MSI Journal
of Medicine and Medical Research
(MSIJMMR)

Frequency:- Monthly Published by MSI Publishers

ISSN:- 3049-1401 (Online)

Journal Link:- https://msipublishers.com/msijmmr/

Volume:- 2, *Issue:-* 3 (March-2025)

Article History

Received on :- 16-03-2025

Accepted on :- 20-03-2025

*Published on :-*27-03-2025

Total Page: - 29-34 **DOI: 10.5281/zenodo.15095472**

Empowering Women to Drive Health Education and Advocacy: Building Healthier Communities in Low-Income Countries

By

Emmanuel Ifeanyi Obeagu[1*]

Department of Biomedical and Laboratory Science, Africa University, Zimbabwe[1*]

Abstract: Empowering women as health educators and advocates is a transformative approach to improving public health outcomes in low-income countries. Women, as primary caregivers and community leaders, have the potential to drive significant changes in health behaviors, spread vital health information, and advocate for better healthcare services. This review explores how empowering women to lead health education initiatives can address critical health challenges, particularly in maternal and child health, infectious diseases, and health access issues in low-income settings. By leveraging women's influence in their communities, health education can become more effective and far-reaching. Despite the clear benefits, several barriers hinder the full participation of women in health education and advocacy roles. These include gender inequality, limited access to education and resources, and cultural norms that restrict women's ability to take on leadership roles. In many low-income countries, women face challenges such as inadequate healthcare infrastructure, lack of support for women-led initiatives, and insufficient access to modern communication tools. Overcoming these barriers is essential to empowering women and ensuring they can effectively contribute to improving public health.

Keywords: Women Empowerment, Health Education, Low-Income Countries, Community Health, Advocacy

Introduction

In many low-income countries, health challenges such as high maternal and child mortality rates, the prevalence of infectious diseases, and limited access to healthcare services disproportionately affect women and children. The lack of resources, healthcare infrastructure, and health education exacerbates these issues, resulting in poorer health outcomes. While healthcare systems in these countries often struggle with resource constraints, women have the potential to play a pivotal role in improving public health through education and advocacy. Women, particularly in rural and marginalized communities, often hold informal leadership positions within families and local social structures, making them well-positioned to influence health behaviors, disseminate important health information, and advocate for better healthcare access.[1-2] Empowering women to lead health education and advocacy efforts in low-income countries can have a transformative effect on public health. Women's unique role as primary caregivers, community connectors, and change agents enables them to bridge the gap between healthcare providers and local communities. Through their day-to-day interactions, women can communicate important health messages, influence behaviors, and encourage others to seek medical care or adopt preventive health measures. Furthermore, women are well-suited to address sensitive health topics, including maternal and reproductive health, child nutrition, hygiene, and disease prevention, as they are often the ones directly responsible for the health and well-being of their families.[3-4]

Despite these natural advantages, many women in low-income countries face significant barriers to participating in health education and advocacy. Cultural norms, gender inequality, and limited access to education and training opportunities can prevent women from assuming leadership roles in health initiatives. In many communities, women are not given the same opportunities as men to access healthcare education, participate in public health programs, or become involved in health policy decision-making. Additionally, limited access to technology and healthcare infrastructure in rural and remote areas further hampers women's ability to deliver effective health education and engage in advocacy efforts.[5-6] While challenges persist, there have been numerous examples of successful women-led health education and advocacy programs in low-income countries. These programs have demonstrated that when women are empowered with knowledge, training, and resources, they can significantly improve health outcomes within their communities. Women's involvement in grassroots health initiatives can enhance local health literacy, reduce the spread of infectious diseases, and improve maternal and child health outcomes. Furthermore, women-led advocacy campaigns have been successful in bringing attention to health disparities, influencing public health policies, and improving access to healthcare services for underserved populations.[7-9] To fully unlock the potential of women as health educators and advocates, it is crucial to implement strategies that address the barriers they face. Providing women with access to education, skills training, and leadership development opportunities is essential for building their capacity to lead health initiatives. In addition, health education programs must be designed to be culturally relevant and adaptable to local contexts. This ensures that women can effectively communicate health messages that resonate with their communities and address specific health challenges. Finally, advocating for gender-inclusive policies that promote women's leadership in health education and advocacy is essential for creating an enabling environment where women can thrive.[10-11] The aim of this review is to explore the role of women in health education and advocacy within low-income countries, examining both the benefits of their involvement and the challenges they face.

