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Consolidated Policy and Programmatic Recommendations for Sustained Human Papillomavirus (HPV) Vaccination Delivery in Kaduna, Kano and Lagos states

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WOMEN ADVOCATES FOR VACCINE ACCESS
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Executive Summary

Nigeria's introduction of the Human Papillomavirus (HPV) vaccine in 2023 marked a historic milestone in the nation's fight against cervical cancer. Joining the WHO's 90–70–90 targets, the country's multi-age cohort campaign reached over 12 million girls, proving that large-scale adolescent immunization is achievable when political will, system coordination, and community trust align.

As the program transitions from campaign to routine delivery, systemic challenges, such as inadequate domestic financing, weak infrastructure, and declining post-campaign demand, threaten sustainability. Without strong state leadership and ownership, these gaps risk reversing campaign gains. Sustaining progress requires embedding HPV vaccination within state health and education systems, backed by predictable financing, policy alignment, and community engagement.

A primary costing analysis using the WHO C4P Tool (2020) estimates that ₦27.5 billion will be required between 2025 and 2029 to vaccinate 2.5 million girls across Kaduna, Kano, and Lagos States, ₦5.2 billion for Kaduna, ₦13.5 billion for Kano, and ₦8.8 billion for Lagos.

Secondary insights from the National Plan for Cervical Cancer Elimination in Nigeria show that approximately ₦426.28 billion ($266.42 million) will be needed to vaccinate 25 million girls and eradicate cervical cancer by 2030.

While vaccine procurement is federally co-financed with Gavi, states bear the operational costs; delivery, supervision, cold chain, and mobilization, underscoring the urgency for domestic resource mobilization ahead of the currently planned Gavi's 2028 transition

To secure long-term success, states must:

- Develop and adopt adolescent immunization blueprints;
- Institutionalize dedicated funding for HPV and adolescent health;
- Strengthen coordination between health, education, and women affairs;
- Embed HPV vaccination in policies and legal frameworks; and
- Invest in continuous capacity building, demand generation, and localized advocacy, framing HPV vaccination as a health and economic investment.

Nigeria stands at a pivotal moment. The HPV rollout proved what is possible through leadership and partnership. The next phase calls for institutionalized, equity-driven delivery and sustained financing to ensure every girl, everywhere, has access to this life-saving vaccine.

Acronyms

BHCPF	-	Basic Health Care Provision Fund
CCEOP	-	Cold Chain Equipment Optimization Platform
CSOs	-	Civil Society Organizations
CSR	-	Corporate Social Responsibility
C4P	-	WHO Cervical Cancer Prevention and Control Costing Tool
DHIS2	-	District Health Information Software, version 2
DPRS	-	Department of Planning, Research and Statistics
GIS	-	Geographic Information System
HAPs	-	Health Action Plans
HPV	-	Human Papillomavirus
IGR	-	Internally Generated Revenue
KSPHCB	-	Kaduna State Primary Health Care Development Board
LGAs	-	Local Government Areas
LSPHCB	-	Lagos State Primary Health Care Board
MAC	-	Multi-Age Cohort
MoE	-	Ministry of Education
MoH	-	Ministry of Health
MSH	-	Management Sciences for Health
MTSS	-	Medium-Term Sector Strategy
MWAPA	-	Ministry of Women Affairs and Poverty Alleviation
NPHCDA	-	National Primary Health Care Development Agency
NTF-CCE	-	National Task Force on Cervical Cancer Elimination
PBB	-	Program-Based Budgeting
PECCiN	-	Partnership to Eliminate Cervical Cancer in Nigeria
PHC	-	Primary Health Care
PHCs	-	Primary Healthcare Centres
PPP	-	Public-Private Partnership
RI	-	Routine Immunization
SBCC	-	Social and Behaviour Change Communication
SCIDaR	-	Solina Centre for International Development and Research
SERICC	-	State Emergency Routine Immunization Coordination Centre
SIO	-	State Immunization Officer
SPHCMB	-	State Primary Health Care Management Board
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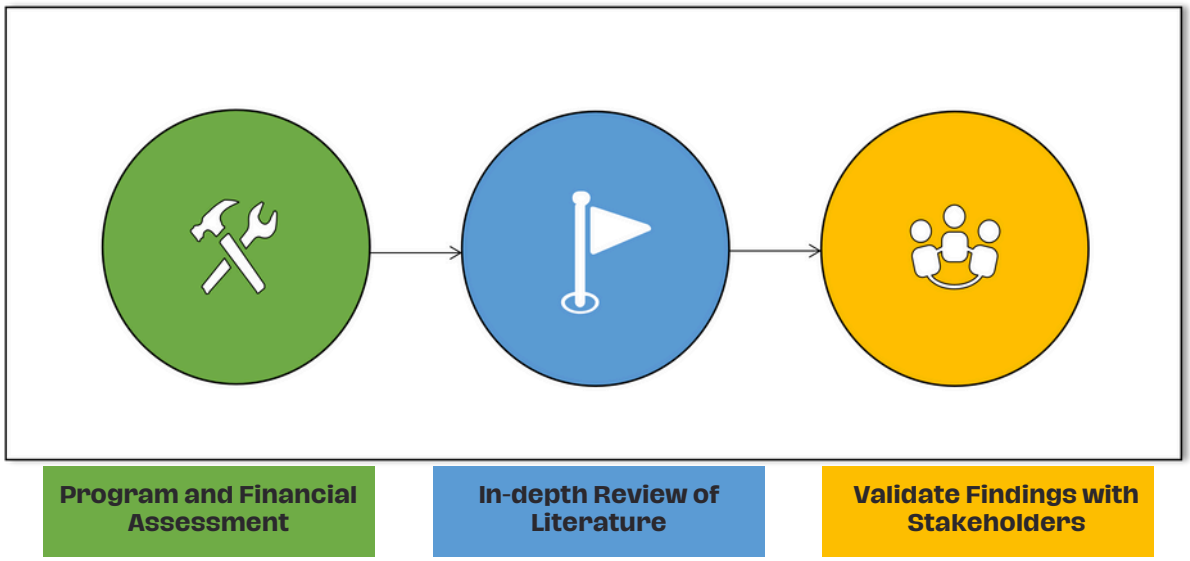
TWG	-	**Technical Working Group**
UNICEF	-	**United Nations Children's Fund**
VDCs	-	**Village Development Committees**
WAVA	-	**Women Advocates for Vaccine Access**
WDCs	-	**Ward Development Committees**
WHO	-	**World Health Organization**

