

Offline contact built trust and reached people who were not online; online tools sustained contact between visits.



An illustrative pathway across several grantees

ONLINE

1. **Health worker peer support**
   WhatsApp groups for frontline workers (India)

OFFLINE

2. **Trusted introduction**
   Pharmacists introduce the tool (Nigeria)

ONLINE

3. **Answers between visits**
   92% answered within 33 minutes (Indonesia)
4. **A prompt and a place**
   Chatbot referrals and dated events (Nigeria)

OFFLINE

5. **Vaccination in person**
   Clinic, outreach event or home visit

Each stage draws on a different grantee; no single programme ran the full pathway. Sources: grantee final reports.

TOP TIP: Plan the handover between online and offline from the start.

HOW?

1. **Start offline to build trust**: health workers, pharmacists or volunteers introduce the tool in person
2. **Use digital between visits**: answer questions quickly and send reminders
3. **Point back offline**: link every online touchpoint to a named place, date or referral

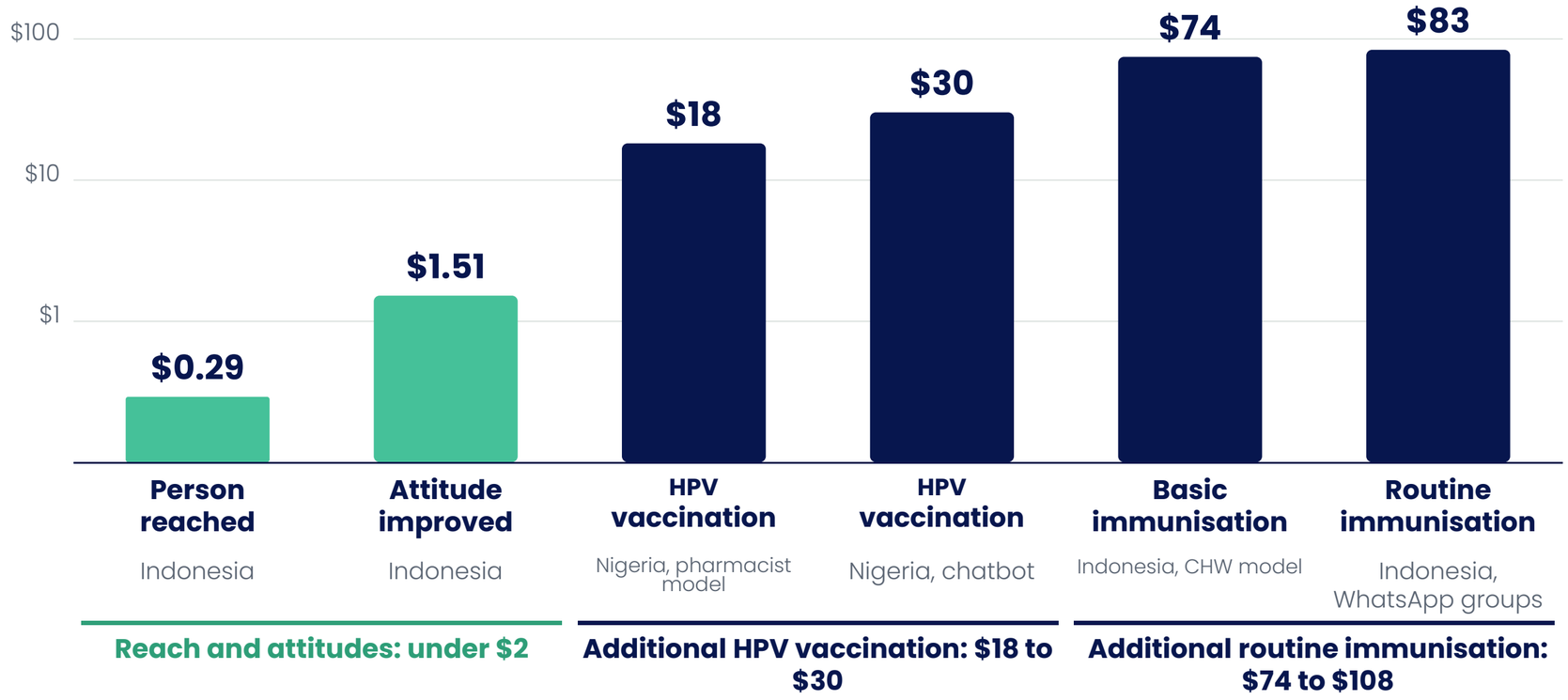
04. Cost-effective and sustainable models

