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World Vision

Reference Guide on Social and Behavior Change for Routine Immunization in Cameroon

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Contents

Introduction

In Cameroon, the journey to routine immunization is a complex, emotional, and deeply social decision-making process, one shaped by individual beliefs, family dynamics, community norms, and systemic realities.

Take Bintou[1], a 22-year-old first-time mother. She's well-informed and wants her baby to receive all recommended vaccines. But when the health center is closed or transport costs pile up, her good intentions get stalled by systems that weren't designed with her life in mind. She needs reminders, nearby services, and emotional support to keep moving forward.

Now meet Cécile. She's 35, runs a small market stall, and cares for multiple children. She's not against vaccines, but she's not convinced either. Her past clinic visits left her feeling unheard. One of her children who was vaccinated experienced serious side effects and she had to bear the brunt alone. When she weighs vaccination against her past experience, it is marred by negative emotion and no trust in the health system.

Both are mothers, but their stories, motivations, and barriers are not the same.

And that's the main point.

Mothers are not a monolith.

And it's not just mothers. Fathers and grandmothers have influence over vaccination decision-making as well.

Jean-Paul, a taxi driver, sees vaccination as a low priority. He's heard too many conflicting stories from peers and holds deep skepticism toward the health system. No one has spent time with him to get his views on vaccination and help him work through his objections. His trust in the health care system is low. Unless someone he respects — maybe a local leader or another driver — clearly vouches for vaccination, he's unlikely to budge.

Marie, a 60-year-old grandmother, blends traditional remedies with cautious curiosity about modern healthcare. The fact that she did not vaccinate her children who are now adults influences their own decision-making. Conflation of traditional African medicine with vaccines causes tension and rejection of modern medicine in the family. She wants her grandchildren safe, but cultural beliefs linger. She moves forward when addressed with respect, not pressure.

Caregivers vary in their needs. Some are hindered by fear from past experiences. Others need more time, more reassurance, or more practical help. Some trust the system. Others carry doubt born from past experiences, family history, or cultural norms. Age, household dynamics, and life stage shape how each one thinks and feels about vaccines. Where Bintou is searching for affordable access and reliable scheduling, Cécile needs trusted voices and clear explanations. Their journeys and the support they require look very different.

These stories show why **understanding individuals, relationships, and systems is essential** to designing effective immunization interventions. Vaccine uptake depends on how the message lands—with whom, in what voice, and under what circumstances. It depends on whether a caregiver feels seen and supported.

Throughout this guide, you'll find practical strategies grounded in this perspective. Informed by Human-Centered Design, the WHO Behavioral and Social Drivers of Vaccination framework, and Gender Equality and Social Inclusion principles, these approaches recognize that **social and behavior change in immunization programming in Cameroon begins with listening and understanding the various perspectives of caregivers.**

1 Names used here are fictional.

Purpose of the Reference Guide

This reference guide is designed to equip program managers, technical specialists, and implementing partners with both **practical guidance** and **ready-to-use tools** to design and deliver effective Social and Behavior Change (SBC) strategies for routine immunization in Cameroon and similar contexts.

It is rooted in World Vision's SBC Framework and integrates insights from the WHO Behavioral and Social Drivers (BeSD) model, Human-Centered Design (HCD) methods, and Gender Equality and Social Inclusion (GESI) principles. The guide draws directly from formative research, tested messages, and implementation learning from the Nkolndongo Health District in Cameroon — meaning you can immediately apply the findings, personas, and communication materials to your own programming without replicating data collection. This will also help you identify exactly what additional data you need before you conduct additional research.

For each step of the SBC process, you will find:

- **A. How to Do It** – Instructions adapted for routine immunization, showing where and how to integrate BeSD, HCD, and GESI approaches.
- **B. Ready-to-Use from Cameroon** – A curated package of resources developed and tested during our project, including caregiver personas, barrier maps, videos, co-creation workshop guides, and implementation lessons.

By combining **action-oriented guidance** with **pre-developed evidence-based tools**, this guide enables program teams to move rapidly into **co-creation, message design, and testing**, ensuring interventions are grounded in real caregiver experiences while saving valuable time and resources.

Box 1: Why this approach?

The foundation of this guide — and the argument for using the Nkolndongo project as a springboard for future immunization work in Cameroon — rests on the fact that the approach was built using **state-of-the-art methodologies** for researching and designing SBC interventions. The integration of the BeSD model, GESI analysis, and HCD principles ensured that our work explored ***why*** barriers persist and how they can be addressed in ways that communities trust and embrace. This methodological rigor means that the insights and tools produced are already of a high standard and meet both national and global best practice.

Our formative research confirmed something important: **most of the major barriers to routine immunization are not new or unique**. They include long-standing concerns about vaccine safety, mistrust in health services, and the influence of social norms. This aligns with findings from previous studies in Cameroon and Africa in general (see the Formative Research Report). The real breakthrough of our project was not in uncovering entirely new barriers, but in demonstrating how to move beyond generic lists of issues and into **segmentation** — identifying distinct caregiver types and designing strategies tailored to each. This segmentation approach is critical for shifting from one-size-fits-all interventions toward targeted, high-impact engagement.

Because of this focus on segmentation, the products from this project — caregiver personas, Parent Champion model and tested videos based on specific barriers — are **immediately applicable to other urban areas** in Cameroon. The urban setting of Nkolndongo shares key similarities with other cities: diverse populations, varying levels of health service access, and overlapping social networks. By using this work as a starting point, program teams can save months of research time and investment, focusing instead on adapting messages and approaches to their specific urban context rather than starting from scratch.

For this reason, **users of this guide are encouraged to accelerate through Step 1**, relying on the data and products generated through this project. Within one to two weeks, they should be able to move to Step 2 — identifying and prioritizing influencing factors — using the caregiver personas, videos, and dashboard as concrete discussion tools in stakeholder consultations. Gaps identified during this process can be noted and integrated into Step 3, ensuring that strategy design reflects both the Nkolndongo evidence base and local context. **Only when critical information is missing and when stakeholders agree it is essential should additional research be commissioned**. This targeted, efficient approach ensures resources are focused on **adapting, implementing, and scaling solutions** that are ready to implement.

Alignment with National Health Policies, EPI Goals, and Gavi Priorities

This Reference Guide is anchored in Cameroon's national immunization strategies and global commitments, ensuring that its recommendations directly contribute to existing health priorities rather than creating parallel systems.

Alignment with National Health Policies

Cameroon's Ministry of Health, through the Expanded Program on Immunization (EPI), is committed to equitable access to vaccines for all children, particularly those in hard-to-reach or underserved communities. The EPI's operational framework prioritizes:Reducing the number of zero-dose children, defined as those who have not received Penta 1, across all regions where prevalence is highest.

- Addressing geographical, social, and economic inequities in vaccine access.
- Strengthening community engagement to build trust in the health system.

This guide complements these priorities by providing evidence-based approaches to understand and respond to the diverse decision-making pathways of caregivers, recognizing that mothers, fathers, grandparents, and extended family members are not a monolithic group but have distinct motivations, barriers, and influencers.

Alignment with EPI Goals

Cameroon's EPI has set ambitious goals to:

- Achieve and sustain high coverage for all antigens in the national schedule.
- Reduce dropout rates between initial and subsequent doses (e.g., DTP1 to DTP3).
- Close equity gaps between urban and rural districts and among socio-economic groups.

By unpacking caregiver decision-making through the BeSD framework, this guide equips program managers with practical strategies to:

- Build vaccine confidence through trusted messengers and tailored communication.
- Shift social norms by leveraging peer influence and culturally relevant narratives.
- Remove logistical and financial barriers through convenient, community-based service delivery.

Alignment with Gavi Priorities

Gavi, the Vaccine Alliance, emphasizes reducing the number of zero-dose children by 25% by 2025 and ensuring that every child completes their full immunization schedule. Gavi's support to Cameroon focuses on:

- Equity: reaching children in the most marginalized and underserved areas.
- Innovation: using data, geospatial mapping, and human-centered design to target interventions.
- Sustainability: strengthening local health systems and community ownership of immunization efforts.

This Reference Guide reflects these priorities by:

- Drawing on qualitative research to target high-burden areas and populations.
- Integrating SBC, HCD, and GESI principles to ensure interventions reach marginalized caregivers.
- Promoting sustainable community-led models, such as the Parent Champion approach, that can be maintained within national systems.

In sum, the guide operationalizes national and global goals by translating them into concrete, context-specific actions that address the realities of caregiver decision-making in Cameroon. Its emphasis on differentiated approaches for distinct caregiver personas ensures that policies and global targets are met through strategies that are socially and culturally resonant, practically feasible, and measurably impactful.