Methodology

This report was written by Women Advocates for Vaccine Access (WAVA) and Management Sciences for Health (MSH), under the Nigeria Policy and Advocacy for Sustained HPV Vaccination project, funded by the Gates Foundation and conducted in Kaduna, Kano, and Lagos states. The policy and programmatic recommendations provided in this document are consolidated from insights across the project states, developed by WAVA through a mixed-method approach.



First, a statewide program and financial assessment of the 2023/2024 HPV vaccination rollout was conducted across key thematic areas by the Solina Centre for International Development and Research (SCIDaR) to identify operational strengths and gaps. This was followed by an in-depth review of academic and grey literature to situate findings within broader national and global evidence. Finally, insights were validated and refined through consultations with a multi-sectoral state core group, including representatives from the state ministries of health, primary health care boards, state ministries of Education, Women Affairs, budget and planning, and representatives of Civil Society Organizations and youth. Together, these steps ensure that recommendations are evidence-based, context-specific, and aligned with national and state priorities.

Background

Nigeria has formally adopted the World Health Organization's cervical cancer elimination strategy; the "90-70-90" targets (90% of girls fully vaccinated by age 15; 70% of women screened with a high-performance test by ages 35 and 45; 90% of women with pre-cancer and cancer receiving treatment)[1]. These targets form the performance benchmarks for national planning and resource mobilisation.[2]

To coordinate nationwide action, the Federal Government and partners have convened a multi-stakeholder National Task Force on Cervical Cancer Elimination (NTF-CCE) and launched the Partnership to Eliminate Cervical Cancer in Nigeria (PECCiN), a platform designed to accelerate implementation, align partners, and marshal political and financial commitment across sectors. This platform anchors national governance, mobilizes high-level advocacy, and provides a mechanism for tracking progress against elimination goals with a proposed target of ₦426 billion to eradicate cervical cancer by 2030.[3]

Operationally, Nigeria made a major programmatic shift by introducing the single-dose HPV vaccine into routine immunization starting in October 2023 and subsequently rolling out phased campaign activity and routine delivery across states. These efforts have resulted in over 12 million girls reached in the initial campaign demonstrating feasibility at scale while also exposing subnational variations in acceptance and coverage, delivery platforms and sustainability structures.[4]

Additionally, the National Strategic Cancer Control Plan (2023–2027) places HPV vaccination at the center of a comprehensive prevention strategy that integrates vaccination, screening, diagnosis and treatment. The Plan sets national objectives, defines programmatic responsibilities across ministries (Health, Education, Finance) and partners, and underscores the need for real-time data, equitable service delivery, and sustainable financing to achieve elimination.[5]

To reach these ambitious targets, Nigeria must do two critical things: devise approaches to sustainably mobilize domestic resources, especially in the face of dwindling fiscal space resulting from reduced donor support and tailor program interventions to effectively utilize available resources.

