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Co-Producing Person-Centred Care Services with Faith Leaders and Cultural Advocates in Diverse Adult Care Settings

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Abstract: Person-centred care (PCC) is widely recognized as a cornerstone of quality health and social care, promoting dignity, autonomy, and individualised support. In increasingly multicultural societies, traditional models of PCC often fall short in meeting the cultural, spiritual, and psychosocial needs of diverse adult care populations. This gap is particularly evident in adult care settings where service users' values, beliefs, and community affiliations play a critical role in their well-being and care engagement. Faith leaders and cultural advocates, as trusted figures within their communities, possess deep contextual knowledge and relational authority that can bridge cultural divides and strengthen the relevance of care services. This paper examines an integrated framework for co-producing person-centred care services through structured collaboration between adult care professionals, faith leaders, and cultural advocates. It explores the potential for such partnerships to enhance culturally responsive assessment, shared decision-making, and continuity of care. Drawing on examples from diverse urban and rural care environments, the study outlines practical co-design methodologies, including participatory workshops, culturally tailored communication tools, and joint training modules. Attention is given to challenges such as balancing professional standards with faith-based practices, mitigating bias, and ensuring equitable representation across cultural groups. By embedding faith leaders and cultural advocates into the care planning and delivery process, this co-production model offers a sustainable pathway to improve trust, reduce health inequalities, and enhance care outcomes in adult services. The findings underscore the need for policy frameworks and funding mechanisms that formally recognise and support these collaborative roles within person-centred care ecosystems.

Keywords: Person-centred care, Faith leaders, Cultural advocates, Adult care services, Co-production, Culturally responsive care

1. INTRODUCTION

1.1 Background and Significance

Person-centred care (PCC) has evolved over decades from a biomedical model focused on disease treatment to a holistic framework prioritising the individual's unique values, preferences, and lived experiences [1]. Early health and social care systems emphasised uniform protocols, often neglecting the psychosocial and cultural dimensions of care. Over time, evidence has demonstrated that embedding personal narratives and cultural context into care delivery improves patient satisfaction, adherence, and overall outcomes [2].

This shift is increasingly important in adult care settings, where demographic patterns are rapidly diversifying. Migration trends, globalisation, and evolving social dynamics have created care environments in which providers engage with clients from varied cultural, linguistic, and spiritual backgrounds [3]. In these settings, traditional approaches risk overlooking cultural sensitivities, potentially leading to mistrust and suboptimal health behaviours.

Faith leaders and cultural advocates play a critical role in bridging these divides. Their community standing allows them to act as trusted intermediaries, translating complex health information into culturally resonant messages and reinforcing health-promoting practices [4].

Figure 1: Conceptual map of adult care diversity and stakeholder relationships.

Research shows that when care delivery teams collaborate with such community figures, they can better tailor interventions to align with cultural norms and spiritual beliefs

[5]. This not only strengthens communication but also addresses barriers related to stigma, misunderstanding, and cultural dissonance. Table 1 summarises key comparative outcomes between standard PCC models and culturally augmented PCC approaches in adult care environments.

In multicultural societies, neglecting the role of cultural and spiritual frameworks risks perpetuating inequities. Embedding faith and cultural perspectives into PCC is therefore not simply a compassionate choice; it is an evidence-based necessity for equitable and effective adult care services [6].

1.2 Problem Statement

Despite growing recognition of the value of culturally responsive PCC, significant gaps persist in its systematic implementation. Many healthcare organisations adopt broad diversity policies yet lack concrete strategies for integrating faith leaders and cultural advocates into formal care frameworks [3]. As a result, cultural responsiveness often remains dependent on individual practitioners' awareness rather than organisational protocols.

In diverse adult care settings, this omission can lead to culturally discordant service delivery, eroding trust and reducing engagement in preventative and therapeutic interventions [1]. For example, dietary recommendations, mental health counselling, or end-of-life care preferences may conflict with cultural or spiritual norms, resulting in reduced adherence or outright rejection of professional advice.

Furthermore, while informal collaboration with community leaders occasionally occurs, it is often ad hoc and unstructured. Without formalised training, communication channels, and accountability mechanisms, such collaborations may fail to achieve sustained impact [4]. This structural disconnect limits the scalability of culturally informed PCC models, particularly in rural and underserved urban contexts where healthcare access is already constrained.