Foundations of SBC, GESI, and HCD

Strengthening immunization in Cameroon is about making sure that every child, no matter where they live or who they are, can be fully protected. To achieve this, we need to understand and apply three key approaches: **Social and Behavior Change (SBC), Gender Equality and Social Inclusion (GESI), and Human-Centered Design (HCD).**

SBC helps us understand *why caregivers choose (or do not choose) to vaccinate their children*. In Cameroon, this may be influenced by factors such as trust in health workers, cultural or religious beliefs, misinformation, or distance to health facilities. SBC gives us tools to address these issues, encourage positive health practices, and build long-term community confidence in immunization.

GESI makes sure that no child is left behind. In many communities, women are the primary caregivers, but they may face barriers in decision-making, mobility, or access to health services. Children with disabilities, families in remote rural areas, or those affected by poverty and displacement are also at higher risk of being excluded from immunization services. Applying a GESI lens ensures that these groups are not only reached but actively supported to access vaccines.

HCD ensures that solutions are *shaped with communities, not imposed on them*. By listening to parents, caregivers, community leaders, and health workers in Cameroon, we learn what works, what doesn't, and why. HCD emphasizes co-creation, testing ideas, and adapting programs so that services are trusted, practical, and sustainable.

When we bring **SBC, GESI, and HCD together**, we create immunization programs that go beyond simply delivering vaccines. We design initiatives that:

- Understand and address the real barriers caregivers face,
- Ensure equity so that all children (especially the most vulnerable) are reached, and
- Build trust and ownership within communities.

This combination is key to closing immunization gaps in Cameroon.

What is SBC?

Social and Behavior Change (SBC) is a systematic, evidence-based approach to understanding and influencing the factors that shape how people think, feel, and act in relation to health and well-being. In the context of routine immunization in Cameroon, SBC focuses on shifting individual behaviors, strengthening positive social norms, and creating supportive environments so that caregivers can confidently and consistently vaccinate their children.

SBC goes beyond simply providing information. While knowledge is important, decades of public health experience show that **information alone rarely changes behavior**. People's decisions (whether to vaccinate, seek care, or follow treatment) are influenced by a complex

World Vision Social and Behavior Change Framework

interplay of:

- **Individual factors** such as beliefs, attitudes, fears, past experiences, and perceived risks or benefits
- **Interpersonal influences** from family members, peers, community leaders, and trusted figures whose opinions shape norms and expectations
- **Structural and systemic conditions** such as service availability, quality of care, affordability, and accessibility

In immunization, this means recognizing that caregivers are not a monolithic group. A young mother in an urban market setting may face different pressures, doubts, and logistical barriers than a grandmother in a rural village or a father in a peri-urban neighborhood. SBC helps unpack these differences and design interventions that resonate with each group's realities.

An effective SBC approach for immunization typically combines:

- **Insight generation** – Using tools such as the BeSD framework to identify the motivators and barriers influencing vaccine uptake.
- **Tailored communication** – Designing messages and stories that connect emotionally, address specific concerns, and are delivered by credible messengers.
- **Norm change** – Promoting healthy behaviors to be seen as normal, valued, and expected within the community.
- **Enabling environments** – Removing practical obstacles (e.g., distance, cost, clinic hours) so that motivation can be translated into action.

For Cameroon's Expanded Program on Immunization, this means designing interventions that speak to the diversity of caregiver journeys, reinforce trust, and make vaccination a simple, supported, and socially reinforced choice.

What is Gender, Equality, and Social Inclusion?

Gender, Equality, and Social Inclusion (GESI) is an approach that ensures health programs recognize and address the different needs, roles, and barriers faced by people based on gender, age, disability, ethnicity, socio-economic status, and other identity factors. In routine immunization, applying a GESI lens means intentionally designing strategies so that **no child is left unvaccinated because of who they are, where they live, or the circumstances of their caregiver.**

GESI begins with the recognition that **health services are not experienced equally**. A mother in a remote rural village, a teenage caregiver, a father working long hours in the informal sector, and a grandmother in an urban settlement may all want to protect their children, but each faces unique challenges:

Access World Vision GESI & Health Reference Guide here!

- **Gender roles** may place the responsibility for child health on women, but also limit their decision-making power or mobility.
- **Cultural and social norms** can influence whether fathers or elders support vaccination, or whether young mothers feel confident to seek services.
- **Economic inequality** can make transport costs, lost income, or clinic fees significant barriers.
- **Disability or chronic illness** can limit access to information or physical mobility, making standard service delivery models insufficient.
- **Ethnic or linguistic diversity** can affect how messages are understood, trusted, or acted upon.

Applying a GESI approach in SBC for immunization means:

- **Analyzing inequities** – Using data and community insights to identify which groups are underserved or at higher risk of being zero-dose.
- **Understanding intersectionality** – Recognizing that overlapping factors (e.g., being a young, low-income mother in a remote area) create compounded barriers that require tailored solutions.
- **Designing inclusive strategies** – Ensuring that messages, messengers, and services are adapted for diverse audiences and accessible to all.
- **Challenging harmful norms** – Addressing beliefs and practices that limit caregiver autonomy, decision-making, or access to services.
- **Building accountability** – Embedding equity goals into monitoring systems so that progress can be tracked and gaps addressed.

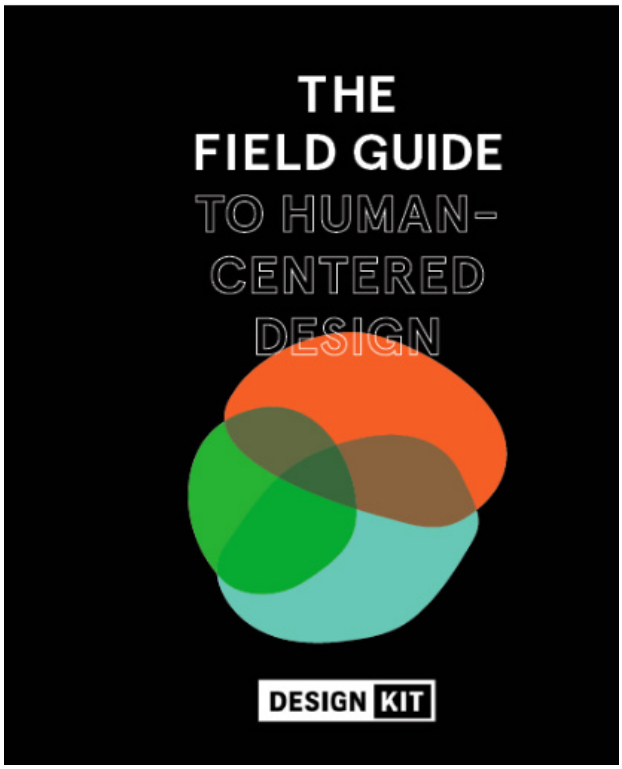
In Cameroon's immunization context, a GESI lens helps programs move beyond the idea of a typical caregiver and instead design for **the full range of caregiver personas,** from confident vaccine advocates to hesitant or resistant parents shaped by social norms, structural barriers, or past negative experiences.

What is What is Human Centered Design?

Human Centered Design (HCD) is a creative, problem-solving approach that places the people most affected by an issue at the center of the design process. In routine immunization, HCD means working *with* caregivers, communities, and health workers to understand their realities, co-create solutions, and test those solutions in real-world contexts before scaling them.

HCD is grounded in the belief that the best solutions emerge when they are shaped by the voices, needs, and lived experiences of the people they aim to serve. For immunization in Cameroon, this means going beyond top-down program planning to:

- **Listen deeply** – Understanding how caregivers think and feel about vaccines, what influences their decisions, and what barriers they face in accessing services.



Access IDEO's Field Guide to Human-Centered Design here!

- **Involve communities as co-designers** – Engaging caregivers, community leaders, health workers, and influencers in identifying problems and generating ideas.
- **Prototype and test** – Trying out promising solutions on a small scale, learning from real feedback, and refining before investing heavily.
- **Design for equity** – Ensuring solutions meet the needs of underserved and marginalized groups, not just the majority.

The HCD process often follows three iterative phases:

- **Inspiration** – Immersing in the community to understand people's needs, behaviors, and motivations.
- **Ideation** – Generating and refining ideas in collaboration with those who will use or deliver the solution.
- **Implementation** – Bringing solutions to life, learning, and adapting as they are rolled out.

In Cameroon's immunization landscape, applying HCD can lead to innovations such as:

- Service delivery models that match caregivers' daily routines.
- Communication strategies that reflect local languages, humor, and storytelling traditions.
- Tools or processes that reduce clinic wait times and improve caregiver experiences.