What it costs, what lasted, and how to design for both

COST-EFFECTIVE AND SUSTAINABLE MODELS: WHAT IT COSTS

Reaching caregivers costs relatively little; most of the cost sat in turning intent into a vaccination.

Cost per result, US$ (log scale)



- Paid social media advertising made up 3–9% of local budgets.
- Partnerships for two-way conversations with caregivers made up 3–43%.

Budget for the step between intent and vaccination: stock-outs and service gaps set the ceiling on what communication can achieve.

Source: Final grantee evaluations, 2026. Methods differ, so costs per vaccination are indicative. Chatbot figure is Nivi delivery cost ($52 all-in).

COST-EFFECTIVE AND SUSTAINABLE MODELS: WHAT SCALES

Cost-effectiveness can improve with scale, but some proven elements stay resource intensive.

CAN SCALE

Efficiency improves with scale

1. Content created for a wider geography or audience
2. Coordinated social media campaigns, with national channels signposting people to digital tools
3. Partners with reach across several geographies
4. Platforms and technology, such as chatbots

STAYS RESOURCE INTENSIVE

Proven, but costs stay high

1. Local delivery: tailored content, hyper-local targeting and trusted messengers
2. Training and ongoing support for health workers
3. Frontline workers' time to engage and respond to caregivers

Share and reuse what scales; budget steadily for local delivery and the people behind it.

COST-EFFECTIVE AND SUSTAINABLE MODELS: WHAT LASTED

No intervention was sustained in full. The elements that continued built on existing health workers and cost little to keep running.



"Don't throw the money or the funding to just the Puskesmas, but make sure it goes to at least provincial or national [level], so you can see the sustainability."

Multilateral stakeholder, Indonesia

MAINTAINED

✓ **WhatsApp channels**
Used by Puskesmas health workers in Indonesia; support groups integrated locally in India

✓ **Skills**
Health workers still applying content and communication skills

✓ **Digital assets**
In some cases, influencer content, open-source training and materials

✓ **Learning**
askNivi's learning used by Girl Effect and UNICEF

NOT MAINTAINED

– **Chatbots**
Required ongoing management and referrals

– **Dedicated support**
Data management, user engagement and content updates

– **Offline engagement**
Sustained work with influencers and community leaders

– **Common factor**
Each needed recurring staff time, technical input and further funding

01 Government adoption

Stakeholders saw this as more realistic than a replacement donor, with government involved from inception.

02 Evidence of how change happened

Impact and value for money mattered, as did evidence of how the intervention changed behaviour.

03 Fit to local context

Standard sustainability plans often missed differences in digital maturity, geography and government systems.

COST-EFFECTIVE AND SUSTAINABLE MODELS: DESIGN ADVICE

How to design cost-effective models: what works

FROM THE SESSION	DESIGN MODELS THAT	AVOID MODELS THAT
KNOWLEDGE vs ACTION	**Link demand to services people can reach,** with clear details of where and when to go	**Generate demand services cannot meet,** or aim only at factual knowledge
REACH vs ENGAGEMENT	**Use trusted local messengers** and two-way engagement	**Prioritise reach over engagement,** or run generic influencer campaigns
ONLINE vs OFFLINE	**Combine online and offline,** with a planned handover between them	**Only engage and recruit** people online
TARGETED PUSH vs ROUTINE	**Match the approach to the vaccine,** and reach caregivers early to reduce drop-out	**Apply one approach to every vaccine,** or wait until doses are missed
NATIONAL vs LOCAL	**Share platforms nationally and build delivery into local roles,** with a pathway to government ownership	**Create recurrent costs** with no local owner or pathway to government ownership
SKILLS AND CAPABILITY	**Invest in health workers' skills and digital confidence,** with ongoing support	**Rely on one-off training,** or assume skills are in place
COST-EFFECTIVENESS	**Reuse proven tools and content,** and track cost per additional vaccination	**Rebuild tools that already exist,** or judge success on reach alone

Build shared infrastructure once, then embed it in local and national systems so it keeps working after the grant.

