Invited Editorial

Empowering Communities: Health Equity through Authentic Leadership

Nor Faiza Mohd. Tohit [1], Mainul Haque [2,3,4,5,6]

Health equity is the absence of systematic disparities in health and its determinants among social groups with varying levels of social advantage or disadvantage [1]. Unlike equality, which assumes everyone should be treated the same, equity recognizes that people with different levels of disadvantage need different approaches and resources to achieve fair health outcomes [2]. Health equity is conceptualized as achieving the highest level of health for all people, emphasizing that attaining equity requires focused attention on those experiencing the most significant disparities [3].

Within the framework of the 2030 Agenda for Sustainable Development, health equity serves as both a clear goal and a core principle woven through numerous Sustainable Development Goals (SDGs), including Goal [4]. SDG-3 specifically calls for ensuring healthy lives and promoting well-being for all ages, while SDG-10 focuses on reducing inequalities within and among countries. The interconnectedness of these goals recognizes that health outcomes are linked to broader social determinants, such as education, economic opportunity, environmental conditions, and social inclusion [5]. Conceptual frameworks for addressing these social determinants highlight that structural drivers are the core causes of health inequities. [6,7].

The Paradox of Health Equity Efforts

Despite unprecedented global commitment to health equity, as evidenced by policy declarations, funding allocations, and institutional frameworks, substantial disparities persist and, in some contexts, have continued or even worsened to be wide [2] (Figure 1). This paradox exposes a core disconnect between intention and implementation. Traditional public health approaches, though well-intentioned, often reinforce the very power imbalances they seek to address by placing external experts as the main decision-makers and communities as passive recipients of interventions [8]. Research increasingly shows that interventions created without meaningful community leadership often do not produce lasting impact, no matter how many resources are invested or how advanced the strategy [9].

The Case for Authentic Community Leadership

Authentic community leadership goes beyond tokenistic consultation or superficial engagement. It entails the real redistribution of power and resources, allowing communities to lead the entire intervention process from identifying problems through implementing solutions to evaluating results [10] (Figure 2).

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Figure 1: Traditional Approaches Fail to Achieve Equity.

Illustration Credit: Nor Faiza Mohd. Tohit.

This approach recognizes that individuals facing health inequities have invaluable expertise gained from lived experience, cultural knowledge systems that inform health-related decisions, and social networks crucial for successful intervention. The shift toward community-led approaches aligns with emerging frameworks in implementation science, which emphasize adaptation, context sensitivity, and co-creation [10]. It also reflects broader movements toward decolonizing global health, acknowledging historical patterns where external actors have extracted knowledge from communities while imposing solutions that prioritize external agendas over local needs [8].

This editorial synthesizes evidence on the role of authentic community leadership in promoting health equity within the SDG framework. The review examines how community-led approaches create better and fairer health outcomes, the barriers to implementing participatory methods, and the link between community empowerment and the long-term sustainability of health interventions beyond external funding cycles.

Overview of Community-Led Initiatives

The literature shows various models of community-led health programs across different health areas and location contexts. Successful examples include maternal and child health programs in which community members act as primary decision-makers regarding service delivery models [11], community-led initiatives for infectious disease prevention [12], and chronic disease management programs in which communities identify culturally appropriate lifestyle modification strategies. Analysis shows that true community leadership includes authority over resource distribution, independence in identifying issues, and control over how solutions are carried out [13].