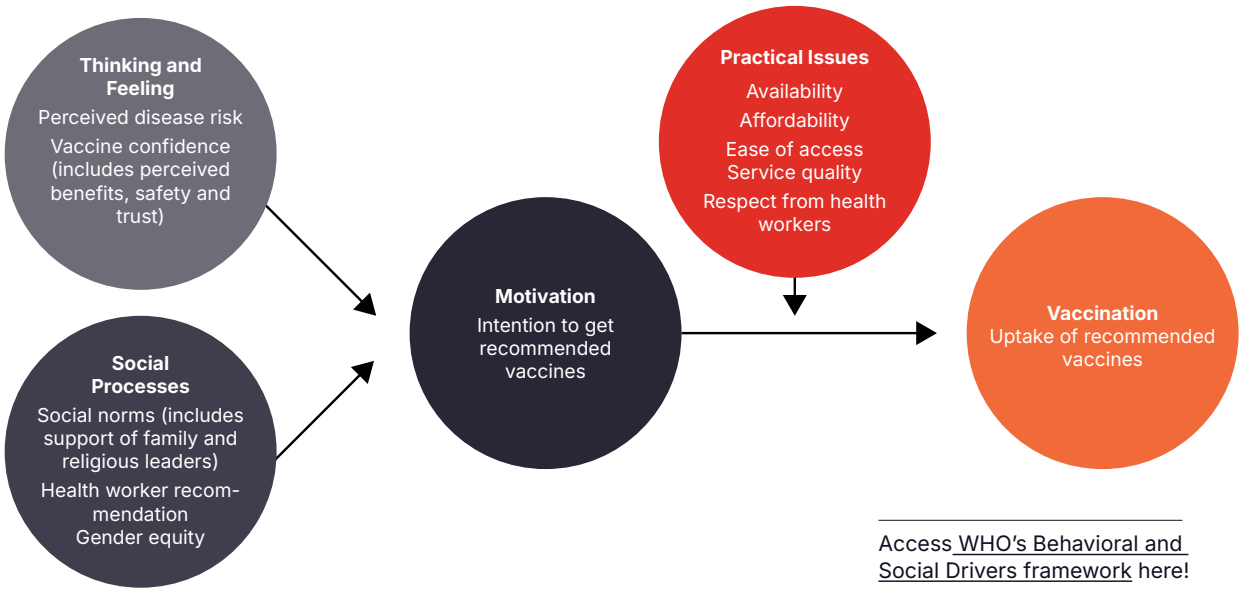
When combined with SBC and GESI, HCD provides a practical pathway to design interventions that are not only effective but also trusted, culturally relevant, and embraced by the communities they serve. The result is stronger relationships between the health system and the people it serves, and greater community ownership of child health outcomes.

Overview of WHO's Behavioral and Social Drivers (BeSD) Framework for Vaccination

The **BeSD framework**, developed by the WHO, is a structured approach for understanding ***why*** people do or do not vaccinate. It identifies the cognitive, emotional, social, and practical factors that shape vaccination decisions, and provides tools to measure and address them.

In the context of routine immunization in Cameroon, the BeSD framework helps health programs move beyond assumptions and uncover the ***specific drivers*** influencing different caregiver groups—recognizing that mothers, fathers, grandparents, and other decision-makers are not a monolithic audience.

Behavioural and Social Drivers of Vaccination Framework



Access WHO's Behavioral and Social Drivers framework here!

The BeSD framework organizes these drivers into four main domains:

1. **What people think and feel**
    - Beliefs about vaccine safety, effectiveness, and importance
    - Emotions such as fear, anxiety, or confidence
    - Past experiences with vaccination or the health system
2. **Social processes**
    - Influence of family members, peers, and community leaders
    - Social norms about whether vaccination is expected, accepted, or discouraged
    - Trust in health workers and institutions
3. **Motivation to vaccinate**
    - Intentions to vaccinate now or in the future
    - Perceived urgency or relevance of vaccination for their child
    - Personal agency and ability to follow through on intentions
4. **Practical issues**
    - Availability and accessibility of vaccination services
    - Affordability, transport, and convenience
    - Quality of service delivery and treatment by health workers

The BeSD framework enables programs to:

- Pinpoint the most significant barriers and enablers for different caregiver personas.
- Design targeted interventions that address both ***emotional*** and ***practical*** determinants of vaccination.
- Monitor changes over time, allowing for real-time adaptation of strategies.

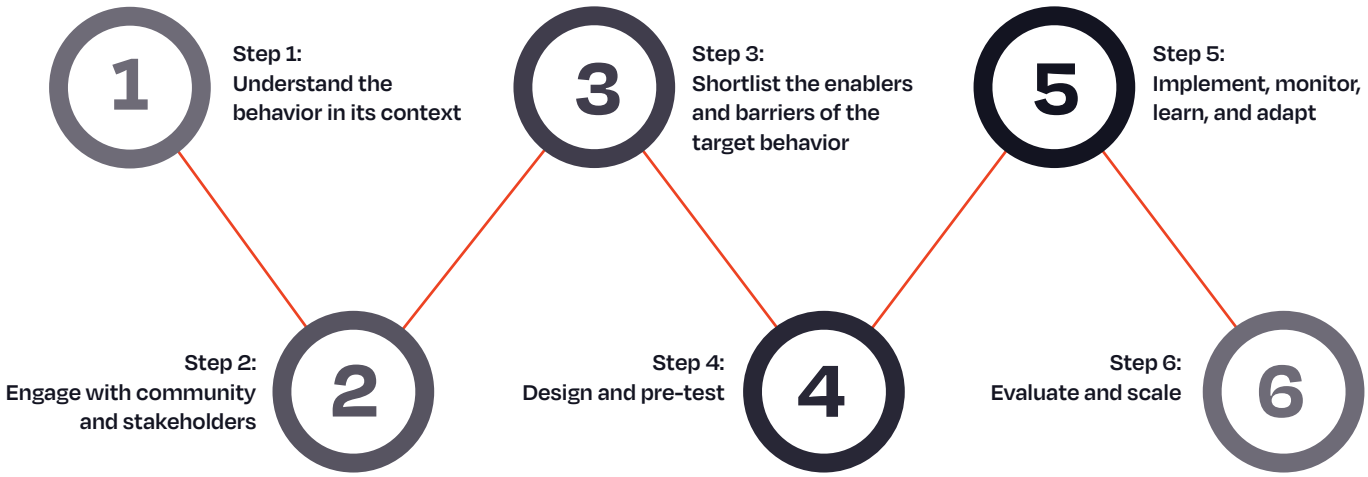
For example, in Cameroon, BeSD-informed analysis might reveal that:

- Some caregivers are motivated but delayed by transport costs or clinic hours (practical issues).
- Others are emotionally moved by stories but hesitate due to unanswered questions about vaccine contents (thinking and feeling).
- In certain communities, elders' endorsement is more influential than health worker advice (social processes).

When integrated with SBC, GESI, and HCD approaches, BeSD offers a powerful way to design interventions that are empathetic, evidence-based, and contextually grounded.

World Vision's SBC Design Steps

World Vision's SBC design process encompasses six steps.



Step 1: Understand the behavior in its context – Identify the target behaviors and analyze how they are perceived within the community. Use participatory methods such as focus groups, interviews, and photovoice to explore behavioral drivers and barriers across the four SBC domains (individual, family, community, society). Apply tools like GESI analysis, root cause analysis, and barrier analysis to uncover the full context.

Step 2: Engage with community and stakeholders – Share and validate findings from the context analysis with community members and stakeholders. Define sub-behaviors, verify audience segmentation, and map power dynamics. Use co-creation sessions and HCD tools (e.g., journey mapping) to identify solutions that resonate locally.

Step 3: Shortlist the enablers and barriers of the target behavior – From the long list identified earlier, select the most feasible and impactful barriers and enablers to address. Align project goals and objectives to focus on increasing ability, motivation, and opportunity for the desired behaviors.

Step 4: Design and pre-test – Translate strategy into activities using the four design principles: grab attention, cause reflection and revaluation, change the context, and normalize positive behaviors. Create a logic model, budget, and implementation plan. Pre-test components for effectiveness and adjust as needed, while strengthening implementer capacity.

Step 5: Implement, monitor, learn, and adapt – Roll out activities following a monitoring and evaluation plan. Regularly collect and analyze data, provide feedback, keep stakeholders informed, and document lessons learned for ongoing adaptation.

Step 6: Evaluate and scale – Conduct an evaluation to assess effectiveness, and where possible, with external reviewers. Use results to provide recommendations for scaling and adapting to new contexts, ensuring the approach can expand its reach and maintain impact.

In this guide, the steps follow the World Vision SBC Framework but are adapted to incorporate the BeSD model, GESI principles, and HCD methods applied in the Nkolndongo project. This version is tailored for program managers who want to use the existing evidence base to accelerate design and implementation.

