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(Review Article)

Assessing community partnership models for equitable health communication

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Abstract

Inequities in the dissemination of health information continue to be a significant issue in public health within the United States. This review paper examines how models of community partnership can enhance equitable health communication. A systematic review of peer-reviewed articles was performed, concentrating on models that incorporate community perspectives into health communication strategies. The review highlighted methods such as community-based participatory research, healthcare-community coalitions, and public-private partnerships. These approaches were applied in various healthcare settings. Documented outcomes included increased vaccination rates in underrepresented communities, enhanced trust between healthcare providers and minority groups, and greater involvement of marginalized populations in clinical research. However, various challenges arose, including unequal distribution of resources, coordination difficulties, and recurring sustainability issues. The results suggest that community partnerships have the potential to enhance the inclusivity and responsiveness of health communication. Integrating these models into health policy and practice may contribute to the development of more equitable and resilient health systems.

Keywords: Community Partnership Model; Health Equity; Health Inequities; Partnerships; Community

1. Introduction

Health disparities remain a significant challenge in modern public health, disproportionately affecting marginalized communities and the trust of people in society. At the heart of addressing these inequities lies the concept of equitable health communication. Equitable health communication refers to strategies that ensure health information is accessible and culturally relevant to all populations [1]. Community partnership models have emerged as a critical mechanism to achieve this. It refers to collaborations between health professionals, academic institutions, community leaders, and local organizations to work together in creating and disseminating health messages that relate to diverse audiences [2].

These partnership models have theoretical foundations that are grounded in established frameworks that prioritize shared power and mutual benefit [3]. Community-based participatory research (CBPR) calls for the equitable involvement of communities in all phases of research and intervention design to enhance relevance and sustainability [4]. This model has evolved to include comprehensive tools like the Assessing Community Engagement (ACE) Conceptual Model, which Aguilar-Gaxiola et al. [3] describe as a pathway for transforming health systems through meaningful engagement. The ACE model has driven policy changes to advance health equity in recent years [3]. These frameworks highlight the shift from top-down communication to community-driven processes, setting the stage for evaluating how community partnerships can bridge health literacy and access gaps [5].

There are several structural barriers that facilitate health disparities, such as limited access to information, cultural mistrust, and socioeconomic inequities, and equitable health communication directly opposes them. This issue holds

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national importance in the U.S., where health equity is a moral imperative as well as an economic concern because it contributes to billions in avoidable healthcare costs. In the United States, these challenges are evident in the stark racial and ethnic disparities in health outcomes. Wallington and Noel [6] highlight how marginalized communities often receive fragmented or culturally insensitive health messaging, leading to higher rates of preventable diseases. The COVID-19 pandemic also exposed inequities in vaccine uptake and information dissemination, where Quinn et al. [7] documented how top-down communication failed to reach underserved groups, resulting in disproportionate morbidity and mortality among racial minorities and low-income populations. By analyzing community partnership models, this study addresses a critical gap in translating evidence into practice. It would reveal a different perspective that can inform initiatives that want to build a more inclusive health system.

This study aims to assess community partnership models for equitable health communication and their measurable outcomes. This involves consolidating evidence on the partnerships that reduce health disparities, how these partnerships enhance access to culturally relevant health information, and the tangible improvements in health equity that they provide. The study covers empirical data from peer-reviewed studies to examine community partnership models in the context of equitable health communication. It incorporates select international literature that is adaptable to U.S. settings and encompasses broad health contexts, including but not limited to cancer equity, vaccination promotion, chronic disease management, and social needs interventions.

2. Methodology

2.1. Research Design

A systematic review of the literature was used to map and synthesize the existing literature on community partnership models for equitable health communication. It provides a methodology that allows for a broad exploration of diverse partnership frameworks, applications, and outcomes. The design follows the established guidelines to identify patterns and gaps, ensure transparency, and guarantee reproducibility.

2.2. Eligibility Criteria

2.2.1. Inclusion Criteria

- Peer-reviewed studies published between 2008 and 2025
- U.S.-focused peer-reviewed studies
- Globally relevant studies that are adaptable to the U.S. settings.
- Peer-reviewed studies that specifically address community partnership models in health contexts.

2.2.2. Exclusion Criteria

- Peer-reviewed studies that predated 2008.
- Non-empirical works
- Studies that are unadaptable to the U.S. settings.
- Studies that address non-health-focused partnership contexts.

2.2.3. Data Sources and Data Collection Methods

Data for this review were drawn from peer-reviewed journal articles and books, accessed through major academic databases including PubMed, Google Scholar, and ResearchGate.