The Role of Women in Health Education and Advocacy

Women play a pivotal role in health education and advocacy, particularly in low-income countries, where their influence as caregivers, community leaders, and educators is undeniable. As primary caregivers within families, women are often the first to recognize health issues, whether related to hygiene, nutrition, disease prevention, or access to healthcare. This gives them a unique opportunity to influence health behaviors within their households. They are well-positioned to teach their children, spouses, and extended family members about essential health practices such as vaccination, sanitation, proper nutrition, and family planning. The impact of these interactions is profound, as families are the foundational

units of society, and the health education passed down within families can shape generations.[12-13] In addition to their roles within the family, women often serve as community connectors and informal leaders in low-income settings. Women's social networks, whether through religious groups, local organizations, or informal gatherings, enable them to spread health information more effectively than other community members. In many communities, women are also involved in local health initiatives, working alongside healthcare workers or non-governmental organizations (NGOs) to distribute health information, provide basic healthcare services, or advocate for local health improvements. Women's influence in these spaces is especially important for addressing public health issues that may be culturally sensitive or stigmatized, such as maternal health, HIV/AIDS prevention, and sexual and reproductive health.[14-15]

Furthermore, women can be powerful advocates for policy changes that promote better healthcare access and services. Their firsthand experiences with health challenges, particularly in maternal and child health, make them credible voices in discussions about health policies and resource allocation. By organizing grassroots campaigns, participating in health-related committees, and collaborating with governmental and non-governmental organizations, women have successfully influenced public health policies in various regions. Their advocacy has led to improved healthcare infrastructure, better maternal and child health programs, and increased awareness of critical health issues within underserved communities.[16-17] Women's involvement in health education and advocacy extends beyond their immediate social circles. As role models and educators, they can shape community norms and attitudes toward health and well-being. For instance, women-led health campaigns focused on hygiene, vaccination, or disease prevention can lead to widespread behavior changes that significantly reduce the incidence of preventable diseases. Women can also bridge gaps between formal health systems and local populations by ensuring that health messages are delivered in culturally appropriate and accessible ways. This makes health education more effective and increases its reach, particularly in rural areas where formal healthcare infrastructure may be lacking.[18-19] However, despite their potential to drive health education and advocacy, women face numerous challenges that hinder their full involvement. These include gender inequality, limited access to education and healthcare resources, and cultural norms that restrict women's roles in public health initiatives. In many low-income countries, women have limited access to formal education and are often excluded from decision-making processes at the community and national levels. These barriers not only prevent women from taking on leadership roles in health education but also limit their capacity to advocate for changes that could improve their health and the health of their communities.[20-21]

Challenges to Empowering Women in Health Education

Empowering women in health education is a critical strategy for improving health outcomes in low-income countries, but several challenges must be addressed to maximize its impact. One of the most significant barriers is gender inequality, which often limits women's access to education and leadership roles. In many communities, traditional gender roles restrict women to domestic responsibilities and exclude them from public life. As a result, women may lack the educational opportunities necessary to become effective health educators or advocates. In addition, societal norms that prioritize male leadership and decision-making further prevent women from taking on influential roles in health education initiatives. These gender-based barriers create a significant gap in women's ability to engage in or lead health programs, hindering the overall effectiveness of community-based health education.[22-23] Another major challenge is limited access to resources and training. Many women in low-income countries lack access to health-related education, training, and professional development programs. Without these resources, women are unable to acquire the knowledge and skills needed to deliver accurate and impactful health messages. This is particularly true in rural areas, where access to education and healthcare infrastructure is already limited. Moreover, health education programs may not be designed with women's needs in mind, or they may not be culturally appropriate or accessible. Without targeted interventions that provide women with the necessary training, their ability to serve as effective health educators and advocates is severely constrained.[24-25]