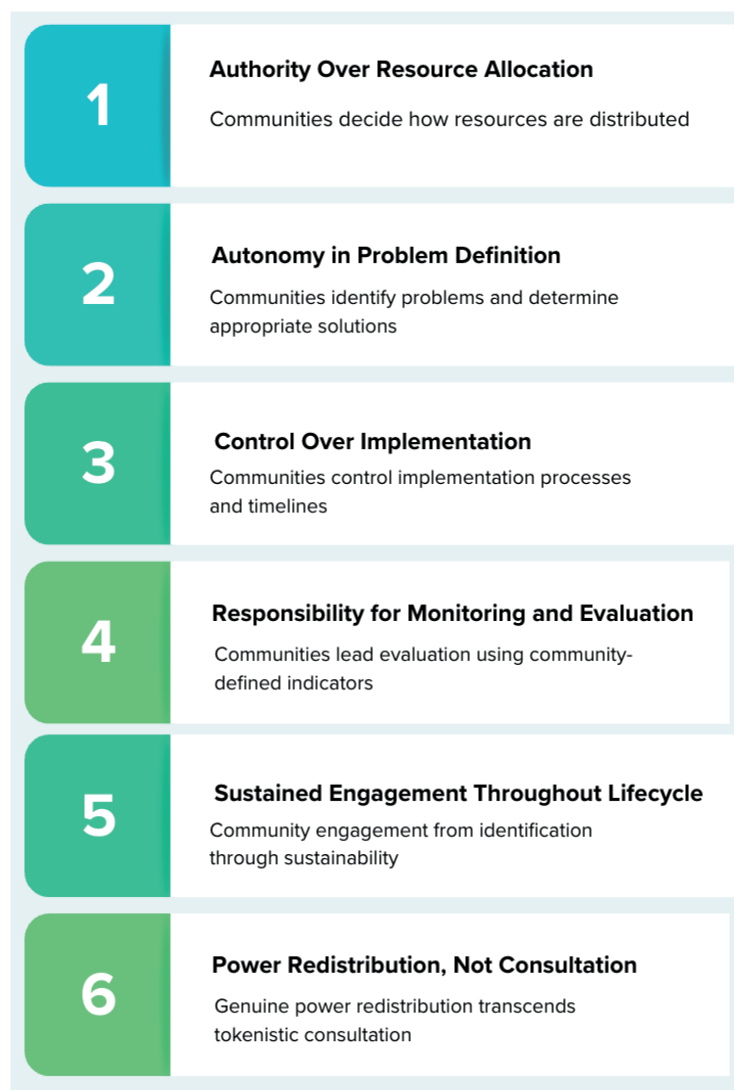

Figure 2: Core Components of Authentic Community Leadership.
Illustration Credit: Nor Faiza Mohd. Tohit.

Impact on Health Outcomes

Quantitative studies included in this review provide strong evidence that community-led approaches yield better health outcomes than traditional service delivery models. A meta-analysis of community participation in women's and children's health found significant improvements in maternal health indicators, with relative risk reductions of 35% for maternal mortality when communities controlled intervention design [11]. Similar patterns appeared in studies examining infectious disease outcomes and social participation among people with disabilities [14]. Beyond overall health metrics, community-led initiatives show particular effectiveness in reaching the most marginalized populations who often face the greatest health disparities [12,15].

Mechanisms of Impact

This editorial highlights key ways in which community leadership contributes to improved health outcomes (Figure 3) [6,13,16-19].

Figure 3: Pathways from Community to Equity.

Illustration Credit: Nor Faiza Mohd. Tohit.

Case Studies of Successful Community Leadership

- **Community-Directed Treatment:** Programs shifting to community-directed models for disease control saw treatment coverage increase dramatically as communities innovated distribution strategies matching local social dynamics structures [17,20].
- **Maternal Health:** Indigenous communities gaining leadership over maternal health programs, integrating traditional midwives and birthing practices, resulting in lower mortality rates and strengthened cultural identity [11].
- **Mental Health:** Peer support networks led by individuals with lived experience, including refugees and asylum seekers, show improved recovery outcomes and less social isolation [21].
- **HIV/AIDS Response:** The shift toward community-led responses, especially among marginalized groups like men who have sex with men (MSM), has transformed HIV programs. Community-driven initiatives for treatment access and stigma reduction have reached hidden populations more effectively than top-down approaches [22].
- **Homelessness and Addiction:** Interventions for populations with lived experience of homelessness developed through community-based participatory research (CBPR) have demonstrated effectiveness in harm reduction and housing stability [23].

Health Equity Impacts

Studies specifically examining equity outcomes show that community-led approaches tend to benefit the most disadvantaged groups more [12]. For example, community-led programs have been shown to reduce equity gaps by focusing on the most marginalized, who are often overlooked by traditional top-down programs [15,24].

Theoretical Implications of Authentic Community Engagement

The evidence summarized in this review supports theoretical frameworks for understanding how interventions can effectively reduce health inequities. The findings align with empowerment theory, which suggests that health outcomes improve when individuals and communities gain control over factors affecting their health lives [25]. This reflects Arnstein's "ladder of citizen participation," which differentiates between superficial participation rituals and real citizen power [26].