Step 1: Understand the Behavior in its Context

Begin by clearly defining the immunization behaviors you aim to influence (e.g., timely completion of the vaccination schedule for children under one year). Use the Nkolndongo formative research findings, which already identify the most common barriers and enablers across caregiver types, as your starting point. Apply the **BeSD framework** to organize insights under thinking & feeling, social processes, motivation, and practical issues. Use **GESI analysis** to examine how these barriers differ for mothers, fathers, grandmothers, and other influencers. If your local context is similar to Nkolndongo, skip fresh data collection and move directly to validation with stakeholders.

How to Do It

Understanding the behavior in its context is the foundation of the SBC process. This step ensures you know *exactly* what behavior you are trying to influence, who performs it, who influences it, and what drives or hinders it. In routine immunization, this means digging beneath surface assumptions ("mothers don't vaccinate because they lack awareness") to uncover the mix of beliefs, social influences, motivations, and structural barriers that shape decisions.

Start by clearly defining the target behavior. Be specific about *who* needs to do *what*, *where*, and *when*. Keep it observable and measurable.

Example:

Caregivers of zero-dose and under-immunized children (0–24 months) take their children for all age-appropriate routine immunizations on time.

If robust research already exists, adapt it rather than starting over. Focus your time on filling priority knowledge gaps that you find from the secondary research, stakeholders, or wider community consultations that you conduct under Step 2. Segment your audience into profiles that feel real and relatable — not just 'women of reproductive age' but distinct types with different drivers, barriers, and influencers.

BOX 2: Stakeholder Consultations

Before any data collection began, the project team held a series of **stakeholder consultations** to ensure that our focus and methods were relevant, culturally appropriate, and aligned with existing priorities.

We met with various stakeholders including **district EPI managers, WHO, UNICEF, and CHAI**. These exchanges helped us to understand whether formative research needed to be conducted and if so, how it needed to be conducted.

If you decide research is needed, use a mixed-methods approach to explore barriers and enablers across all SBC domains (individual, family, community, and societal), integrating **GESI, BeSD**, and **faith norms** analysis to capture nuances in decision-making. **Make sure that you understand the ethical approval process in detail.** As of the time of writing (August 2025), it is possible to seek ethical approval through the national level and district level in Cameroon. It is important to contact the EPI before initiating any formative research process.

Identify all decision-makers and influencers. Map who has voice, veto, or influence at household and community levels (e.g., young/older mothers, fathers, grandmothers/ grandfathers, aunts, older siblings, CHWs, health workers, religious/traditional leaders, peers, market associations, taxi unions).	Apply BeSD across four domains. For each audience segment, capture drivers/barriers under: Thinking & Feeling, Social Processes, Motivation, Practical Issues. Use both qualitative (IDIs/FGDs) and rapid surveys if you have time and resources to rate salience and direction (enabler vs. barrier). The data collection tools are already available in the BeSD guidelines. Adapt them to your context.
Use a GESI lens. Examine power and participation (who decides, who speaks, who is excluded), differential access to information/ services, social norms and stigma, safety and well-being, and systemic barriers (policies, procedures). Consider intersectional factors (age, disability, migration, conflict-affected status, occupation).	Use HCD immersion to observe lived experiences. Pair interviews with shadowing, guided tours, day-in-the-life, role plays, and artifact walk-throughs (home-based records, appointment cards). Capture exact moments of friction (transport, fees, stock-outs, disrespect, time trade-offs) and moments of meaning (pride, protection, faith, solidarity).

Field Box: How we executed Step 1

We began by assembling a multidisciplinary core team (SBC specialists, an HCD expert, routine immunization (RI) technical leads, and an experienced in-country SBC consultant) and agreed from the outset that the BeSD framework would be our analytic framework, with GESI as a cross-cutting lens.

Because we were entering households and discussing health decisions, we moved carefully through ethics. The Ministry of Health issued a letter authorizing a steering committee meeting; the committee was convened; and after three months, we received final IRB approval. What made that possible was having the in-country consultant steer the process, covering meeting costs so key officials could participate, keeping the EPI focal point engaged throughout, and exploring regional IRB pathways in parallel so delays did not stall fieldwork planning.

With approvals in hand, we recruited and trained data collectors. The Chief of District issued a signed service note, and we introduced the team to facility heads and CHWs to legitimize the work at the local level. Training emphasized ethical interviewing, GESI-sensitive rapport building, and strict alignment to BeSD domains so the field team could surface cognitive, social, motivational, and practical drivers consistently.

Data collection was door to door, guided by facility defaulter lists and CHW knowledge of households. To reduce empty visits, we placed pre-scheduled calls to caregivers whenever possible, which markedly improved hit rates. Each evening we ran daily debriefs to troubleshoot (e.g., language or access issues), fine-tune prompts, and adjust the next day's route—small course corrections that protected data quality and momentum.

In total, we captured 135 valid interview transcripts across caregiver types. Analysis combined rapid, AI-assisted sentiment analysis with human review, mapping responses to the four BeSD domains to reveal patterns by segment (for example, differences between younger and older mothers in trust, perceived benefits, and reliance on elders). Those patterns were synthesized into a set of personas that translated raw findings into design-ready profiles—clear, relatable starting points for co-creation, message testing, and targeted implementation.

Ready-to-Use from Cameroon

1. **Clear behavior statement for RI.** Adopt wording to your health area and translate for field use.
2. **BeSD barrier matrix.** Below are the main barriers we identified amongst mothers.

BeSD Domain	Main barriers amongst mothers
Thinking & Feeling	• Fear of side effects • Mistrust of health system • Confusing or conflicting information • Skepticism about perceived benefits (especially amongst older mothers due to negative experience)
Social Processes	• Isolation in decision-making - lack of family and community support • Weak normative pressure – routine immunization is not generally talked about and normalized • Pockets of cultural resistance still exist against "foreign medicine" • Competing demands and insufficient support prevent action
Motivation	• Negative past experiences with the healthcare system or with (management of) adverse events • Weak outreach and support systems
PracticalIssues	• Logistical issues like transportation and occasional affordability challenges • Long waiting times

Segmented caregiver personas.
Please see page 22 for the final personas that can be used in future programming.

3. **GESI insights & implications.** We found differences between older and younger mothers. Younger mothers tended to be generally more positive about vaccination, but faced logistical challenges. Older mothers on the other hand, possibly due to the fact that they have had other children and have had negative encounters with the health care system, were less positive about immunization.

We also found that fathers were largely left out of the conversation around immunization with no interventions that seemed to target them specifically. We found this to be a significant missed opportunity as they are influential decision-makers.

Resources: Research Protocol | Formative Research Report | Process Learning Report

Step 2: Engage with Community and Stakeholders

Hold co-creation workshops that bring together caregivers, health workers, community leaders, and other influencers. Present the existing personas, barrier/enabler maps, and videos from Nkolndongo as discussion tools. Encourage participants to validate which factors are relevant locally and adapt them if necessary. Use HCD tools like journey mapping to trace caregiver decision-making, and map the power dynamics that influence vaccination.

How to Do It

Once you understand the behavior in its context, the next step is to identify and prioritize the factors that influence whether the behavior happens recognizing that not all drivers are equal, and some lie outside your program's span of control.

Begin by mapping stakeholders across the system, community, and social networks, including EPI/MOH, district teams, facility staff, CHWs, municipal authorities, traditional and faith leaders, women's and market groups, youth groups, taxi associations, schools, media, and civil society organizations. Use targeted consultations to validate your focus and secure early buy-in: share the formative insights, co-review and rank barriers, align on roles and decision rights, set ground rules for respectful dialogue, and agree on quick wins and constraints. **Use this opportunity to gain insights into additional barriers that you may not have identified previously.** From the outset, engage champions and gatekeepers intentionally: gain insight into who may be credible messengers, brief influential leaders before public activities, invite skeptics into safe, small-group dialogues, and document specific commitments so they translate into action. Here are the steps to follow in preparation for Step 2:

Box: How we executed Step 2

Due to time constraints, we executed Step 3 before Step 2 and went into Step 2 with pre-defined barriers and behaviour change techniques that we wanted to focus on. We used these specific behaviour change techniques to design prototypes for Step 2.

In January 2025, we convened a three-day co-creation workshop at CASS de Nkolndongo Hospital, bringing together EPI officials, district and facility staff, community health workers, community and faith leaders, and caregivers. On Day 1, participants validated the formative research findings and surfaced the dominant barriers to routine immunization, misinformation, distrust of services, safety concerns, limited family support, and financial constraints. Day 2 focused on reviewing seven prototype concepts (including storytelling, role-play, peer support, humor, and leader endorsements), which teams scored for desirability, feasibility, and cultural fit. By Day 3, the group reached consensus on two core interventions: Parent Champions and locally produced SBC videos; then clarified roles, approvals, and immediate next steps. To secure early buy-in throughout, facilitators grounded decisions in real caregiver quotes and rough storyboards, building shared ownership from the start.