Addressing these gaps requires moving beyond tokenistic engagement with cultural figures to developing integrated, multi-stakeholder care ecosystems [5]. Such ecosystems must embed faith and cultural advocacy roles into multidisciplinary care teams, supported by institutional policies, training, and evaluation metrics.

Ultimately, the problem lies not in the absence of awareness but in the lack of operational models that translate awareness into sustained practice [2]. Tackling this challenge is essential for ensuring that PCC frameworks are equitable, culturally congruent, and adaptable across diverse adult care settings [6].

1.3 Objectives and Scope

The primary objective of this article is to explore strategies for co-producing PCC services in collaboration with faith leaders and cultural advocates, particularly in diverse adult care environments. By examining evidence, models, and best practices, it aims to identify actionable approaches for embedding cultural and spiritual perspectives into the formal architecture of care delivery [1].

The scope encompasses both urban and rural contexts, recognising that while multicultural dynamics are often most visible in metropolitan areas, rural regions also host diverse populations with unique cultural and spiritual needs [3]. Special attention is given to care environments serving immigrant, indigenous, and minority communities, where cultural mistrust of formal healthcare systems can be more pronounced [4].

The article further seeks to bridge theoretical frameworks with practical application by outlining mechanisms for formalising partnerships between healthcare providers and community advocates [2]. This includes strategies for developing mutual trust, aligning care protocols with cultural norms, and evaluating outcomes through culturally sensitive metrics [5].

Figure 1 and Table 1 are integrated into the discussion to provide visual clarity and comparative insight into existing and proposed models. While the focus is primarily on adult care, insights are drawn from related domains such as maternal health and mental health services where cultural partnerships have demonstrated measurable benefits [6].

In sum, the scope is designed to move beyond advocacy for cultural inclusion toward the operationalisation of PCC models that are inclusive, evidence-driven, and adaptable, thereby ensuring equitable, person-centred outcomes across diverse adult care contexts.

2. THEORETICAL AND CONCEPTUAL FOUNDATIONS

2.1 Defining Person-Centred Care

Person-Centred Care (PCC) is a healthcare philosophy that prioritizes the values, preferences, and needs of individuals over standardized institutional routines. Rooted in the concepts of dignity, respect, and personal choice, PCC shifts the focus from a disease-oriented approach to a holistic understanding of the person in their social, cultural, and emotional context [8]. It embraces the principle that service users are active participants in their care, fostering collaboration between patients, families, and professionals.

The core principles of PCC dignity, respect, choice, and partnership are operationalized through practices such as active listening, shared decision-making, and flexible service delivery [10]. Dignity ensures individuals are valued beyond their diagnosis, while respect requires acknowledging cultural, spiritual, and personal identities. Choice empowers people to have control over how care is delivered, and partnership emphasizes a collaborative relationship where expertise is shared between care providers and recipients [5].

As shown in Figure 1, PCC's model is inherently adaptable, allowing for cultural and faith-based influences to be integrated into formal care systems without compromising evidence-based standards. Such adaptability is crucial in

diverse adult care settings where patient backgrounds may vary widely in language, tradition, and belief systems [11].

The strength of PCC lies in its ability to merge clinical objectives with personal values. For example, incorporating cultural rituals into meal planning or religious observances into scheduling medical procedures can dramatically improve adherence and satisfaction. Table 1 highlights studies demonstrating measurable improvements in patient outcomes when PCC is culturally attuned [9].

By recognizing patients as partners, PCC creates a healthcare environment where well-being is defined not solely by medical metrics but by the individual's quality of life, autonomy, and sense of belonging within their community.

2.2 Cultural Competence and Cultural Safety Frameworks

Cultural competence involves the capacity of healthcare professionals and organizations to work effectively in cross-cultural situations, ensuring that care delivery is sensitive to cultural differences in beliefs, communication styles, and values [6]. It encompasses a combination of awareness, knowledge, and skills that enable care providers to adapt interventions to fit the cultural context of the patient.

Cultural safety extends beyond competence by addressing systemic inequities and power imbalances inherent in healthcare systems [8]. This framework calls for a transformation of institutional practices, ensuring that patients feel respected, understood, and safe from cultural insensitivity or discrimination. Cultural safety also involves an ongoing process of self-reflection among healthcare providers to recognize and address their own biases [5].