Furthermore, the approach is based on Freire's critical consciousness frameworks [27] and "street science" perspectives that prioritize community knowledge alongside professional expertise [28]. It has been emphasized that social capital highlights the health-protective effects of social networks and collective efficacy [29]. These perspectives together propose a framework in which health equity develops through genuine empowerment and the recognition of community strengths [30,31].

Implementation Barriers and Challenges

Despite compelling evidence, major barriers hinder the widespread adoption of community-led approaches for healthcare for all (Figure 4) [18,32-38].

Figure 4: Major Barriers Preventing Community-Led Health Programs.

Illustration Credit: Nor Faiza Mohd. Tohit.

Strategies for Overcoming Implementation Barriers

Strategies for overcoming these barriers include (Figure 5) [19,31,39,40].

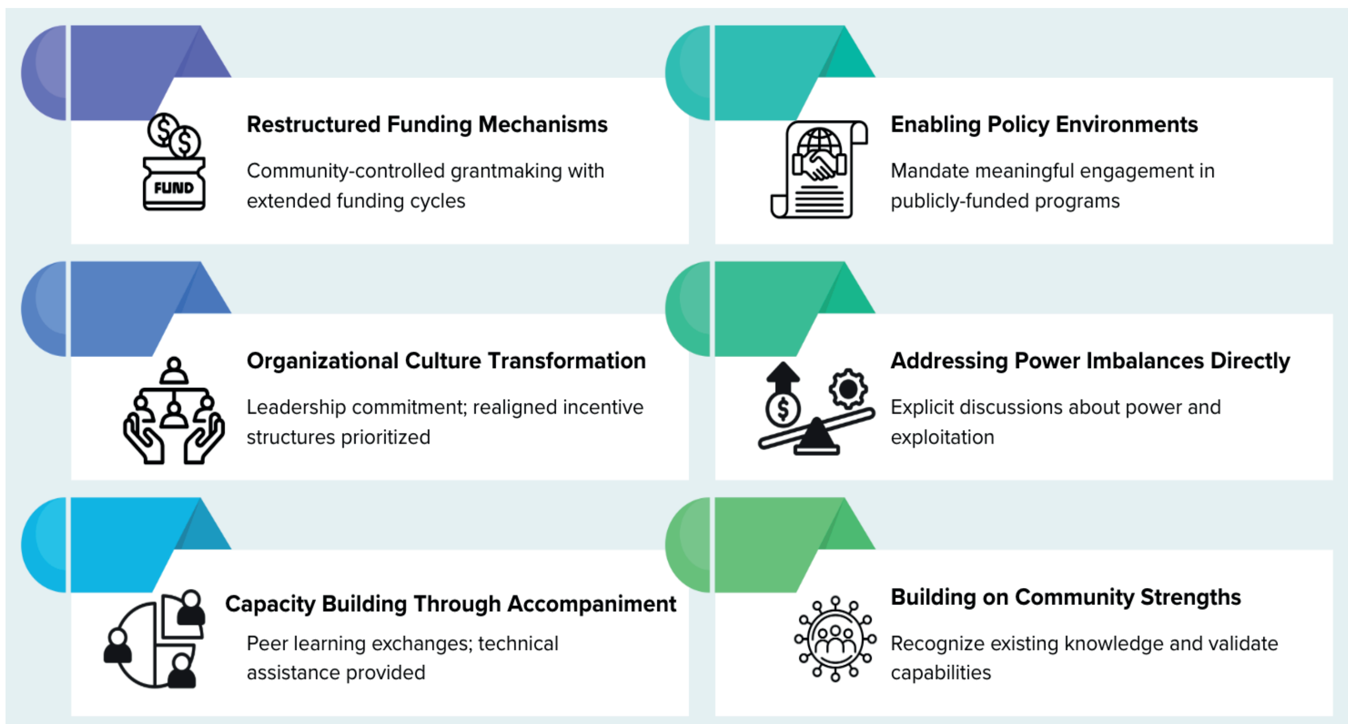

Figure 5: Evidence-Based Solutions to Enable Community Leadership.

Illustration Credit: Nor Faiza Mohd. Tohit.