Ready-to-Use from Cameroon

Stakeholder consultation process & agenda

Three-day co-creation at the district hospital designed to move from shared evidence to agreed action. **Day 1** focused on validating the formative findings: facilitators presented BeSD-organized insights and caregiver personas; mixed tables (health staff, leaders, caregivers) surfaced dominant barriers (misinformation, distrust, safety concerns, limited family support, and financial constraints) then documented where these show up locally. **Day 2** shifted to solutioning: the group reviewed **6–8 prototype ideas** (e.g., storytelling, role-play, peer support, humor pieces, leader endorsements, small-group dialogues) using a simple scoring grid for **desirability, feasibility, and cultural fit**; low-fidelity materials (persona cards, mock scripts, storyboard sketches) kept the discussion concrete. **Day 3** converged on a package: **Parent Champions + a locally produced video series** as the core, with clear **roles, approvals, timelines, and 'quick wins'** (e.g., first orientation for Parent Champions, priority neighborhoods, content adaptations). Each day closed with a short "decisions & actions" recap so commitments were visible and owned.

Lessons on building trust & sustaining engagement

Pair **formal authorizations** (letters from district/EPI; ethics and facility approvals) with **informal relationship-building** (pre-briefs with chiefs, clergy, women's leaders). Engage CHWs to open doors, translate norms, and vouch for the process. **Set clear ground rules** for respectful dialogue and confidentiality; acknowledge concerns without dismissing them.

Resources: Process Learning Report | Final Report (co-creation decisions)

Step 3: Shortlist the Enablers and Barriers of the Target Behavior

From the validated list, identify the highest-impact and most feasible factors to address. For example, in Nkolndongo these included building trust in health services, addressing safety concerns, increasing positive peer modeling, and improving convenience of services. Using a scoring system from 1 (low) to 5 (high), conduct a prioritization of the barriers identified based on these criteria:

- How strongly does this barrier influence the target behavior?
- Does EPI see this as a high-priority issue?
- How feasible is it to address this barrier with available methods and tools?
- Will addressing this barrier positively influence other barriers or determinants?

Add other criteria that make sense for your project and approach.

How to Do It

Cluster insights by BeSD domain and by persona and score each barrier using the criteria above.

For example:

	Older Mothers	How strongly does this barrier influence the target behavior?	Does EPI see this as a high-priority issue?	How feasible is it to address this barrier with available methods and tools?	Will addressing this barrier positively influence other barriers or determinants?	Average Score
Thinking and Feeling	Low trust in health systems and providers amongst older mothers	4	4	5	5	**5**
	Safety of vaccines	3	4	4	3	**4**
	Skepticism about perceived benefits (especially amongst older mothers due to negative experience)	4	4	5	4	**4**

The next step is to choose the correct behaviour change technique that is recommended to address the type of barrier identified.

Here's a ready-to-use menu of **SBC techniques mapped to each WHO BeSD domain** drawing on World Vision's SBC Toolkit and depending on the types of barriers that you prioritize.

BeSD domain	SBC technique	What it does	Cameroon-ready example / activity
Thinking & Feeling	Persuasive narratives + plain-language facts	Addresses fears and misconceptions; builds confidence in safety/benefits	Use caregiver stories that mirror local doubts; pair with a one-pager on "what's in the vaccine" and normal side effects
Thinking & Feeling	Structured Q&A	Provides clear answers to common questions in a calm format	Short FAQ cards for CHWs/Parent Champions to use in home or courtyard conversations
Thinking & Feeling	Credible modeling (peer or provider)	Shows "people like me" choosing vaccination and doing well	Invite a respected mother/grandmother who completed RI to share her journey during small dialogues
Thinking & Feeling	Self-reevaluation / future-casting	Helps caregivers visualize consequences of delaying vs. vaccinating	Guided prompt: "Imagine your child at school next year—what protects them?" followed by benefits recap
Thinking & Feeling	Guided observation (clinic walk-through)	Demystifies the process; reduces anxiety	10-minute facility walk-through before market-day outreach; introduce the named vaccinator
Social Processes	Mobilize social support circles	Makes pro-vaccination talk visible and normal	Mother-to-mother (or mixed caregiver) micro-groups; WhatsApp reminder/support threads
Social Processes	Peer/parent educators (Parent Champions)	Leverages trusted neighbors as messengers	Train Parent Champions to host 6–10 person dialogues and make warm referrals to a named nurse
Social Processes	Leader endorsement & norm cues	Shifts perceived norms via respected voices	Brief faith/traditional leaders; include a 60-second RI mention in services/meetings

Social Processes	Public commitment / recognition	Uses commitment and social proof to reinforce behavior	"My child is up-to-date" cards; light recognition at community meetings (opt-in)
Social Processes	Strengthen linkages (network weaving)	Connects caregivers to supportive people / places	Share a simple contact map: Parent Champion → CHW → facility focal point; share clinic days and phone numbers
Motivation	Anticipated regret / consequence framing (done ethically!)	Converts concern into intention with agency	"If we miss Thursday, what might we worry about later? Here's how to make it easy on Thursday."
Motivation	Implementation intentions ("if–then" plans)	Turns intent into a concrete plan	Write a mini-plan: "If it's market day at 9:30, then I go to the outreach tent at 10:00 with Auntie"
Motivation	Simple cues & reminders	Prompts timely action	Paper reminder slips; neighbor prompts; WhatsApp ping the evening before session day
Motivation	Positive reinforcement / recognition	Sustains momentum dose-to-dose	Parent Champion or nurse sends a short "well done—next date is…" message after each visit
Motivation	Address fears with reassurance scripts	Keeps motivation from collapsing under anxiety	Two-minute script on expected side effects + what to do and who to call (named contact)
Practical Issues	Service redesign / outreach alignment	Reduces time, cost, and hassle	Pop-up posts near markets; align Parent Champion mobilization with facility outreach days; fast-track under-ones
Practical Issues	Quick facility diagnostics + fixes	Improves client experience quickly	10-point checklist (wait time, signage, seating, respectful greeting); agree 2 quick fixes per month
Practical Issues	Provider communication coaching	Increases respectful, clear counseling	On-the-job coaching for vaccinators on empathetic, GESI-sensitive counseling and Adverse Event Following Immunization (AEFI) guidance
Practical Issues	Navigation & referral support	Makes follow-through easy	Parent Champion issues a referral slip to a **named** vaccinator on a **specific** day; shares map and phone
Practical Issues	Local transport / scheduling solutions	Removes last-mile barriers	Organize group walks from meeting points; align hours with peak caregiver availability; micro-stipends where feasible

Box: How we executed Step 3

The prioritization exercise converged on a small set of high-leverage issues across the BeSD domains. Under **Thinking & Feeling**, the team focused on **low trust in the health system and providers among older mothers**, **concerns about vaccine safety**, and **skepticism about perceived benefits**—the latter often rooted in older mothers' **negative prior experiences**. In the **Social Processes** domain, **minimal peer networks** emerged as a critical gap, limiting positive social proof and day-to-day encouragement to vaccinate. For **Motivation**, **negative past experiences** were directly linked to a **lower perceived importance of vaccination**, depressing intention and follow-through even when services were available. Together, these priorities sharpened the strategy on rebuilding trust and perceived benefits (especially for older mothers) while growing peer support and addressing the motivational drag created by prior adverse or discouraging encounters.

From this mapping, seven prototype concepts moved into Step 4 for co-creation and testing. Ultimately, the **Parent Champion model** paired with **locally produced video storytelling** was selected as the backbone, because together they touch multiple BeSD domains at once: shifting beliefs and norms, strengthening motivation, and easing practical barriers.

Ready-to-Use from Cameroon

Using the qualitative data we had, we conducted a sentiment analysis of the data. The first sentiment analysis that was completed was of younger and older mothers of zero-dose children (all data is available on the project website).

Since twelve barriers across the BeSD were identified, it was not realistic to base the planned co-creation workshop around all these barriers. The team thus conducted a barrier prioritization exercise to shortlist the barriers to focus on for the co-creation workshops. These were shared with the team and the Cameroon SBC consultant designed the prototypes that would be included in the co-creation.