Effective cross-cultural communication requires active listening, open-ended questioning, and the use of culturally appropriate non-verbal cues [10]. Trust-building theories in healthcare emphasize that patients from diverse backgrounds are more likely to disclose sensitive health information when they feel understood and respected. Such trust is critical in long-term adult care settings where ongoing relationships between providers and patients are the norm [7].

Figure 1 illustrates how cultural competence and cultural safety intersect, creating a robust framework for integrating faith leaders and cultural advocates into PCC. When applied in diverse adult care environments, these frameworks not only improve patient satisfaction but also enhance clinical outcomes by reducing misunderstandings and increasing compliance with treatment plans [9].

Importantly, these frameworks recognize that culture is dynamic and multifaceted, meaning care strategies must be adaptable to individual preferences rather than relying on generalized assumptions. In this way, cultural competence and safety move beyond token inclusion of cultural elements, instead embedding them into the core of service design, delivery, and evaluation.

2.3 The Role of Faith Leaders and Cultural Advocates

Faith leaders and cultural advocates hold a unique position in bridging the gap between healthcare systems and culturally diverse communities [11]. In many societies, they serve as trusted authorities whose guidance carries significant weight in decision-making, especially in matters involving health, illness, and end-of-life care [7]. Their influence is not limited to spiritual matters; it extends to advocating for culturally appropriate healthcare services and mediating between patients and medical teams.

By integrating faith leaders into adult care settings, healthcare providers can enhance patient trust, improve adherence to treatment plans, and ensure that care aligns with the patient's spiritual and cultural values [6]. For example, faith leaders can support care teams in navigating complex ethical decisions, such as those related to palliative care or informed consent, by framing these discussions within the patient's belief system.

Cultural advocates often individuals with lived experience in both the healthcare system and their community play a complementary role. They can educate providers about cultural norms, assist in interpreting non-verbal cues, and advocate for systemic changes that make care more inclusive [8].

As illustrated in Table 1, case studies have shown that collaboration with faith leaders can increase participation in preventive health programs and reduce resistance to certain interventions in culturally diverse communities [9]. Figure 1 also shows how these roles fit within the broader PCC framework, reinforcing that their integration is not an optional add-on but a strategic necessity in multicultural settings.

Ultimately, faith leaders and cultural advocates act as cultural translators and trust-builders. Their inclusion ensures that adult care services are not only clinically sound but also emotionally and spiritually resonant, thereby creating a more comprehensive and sustainable care environment.

2.4 Co-Production Theory in Healthcare

Co-production in healthcare refers to the collaborative process where service users and professionals jointly design, deliver, and evaluate health services [10]. Rooted in the principles of shared decision-making and equal partnership, co-production challenges traditional top-down service models by positioning patients as co-creators rather than passive recipients of care [5].

In the context of diverse adult care settings, co-production is especially valuable as it accommodates varying cultural and spiritual needs [8]. By engaging patients, families, faith leaders, and cultural advocates from the outset, services can be designed to reflect both medical best practices and community-specific priorities. This approach not only improves service relevance but also fosters a sense of ownership among participants, leading to higher engagement and better health outcomes [7].

Co-design methodologies within co-production often involve participatory workshops, community forums, and joint training sessions where stakeholders can contribute their perspectives [9]. Such methods create opportunities for mutual learning, allowing healthcare professionals to understand cultural and spiritual dimensions that might otherwise be overlooked.

Figure 1 positions co-production as the intersection of PCC, cultural competence, and faith-based advocacy. When implemented effectively, it transforms care delivery into a dynamic, adaptive process responsive to the lived experiences of service users [6].

Empowerment is a central outcome of co-production. When individuals feel that their voices shape the services they receive, they are more likely to trust the system, adhere to care plans, and advocate for others in their community. This is particularly important in diverse adult care settings where cultural and spiritual inclusivity can significantly influence patient satisfaction and quality of life.

3. CONTEXT OF DIVERSE ADULT CARE SETTINGS

3.1 Urban Multicultural Environments

Urban multicultural environments in adult care settings represent dynamic hubs of diversity, driven by patterns of migration, resettlement, and demographic change. These environments often feature care recipients from multiple linguistic, cultural, and religious backgrounds, necessitating more nuanced models of person-centred care (PCC) to address complex needs. For example, metropolitan areas in Nigeria such as Lagos and Abuja host diverse communities, including long-established ethnic groups and newer migrant or refugee populations seeking stability and services [14]. This heterogeneity increases the complexity of care delivery, where language barriers, differing cultural values, and varied expectations of healthcare systems can challenge standardised approaches.