The Role of Cultural Context in Health Interventions

The importance of culture emerged as a consistent theme [41]. Culture influences how communities understand health, illness, and healing [13]. The review highlights the difference between cultural competence and cultural humility. While cultural competence often centers on gaining knowledge about other cultures [42,43], Cultural humility emphasizes self-reflection, addressing power imbalances, and building mutually beneficial partnerships [44,45] (Figure 6).

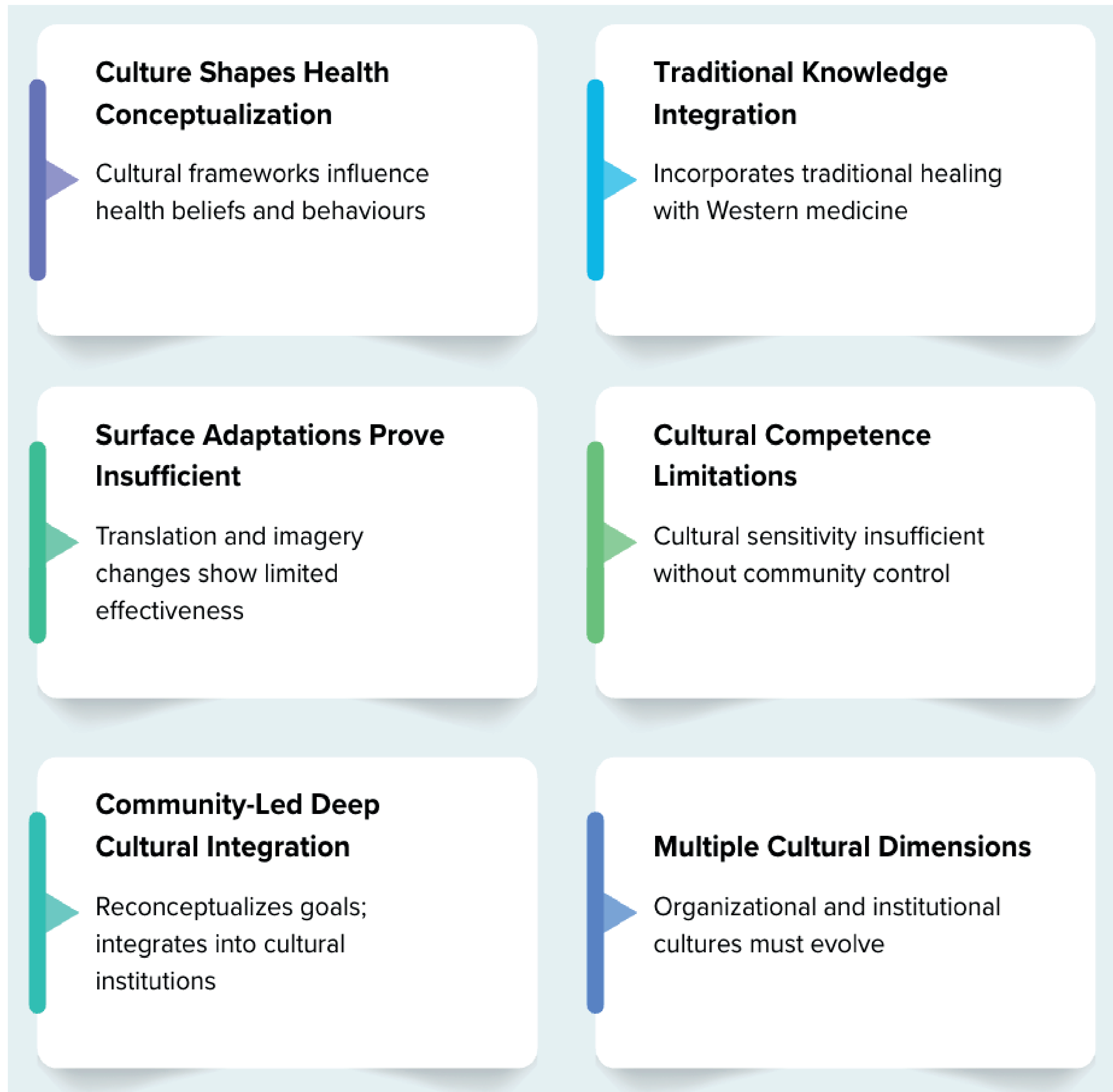

Figure 6: Culture Central to Health Equity Success.
Illustration Credit: Nor Faiza Mohd. Tohit.