Thinking & Feeling	Low trust in health systems and providers amongst older mothers
	Safety of vaccines
	Skepticism about perceived benefits (especially amongst older mothers due to negative experience)
Social Processes	Minimal peer networks
Motivation	Negative past experiences - linked to low perceived importance of vaccination

In line with this, the following behavior change techniques (BCTs) were identified as most relevant:

Domain	Barrier	BCT	Idea to discuss during co-creation session
Thinking & Feeling	Low trust in health systems and providers amongst older mothers	Persuasive Communication	• Real stories of how vaccination has saved lives. • 'Vaccination Fake News' comedy segment (to be trialled during the co-creation sessions)
		Modeling	Video testimonials of older mothers who previously doubted vaccination but later had positive experiences with their children being vaccinated; Highlight their journey from skepticism to trust in healthcare systems
	Safety of vaccines	Consciousness Raising	Videos answering the most frequent concerns about vaccines; Normalizing that fear is normal but addressable
	Skepticism about perceived benefits (especially amongst older mothers due to negative experience)	Self-Reevaluation	Role-playing to help mothers visualize future benefits and risks of vaccination (community activity)
		Direct Experience	Arrange visits to vaccination clinics where hesitant mothers can observe the vaccination process
Social Processes	Minimal peer networks	Mobilizing Social Support	Create peer-led vaccination support groups in the community, where mothers can share experiences, successes, and challenges
Motivation	Negative past experiences - linked to low perceived importance of vaccination	Anticipated Regret	A humorous video where parents imagine "what could go wrong" if they skip vaccination, with exaggerated scenes (e.g., chasing down a flu virus dressed as a mischievous villain); Follow with a reassuring message emphasizing the ease and benefits of vaccination

This formed the basis for the final prototypes that were designed.

Resources: Project website | Process Learning Report | Prototypes | Videos

Step 4: Design and Pretest

Translate your shortlist into a **clear SBC strategy** with objectives, activities, and delivery channels tailored to each caregiver segment. Draw on the tested Nkolndongo activities — such as home visits with video screenings and Parent Champion-led group dialogues — as adaptable templates. Follow the four design principles: grab attention, cause reflection, change the context, and normalize the behavior. Pre-test messages and materials with local caregivers, adapting based on feedback.

How to Do It

With the priority drivers clear, **co-create** solutions directly with audiences and stakeholders—caregivers from each persona group, CHWs, facility staff, and local leaders. In these sessions, the techniques defined under Step 3 are translated into concrete concepts using World Vision's design principles:

- **Grab attention** (hooks that make people look up)
- **Cause reflection/re-valuation** (stories and prompts that reframe risk and benefit)
- **Change the context** (make the desired action easier and more convenient)
- **Normalize positive behavior** (show that "people like me" vaccinate on time)

Then **develop lightweight prototypes** that are quick to make and easy to change: message drafts and talking points, simple **video storyboards**, **referral cards** that name a specific vaccinator and clinic day, **parent-to-parent conversation scripts**, and short small-group facilitation guides. **Using AI tools is very beneficial at this stage to generate short video clips, story boards or other visuals.** Prototypes move straight into **pre-testing** with each persona through rapid cycles. Check:

- **Clarity** (do they understand?)
- **Relevance** (does it speak to their reality?)
- **Emotional resonance** (does it feel right and respectful?)
- **Comprehension and believability** (do they trust it?)
- **Motivation** (does it make them want to act?)
- **Perceived fit** (with local norms and logistics)

Based on response and feedback, revise scripts, tighten visuals, swap messengers if needed, and repeat—so only the versions that work in real conversations move forward to implementation.

Box: How we executed Step 4

We began with co-creation sessions that turned the prioritized BeSD drivers into on-the-ground concepts. Creative briefs were developed based on the outcomes of Step 2. Using real caregiver quotes as anchors, the team drafted scripts and storyboards designed to grab attention, prompt reflection, and normalize timely vaccination. We initially planned five scripts, then expanded to seven to address father involvement explicitly. Parent Champions role-played scenes with facilitators and health staff; quick pre-tests with each persona group sharpened casting, tone, and message clarity before anything was filmed.

Production choices were deliberate. We shot in familiar places—health centers, markets and town halls, and Parent Champion homes—to make services feel routine and accessible. Trusted messengers (nurses, CHWs, and peers) featured prominently so viewers could see "people like me" and "the nurse I know" guiding the way.

To ensure the videos worked in real conversations, we trained Parent Champions on a simple **before–during–after** viewing guide: **prime** the discussion with one question that surfaces the local barrier; **screen** the clip with short pauses for dialogue; **close** with a clear next step and a warm referral to a named vaccinator on a specific day. What resonated most were emotionally authentic stories, credible peers, and concrete next steps. What under-performed were generic fact lists delivered without a trusted voice—and any content that missed the local language or tone.

Ready-to-Use from Cameroon

Videos and Parent Champion Model

Storylines are grounded in the BeSD priorities and written for short, high-impact scenes:**dramatic scenarios** that start with a common rumor and end with a trusted explanation; **parent testimonials** where formerly hesitant caregivers describe what changed their minds; **caregiver conversations** that model respectful, two-way dialogue; and **home-based scenes** that show real constraints and how families solve them. Each script includes a clear **call to action**.

> Other material can be created using the personas below.
>
> *Please note that we tested Message Reception, Message Credibility and Behavioral Outcome based on our intervention using videos and the Parent Champion model, which was only tested with mothers. That is why these markers are not included for other caregiver types.*

How to use: Match household to persona; apply What works + approaches; track signals to verify progress.

Legend – Sentiment scale:

🔴⚪⚪ 1 = negative 🟡🟡⚪ 2 = mixed 🟢🟢🟢 3 = positive

The Ready-but-Blocked Mother

Often converts after Parent Champion referral

Wants her child protected and believes vaccines work. Misses visits because of queues, timing, transport costs, or childcare. Emotional stories plus a clear, doable next step turn intention into action.

BeSD snapshot

- 🟠🟠⚪ Thinking & Feeling
- 🟢🟢🟢 Motivation
- 🟢🟢🟢 Message Reception
- 🟢🟢🟢 Behavioral Outcome
- 🟢🟢🟢 Social Processes
- 🟠🟠⚪ Practical Issues
- 🟢🟢🟢 Messenger Credibility

Key barriers

- Time/queue length; clinic hours clash with market work
- Transport money and traveling with multiple children
- Fear of missing documents or being scolded

What works

- Short, emotive videos + peer stories that normalize vaccinating now
- Specific next step: date, place, what to bring; SMS/WhatsApp reminders
- Doorstep/nearby options, fast-track or appointment windows

Effective messenger

Warm, local Parent Champion (similar life stage) linked to a named nurse

Best channels

Video watch parties, one-to-one home visits, WhatsApp voice notes

Program Approaches

- Micro-scheduling on market days; queue-busting windows
- Transport vouchers or group walking buses
- No-shame document replacement and clear signage at facility

Indicators

- Higher kept-appointment rate after reminder
- Walk-ins increase when outreach is within 10–15 minutes of home

The Natural-Care Mother

Refuses referral; requires value-aligned, long-horizon engagement.

Refuses referral on principle. Grounds her parenting in natural care, tradition and culture. Sees vaccination as risking purity and control over her child's body; perceives outreach as pressure or shaming. Logistics fixes alone won't move her.

BeSD snapshot

- 🔴⚪⚪ Thinking & Feeling
- 🔴⚪⚪ Motivation
- 🟢🟢🟢 Message Reception
- 🔴⚪⚪ Behavioral Outcome
- 🟠🟠⚪ Social Processes
- 🟠🟠⚪ Practical Issues
- 🟢🟢🟢 Messenger Credibility

Key barriers

- Identity-linked beliefs (purity, fertility, too many injections) and preference for herbal/traditional care
- High mistrust from prior negative facility encounters or stories
- Skeptical social network; fears judgment or loss of autonomy

What works

- Moral reframing around care/protection using local mothers' stories
- Non-pressured invitations: attend growth monitoring or vitamin A first (no immediate vaccination ask)
- Private, trauma-informed conversations; explicit no-shame approach; pre-bunk and answer questions only when invited

Effective messenger

Senior female nurse/midwife paired with a respected traditional birth attendant or faith mother; Parent Champion as bridge

Best channels

Discreet home visits, small closed-group circles, one-to-one audio notes (not public watch parties)

Program Approaches

- Private consult slots and grievance-redress channel
- Bridge services at outreach (growth checks, nets) to build reciprocity
- Negotiation support where a partner blocks access; safeguarding protocol if risk is flagged

Indicators

- Reduced confrontational language; willingness to talk again
- Acceptance of non-vaccine services; keeps/requests child card
- Agrees to visit with trusted messenger; first vaccine given after staged contact

The Cautious Experienced Mother

Accepts referral but may delay without follow-up

Has prior experiences (side effects, confusing guidance). Open but holds back without precise, credible answers about vaccine contents, safety, and schedules.