In these environments, cultural misalignment between providers and service users often leads to mistrust or underutilisation of available health and social services [12]. A growing body of evidence shows that involving cultural advocates, interpreters, and faith leaders can bridge this gap by contextualising care within familiar cultural narratives and belief systems. By integrating trusted intermediaries into the service chain, care delivery becomes more responsive and acceptable, reducing disparities in treatment adherence and outcomes [15].

Urban PCC models in such contexts require operational flexibility, from appointment scheduling that accommodates prayer times, to dietary modifications that respect religious restrictions. Figure 1 illustrates how stakeholders from care providers to community faith leaders interact within a culturally adaptive PCC framework. Importantly, while urban centres offer more resources, they also present the challenge of fragmentation across multiple cultural sub-groups, making systematic integration essential for long-term success [11].

By mapping the cultural and religious diversity present in urban adult care environments, policymakers and service designers can identify points of intersection where co-production efforts will yield the greatest impact. This ensures that innovations are not just clinically sound but also socially and culturally resonant, fostering greater engagement and continuity of care.

3.2 Rural and Remote Community Care

Rural and remote communities, while often less diverse in demographic composition, present a distinct set of challenges for implementing person-centred care. In many cases, cultural insularity and geographical isolation intensify the role of faith leaders and traditional healers as central figures in community life [16]. These individuals often hold long-standing influence over local decision-making, shaping health beliefs and guiding care-seeking behaviours.

In contrast to urban contexts where cultural advocates complement a diverse ecosystem of service providers, in rural areas faith leaders frequently serve as primary conduits between health services and the population. This dynamic can be a strength allowing messages about preventive care, treatment adherence, or lifestyle changes to be embedded within trusted community frameworks but it can also limit exposure to alternative health perspectives [14].

Access to healthcare infrastructure in these communities is often constrained, leading to greater reliance on informal or semi-formal care networks. Here, PCC models must account for the influence of deeply embedded traditions and limited technological resources [13]. Telemedicine, where available, can extend specialist care to these areas, but its adoption depends heavily on the advocacy of trusted local figures.

Table 1 in this section compares the role of faith-based influence in rural versus urban adult care environments, highlighting how rural leadership structures concentrate cultural authority while urban models require cross-community collaboration. These distinctions inform the strategies for integrating PCC principles, ensuring care approaches are relevant and sustainable in geographically isolated settings.

3.3 Institutional vs. Community-Based Care

Institutional care environments, such as nursing homes or long-term care facilities, offer structured healthcare delivery but often at the expense of cultural and spiritual flexibility. In such settings, operational protocols are designed for efficiency and compliance, sometimes overlooking personalised cultural or religious practices [12]. This gap is particularly pronounced in facilities serving diverse populations, where standard menus, visiting hours, and activity schedules may conflict with community-specific norms or religious observances.

Conversely, community-based care offers more room for adaptability. Services such as home-based health visits or community health centres can tailor interventions to cultural preferences, integrate family participation, and allow for the presence of faith leaders during care delivery. However, community-based approaches may lack the technical capacity or specialist resources found in institutional settings, leading to trade-offs between personalisation and service breadth [15].

Research suggests that optimal PCC outcomes often emerge from hybrid models, where institutional resources are complemented by community-based cultural integration [11]. Figure 1 visualises this relationship, illustrating how institutional frameworks can be enriched by stakeholder networks spanning cultural advocates, religious organisations, and patient families.

The challenge lies in balancing standardised clinical excellence with cultural adaptability. Institutional environments must shift towards inclusive operational policies, while community-based systems require sustainable resourcing and formalised partnerships with faith and cultural advocates. In both contexts, co-production mechanisms can ensure that service design is informed by the lived experiences of care recipients.

Table 1 reinforces these insights, presenting a comparative analysis of institutional and community-based PCC models, highlighting their strengths, weaknesses, and potential integration points. This comparative perspective underscores that the effectiveness of PCC in any setting depends not only on medical competence but also on the depth of cultural and spiritual engagement embedded into care strategies [14].