Cultural and societal norms also present significant barriers to women's empowerment in health education. In many communities, certain health topics, such as sexual and reproductive health, HIV/AIDS, and family planning, are considered taboo or culturally sensitive. These topics may be seen as inappropriate for discussion, particularly by women, and this can hinder women's ability to engage in open dialogues about health with their families and communities. Additionally, women may face resistance or even backlash when attempting to challenge traditional health practices or advocate for more progressive health policies. This cultural resistance can create an environment where health education efforts are undermined or ignored, limiting women's ability to drive health changes in their communities.[26-27] Moreover, political and economic instability in low-income countries often exacerbates these challenges. In many regions, women's participation in public health initiatives is not prioritized by governments, particularly when resources are scarce. Health education programs may be underfunded or poorly implemented, and women's needs may be overlooked in favor of more pressing economic or political concerns. Furthermore, political instability and conflict can disrupt local healthcare systems, limiting women's access to both education and healthcare

services. In such unstable environments, empowering women in health education becomes even more difficult, as the focus often shifts to immediate survival rather than long-term health initiatives.[28-29] Finally, lack of community support and the absence of strong female role models in health education can also impede women's empowerment. In some areas, there may be limited recognition of the value of women's contributions to public health, and women may not receive the encouragement or support they need to take on leadership roles. This can result in a lack of motivation for women to engage in health education and advocacy, as they may feel their efforts will not be valued or supported. Additionally, without visible female role models who have successfully navigated the barriers to health education, younger generations of women may lack the confidence to pursue similar paths.[30-32]

Recommendations for Strengthening Women's Roles in Health Education

To strengthen women's roles in health education, particularly in low-income countries, several key strategies should be implemented. These strategies focus on empowering women, overcoming barriers, and creating an environment that fosters gender equality and encourages active participation in public health initiatives.

1. Promoting Gender Equality in Education and Leadership

One of the foundational steps to strengthening women's roles in health education is to ensure equal access to education and leadership opportunities. Governments, NGOs, and community organizations should prioritize girls' education, ensuring they have the tools, knowledge, and skills to lead health education initiatives. This involves offering gender-sensitive curricula, scholarships, and mentorship programs that encourage women and girls to pursue careers in health and leadership. Women should also be included in decision-making bodies at both local and national levels, which will ensure their perspectives and needs are considered when designing health education programs.

2. Providing Targeted Health Education and Training

To ensure that women are equipped to lead health education efforts, it is essential to provide them with comprehensive training in health topics, communication skills, and leadership. This training should be practical, culturally relevant, and accessible to women from diverse backgrounds, particularly those in rural or marginalized communities. Programs that focus on health literacy, disease prevention, maternal and child health, and sexual and reproductive health can help women become effective health educators. Moreover, training should also include leadership and advocacy skills so that women can effectively campaign for better health policies and drive community health improvements.

3. Addressing Cultural Sensitivity and Gender Norms

Health education programs must be designed with an awareness of local cultural norms and values. It is essential that these programs respect cultural sensitivities while encouraging positive health behaviors. In many low-income countries, topics such as sexual health, family planning, and HIV prevention are taboo or stigmatized. To address this, community-based health education efforts should involve dialogue and discussions led by trusted female community members who can openly engage with local populations. Programs that aim to change attitudes and behaviors around sensitive topics should use culturally appropriate messaging and involve male counterparts in promoting gender equality and shared responsibility for health.

4. Leveraging Technology and Social Media for Outreach

With the increasing access to mobile phones and internet services, technology offers a unique opportunity to expand the reach of health education. Women in low-income countries can be trained to use mobile platforms, social media, and other digital tools to disseminate health information. Digital health education tools can bridge the information gap, particularly in rural areas, by providing timely and accurate health messages. Mobile health (mHealth) campaigns have proven effective in delivering vital information on maternal health, nutrition, vaccination, and disease prevention. Empowering women with digital skills ensures they can take on leadership roles in health education using innovative and accessible platforms.

5. Building Community Support and Networks

Strengthening the role of women in health education requires building supportive networks at the community level. Local leaders, both men and women, should recognize and support women's contributions to health education. This can be achieved by integrating women into community health teams, empowering them to lead workshops, conduct health screenings, and engage in public health campaigns. Community-based organizations can also provide a platform for women to exchange ideas, share experiences, and collaborate on health-related initiatives. These networks create a sense of solidarity and shared responsibility for health, which is essential for sustaining long-term behavior change.

6. Securing Funding and Political Support

For women to effectively lead health education initiatives, adequate funding and political support are necessary. Governments and international organizations must allocate resources to empower women as health educators and advocates. This includes funding training programs, establishing women's health education centers, and supporting community-led health projects. Additionally, it is vital to advocate for policies that support women's participation in public health initiatives, ensuring that

women's voices are represented in national health policy decisions. Political will and sustained funding are crucial to create an enabling environment where women can thrive as health educators and advocates.

