

Reaching Out-of-School Girls with HPV Vaccination:

Practical Actions for Planning and Implementation

Most human papillomavirus (HPV) vaccination programs predominantly rely on school-based delivery and, therefore, consistently miss girls who are out of school (OOS). As programs mature and transition from campaign-based delivery toward routine implementation, reaching OOS girls requires more deliberate identification, outreach, and community engagement than was needed during initial campaigns. A study across 10 countries found that school-based programs reached 89 percent of enrolled girls, but only 54 percent of OOS girls received even a single dose. Closing this gap requires national and subnational immunization programs and implementing partners to adapt existing systems to the realities of girls who are not reached through school-based delivery.

Successful program implementation starts by identifying who is being missed, where they are, and the barriers they face. Then, planning and service delivery are adapted accordingly. Evidence generated across HAPPI's multi-country work points to five priority areas for action: identifying distinct OOS profiles, strengthening community-level enumeration, improving intersectoral coordination, building community awareness and demand, and expanding flexible delivery approaches.

89%



**of school-enrolled girls
are vaccinated**

54%



**of out-of-school girls
are vaccinated**

KEY TAKEAWAYS



Identify which girls are being missed and tailor communications and delivery to their specific circumstances.



Combine population estimates with community-level verification to strengthen microplanning.



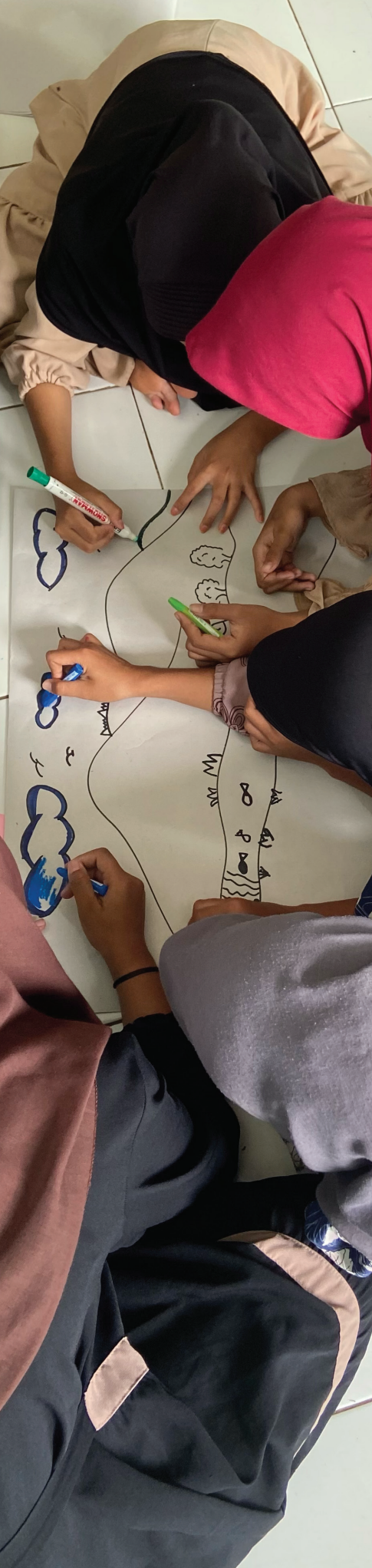
Coordinate early across sectors to align data, resources, and responsibilities.



Use trusted community voices and gender-responsive communication to build caregiver confidence and strengthen demand.



Bring HPV vaccination services to where girls live, work, and spend their time through flexible and integrated platforms.



ACTION 1: Identify which girls are being missed and tailor outreach to their specific circumstances.

OOS girls are not a homogeneous group; however, four categories are consistently identified: girls in income-generating work; girls displaced by conflict or environmental shocks; girls excluded by gender norms or early marriage, including some in non-formal schools; and girls with disabilities kept at home due to stigma. Knowing why a girl is out of school can help programs find her, whether at home, in a market, at a displacement camp, or in a religious school. Instead of relying on broad population estimates, use these specific locations to find and vaccinate every girl.