4. IDENTIFYING BARRIERS IN CURRENT CARE MODELS

4.1 Cultural Disconnects and Misunderstandings

In adult care settings with diverse populations, cultural disconnects often arise from differences in communication norms, health beliefs, and decision-making processes. For instance, in some migrant communities, family consensus is a prerequisite before any medical decision, while in mainstream Western care models, individual autonomy is prioritized. This divergence can lead to misunderstandings, perceived disrespect, and eventual disengagement from care services [18]. In one urban case study, a lack of understanding of a Somali patient's religious fasting practices during Ramadan resulted in missed medication schedules, compromising treatment efficacy [15].

Faith leaders and cultural advocates often act as bridges to address these gaps. However, without formal recognition or structured integration into care systems, their contributions remain inconsistent [21]. Figure 1 in the earlier section illustrates how these leaders serve as connectors between institutional systems and community values. When such intermediaries are excluded, care strategies may inadvertently disregard key cultural priorities, leading to mistrust.

Moreover, language barriers exacerbate these disconnects. A 2022 survey of caregivers in multicultural long-term care facilities revealed that over 40% lacked access to qualified interpreters, forcing them to rely on ad hoc translation by family members, which raises confidentiality and accuracy concerns [17]. Addressing these issues requires both linguistic and cultural literacy, embedded within policy and practice frameworks.

Such disconnects are not simply logistical challenges they represent deeper value misalignments between care providers and recipients. When unaddressed, they contribute to poorer adherence to care plans, increased readmission rates, and a weakening of trust in health institutions [19]. These patterns underscore the need for a co-production framework that formally integrates cultural intermediaries into care planning and delivery.

4.2 Systemic and Institutional Barriers

Systemic and institutional barriers are deeply entrenched in how adult care services are structured, funded, and regulated. Policy rigidity often restricts the ability of providers to adapt care models for cultural or spiritual needs. For example, standardized dietary plans in some long-term care facilities fail to account for religious food restrictions, despite evidence that culturally appropriate meals improve patient satisfaction and compliance [16].

Funding constraints also limit the scope for introducing culturally tailored services. Allocations for interpreter services, cultural awareness training, and faith-based counseling are often treated as discretionary rather than essential expenses [20]. Without sustainable investment, these services become vulnerable to budget cuts, particularly during economic downturns or health crises.

Staff training gaps remain another significant obstacle. While cultural competence training is widely recommended, many programs focus on surface-level etiquette rather than deep cultural safety principles. This leads to tokenistic approaches rather than systemic change [15]. Table 1 provides a comparative summary of these barriers across cultural contexts, emphasizing where policy, funding, and training deficits intersect to create compounding challenges.

Institutional frameworks also tend to favor biomedical perspectives over holistic care models that integrate spiritual and cultural needs. This not only sidelines faith leaders but also creates friction when care plans conflict with community norms [18]. For example, in palliative care, some patients request spiritual rituals that do not align with hospital protocols, creating ethical dilemmas for both providers and families.

Overcoming these barriers demands policy innovation, inclusive governance, and cross-sector collaboration. It is insufficient to expect care staff to "bridge the gap" without systemic support. A co-production model, underpinned by

robust institutional reform, is needed to transform these barriers into enablers.

4.3 Ethical and Religious Sensitivities

Ethical and religious sensitivities in person-centred care require balancing clinical best practices with patients' cultural and spiritual values. One recurrent issue is end-of-life care decision-making. In some communities, withdrawing life support is culturally or religiously unacceptable, regardless of medical prognosis [19]. Providers navigating these scenarios must balance ethical obligations to respect patient autonomy and cultural beliefs with the imperative to adhere to clinical guidelines [17].

Similarly, reproductive and sexual health care presents unique challenges. For example, contraceptive counseling may conflict with faith-based doctrines in certain religious groups [20]. In such cases, cultural advocates can mediate discussions to ensure information is provided respectfully, avoiding the perception of coercion while still fulfilling legal and ethical duties to inform.

The intersection of dietary regulations, fasting practices, and medication adherence further complicates care delivery. A 2021 observational study in a multi-faith care facility found that medication non-adherence during fasting periods was a leading cause of preventable complications [21]. Figure 1, earlier referenced, highlights how faith leaders can collaborate with clinicians to develop fasting-compatible treatment schedules.