Nigeria's immunization financing architecture, however, remains mixed: vaccine procurement is handled solely at the federal level through government-donor (Gavi) co-financing agreements, while the operational costs for service delivery, logistics, and community mobilization increasingly fall under state and local government budgets. Gavi's extended support timeline, which now runs through 2028, provides a predictable short-term funding window. However, it also underscores the urgency for deliberate, time-bound transition planning. States must strengthen domestic resource mobilization, improve operational planning, and build absorptive capacity to ensure sustainability beyond donor support. Without institutionalized budget lines, structured co-financing mechanisms, and contingency funding at the subnational level, there is a real risk of reversing coverage gains.[6]

Programmatically, cross-cutting challenges including: limited human resources for health (skill gaps for adolescent vaccination and school-based delivery), manual data systems that undermine real-time performance management, varied demand due to misinformation and sociocultural barriers, and sub-par integration between health and education sectors for school-based vaccination, with not enough attention and planning for underserved populations and girls in informal settings pose a threat to the equity objective embedded in the 90-70-90 agenda.

Achieving cervical cancer elimination in Nigeria, therefore, depends on state-owned systems. Policies and strategies designed at national must be adapted and contextualized at state and local levels to be effective. State policymakers and program managers need tools, data, and autonomy to shape HPV vaccination strategies that reflect their epidemiology, equity challenges, human resources, financing constraints, and community dynamics.

[1] World Health Organization (WHO) Cervical Cancer Elimination initiative (2018) https://www.who.int/initiatives/cervical-cancer-elimination-initiative
[2] ELIMINATION PLANNING TOOL: ADVANCING TOWARDS CERVICAL CANCER ELIMINATION NIGERIA. 566-NGA-nigeria.pdf
[3] NPHCDA, Launching of a Partnership to Eliminate Cervical Cancer in Nigeria (PECCiN) – NPHCDA
[4] Johns Hopkins Bloomberg School of Public Health, https://publichealth.jhu.edu/ivac/2024/one-dose-at-a-time-mobilizing-to-eliminate-cervical-cancer-in-nigeria
[5] National Institute for Cancer Research and Treatment (NICRAT). https://publichealth.jhu.edu/ivac/2024/one-dose-at-a-time-mobilizing-to-eliminate-cervical-cancer-in-nigeria
[6] .Internal Finance Facility for Immunization. https://iffim.org/impact/success-stories/support-vaccines-nigeria

Without state buy-in and integration, national targets risk remaining aspirational. The success of elimination efforts will hinge on how well states translate national frameworks into real, sustained action within their immunization systems, health infrastructure, education sectors, and community networks.

Translating national policy into measurable progress requires state policymakers and program managers to: (1) adopt and budget for HPV delivery within MTSS/costed operational plans, (2) tailor delivery modalities (school, facility, outreach) to local context, (3) invest in digital monitoring and supervision, and (4) embed risk-communication strategies that leverage religious, traditional and civil society networks. In short, elimination is only achievable when national ambition is matched by sustained state ownership and capacity.

This project consolidates existing evidence to accelerate state-led action toward elimination. Our core activities comprised synthesizing state-specific data and stakeholder insights; facilitating co-creation with state policymakers, education and health managers, and community leaders; conducting adolescent awareness and digital advocacy; and developing targeted, actionable recommendations that states can adopt within existing RI planning cycles.

The aim is to move from high-level commitments to implementable interventions that strengthen sustainability and equity at the state level. From our analyses, several key recommendations emerge across states (common themes):

- Institutionalize dedicated HPV budget lines in state health financing mechanisms (e.g. via MTSS).
- Strengthen digital, real-time data systems and dashboards to support decision-making.
- Build health workforce capacity, especially in neglected and underserved areas.
- Deepen multi-sector coordination (health, education, finance, community) for integrated delivery.
- Leverage religious, community, and CSO networks for demand generation, consent advocacy, and misinformation mitigation.
- Mobilize public-private co-financing, CSR support, and logistics partnerships to reduce state burden.
- Engage policymakers regularly with state-specific HPV data to drive accountability and course correction.

This report synthesizes state-level insights and tailored recommendations (Kaduna, Kano, Lagos and others). Each section presents the evidence base, stakeholder perspectives, programmatic gaps, and prioritized actions that map a pathway from national commitments to sustained subnational implementation and progress toward cervical cancer elimination.