Community leadership offers the most dependable way to ensure cultural appropriateness because communities naturally understand their own contexts [46]. Research indicates that cultural humility among researchers and practitioners is crucial for effective community engagement [47,48]. Measuring openness to culturally diverse clients and communities is an essential part of this process [49].

Policy to Action

Putting these principles into action involves efforts at various levels. (Figure 7) [40,50-52].

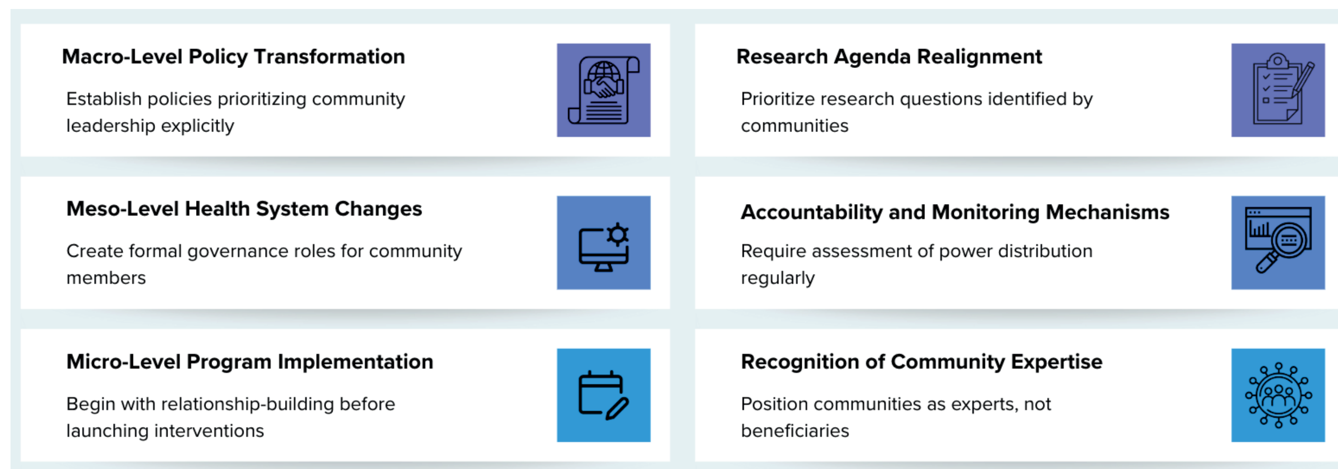

Figure 7: Multi-Level Framework for Translating Evidence to Action.

Illustration Credit: Nor Faiza Mohd. Tohit.

Research Gaps

Future research should focus on developing evaluation methods suitable for community-led initiatives, conducting economic analyses, and understanding the mechanisms of scale-up [53]. There is a need for comparative effectiveness research to determine which aspects of community leadership are most essential [34].

This editorial shows that true community leadership is a strong yet underused strategy for promoting health equity. The evidence consistently indicates that initiatives led by affected communities achieve better health outcomes, mostly benefit the most marginalized groups, and build lasting local capacities. These benefits happen through mechanisms like improved cultural relevance, greater trust, and the ability to tackle the root causes of inequality. However, realizing this potential requires overcoming major barriers related to funding, organizational culture, and power imbalances. Policymakers need to change funding systems to support long-term empowerment, while health professionals should engage in self-reflection to move away from paternalism and towards genuine partnership. The path to health equity involves not only providing services to underserved populations but also empowering these populations to lead their own health improvements. The evidence is clear: authentic community leadership is essential for achieving the SDG goal of health for all.

Consent for Publication

The author has reviewed and approved the final version and agrees to be accountable for all aspects of the work, including any accuracy or integrity issues.

Disclosure

Mainul Haque works on the editorial board of the Bangladesh Journal of Medical Science. The authors declare that they do not have any financial involvement or affiliations with any organization, association, or entity directly or indirectly related to the subject matter or materials presented in this review paper.

Data Availability

Information for this review paper is taken from freely available sources.

Authorship Contribution

All authors contributed significantly to the work,

whether in the conception, design, utilization, collection, analysis, or interpretation of data, or all these areas. They also participated in the paper's drafting, revision, or critical review, gave their final approval for the version that would be published, decided on the journal to which the article would be submitted, and made the responsible decision to be held accountable for all aspects of the work.

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