7. Monitoring and Evaluation of Health Education Programs

Finally, it is essential to regularly assess and evaluate the effectiveness of health education programs led by women. Monitoring and evaluation (M&E) frameworks should be put in place to track the progress and outcomes of these initiatives. By gathering data on the impact of women-led health education efforts, stakeholders can identify what works and what needs improvement. This evidence can be used to advocate for continued support and adjustments to the programs to maximize their impact.

Conclusion

Empowering women as health educators and advocates is a critical strategy for improving health outcomes in low-income countries. Women's unique position within their communities, combined with targeted education, resources, and training, enables them to drive meaningful changes in public health practices. By promoting gender equality, addressing cultural norms, providing targeted health education, and leveraging technology, women can play a central role in delivering essential health information and advocating for healthier practices and policies. However, significant challenges remain, including gender inequality, limited access to resources, and societal resistance to women's leadership in health. To overcome these barriers, it is essential to implement comprehensive strategies that involve local communities, engage political stakeholders, and ensure adequate funding for women-led health education initiatives. Community-based networks, digital health tools, and culturally sensitive programs are all crucial in ensuring the success and sustainability of women-driven health education efforts.

References

1. Mark M. The international problem of HIV/AIDS in the modern world: a comprehensive review of political, economic, and social impacts. Res Output J Public Health Med. 2024; 42:47-52.
2. Rodrigo C, Rajapakse S. HIV, poverty and women. International Health. 2010; 2(1):9-16.
3. Bekker LG, Alleyne G, Baral S, Cepeda J, Daskalakis D, Dowdy D, Dybul M, Eholie S, Esom K, Garnett G, Grimsrud A. Advancing global health and strengthening the HIV response in the era of the Sustainable Development Goals: the International AIDS Society—Lancet Commission. The Lancet. 2018; 392(10144):312-358.
4. Idele P, Gillespie A, Porth T, Suzuki C, Mahy M, Kasedde S, Luo C. Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. JAIDS Journal of Acquired Immune Deficiency Syndromes. 2014; 66:S144-153.
5. Zhang J, Ma B, Han X, Ding S, Li Y. Global, regional, and national burdens of HIV and other sexually transmitted infections in adolescents and young adults aged 10–24 years from 1990 to 2019: a trend analysis based on the Global Burden of Disease Study 2019. The Lancet Child & Adolescent Health. 2022; 6(11):763-776.
6. Saul J, Bachman G, Allen S, Toiv NF, Cooney C, Beamon TA. The DREAMS core package of interventions: a comprehensive approach to preventing HIV among adolescent girls and young women. PloS one. 2018;13(12):e0208167.
7. Obeagu EI, Obeagu GU. CD8 Dynamics in HIV Infection: A Synoptic Review. Elite Journal of Immunology, 2024; 2(1): 1-13
8. Obeagu EI, Obeagu GU. Implications of B Lymphocyte Dysfunction in HIV/AIDS. Elite Journal of Immunology, 2024; 2(1): 34-46
9. Echefu SN, Udosen JE, Akwiwu EC, Akpotuzor JO, Obeagu EI. Effect of Dolutegravir regimen against other regimens on some hematological parameters, CD4 count and viral load of people living with HIV infection in South Eastern Nigeria. Medicine. 2023; 102(47):e35910.
10. Njenga R, Shilabukha K. Secondary school life skills education and students' sexual reproductive health in Kenya: Case Study of Ruiru Sub-County. Gender statistics for evidence-based policies on women's economic empowerment, health and gender-based violence. 2017:118-131.
11. Visser MJ. Life skills training as HIV/AIDS preventive strategy in secondary schools: evaluation of a large-scale implementation process. SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance. 2005; 2(1):203-216.
12. Botvin GJ, Griffin KW. Life skills training: preventing substance misuse by enhancing individual and social competence. New directions for youth development. 2014; 2014(141):57-65.
13. Obeagu EI, Obeagu GU. Platelet-Driven Modulation of HIV: Unraveling Interactions and Implications. Journal home page: http://www. journalijiar. com. 2024;12(01).
14. Obeagu EI, Anyiam AF, Obeagu GU. Unveiling B Cell Mediated Immunity in HIV Infection: Insights, Challenges, and Potential Therapeutic Avenues. Elite Journal of HIV, 2024;2(1): 1-15
15. Obeagu EI. Understanding the Intersection of Highly Active Antiretroviral Therapy and Platelets in HIV Patients: A Review. Elite Journal of Haematology. 2024; 2(3):111-117.
16. Lwamba E, Shisler S, Ridlehoover W, Kupfer M, Tshabalala N, Nduku P, Langer L, Grant S, Sonnenfeld A, Anda D, Eyers J. Strengthening women's empowerment and gender equality in fragile contexts towards peaceful and inclusive