BeSD snapshot

- 🟠🟠⚪ Thinking & Feeling
- 🟠🟠⚪ Motivation
- 🟢🟢🟢 Message Reception
- 🟠🟠⚪ Behavioral Outcome
- 🟢🟢🟢 Social Processes
- 🟠🟠⚪ Practical Issues
- 🟢🟢🟢 Messenger Credibility

Key barriers

- Safety concerns after a previous adverse event or rumor
- Confusion about schedules/contraindications and mixing brands
- Low trust from past negative facility interactions

What works

- Respectful, slow conversation; acknowledges fears without arguing
- Clear, specific answers with simple visuals (what, why, when)
- Offer presence during next visit; follow-up call after vaccination

Effective messenger

Parent Champion + named nurse/pharmacist for tech questions

Best channels

Kitchen-table chats, small women's groups, clinic open days

Program Approaches

- FAQs in local language; what to expect after vaccination cards
- Dedicated quiet corner at facility for questions
- Proactive adverse-event counseling and callback protocol

Indicators

- Increase in questions asked (good sign) preceding vaccination
- Drop in no-shows when a nurse is pre-introduced by the Parent Champion

The Father Gatekeeper

Mixed; moves when peers/leaders endorse and logistics are easy

Controls household decisions and spending. Can derail mothers' positive intentions. Skeptical and busy; needs practical, status-affirming reasons to green-light vaccination and proof that it is safe.

BeSD snapshot

- 🔴⚪⚪ Thinking & Feeling
- 🔴⚪⚪ Motivation
- 🔴⚪⚪ Social Processes
- 🟠🟠⚪ Practical Issues

Key barriers

- Sees immunization as unsafe
- Suspects hidden costs or time loss at clinics
- Limited exposure to credible male messengers

What works

- Male role-model testimonies tying vaccination to protecting earnings
- Guarantee of speed (appointment ticket) and transparency of costs
- Community leader endorsement; invite him to the plan (date/time)

Effective messenger

Respected male Parent Champion or leader; employer/association rep

Best channels

Men's groups, moto parks, faith meetings, short WhatsApp videos

Program Approaches

- Stamped express lane chits given by the Parent Champion
- Cost-clarity posters (vaccination is free; bring X/Y only)
- Fathers' info sessions tied to social or savings groups

Indicators

- More fathers accompanying caregiver
- Increased verbal permission reported by Parent Champions during home visits

The Tradition-First Grandmother

Shifts with respectful dialogue and social proof

Holds family health memory and norms. Mixed views—respects tradition and stories from her generation; becomes a strong ally when engaged respectfully and shown local proof.

BeSD snapshot

🟠🟠⚪ Thinking & Feeling	🟠🟠⚪ Social Processes
🟠🟠⚪ Motivation	🟢🟢🟢 Practical Issues

Key barriers

- Prefers familiar remedies; worries about too many injections
- Influenced by community rumors and prior negative clinic stories
- Feels overlooked by health staff

What works

- Invite her counsel; show local babies thriving after vaccines
- Grandmothers' circles; honorific greetings; role in record-keeping
- Pastor/traditional leader co-messaging to bless clinic plan

Effective messenger

Senior Parent Champion, faith/traditional leader + nurse partnership

Best channels

Courtyard chats, women's fellowships, after-service screenings

Program Approaches

- Grandmother proof cards with milestones and appointment dates
- Photo boards of local vaccinated children
- Recognition of grandmothers who accompany caregivers

Indicators

- More elders accompanying to clinic
- Grandmothers prompting schedule adherence at home

The Resistant Patriarch

Commonly refuses referral; needs long-horizon engagement

Anchors identity in natural/traditional healing and deep mistrust of hospitals or chemicals. Views outreach as intrusive; standard persuasion backfires.

BeSD snapshot

🟠⚪⚪ Thinking & Feeling	🟠⚪⚪ Social Processes
🟠⚪⚪ Motivation	🟠⚪⚪ Practical Issues

Key barriers

- Identity-linked beliefs; prior trauma with institutions
- Rejects scientific framing; distrusts messengers
- Controls household decisions and access

What works

- Culturally aligned dialogue led by trusted traditional/faith figures
- Non-confrontational invitations to community events (no hard ask)
- Bridge activities: child growth checks, vitamin A, or malaria nets

Effective messenger

Senior traditional/faith leader with Parent Champion as liaison

Best channels

Elder councils, mediation visits, community ceremonies

Program Approaches

- Memoranda with councils; joint blessings of outreach days
- Safety net services at outreach to build reciprocity
- Escalation pathway for protection of caregiver autonomy

Indicators

- Reduced active obstruction; neutral stance over time
- Occasional permission for child health services

The Quiet Influencer (Aunt/Sister)

Often accepts referral when logistics are simple

Co-decides childcare and helps on clinic day. Opinions are malleable; practical hassles create drag but she amplifies clear plans and neighbors' examples.

BeSD snapshot

🟢🟢🟢 Thinking & Feeling	🟢🟢🟢 Social Processes
🟠🟠⚪ Motivation	🟠🟠⚪ Practical Issues

Key barriers

- Competing chores; unclear who holds the child's documents
- Uncertain about clinic hours and what to expect
- Follows the household majority view

What works

- Checklists and packing reminders the night before
- Neighbor testimonials; we go together prompts
- Simple role assignment: who carries card, who escorts

Effective messenger

Parent Champion from her social circle; neighbor champions

Best channels

Group chats, door-to-door, courtyard viewing sessions

Program Approaches

- Household planning cards with roles and times
- Block-level walk with me days
- Targeted WhatsApp reminders tagged to her number

Indicators

- More two-adult clinic visits
- Timely production of child health card at triage

Resources: Creative Briefs | Videos | Final Project Report

Step 5: Implement, Monitor, Learn and Adapt

Deploy your interventions with trained, trusted messengers (e.g., Parent Champions). Use the Parent Champion reporting tools to track referrals, vaccination uptake, and persona reach in real time. Hold regular review meetings to adapt quickly — as Nkolndongo did by shifting from large gatherings to small group sessions when engagement was higher.

How to Do It

Integrate with service delivery.

Co-plan activities with facility teams so demand generation and vaccine availability move in lockstep. Create a simple referral workflow (Parent Champion/CHW → named vaccinator → same-day or next available session) and share schedules so Parent Champions know exactly when/where to send families. Align community dialogues and market-day events with vaccination days, give facilities a heads-up on expected turnout, and prep for increased flow (extra registration sheets, fast-track for under-ones, clear signage).

Establish feedback loops.

Hold a short weekly huddle (30–45 minutes) for supervision and peer learning with Parent Champions, CHWs, and the facility focal person—review what worked, what didn't, and the plan for the coming week. Use **simple registers** to track referrals, show-ups, doses received, and reasons for no-shows; complement with quick **pulse checks** (2–3 questions) to caregivers and providers on message clarity, service experience, and barriers encountered. Share a one-page summary back to the group so lessons turn into shared adjustments, not individual fixes.

Adapt in real time.

Adjust deployment by neighborhood based on weekly data—send more Parent Champion time where intent is high but completion lags; shift to small-group sessions where large events underperform. Tweak **scripts**, **video sequence**, and **visit timing** to better match persona needs (e.g., after-work father sessions, morning market screenings). Escalate and resolve bottlenecks with district teams—queues, opening hours, or stock-outs—using a simple issue log with an owner and a due date so service constraints don't undermine demand.

Box: How we executed Step 5

Deployment began with **14 Parent Champions (PCs)** assigned to familiar neighborhoods across four health areas—**Mimboman 2 (4 PCs), Mimboman 1 (3 PCs), Emombo (4 PCs), and Essomba (3 PCs)**—so outreach could leverage existing trust. Activities were **staggered over roughly six weeks**, allowing for repeated contacts and timely follow-ups. Parent Champions met in **weekly supervision and peer-learning huddles with the project team from Christian Health Association of Cameroon (CHAC)**, using the sessions to troubleshoot, swap tactics, and plan the next week's focus.

From the outset, community engagement was **integrated with service delivery**. Parent Champions coordinated with facility teams for **warm referrals** and **session readiness**, and community events were deliberately **aligned with vaccination days** to enable same-day access. To equip and track the work, Parent Champions carried **tablets pre-loaded with videos**, **referral cards/flyers**, **BeSD-aligned job aids**, and **simple tracking forms**. Because Kobo Toolbox had limits for visit-level tracking, the team introduced **paper registers** and **triangulated** Parent Champion records with facility tallies to maintain a clear line of sight from mobilization to dose administered.

As data came in, the approach **adapted in real time**. Coverage was rebalanced toward **denser zones**; outreach was **synced with market days**; facilities introduced **fast-track cues for under-ones**; reminder scripts were tightened; and **language gaps** were addressed with clearer phrasing and translation where needed. **Home-based vaccination** helped build trust but also raised expectations for continued door-to-door services; the team **mitigated this by emphasizing clinic follow-up** and providing precise directions and named contacts for facility visits.