State-specific Insights into the HPV Vaccination Landscape

Kaduna State

Kaduna state is one of Nigeria's most strategically positioned states in terms of immunization infrastructure and institutional capacity.[7, 8] With a population of approximately 9.5 million and a large adolescent cohort, Kaduna plays a central role in national immunization outcomes. During the HPV vaccine rollout, the state achieved 100% coverage, with more than 600,000 girls vaccinated. Kaduna state demonstrates strong political commitment to Routine Immunization (RI), supported by development partners. It has consistently been one of the better performing northern states, benefiting from legacy investments as a pilot site for innovative RI models such as GIS-enabled microplanning, accountability scorecards, and digital supervision platforms. Kaduna also pioneered the Immunization Leadership Challenge, which incentivized local government performance and fostered a culture of data-driven accountability. However, while Kaduna has long been a pioneer in leveraging digital tools for RI, HPV vaccination data remains fragmented, poorly disaggregated, and often captured manually, leading to gaps in real-time monitoring. The absence of an adolescent health data dashboard means HPV performance is not tracked with the same rigor as childhood RI. Strengthening HPV-specific reporting, embedding digital data capture, and aligning with broader adolescent health indicators are necessary to improve accountability and inform decision-making during routinization.[9]

[7] Umeh, G. C., Madubu, D. M., Korir, C., Loveday, N., Ishaku, S., Iyal, H., Omoleke, S. A., I Nomhwange, T., Aliyu, A., Musa, A., Dankoli, R., Mi Ningi, A., Braka, F., Dogo, P. M., Soba, H., & Iliyasu, N. (2018). Micro-planning for immunization in Kaduna State, Nigeria: Lessons learnt, 2017. Vaccine, 36(48), 7361–7368. https://doi.org/10.1016/j.vaccine.2018.10.020

[8] Cold Chain Equipment Optimization Platform (CCEOP). (2021). Evaluation of the CCEOP investment in Gavi-supported countries. https://www.gavi.org/our-impact/evaluation-studies/cceop-evaluation

[9] SCIDaR (2025) Kaduna State HPV Vaccination Programmatic and Financial Assessment. (Unpublished)

Kano State

Kano state, on the other hand, is home to over 14 million people, including more than 2 million girls aged 9-14: the pre-adolescent and adolescent target cohort for HPV vaccination.[10] As one of the country's most influential states, both demographically and politically, Kano plays an outsized role in Nigeria's broader immunization and public health outcomes. Consequently, its participation and performance are critical to Nigeria's cervical cancer elimination targets,[11] in line with the World Health Organization's global strategy for cervical cancer elimination, which has set a target of achieving 90% HPV vaccination coverage among girls by age 15. While Kano state's immunization system has improved over the years, routine immunization coverage is still below national target at less than 40%. This subpar performance is due to gaps in workforce capacity, cultural barriers, and service delivery barriers in hard-to-reach areas. The 2023 HPV multi-age cohort (MAC) campaign was a high point, reaching 94% coverage across the 44 LGAs (with over 920,000 girls vaccinated). However, these numbers have seen a huge decline since the campaign. This sharp drop highlights the difference between campaign-style mobilization and slower routine delivery. Similar to many states, Kano's HPV delivery is currently largely supported by donor contributions. While Basic Health Care Provision Fund (BHCPF) and state funds cover infant and under-5 vaccines, adolescent vaccination is not adequately accounted for. Without earmarked state funds, operational activities such as outreach, microplanning updates, and social mobilization will remain underfunded, threatening sustainability.

Lagos State

Conversely, Lagos state is Nigeria's most populous state with over 20 million people, and has a strong immunization track record. With a robust PHC system and history of innovation, it has consistently outperformed national averages.[12] In 2018, full immunization coverage in Lagos was over 70%[13], com-

-pared to 31%[14] nationally, driven by effective PHC governance, data-informed micropanning[15], and moderate local government financing.[16] Lagos has over 2 million girls aged 9–14, the largest adolescent population in Nigeria, including over 1 million nine-year-olds.

As one of the first states to launch the HPV vaccination in-country, Lagos mobilized strong political support[17]. Post-campaign reviews revealed clear gaps: cold chain shortages in underserved areas, poor awareness among educators, and weak coverage of out-of-school girls.[18] The HPV vaccine program, unlike childhood routine immunization, exposed weaknesses in adolescent-targeted service delivery, particularly around data systems and inter-sectoral coordination between health and education sectors. Lagos' media-rich environment boosted initial demand via radio, social media, and faith-based outreach.[19] But misinformation, especially around fertility, spread rapidly on social media, especially WhatsApp and Facebook, making Lagos one of UNICEF's high-risk misinformation states. Unfortunately, many teachers were ill-equipped to counter this. Ministry of Women Affairs and Poverty Alleviation (MWAPA), Ministry of Education (MOE), and community stakeholders helped, but a more structured, pre-adolescent and adolescent-focused communication model is needed.

Additionally, despite Lagos' high Internally Generated Revenue (IGR)[20] and considerable government contributions, immunization and HPV vaccine delivery remain heavily reliant on donor funding, creating a vulnerability to funding cuts post-campaign and underscoring the urgent need for a more inclusive, sustainable domestic financing. Lagos benefits from strong governance and a dense health facility network; however, it lacks institutionalized adolescent-friendly services, which must be addressed to sustain HPV service delivery.