In **Indonesia's** Lombok Timur District, health authorities classified OOS girls as either linked to institutions such as religious and non-formal schools or having no institutional affiliation. This enabled programs to move from broad estimates to a verified registry of OOS girls, informing tailored approaches for reaching each group. In **Cameroon**, recognition that conflict and displacement had altered where girls could be found guided a shift from school-based delivery to mobile outreach in regions where insecurity disrupted routine vaccination platforms.



ACTION 2: Combine population estimates with community-level verification to strengthen microplanning.

National estimates indicate the number of girls who may be out of school but do not reveal who they are or where they live. A perfect count is not necessary; sufficiently accurate information can guide planning, resource allocation, and targeted outreach. Build on existing health, education, and community data sources; for example, enrollment records, household registration, and community mapping can be combined to identify low-coverage areas and concentrate efforts where need is greatest. Keep in mind that school status can change quickly. Girls drop in and out of school, families migrate for seasonal work, and local conflicts may fluctuate. Where feasible, explore opportunities to incorporate information on OOS and underserved populations into routine, iterative microplanning and monitoring systems.

In **Ethiopia**, combining school enrollment records with village-level family folders and health extension worker registers revealed that using school enrollment data alone missed nearly one-fifth to one-quarter of eligible girls. The combined data enabled more accurate microplanning and better targeting of outreach resources toward communities where girls were most likely to be missed. In **Bangladesh**, community health workers conducted house-to-house visits to register OOS girls by name. Program managers used this data to estimate target populations and plan outreach activities, demonstrating how individual-level community data can directly inform operational planning.



ACTION 3: Coordinate across sectors early in the planning process to align data, resources, and responsibilities.

Health ministries alone cannot reach OOS girls. Education offices maintain data on those who have dropped out. Social welfare offices track vulnerable children. Religious and community organizations can help reach girls outside formal education systems. Gender and women's ministries connect programs to community networks. In fragile and crisis-affected settings, humanitarian organizations and networks are vital to align efforts and provide access. Engage these sectors early in the planning process, establish clear roles and responsibilities for each, and explore opportunities to incorporate HPV vaccination into routine government planning and budgeting so programs are sustained beyond individual campaigns.

Before its April 2025 multi-age HPV campaign, **Côte d'Ivoire** established a three-tier coordination structure with clear roles across national, regional, and community levels. At the national level, the Ministry of Women, Family and Children and the Association of Ivorian Midwives supported planning for the census of OOS girls and reviewed monitoring tools. Regional delegations coordinated census activities and managed rumor response. At the community level, social workers, village leaders, and women's associations identified OOS girls, conducted community education, and supported outreach. Through this campaign, 788,846 OOS girls received vaccinations, accounting for 22 percent of the total vaccinated and contributing to a national coverage of 93 percent. In Makassar City, **Indonesia**, sectoral meetings mapped roles among the Social Service Office, the Ministry of Religious Affairs, and the Paediatric Society, enabling the program to identify and reach girls in welfare institutions and non-formal religious schools who were not captured by routine school-based planning.



ACTION 4: Use trusted community voices and gender-responsive communication to build caregiver confidence and strengthen demand.

Caregivers rely on people they trust when making decisions about vaccinations. Identify trusted voices, such as religious leaders, village elders, women's group leaders, and peer advocates, and engage them early. Address mothers and fathers separately since their concerns may differ. Fathers often have questions rooted in misinformation about vaccine safety, while mothers often focus on practical barriers such as time and distance. Community engagement can improve confidence and demand, but is most effective when paired with delivery strategies that also address practical barriers to access. Use peer advocacy where feasible: when vaccinated girls encourage OOS peers, uptake can improve.