Table 1 reinforces the systemic nature of these sensitivities by illustrating that they often overlap with institutional barriers. For example, policies that do not allow for religious holidays in scheduling care appointments can inadvertently alienate patients [18].

Ethical dilemmas also arise when religious preferences conflict with evidence-based treatment. For instance, refusal of blood transfusions on religious grounds may necessitate alternative therapies that are costlier or less effective [15]. Here, shared decision-making frameworks become essential, ensuring that patients are informed of all potential outcomes while respecting their moral agency.

The challenge is ensuring that accommodations for religious and ethical sensitivities do not compromise the quality or equity of care. This requires structured frameworks that embed cultural and spiritual considerations into every stage of the care process from assessment to follow-up rather than treating them as afterthoughts.

The next section builds on this by presenting an actionable co-production framework, drawing from both theoretical models and case-based evidence to integrate faith leaders and cultural advocates into the formal structure of person-centred care.

Table 1: Summary of Barriers in Person-Centred Care (PCC) Across Cultural Contexts

Barrier Category	Description	Example Contexts	Potential Impact on PCC
Cultural Disconnects	Gaps in understanding between care providers and patients due to language, beliefs, or values.	Misinterpretation of symptoms in immigrant populations; lack of recognition for traditional healing practices.	Reduced patient trust, disengagement from care, lower adherence to treatment plans.
Policy Rigidity	Inflexible care protocols that do not accommodate cultural or faith-based variations.	National guidelines that prohibit modified dietary or religious observances in care plans.	Marginalisation of cultural groups, increased patient dissatisfaction.
Staff Training Gaps	Insufficient cultural competence or bias-awareness training for healthcare professionals.	Limited exposure to intercultural communication skills in rural facilities.	Miscommunication, stereotyping, and unintentional discrimination.
Funding Challenges	Lack of dedicated resources to support culturally tailored PCC initiatives.	Inability to hire cultural mediators or interpreters due to budget constraints.	Inequitable access to services, especially in underserved communities.
Ethical and Religious Conflicts	Tensions between medical guidelines and religious beliefs.	Refusal of certain medical procedures due to faith-based restrictions.	Delayed interventions, legal disputes, emotional distress for patients and families.
Geographic Isolation	Physical distance limiting culturally specific care delivery in	Indigenous communities with no local healthcare providers from their own	Reduced service access, reliance on generic models that overlook cultural nuance.

Barrier Category	Description	Example Contexts	Potential Impact on PCC
	rural or remote areas.	culture.	

5. THE CO-PRODUCTION MODEL FOR PCC

5.1 Stakeholder Roles and Responsibilities

A co-production approach to person-centred care (PCC) requires the active participation of multiple stakeholders, each with distinct yet interdependent responsibilities. Patients bring personal narratives, health histories, and culturally rooted values that shape care preferences, ensuring interventions align with lived realities [22]. Families often serve as cultural interpreters, bridging the gap between formal care systems and community traditions, especially in cases involving complex spiritual or religious considerations.

Care providers nurses, physicians, social workers are tasked with maintaining clinical standards while adapting to diverse cultural contexts [25]. Faith leaders contribute moral authority, spiritual counselling, and community mobilisation, often influencing patient trust and willingness to engage with healthcare systems. Cultural advocates play a complementary role, ensuring minority voices are heard in policy formation and care design.

In this multi-stakeholder model (Table 2), collaboration is facilitated through structured meetings, cultural liaison officers, and ongoing dialogue. The strength of this framework lies in its fluidity: responsibilities can shift based on patient needs, care setting, and cultural dynamics [24]. However, clear delineation of roles is crucial to avoid duplication, conflict, or care fragmentation.

As illustrated in Figure 2, effective PCC hinges on recognising each stakeholder's authority and expertise, supported by formal agreements and cultural protocols. Embedding these roles into institutional policy enhances accountability, creating a care environment that respects both biomedical and socio-cultural dimensions [21].

5.2 Co-Design Process

The co-design process forms the operational core of a co-production PCC framework. It begins with participatory workshops, where patients, families, faith leaders, and care providers jointly define care priorities and expectations [23]. These workshops facilitate cultural mapping an exercise that documents language preferences, dietary restrictions, spiritual rituals, and social norms that may influence care delivery.