COST-EFFECTIVE AND SUSTAINABLE MODELS: DESIGN ADVICE

How to design cost-effective models: what works, and what to avoid

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05. Practitioner panel

Lessons from Ghar Ghar Teeka, askNivi and Keluarga Berimun

PRACTITIONER PANEL

Three programmes: what worked, what they would change, and what comes next

	Ghar Ghar Teeka • WPP Media, India	askNivi Chatbot • askNivi, Nigeria	Keluarga Berimun • CISDI, Indonesia
	WhatsApp groups for frontline workers, chatbot, influencers and social listening	WhatsApp chatbot journeys for routine immunisation and HPV	Social media, WhatsApp support groups, a hotline and health worker training
01 WHAT WORKED BEST	**Digital built into ASHAs' existing work:** WhatsApp groups supported their regular visits, reaching 63,200 households.	**Community health volunteers converted best:** 98% completed onboarding, against 55% via digital ads.	**Support groups and hotline were most trusted;** reaching mothers in pregnancy gave the strongest signal.
02 WHAT THEY WOULD CHANGE	**Allow more time:** trust with hard-to-reach families builds through repeated contact.	**Run inside government systems** (NPHCDA and Lagos State) from day one.	**Fix service readiness alongside demand,** and link promotion to an actual appointment.
03 WHAT COMES NEXT	**Better measurement** of whether digital engagement changes behaviour.	**National infrastructure, local delivery,** with owners and funders named at the design stage.	**Build into antenatal care** and plan government ownership from day one.

06. Open Q&A and close

What confirmed or surprised you?

Q&A

Open Q&A: your questions and reflections

THE FIVE DESIGN CHOICES

- **A** National vs local
- **B** Reach vs engagement
- **C** Knowledge vs action
- **D** Targeted push vs routine
- **E** Online vs offline



Which findings confirmed what you expected?

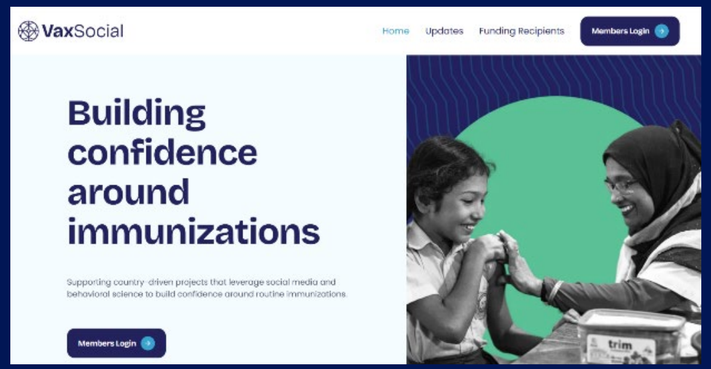
Which surprised you?

Has your view changed? The poll is still open: update your answers in the Teams chat.

Raise your hand or use the Teams chat.

Stay involved…

- The final report will be published in November, alongside **country briefs and best-practice guidance**. We will email you once they are live.
- All our Evaluation and Learning reports are available on the **VaxSocial website.**
- You can find and reuse **the key insights, best practices**, and **lessons learned.**
- Follow the QR code to find the **Learning and Resources Hub.**



Closing Remarks

Thank you

Please contact the VaxSocial MEL Team at:
Ana Babic (Ana.Babic@mcsaatchiws.com)
Steven Ginnis (Steven.Ginnis@ipsos.com)