societies: A systematic review and meta-analysis. Campbell systematic reviews. 2022; 18(1):e1214.
17. Lwamba E, Ridlehoover W, Kupfer M, Shisler S, Sonnenfeld A, Langer L, Eyers J, Grant S, Barooah B. PROTOCOL: Strengthening women's empowerment and gender equality in fragile contexts towards peaceful and inclusive societies: A systematic review and meta-analysis. Campbell Systematic Reviews. 2021; 17(3):e1180.
18. Chi X, Hawk ST, Winter S, Meeus W. The effect of comprehensive sexual education program on sexual health knowledge and sexual attitude among college students in Southwest China. Asia Pacific Journal of Public Health. 2015; 27(2):NP2049-2066.
19. Akuiyibo S, Anyanti J, Idogho O, Piot S, Amoo B, Nwankwo N, Anosike N. Impact of peer education on sexual health knowledge among adolescents and young persons in two North Western states of Nigeria. Reproductive health. 2021; 18:1-8.
20. Hamdanieh M, Ftouni L, Al Jardali BA, Ftouni R, Rawas C, Ghotmi M, El Zein MH, Ghazi S, Malas S. Assessment of sexual and reproductive health knowledge and awareness among single unmarried women living in Lebanon: a cross-sectional study. Reproductive Health. 2021; 18:1-2.
21. Anyiam AF, Arinze-Anyiam OC, Irondi EA, Obeagu EI. Distribution of ABO and rhesus blood grouping with HIV infection among blood donors in Ekiti State Nigeria. Medicine. 2023; 102(47):e36342.
22. Obeagu EI, Obeagu GU, Buhari HA, Umar AI. Hematocrit Variations in HIV Patients Co-infected with Malaria: A Comprehensive Review. International Journal of Innovative and Applied Research, 2024; 12 (1): 12-26
23. Obeagu EI, Obeagu GU. Assessing Platelet Functionality in HIV Patients Receiving Antiretroviral Therapy: Implications for Risk Assessment. Elite Journal of HIV, 2024; 2(3): 14-26
24. Ifeanyi OE, Uzoma OG, Stella EI, Chinedum OK, Abum SC. Vitamin D and insulin resistance in HIV sero positive individuals in Umudike. Int. J. Curr. Res. Med. Sci. 2018;4(2):104-8.
25. Najjuma SM, Yates HT. Economic empowerment for enhanced health equity: A qualitative study of women living with HIV in Wakiso District, Uganda. Affilia. 2024; 39(4):644-663.
26. Campbell C, Scott K, Nhamo M, Nyamukapa C, Madanhire C, Skovdal M, Sherr L, Gregson S. Social capital and HIV competent communities: the role of community groups in managing HIV/AIDS in rural Zimbabwe. AIDS care. 2013; 25(sup1):S114-122.
27. Bluthenthal RN, Palar K, Mendel P, Kanouse DE, Corbin DE, Derose KP. Attitudes and beliefs related to HIV/AIDS in urban religious congregations: Barriers and opportunities for HIV-related interventions. Social science & medicine. 2012; 74(10):1520-1527.
28. Wagner C, Gossett K, Hasnain M, Linsk N, Rivero R. Integration of the national HIV curriculum in medicine, nursing, and pharmacy programs in the United States. BMC Medical Education. 2025; 25(1):1-0.
29. Feyissa GT, Woldie M, Munn Z, Lockwood C. Exploration of facilitators and barriers to the implementation of a guideline to reduce HIV-related stigma and discrimination in the Ethiopian healthcare settings: A descriptive qualitative study. PLoS One. 2019; 14(5):e0216887.
30. Eholié SP, Aoussi FE, Ouattara IS, Bissagnéné E, Anglaret X. HIV treatment and care in resource-constrained environments: challenges for the next decade. Journal of the International AIDS Society. 2012; 15(2):17334.
31. Parker R, Aggleton P. HIV-and AIDS-related stigma and discrimination: A conceptual framework and implications for action. InCulture, society and sexuality 2007: 459-474. Routledge.
32. Djellouli N, Quevedo-Gómez MC. Challenges to successful implementation of HIV and AIDS-related health policies in Cartagena, Colombia. Social Science & Medicine. 2015; 133:36-44.