[10] City Population (2022) Kano State in Nigeria. https://citypopulation.de/en/nigeria/admin/NGA020__kano/
[11] This Day (2023) Nigeria, Gavi to Launch HPV Vaccine for Cervical Cancer Tuesday. https://www.thisdaylive.com/2023/10/16/nigeria gavi-to-launch-hpv-vaccine-for-cervical-cancer-tuesday/
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[14] Olufadewa, I., Adesina, M., Oladele, R. et al. Trends and predictors of full immunization coverage in Nigeria. Discov Public Health 21, 151 (2024). https://doi.org/10.1186/s12982-024-00283-x
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[16] Ihebuzor C, Oteri AJ, Bawa S, Kolawole AO, Dieng B, et al. (2022) "Campaign Staggering" a Way to Bridge Resources Gaps in Supplemental Immunization Activities-Lagos State 2018 Measles Vaccination Campaign's Experience. J Community Med Public Health 6: 270. DOI: https://doi.org/10.29011/2577-2228.100270
[17] Evans. (2024, November). Achieving 71% HPV Vaccination Coverage in Nigeria. University of Washington Evans School of Public Policy & Governance. Retrieved from https://evans.uw.edu/achieving-71-hpv-vaccination-coverage-in-nigeria/
[18] Gavi, the Vaccine Alliance. (2024, August 6). Lagos aims to reach one million girls with cancer-blocking HPV shot by year's end.
[19] Lagos State Ministry of Youth & Social Development. (2023). LASG, UNICEF sensitise youths in LGAs on HPV vaccine. Retrieved from https://lagospost.ng/lasg-unicef-sensitise-youths-in-local-government-areas-on-hpv-vaccine
[20] World Bank. (2021). Nigeria Immunization Financing Assessment: Sustaining Immunization Financing in the Decade of Vaccines.https://documents1.worldbank.org/curated/en/955881615801705759/pdf/Nigeria-Immunization-Financing-Assessment.pdf

Strengths and Gaps

Strengths	Gaps
Dedicated, adaptable workforce: Health workers were actively engaged with communities and schools, extending efforts to special needs groups.	**No dedicated HPV vaccination budget line:** Reliance on external donor funding makes the HPV program vulnerable to funding gaps. Additionally, states have not consistently met their 1% Internally Generated Revenue (IGR) Immunization co-financing obligation.
Robust religious and traditional support: Endorsement by Muslim leaders facilitated high trust and acceptance of the HPV vaccine.	**Data integration and issues:** HPV-specific indicators are not fully integrated into DHIS2, affecting real-time monitoring. Manual data capture limits timely decision-making and accountability. Additionally, delays and inaccuracies reduce confidence in vaccination coverage data.
Multi-sectoral collaboration: Strong coordination between health, education, and community actors enhanced HPV vaccine delivery.	**Limited use of public–private partnerships for health:** States have not adequately leveraged their private sector partners to strengthen domestic resource mobilization for health. Unlocking this potential could provide sustainable financing, and accelerate progress toward improved routine immunization, including HPV vaccination.
Effective cold chain: Functional cold chain and logistics support that boosts service delivery	**Vaccine hesitancy due to misinformation:** Persistent myths and misinformation spread via social media, such as misconceptions around infertility hamper uptake. Also, fuelled by poor awareness among educators.
Extensive grassroots mobilization: Large community resource network active across all LGAs for demand generation and misinformation countering.	**Equity gaps leading to insufficient reach of underserved populations:** Out-of-school girls, nomadic communities, and persons with disabilities underserved by routine vaccination. Mechanisms to identify and vaccinate marginalized adolescents remain weak.
Effective school-based delivery: Integrated HPV vaccination into public and private schools with trained mobilizers building parent/student trust.	**Limited workforce capacity, strain and attrition of existing health workers:** Overburdened and inadequately supported frontline health workers face high workloads and limited refresher training, leading to declining performance and service inconsistency.
Digital tools and microplanning: Use of GIS-enabled microplanning, mobile supervision apps, and performance scorecards improve monitoring.	**Fragile logistics in security-compromised LGAs:** Challenges in consistent vaccine delivery in some regions.
Strong political commitment: Early high-level political buy-in enabled effective coordination of the HPV vaccination rollout.	**Cultural and socio-economic barriers:** Early marriage, male-led decisions, and vaccine myths limit access and acceptance in some populations.
Community engagement: Leveraged traditional and community leaders for mobilization and rumour management.	**Limited adolescent health service integration:** HPV vaccination not fully embedded across schools and adolescent service platforms.

Legend:
- Kaduna
- Kano
- Lagos

Costing

Methodology

A financial assessment was conducted concurrently across Kaduna, Kano, and Lagos states, engaging key stakeholders within each state's primary health care ecosystem to provide firsthand insights into operational realities, resource flows, and delivery mechanisms. Data collection combined both qualitative and quantitative methods.