In **Senegal**, the Cercles de Pères (Fathers' Circles) provided male decision-makers with direct HPV education and countered misinformation. The Cercle de Filles (Girls' Circle) mobilized school-enrolled girls as peer champions who accompanied OOS peers to vaccination sites. Both approaches worked within a broader system led by neighborhood godmothers, imams, and mothers' associations. In **Solomon Islands**, church leaders integrated HPV education into Sunday programs, using existing trust in religious institutions to inform families and encourage uptake. In **The Gambia**, village leaders known as alkalís and mothers' clubs used their trusted positions in communities to connect health workers with families, support mobilization efforts, and encourage HPV vaccine uptake.



ACTION 5: Bring HPV vaccination services to where girls live, work, and spend their time through flexible and integrated platforms.

Facility-based services, including fixed outreach activities alone, may not reach all eligible girls. Flexible delivery approaches should be prioritized where they are most likely to reach substantial numbers of previously missed girls, balancing impact with operational feasibility and cost. Consider offering sessions at markets, factories, transit points, border crossings, and places of worship. Add evening and weekend outreach when working families may be more available. Integrating HPV vaccination with other health services can reduce costs and increase the value of each community visit.

In **The Gambia**, health authorities integrated HPV vaccination into biannual Child Health Days, bundling it with vitamin A, deworming, and tetanus services and using existing cold chain and transport systems to cut costs and extend reach to remote farming and pastoral communities. In **Burkina Faso**, health workers introduced vaccination sessions after 6 p.m. in informal settlements and markets to reach girls returning from income-generating activities. In **Cambodia**, vaccination posts at international border crossings reached daughters of migrant-worker families during holiday returns, showing that delivery can meet girls wherever they are.



CONSIDERATIONS FOR PROGRAM PLANNING

- Combine health, education, and community records to identify who is being missed, and integrate this information into routine planning and monitoring.
- Set up formal agreements between health, education, social welfare, and community leaders at the start of the planning process to streamline how OOS girls are identified and vaccinated.
- Allocate resources in communities with large populations of OOS girls to fund local tracking, community mobilization, and mobile health services.
- Support adaptable vaccination strategies that can be customized to match local schedules, barriers, and access levels
- Leverage existing community structures and trusted local networks to support identification, mobilization, and follow-up of OOS girls.
- Transition to a single-dose schedule to reduce costs and free up staff time. Use those savings to strengthen community outreach and identification of underserved girls.

CONCLUSION

Reaching OOS girls requires more than expanding delivery beyond schools. Successful programs first understand who is being missed, where they are, and the barriers they face, then adapt planning, community engagement, and service delivery accordingly. While no single approach will work in every setting, the experiences highlighted in this brief demonstrate that targeted identification, intersectoral collaboration, trusted community engagement, and flexible delivery strategies can help programs reach girls who might otherwise be left behind. Every eligible girl, regardless of school attendance, should have access to protection against cervical cancer.

ADDITIONAL RESOURCES

[JSI. Assessing HPV vaccination reach among out-of-school girls: A retrospective analysis across 10 countries.](#)

[International Vaccine Access Center \(IVAC\). Strategies, challenges, and opportunities to reach out-of-school girls with HPV vaccination in six low- and middle-income countries.](#)

[PATH. Insights on reaching out-of-school girls with HPV vaccination from seven low- and middle-income countries.](#)

[Clinton Health Access Initiative \(CHAI\). \(2024\). Pilot Project: Strategy to reach out-of-school girls with HPV vaccination in Indonesia.](#)

[HAPPI Consortium. \(2025\). Expanding reach: Insights from multi-country approaches to HPV vaccination for out-of-school girls \[Webinar presentation\].](#)



The HPV Vaccine Acceleration Program Partners Initiative (HAPPI) Consortium is a Gates Foundation-funded collaboration led by JSI with CHAI, IVAC, Jhpiego, and PATH.

OVERVIEW: THE HAPPI PROJECT AND BRIEF SERIES

We support countries to accelerate HPV vaccine introduction and scale-up through implementation research, technical assistance, and shared learning. This brief is part of a series that translates lessons from 19 countries into practical actions for program planners to support the global goal of achieving 90 percent HPV vaccination coverage by 2030.