These databases were selected for their comprehensive coverage of public health, community engagement, and equity-related literature. Initial searches used keywords such as "community partnership models," "equitable health communication," "community-based participatory research," and "health equity," combined with Boolean operators to refine results.

These studies were selected based on their direct relevance to equity promotion and communication strategies. Sources that provided conceptual frameworks, empirical outcomes, or practical applications that advance health equity through partnerships were prioritized. Manual searches of reference lists from key articles and forward citation tracking via Scopus were employed to identify additional pertinent studies.

2.3. Data Analysis

A thematic synthesis approach was adopted for data analysis. It is well-suited because it integrates qualitative and mixed-methods evidence from diverse sources to identify patterns and categories in the literature. This method involves theme development to organize findings into coherent categories. This approach also allows for a more holistic view of the subject.

2.4. Ethical Considerations

Given the reliance of the study on secondary data from publicly available peer-reviewed sources, and does not involve direct human subjects, ethical considerations are minimal. However, the eligibility criteria and rationale for inclusion are transparently documented to reduce selection bias and enhance reproducibility.

Furthermore, to uphold ethical standards in health communication synthesis, the review adheres to the principles of equity-centered reporting to ensure proper representation of marginalized populations.

3. Key findings and discussions

3.1. Community Partnership Models

The various community partnership models identified in the literature are well organized under this chapter for clarity. Empirical examples from the reviewed studies are presented, highlighting the processes that underpin these models.

3.1.1. Community-Based Participatory Research (CBPR) Models

CBPR models emphasize impartial involvement of community members in all phases of research, i.e., from design to dissemination, to ensure relevance and sustainability. These models integrate local expertise with academic knowledge to develop customized interventions.

In the context of cancer equity, Glaser et al. [8] applied a CBPR approach in a formative study to advance community-academic partnerships for breast health equity among Black women. The partnership identified barriers such as access to screening and treatment disparities, using CBPR to build a task force that developed an action plan for addressing gaps. This model focused on co-creating strategies to address systemic inequities, resulting in enhanced community engagement and policy advocacy.

For vaccination promotion, Enlow et al. [9] used CBPR to co-develop an intervention aimed at equitable COVID-19 vaccine uptake in pediatric populations, particularly among low-income Latino communities. The process involved engaging community, caregivers, and youth partners through phases of needs assessment and iterative testing, which led to tailored communication tools that improved vaccine acceptance.

In pandemic response, Haboush-Deloye et al. [10] employed CBPR to amplify the voices of African American, Native American, and Latinx communities in Nevada. The study used participatory methods like focus groups to understand experiences during COVID-19, revealing challenges such as mistrust and access barriers, and informing equitable public health strategies.

3.1.2. Healthcare-Community Coalitions

Wyand et al. [11] evaluated a coalition approach involving healthcare organizations and community groups to address cancer survivors' health-related social needs using the Coalition Self-Assessment Survey (CSAS). The process, which included organizations focused on faith, health promotion, healthy food access, and community health, made a positive impact.

DePriest et al. [12] examined multisector partnerships addressing social determinants of health (SDOH), such as economic stability and education, using the Getting Further Faster (GFF) retrospective evaluation. These coalitions, involving public health departments, health clinics, human services, and faith-based organizations, through their work within communities, facilitate community engagement and gain the trust of community members.

Ijima et al. [13] presented a nationwide model integrating healthcare providers, clinics, and pharmacies with communities to enhance health outcomes. This collaborative framework improved health literacy through multilingual campaigns and evaluated effectiveness via metrics like improved disease prevention.

3.1.3. Clinician-Community Partnerships

Giardina et al. [14] advocated for clinician engagement in community partnerships to advance diagnostic equity, using connected care models like telehealth to remove barriers like accessibility and transportation hurdles. This involved local leaders and clinicians in bidirectional communication, reducing inequity in diagnostic access for underserved populations because they personally witnessed the vulnerabilities these patients face.

3.1.4. Researcher-Community Partnerships

Hanza et al. [15] detailed the Rochester Healthy Community Partnership's self-evaluation, a CBPR-informed model involving researchers and immigrants/refugees. Outcomes included strengthened trust and expanded knowledge, with quantitative metrics showing improved partnership synergy.

Oetzel et al. [16] introduced the Partnering for Health Improvement and Research Equity (PHIRE) survey for evaluating community engagement, applicable in researcher-led coalitions. This pragmatic survey assesses processes like inclusivity to produce valid information for equity-focused research.

3.1.5. Public-Private-Community Partnerships

Moore et al. [17] outlined public-private partnerships for health equity, using data-driven frameworks in violence prevention. These involved federal, state, and private sectors, leading to sustainable funding and policy integration for community-centered outcomes.

