

Polio programming in Ethiopia reduces gender barriers to immunization through built-in strategies



Ethiopia’s progress in polio eradication, despite historically high numbers of zero-dose children, shows how strategies that are standard for polio programming address several gender-related barriers to immunization.ⁱ

Focus on campaign quality and availability of women frontline workers (FLWs) is helping GPEI partners reduce inequalities and reach children:

Ethiopia is among the ten countries with the highest number of zero-dose (ZD) children globally, with an estimated 3.9 million in early 2025.ⁱⁱ **Strategies that are standard for polio campaigns address some of the gender-related barriers** that contribute to ZD (see boxⁱⁱⁱ). **House-to-house (H2H) campaigns** reduce the need for women to negotiate permission or pay for transport. Reducing the time and cost burdens for caregivers is particularly important for rural and low-income women, who may otherwise face barriers traveling to health facilities.

H2H campaigns are effective in providing health information for women who may not have had access through education or antenatal visits.^{iv} The personalized, repeated engagement of H2H vaccination teams, that in Ethiopia are majority women, can help

Polio snapshot

In 2025 the country was managing **Africa’s largest active cVDPV2 outbreak**, largely the result of vaccine shortages in 2024. However, since late 2024, Ethiopia (with an estimated population of 129M)^x has shown strong progress: campaigns are expected to cover all regions by January 2026; surveillance remains sensitive; and transmission has narrowed to a single Somalia-linked lineage concentrated in Oromia Region^{xi}. Stopping transmission of the polio virus in 2026 will depend on sustaining high-quality national campaigns and ensuring close cross-border coordination.

Research from the Gates Foundation-funded **Zero-Dose Learning Agenda (ZDLA)** highlights interconnected gender-related barriers that affect routine immunization in Ethiopia:

- » Women’s lack of control over household decision-making, including immunization.
- » Men’s limited involvement in child health.
- » Limited mobility constrains women’s ability to seek vaccination services, compounded in some areas by long distances and unreliable roads during rainy season, and aggravated by a fear of harassment or violence on the road.
- » Women’s low literacy and early marriage, affecting autonomy and awareness.
- » Fear of side effects and potential domestic conflict following these.
- » Negative experiences with health facilities and limited postnatal care.

foster trust with women who may not have the same comfort with health workers at a facility. Engaging **community-level structures such as the Women’s**

Development Army (WDA) further supports community trust in the campaign.

Follow-up visits further address gender barriers

“Mop-up” efforts to reach missed households make sure that mothers who were working in fields or unavailable at first visit are not left behind. Follow-up visits are also an opportunity to address other barriers to vaccination, such as correcting misinformation or speaking to fathers who are hesitant to allow vaccination about its importance for their children’s health. H2H polio campaigns also link caregivers whose children are missing routine vaccines to health facilities for follow-up.

Community engagement activities in advance of campaigns facilitate success. Polio partners seek the support of community leaders. Although these leaders are primarily men, partners also work to **involve senior women – traditional birth attendants and midwives** – either directly or indirectly, in pre-campaign sensitization meetings, increasing the number of trusted avenues that reach the population^v.



GPEI strategies that reduce gender barriers reach more children. In 2025, two nationwide nOPV2 campaigns cumulatively reached over 110,000 previously unvaccinated children and achieved high campaign quality, with 90% of lots passing LQAS thresholds.

Building on women’s role as community health workers and volunteers

Women constitute the majority of Ethiopia’s **health extension workforce** and are central to polio campaigns, filling a majority of roles as vaccinators and community mobilizers. Community-based groups like the **WDA** further support social mobilization and surveillance. Women vaccinators who are trusted and embedded in their communities can better identify missed children (as they know the families), counter misinformation, and ensure coverage. In some rural and conservative communities, for example in parts of the Somali region, norms against interaction with unrelated men make women’s presence on vaccination teams

essential. Although most other communities do not have these constraints, mothers are often more comfortable with women FLWs, which facilitates information sharing and strengthens the FLWs’ opportunity to build health literacy in communities over time.