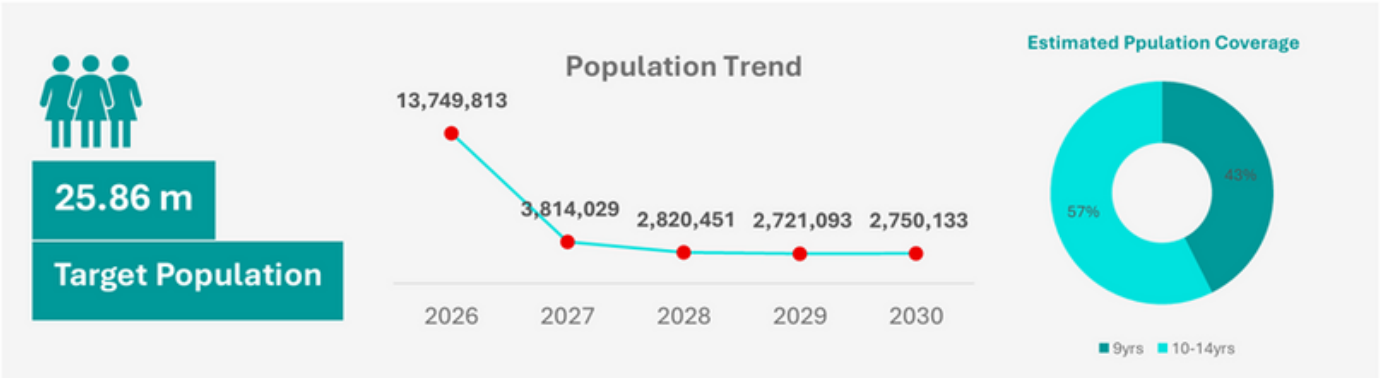
- Primary data were obtained from State HPV focal persons, Monitoring and Evaluation Officers, State Immunization Officers (SIOs), and Cold Chain Officers between May and June 2025.
- Secondary data were drawn from state microplans, program reports, budget documents, and previous assessments to enable triangulation and validation.

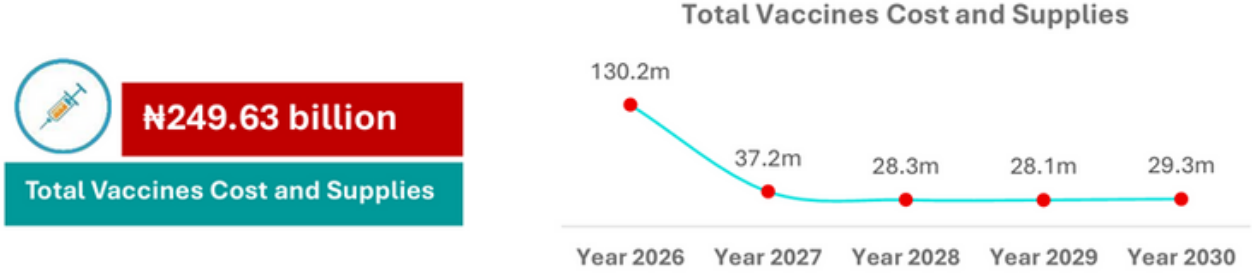
The analysis employed the WHO's Cervical Cancer Prevention and Control Costing (C4P) Tool – HPV Vaccination Module (2020), adopting a government perspective and an activity-based costing approach. It assessed the incremental costs associated with vaccine delivery, training, social mobilization, supervision, and cold chain logistics. The primary delivery strategy modelled is school-based outreach, complemented by fixed post services to enhance coverage. The costing analysis covers the 2025–2029 period for the three focus states.

To add a national perspective, we derived some costing elements from the National Plan for Cervical Cancer Elimination in Nigeria, Volume Two[21]. All national-level projections are adapted for the 2026-2030 period.

National HPV Vaccination Delivery Costs

Drawing from National Cervical Cancer Elimination costing estimates from the NTF-CCE, Nigeria requires a total investment of ₦426.28 billion ($266.42 million) to effectively vaccinate 25 million adolescent girls from 2026-2030. Coverage is split between two modes: fixed sessions at health facilities and outreach based routine immunizations. The cost of vaccines and related supplies account for the most significant budget item, totaling ₦253.12 billion for the 2026-2030 period. The immunization program will require a total of 28.44 million vaccine doses, syringes, and safety boxes over the five-year period. Other program costs include personnel and facility – ₦14.34BN, training and capacity building – ₦784.31M, sensitization and social mobilization – ₦1.14BN, media and engagement – ₦64.98BN.





[21] National Task Force on Cervical Cancer Elimination. National Plan for Cervical Cancer Elimination in Nigeria, Volume Two.