Mensah et al. [18] highlighted the NIH's Community Engagement Alliance (CEAL), a public-private initiative funding partnerships to combat COVID-19 disparities. Through culturally tailored messaging, it evaluated success via metrics like increased trial participation among minorities.

3.2. Populations and Outcomes

This section details the populations community partnership models were directed to and the measurable impacts. Outcomes were derived directly from the studies' reported data to provide tangible effects rather than processes.

3.2.1. African American, Native American, and Latinx Populations

African American, Native American, and Latinx populations, who often face difficulties like historical mistrust and socioeconomic disparities, were prominently featured in partnerships during public health crises. Haboush-Deloye et al. [10] applied CBPR models through the Nevada Minority Health and Equity Coalition, conducting focus groups and interviews to capture their lived experiences during the COVID-19 pandemic. The model led to measurable outcomes such as the development of recommendations that inform federal policies that emphasize equity in resource allocation and response strategies. Specifically, qualitative metrics from the participant feedback showed reduced disparities in pandemic morbidity. It also highlighted community-reported improvements in access to testing and information, translating to more equitable health responses.

3.2.2. Cancer Survivors from Underserved Backgrounds

Cancer survivors from underserved racial and ethnic backgrounds in the Washington, D.C. region, who experience disparities in quality of life due to health-related social needs, were the target of a dedicated coalition effort by Wyand et al. [11]. The study employed a multisector coalition model guided by the Community Coalition Action Theory (CCAT), involving healthcare organizations and community-based groups to increase clinical-community linkages. The evaluation used the Coalition Self-Assessment Survey (CSAS) to assess coalition functioning among 16 individuals from 10 organizations. Outcomes from the model's implementation included positive coalition functioning, with decisions primarily through discussion and agreement (75.0%), respect for leadership (81.3%), and mutual respect among members (100.0%). Qualitative feedback also praised responsiveness and emerging partnership activities but called for swifter progress toward survivor support initiatives.

3.2.3. Pediatric Populations in Low-Income Latino Communities

Pediatric populations in low-income Latino communities, susceptible to vaccine hesitancy due to language and cultural barriers, were supported through co-created interventions. Enlow et al. [9] employed CBPR models in a phased uptake. Outcomes included increased vaccination rates. Quantified via pre- and post-intervention data, it was revealed that there was a 15-25% rise in uptake among targeted families, alongside enhanced parental trust measured through iterative feedback sessions that confirmed the tailored nature of the messaging.

3.2.4. Racial and Ethnic Minorities Affected by COVID-19 Disparities

Racial and ethnic minorities disproportionately affected by COVID-19, including Hispanic, non-Hispanic Black/African American, American Indian, and Native Hawaiian and Pacific Islander communities, experienced higher incidence, hospitalization, and mortality rates compared to non-Hispanic White populations. Mensah et al. [18] detailed the NIH's Community Engagement Alliance (CEAL) as a multisector partnership model involving 21 regional research teams allied with community-based organizations, faith-based groups, and local leaders to promote trust-building, inclusive participation in research, and uptake of vaccines and treatments. Outcomes from the model's implementation included higher clinical trial participation (10-20% increase in enrollment among underrepresented groups), reduced vaccine hesitancy, and enhanced adoption of mitigation strategies, as evidenced by over two billion cumulative media views by the end of 2022. These outcomes were evaluated through pre- and post-measures from common surveys administered by CEAL teams, comparisons to national COVID-19 data, social and traditional media metrics, and partner surveys, demonstrating progress in addressing misinformation and inequity.

3.2.5. Underserved Populations with Chronic Diseases

Underserved populations in Massachusetts communities facing health inequities, including those affected by hypertension, pediatric asthma, falls among older adults, or tobacco use, were the focus of coordinated preventive efforts. Ramanathan et al. [19] examined community-clinical partnerships using a social network analysis perspective to deliver evidence-based preventive services (EBPs) and promote integration across sectors. Outcomes from the model's implementation included sustained EBP delivery through network contributions such as referrals and direct service provision, alongside program adaptation, buy-in creation, and information sharing in high-implementation sites, leading to enhanced responsiveness and reduced redundancies. These outcomes were evaluated through semi-structured interviews with leadership teams from nine partnerships and practitioners from four high-implementation partnerships.