A recent initiative by the Ministry of Health to pilot **direct digital payments** to FLWs, can contribute to motivation and retention of women workers. Digital payments in other countries have reduced delays in wages^{vi} and can minimize the risk of intermediaries, like other household members, collecting women’s wages, thereby supporting women’s financial independence.^{vii}

Reducing geographic inequities

The polio program in Ethiopia covers the entire country, helping to reduce inequities between regions and reduce transmission^{viii}. However, **pastoralist and conflict-affected communities**, remain challenging to reach as community mobility, insecurity, and geography constrain access. **Men vaccinators** remain important for these remote and challenging contexts, underscoring the need for a **balanced workforce** that is sensitive to local gender dynamics.



Increasing equity across levels of the workforce

Gender gaps remain in the health workforce and in leadership. While women dominate in the frontline workforce, most surveillance officers (90%) are men. Partners share that reasons include lower literacy among women and fewer applications for vacancies. A recent gender analysis also noted challenges for women's leadership more generally, as men "dominate customary institutions and are responsible for community-level planning and control of communal

natural resources along clan and subclan lines"^{ix}. GPEI partners are actively working with the Ministry of Health to increase women's representation in decision-making positions. For example, the Ethiopia polio program has made it a priority to track the **proportion of women in emergency operation centers (EOCs)**, revealing a slight increase from previous years.

Endnotes

- i This brief is a snapshot of work being done by GPEI partners in 2025 to increase the effectiveness of polio programming by addressing gender barriers. It was developed by the Global Center for Gender Equality (GCGE), with support from the Gates Foundation, based on a review of key country documents and interviews with representatives of GPEI partners and GMG members in Ethiopia, regional and global offices, between August and October 2025.
- ii WHO (2025, April 14) "Ethiopia Reignites its Big Catch-up Program: Close to 1 Million Zero Dose Children Vaccinated" <https://www.afro.who.int/countries/ethiopia/news/ethiopia-reignites-its-big-catch-program-close-1-million-zero-dose-children-vaccinated>
- iii ZD Learning Session Presentations: <https://transforming.notion.site/zdlearningsessionpresentations>
- iv For example, in 2016 73% of births were at home: Ministry of Women and Social Affairs Ethiopia, UN Women, ADBG "Country Gender Equality Profile 2024"
- v Note that the polio campaigns reached these ZD children after the Ethiopia Big Catch-Up had already reached 958,725 previously unvaccinated children.
- vi WHO (2025, Oct 23) "From 15 days to 72 hours: digital payments accelerate compensation for 120 000 health workers in Kenya" <https://www.afro.who.int/countries/kenya/news/15-days-72-hours-digital-payments-accelerate-compensation-120-000-health-workers-kenya>
- vii Aker, J. C., Boumrijel, R., McClelland, A., & Tierney, N. (2016). Payment Mechanisms and Antipoverty Programs: Evidence from a Mobile Money Cash Transfer Experiment in Niger. *The World Bank Economic Review*, 30, 1-27. https://www.povertyactionlab.org/sites/default/files/research-paper/4277_Payments-Mechanism-and-anti-poverty-programs_Aker_Nov2016.pdf
- viii See for example: Endehabtu BF, Alemu K, Mengiste SA, Zelalem M, Gullstett MK, Tilahun B (2025) Spatial disparities in zero-dose vaccination coverage for children aged 12–23 months in Ethiopia: A geographically weighted regression analysis. *PLoS One* 20(9): e0332162. <https://doi.org/10.1371/journal.pone.0332162>
- ix ACAPS (2023) Ethiopia Gender Analysis: roles and needs in humanitarian crises
- x [2023 population estimates in WHO Health Data Overview for Ethiopia](#)
- xi Ethiopia has reported 40 cVDPV2 cases in 2025, nearly 80% in Oromia, compared with 1 detection in the same quarter of 2022.