Total Investment

₦426.28 billion

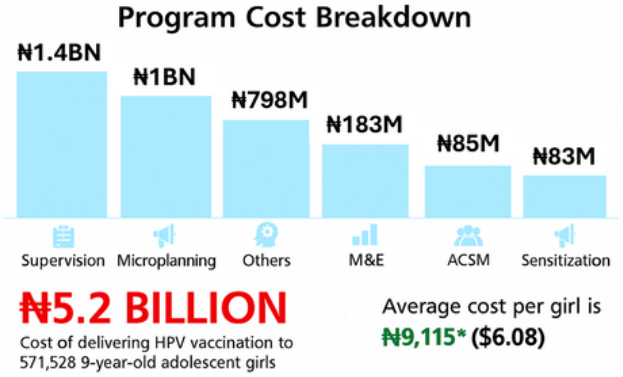
$266.42 million

State-specific HPV Vaccination Delivery Costs

The state-specific costing provided below draws from the costing assessment conducted in this project.

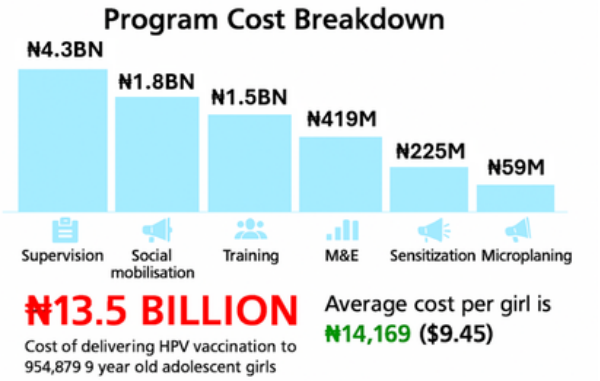
Kaduna

Kaduna state requires ₦5.2 billion to vaccinate 571,528 9-year-old pre-adolescent girls between 2025-2029. For 2025, this cost is estimated at ₦850 million, representing 0.007% of the ₦127 billion approved state health budget. The highest proportion of the program costs (₦1.45 billion) are allocated to supervision, followed by microplanning (₦1.06 billion). These two activities alone constitute the majority of the program's budget, underscoring the state's strategic emphasis on operational oversight.



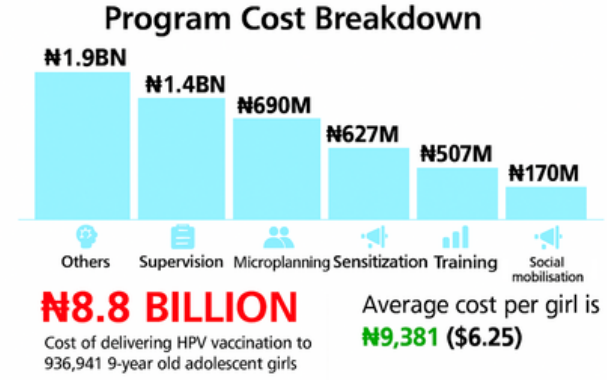
Kano

Kano state requires ₦13.5 billion to vaccinate 954,879 9-year-old pre-adolescent girls between 2025-2029. For 2025, estimated delivery cost is ₦4.4 billion, representing 4.03% of the ₦109 billion approved state health budget. Supervision and cold chain expansion represent a dominant majority of the critical investments required for the program's success.



Lagos

Lagos state requires ₦8.8 billion to vaccinate 936,941 9-year-old adolescent girls between 2025-2029. For 2025, this cost is estimated at ₦1.39 billion, representing 0.6% of the ₦221.4 billion approved state health budget. Key cost drivers include service delivery, supervision, cold chain expansion, amongst others.



Currently, vaccine delivery costs are majorly co-financed by the federal government, state governments, and donors, such as Gavi, who provides vaccines. While vaccine procurement is solely at the national level, these costs contribute to the total cost of vaccine delivery in the state. Additionally, given the changing donor financing landscape, states need to incrementally increase funding for vaccines and create a structured plan to account for Nigeria's Gavi-transition by 2028. This would require pairing sustained budget allocations with innovative resource mobilization to close the HPV financing gap and protect future generations of women and girls from cervical cancer.

Recommendations

These cross-cutting policy and programmatic recommendations have been put forward to improve HPV vaccine delivery across states

Policy

Develop State-Led Adolescent Immunization Blueprints

Each state should develop a government-led roadmap positioning adolescent immunization, especially HPV vaccination, a core health priority. Led by the MoH and SPHCB with support from state immunization working groups, CSOs, and partners, it should set coverage targets, outline strategies to reach out-of-school girls and strengthen school-PHC linkages resulting in an approved plan and budget line for adolescent immunization.