Ready-to-Use from Cameroon

Implementation plan & sequencing

Assign **Parent Champions (PCs)** to specific neighborhoods/streets they already know to leverage trust and reduce travel time. Create a **6-week rollout calendar** that staggers coverage by health area so each household can receive **at least two contacts** (intro + follow-up). Open each week wit**h a 15–30 min alignment huddle (**PCs, CHW/facility focal person, supervisor) to confirm target blocks, messages to emphasize, and the referral focal at the facility. Close the week with a **review/adaptation session** (what worked/what didn't, barriers encountered, actions for next week). Integrate tightly with facilities: share the list of **named vaccinators** and **session days/hours**, agree on a **warm-referral process** (PC → CHW → named vaccinator), and alert facilities of **anticipated turnout** after community events so queues and supplies can be managed (extra registers, fast-track for <12 months, signage).

Monitoring tools & indicators (samples)

Use **paper registers** to log each visit (HH ID, caregiver type/persona, barrier, referral issued Y/N, next appointment date), and a simple **referral slip** with the **named vaccinator and session time**. Combine three sources in a **light dashboard**: (1) **tablet notes** or daily SMS tallies from PCs; (2) **paper registers**; (3) **facility immunization tallies** for triangulation. Suggested indicators and calculations:

1. **# households visited** (count of unique HH IDs per week)
2. **# referrals issued** (count of slips given)
3. **# children vaccinated** (facility-verified doses linked to referral or HH ID)
4. **% positive intention** = caregivers expressing intent / total caregivers contacted × 100
5. **Referral→vaccination conversion rate** = vaccinated after referral / referrals issued × 100
6. **Median time to vaccination** = median days from referral date to dose date
7. **Follow-up completion rate** = households receiving a second contact / households due for follow-up × 100

Build in **data quality checks**: spot-match 10% of PC registers to facility tallies weekly; resolve mismatches in the Friday review; keep a **one-page report** so the process is repeatable.

Mid-course adaptations (examples)

Rebalance **Parent Champion deployment** toward denser areas or blocs where intention is high but conversion lags (use the dashboard map or a simple heat table). **Align outreach to market days** and peak footfall windows; shift from large gatherings to **small, courtyard dialogues** if engagement is better. Introduce **fast-track cues** for under-ones (separate queue, clear signage, pre-filled cards) and **reinforce reminder scripts** with exact dates/times, what to bring, and a named contact. Where language or literacy is a barrier, **swap scripts for pictorial aids** and use **peer interpreters**. If stock-outs, queues, or opening hours become bottlenecks, log them in an **issue tracker** (problem/owner/due date) and escalate in the weekly district call so service fixes keep pace with demand.

Resources: Final Report (rollout plan, monitoring tools, indicators, adaptations)

Step 6: Evaluate and Scale

After a set period, evaluate both behavior change outcomes and process indicators. Use the Nkolndongo evaluation tools to guide data collection. If successful, integrate the Parent Champion model, tested messages, and monitoring system into district EPI microplans and health worker supervision structures. When scaling to other urban areas, adapt personas, messages, and videos to reflect local language, culture, and influencers, while retaining the evidence-based strategy structure.

How to Do It

Measure outcomes using behavioral *and* service indicators.

Define a slim set of indicators that track change at two levels and disaggregate them by caregiver segment (younger/older mothers, fathers, grandmothers), sex, and neighborhood.

- **Behavioral (BeSD-aligned):** *Intention* (e.g., "I plan to vaccinate my child this week"—% "agree/strongly agree"), *Confidence* (safety/effectiveness trust score on a 5-point scale), and *Perceived norms* (e.g., "Most parents here vaccinate on time"—% "agree/strongly agree")
- **Service/uptake:** *Referral acceptance* (referrals accepted ÷ referrals offered × 100), *Conversion* (vaccinated after referral ÷ referrals issued × 100), *Completed doses by age* (Penta1/3, MR1 by 12 months), and *Zero-dose reduction* (change in #/rate of children with no Penta1)

Collect behavioral mini-surveys during follow-ups (2–3 questions, verbally), log referrals and outcomes in PC registers, and triangulate with facility tallies weekly. Set baselines in week 0, review trends weekly, and judge success against simple thresholds (e.g., +15–20% gain in intention, ≥60% referral→vaccination conversion, ≥10% reduction in zero-dose in pilot areas).

Capture learning for replication

Run a short **summative review** at the end of each 6-week cycle that mixes numbers with narratives. Use three sources:

1. **Quantitative**—facility tallies + PC registers (visits, referrals, vaccinations, time-to-dose)
2. **Qualitative**—rapid interviews/voice notes with caregivers (by persona), Parent Champions, and health workers
3. **Process evidence**—what scripts/videos were used, how events were timed, what bottlenecks arose

Structure the debrief with four questions:

1. *What did we plan?*
2. *What happened?*
3. *Why?*
4. *What will we change?*

Code insights to BeSD domains (thinking/feeling, social processes, motivation, practical issues) so lessons translate directly into design tweaks. Produce two outputs: a **one-page learning brief** (metrics + 5–7 takeaways + next actions) and a **toolkit update** (revised scripts, reminders, referral flow), ready for the next district to adopt.

Plan for scale

Define and cost a **minimum viable package (MVP)** that preserves what drives impact while keeping delivery simple:

- **Parent Champions** (selection + 1-day orientation + weekly huddles), a video/message kit (storyboards/ scripts + local language versions)
- **Referral/monitoring tools** (PC register, referral slip to a named vaccinator, simple dashboard), and **facility readiness tweaks** (fast-track for <12 months, posted session days, respectful counseling script)
- Specify **fidelity criteria** (e.g., ≥2 contacts/household, weekly facility huddle, same-day warm referral when possible) and an **adaptation menu** (market-day timing, language swaps, small-group vs. courtyard dialogues)
- Map integration into EPI microplans (who owns PCs, supervision cadence, data flow), identify financing (district budgets, partners, faith/community co-funding), and set **scale gates**: only expand when conversion ≥60%, complaint rates low, and facilities can absorb added demand

Box: How we executed Step 6

We measured progress with a simple mixed-methods system. On the quantitative side, tablets, Parent Champion paper registers, and facility records were used together to track household visits, referrals issued, and verified vaccinations. On the qualitative side, we conducted short interviews with caregivers (grouped by their referral response), Parent Champions, and health staff; rapid syntheses were mapped back to BeSD domains so emerging lessons pointed directly to behavioral drivers.

The picture was clear. During outreach, **728 children were vaccinated**; about **90% of caregivers expressed positive intention**, and the **overall reported success rate was 92.5%**. Uptake peaked during the first outreach wave and then tapered, while distribution of results was relatively balanced across **Emombo, Essomba, Mimboman 1, and Mimboman 2**. For deeper insight, we analyzed caregivers by response group: **vaccinated (n=5)**, **accepted referral but not yet vaccinated (n=3)**, and **refused (n=6)**—which helped distinguish where motivation faltered versus where practical barriers persisted.

For scale, we're locking in a **minimum viable package (MVP)**: the **Parent Champion model**, a **video/message kit**, **warm referrals** to a named vaccinator, basic **facility readiness tweaks** (e.g., fast-track for under-ones), and **simple registers** that align with facility tallies. As we expand, we'll localize content into non-French dialects, deepen **father-focused engagement**, bring **traditional and spiritual leaders** into the messenger mix, and maintain **weekly learning loops** so adaptations keep pace with what the data and communities tell us.

Ready-to-Use from Cameroon

The evaluation shows a clear pattern: strong early mobilization, high stated intention to vaccinate, and a meaningful conversion from referral to verified vaccination. Uptake was broadly balanced across the four health areas, with expected local variation driven by service readiness and community dynamics. The trajectory peaked in the first outreach wave and tapered thereafter, underscoring the value of timely follow-up and consistent reinforcement.

What drove this impact was the **combined approach**. Peer-led interpersonal communication, paired with short, locally grounded video storytelling and **warm referrals** to a named vaccinator, worked in concert to address multiple BeSD barriers at once—boosting **confidence** (credible messengers and plain-language answers), shifting **norms** (peers and leaders modeling uptake), strengthening **motivation** (emotionally resonant narratives and concrete next steps), and easing **logistics** (clear pathways and synchronized service access).

To scale, double down on what matters most and refine where gaps remain. Deepen **tailored messaging for fathers and resistant groups**, and expand **community-led content creation** so stories reflect local language and nuance. Invest in **respectful care and queue management** so the service experience reinforces demand, and **formalize leader endorsements** to keep norms moving in the right direction. Maintain **weekly learning loops** during expansion to spot variation early, adapt messages and deployment, and ensure facilities can absorb increased demand without compromising quality.

Resources: Formative research, summative review qualitative and quantitative dashboards
Final Report | Process Learning Report

www.WorldVision.org