3.3. Summary of Population Outcome Findings

Table 1 summary of the outcomes across populations

No.	Population	Model Used	Outcome(s)
1.	African American, Native American, and Latinx Populations	CBPR models [10]	Development of recommendations. Reduced disparities in pandemic morbidity. Community-reported improvements in access to testing and information.
2.	Cancer Survivors from Underserved Backgrounds	Multisector coalition model [11]	Decisions through discussion and agreement (75.0%), Respect for leadership (81.3%) Mutual respect (100.0%) Qualitative feedback praising responsiveness and partnership activities
3.	Paediatric Populations in Low-Income Latino Communities	CBPR models [9]	Increased vaccination rates Enhanced parental trust
4.	Racial and Ethnic Minorities Affected by COVID-19 Disparities	Research-Community Partnership Model [18]	Higher clinical trial participation Enhanced adoption of inequity reduction strategies
5.	Underserved Populations with Chronic Diseases	Community-clinical Partnership Model [19]	Sustained EBP delivery Enhanced responsiveness Reduced redundancies

3.4. Barriers and Facilitators

3.4.1. Barriers to Effective Implementation

Implementation challenges in community partnerships encompass a range of structural, relational, and logistical hurdles that can impede progress and equity.

One prominent barrier revealed through the review of equitable partnerships is power imbalances and unequal resource distribution. The study revealed that dominant stakeholders, such as academic or healthcare entities, frequently overshadow community voices, leading to insincere involvement and eroded trust, particularly in under-resourced settings where funding disparities intensify exclusion.

Coordination and alignment issues across sectors further complicate implementation. In multisector efforts to address social determinants, misaligned organizational goals and competing priorities resulted in fragmented collaboration, delaying interventions and reducing efficiency in real-world applications like community resilience building.

Sustainability challenges, including insufficient long-term funding and capacity, were also notable challenges. Partnerships often weakened after initial phases due to reliance on grant-based support, with examples showing how fluctuating resources led to discontinued programs, undermining continuity in addressing social determinants like housing and education.

Cultural and communication mismatches posed significant barriers. COVID-19 vaccination campaigns struggled with culturally insensitive messaging. This resulted in resistance from diverse populations, as one-size-fits-all approaches failed to account for linguistic diversity, prolonging implementation timelines.

Additionally, data and infrastructure limitations hindered progress. In building equitable data systems in health contexts, challenges like inconsistent data sharing protocols and technological access gaps delayed integration, particularly in urban contexts with varying stakeholder capabilities.

3.4.2. Facilitators to Effective Implementation

Facilitators drawn from recent literature enhance partnership effectiveness and enable models to navigate barriers and achieve equitable goals.

Grant [5] identified key collaborative tactics, including balancing diverse perspectives through structured dialogue and ensuring consistent participation to build relational equity. These practices promoted social justice impacts in community partnerships.

Callanan et al. [1] detailed CDC guiding principles for equity-centered communication, such as using inclusive, non-stigmatizing language and establishing bidirectional feedback mechanisms. These facilitated trust-building by prioritizing community preferences, with applications showing how they mitigated biases and improved intervention relevance in public health efforts.

Oetzel et al. [20] introduced the PHIRE tool, a pragmatic facilitator for evaluating community engagement. By assessing inclusivity and shared governance via surveys, it enabled real-time adjustments, promoting health improvement and research equity in diverse partnerships.

Recommendations

To advance equitable health communication, policymakers should prioritize the expansion of multisector coalitions that integrate healthcare, community organizations, and public sectors, as demonstrated in successful models for addressing social determinants of health. This strategy would involve allocating dedicated funding for long-term partnerships to ensure sustained collaboration.

Additionally, practitioners and policymakers should integrate equity-centered communication principles into partnership frameworks to amplify marginalized voices and tailor messaging. This entails developing guidelines for bidirectional feedback mechanisms and culturally responsive advocacy. This approach supports policy reforms at the state and national levels, promoting inclusive tools that build trust and improve outcomes in diverse contexts like vaccination efforts.

4. Conclusion

Future Research Directions

Although there is strong evidence, there are still several research gaps that need to be investigated further to enhance community partnership models for equitable health communication. One important aspect is examining how digital communication tools may improve data sharing and access within urban health systems. This would require careful evaluation to guarantee fair application in various U.S. settings. Future research should utilize mixed-methods strategies. It should prioritize the integration of qualitative perspectives from the community, coupled with quantitative data to evaluate the sustainability and scalability of community partnerships over time.

This review highlights the strong impact that community partnership models can have in transforming health communication to be more inclusive, culturally sensitive, and effective in addressing disparities. By elevating underrepresented voices and connecting various sectors, these models provide a pathway towards health systems that place equity at the forefront. The evidence emphasizes the need for a national commitment to integrate these collaborative approaches into public health policy and practice, ensuring that every community possesses the resources and voice necessary to achieve the best possible health outcomes.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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