All states should Establish Dedicated Routine Immunization Budget Lines

Sustaining HPV vaccination depends on predictable and protected financing. States should create dedicated budget lines for routine and adolescent immunization within their annual budgets and Medium-Term Sector Strategies (MTSS). Embedding these allocations in program-based budgeting (PBB) frameworks will promote transparency, improve planning and forecasting, and strengthen alignment with domestic and partner co-financing arrangements.

Establish Transparent Financing and Accountability Mechanisms

States should adopt transparent financial tracking tools, such as HPV vaccination dashboards or state-level financing trackers, to monitor allocations, disbursements, and performance milestones. Regular joint financing reviews with development partners, CSOs, and private sector actors will improve coordination, reduce duplication, and strengthen accountability in resource utilization.

Embed HPV Vaccination in State Policies and Legal Frameworks

Institutionalizing HPV vaccination as part of state School Health Policies, Adolescent Health Strategies, and related public health laws will transition the intervention from programmatic activity to policy-backed entitlement. Legal and policy inclusion will ensure continuity, accountability, and sustained financing across government transitions, while promoting integration into school health curricula and adolescent health programs.

Ensure Equity and Inclusion in Service Delivery

Equitable coverage must extend beyond schools to reach marginalized, out-of-school, and underserved girls, especially those in informal settlements and hard-to-reach areas. States should institutionalize periodic adolescent mapping exercises, integrate data into DHIS2, and use them to design microplans that guide outreach. Leveraging existing community structures such as Ward Development Committees (WDCs), Village Development Committees (VDCs), and volunteer networks can help bridge last-mile delivery gaps.

Strengthen Cross-Sector Governance and Coordination

Adolescent immunization lies at the intersection of health, education, youth, and social development sectors. States should formalize and strengthen cross-sectoral coordination structures, anchored within existing immunization technical working groups or State Emergency Routine Immunization Coordinating Centres (SERICCs), to ensure shared decision-making, joint planning, and accountability. Transforming HPV or adolescent vaccination technical working groups into statutory, multi-sectoral coordination bodies will foster program coherence and effective oversight.

Foster Strategic Resource Mobilization and Domestic Transition Planning

As Nigeria approaches the Gavi transition period, states need to prioritize sustainable domestic resource mobilization. Aligning local budgets with estimated HPV vaccination financing envelopes (e.g., ₦5–13 billion over five years for Kaduna, Kano and Lagos), will ensure long-term program viability. States should leverage Basic Healthcare Provision Fund (BHCPF) mechanisms, public–private partnerships, and CSR platforms to co-finance adolescent health interventions.

Program

Strengthen Continuous Capacity Building and Frontline Empowerment

Teachers, health workers, and youth influencers form the first line of contact between HPV vaccination programs and communities. Continuous, adolescent-focused capacity building is essential to sustain quality service delivery and strengthen trust. Institutionalizing periodic joint trainings, supportive supervision, and recognition systems will enhance motivation, performance, and program ownership.

Intensify Demand Generation and Community Engagement

Sustaining demand requires consistent, community-rooted engagement that extends beyond campaign periods. States should embed culturally sensitive, values-driven social and behaviour change communication (SBCC) strategies into local health communication plans. Leveraging storytelling, local champions, radio, and digital platforms can help normalize HPV vaccination and address community-specific concerns.

Build Trust through Localized Advocacy and Dialogue

Mistrust and not lack of awareness, remains a major barrier to HPV vaccine uptake. Continuous dialogue through trusted intermediaries such as religious leaders, traditional councils, teachers, and parents' associations is vital. Using testimonials, interpersonal communication, and participatory forums reinforces vaccine confidence and community ownership.

Ensure Equitable and Adolescent-Friendly Service Delivery

Equity must be embedded in HPV vaccination delivery. States should institutionalize mechanisms to reach marginalized, out-of-school, and underserved girls through mobile outreach, adolescent-friendly health corners, and school–PHC linkages. Routine adolescent mapping should feed into microplans to ensure no eligible girl is left behind.

Strengthen coordination with Local Resource Networks for Grassroots Mobilization

Existing community networks, including faith-based groups, women's associations, CSOs, and traditional structures, are critical for last-mile engagement. Strengthening coordination with these actors enables early rumour detection, tailored messaging, and sustained community mobilization for HPV vaccination.

Frame HPV Vaccination as a Health and Economic Investment

Policymakers and partners should be consistently presented with clear, evidence-based data on the cost-effectiveness and long-term benefits of HPV vaccination. Framing it as both a cancer prevention and an economic growth intervention promotes policy prioritization, budget protection, and multi-sectoral commitment.

Prioritize Equity and Impact in Resource Allocation

Equity-focused financing should prioritize reaching hard-to-reach girls through mobile sessions and community outreach. States should earmark targeted equity funds within PHC or adolescent health budgets to support flexible, needs-based service delivery models that address coverage gaps.

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SCAN ME

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