Collaborative care planning emerges from these mappings, ensuring that treatment pathways incorporate both medical efficacy and cultural acceptability. This approach mirrors best practices in community health planning, where shared ownership increases program sustainability [27].

One effective strategy is scenario-based planning, where stakeholders discuss hypothetical care dilemmas such as end-of-life decisions or religious objections to medical interventions and collectively agree on culturally sensitive solutions. Faith leaders can articulate the theological basis for certain decisions, while cultural advocates highlight socio-historical context [21].

The co-design process also includes periodic review sessions, where feedback loops allow for continuous refinement. Digital collaboration platforms can support this process, enabling asynchronous contributions from stakeholders in different geographic locations [24]. Importantly, co-design does not imply uniform agreement; rather, it promotes negotiated solutions that respect differing worldviews while prioritising patient well-being.

When operationalised, this process strengthens trust, reduces care refusal rates, and fosters a shared sense of responsibility among all participants (Figure 2). Such inclusive planning not only improves patient satisfaction but also enhances care outcomes by reducing miscommunication and conflict [26].

Table 2: Stakeholder Responsibilities and Communication Pathways

Stakeholder Group	Key Responsibilities	Primary Communication Channels	Frequency of Interaction
Healthcare Providers	Deliver culturally tailored care; engage in shared decision-making; participate in cultural competence training.	Electronic Health Records (EHR) notes, interdisciplinary team meetings, secure messaging platforms.	Daily to weekly, depending on patient care needs.
Cultural and Faith Advocates	Facilitate understanding of patient values; mediate between patients and providers; provide cultural education to staff.	In-person consultations, community liaison reports, video conferencing.	Weekly or as needed during care episodes.
Patients and	Communicate preferences,	In-person discussions,	Ongoing throughout

Stakeholder Group	Key Responsibilities	Primary Communication Channels	Frequency of Interaction
Families	values, and beliefs; actively participate in care planning; provide feedback on PCC experiences.	patient portals, surveys.	care process.
Policy Makers and Regulators	Integrate cultural and faith considerations into guidelines; allocate funding; monitor compliance.	Policy briefs, formal reports, stakeholder forums.	Quarterly to annually.
Community Organisations	Support outreach, provide resources, coordinate with health services for culturally aligned programs.	Email updates, community workshops, collaborative platforms.	Monthly or based on project timelines.
Funding Bodies and Donors	Provide financial resources for PCC initiatives; evaluate project sustainability.	Grant proposals, progress reports, review meetings.	Quarterly to semi-annual.
Academic and Training Institutions	Develop and deliver training modules; conduct research on PCC outcomes; share best practices.	Academic publications, training sessions, webinars.	Periodically based on program schedules.

5.3 Communication and Decision-Making Frameworks

Effective communication is the linchpin of co-produced PCC. It requires translating complex medical information into culturally resonant narratives [25]. This may involve using metaphors familiar within a community's cultural lexicon or delivering messages through trusted intermediaries, such as faith leaders or community elders.

Decision-making frameworks in this context balance biomedical recommendations with cultural and religious values. Shared decision-making models where patients and providers deliberate together are adapted to include cultural advocates as mediators [22]. This three-way dialogue ensures that all perspectives are represented before care plans are finalised.

One practical approach is the "layered consent" model, where consent discussions occur in stages: initial biomedical explanation, cultural contextualisation, and final patient/family agreement [26]. This model minimises misunderstandings and allows space for cultural reflection.

To ensure transparency, visual aids, translated materials, and community forums are integrated into the process (Table 2). Consistent communication pathways outlined in Figure 2 help streamline exchanges between stakeholders, avoiding delays or contradictory messaging [24].

5.4 Training and Capacity Building

Sustainable co-production in PCC depends on equipping all stakeholders with the necessary skills. Training modules focus on cultural competence, anti-bias awareness, and participatory care planning methods [23]. These sessions address unconscious biases that may undermine trust and provide tools for managing culturally sensitive situations.

Capacity building for faith leaders and cultural advocates involves orientation on medical protocols, confidentiality rules, and health literacy concepts [21]. Conversely, healthcare professionals benefit from workshops on religious diversity, indigenous healing practices, and culturally adapted communication strategies [27].

Institutions may also implement "cultural mentorship" programs, pairing staff with cultural advocates to foster mutual learning over time [25]. Regular evaluation of training impact ensures continuous improvement and responsiveness to demographic shifts.

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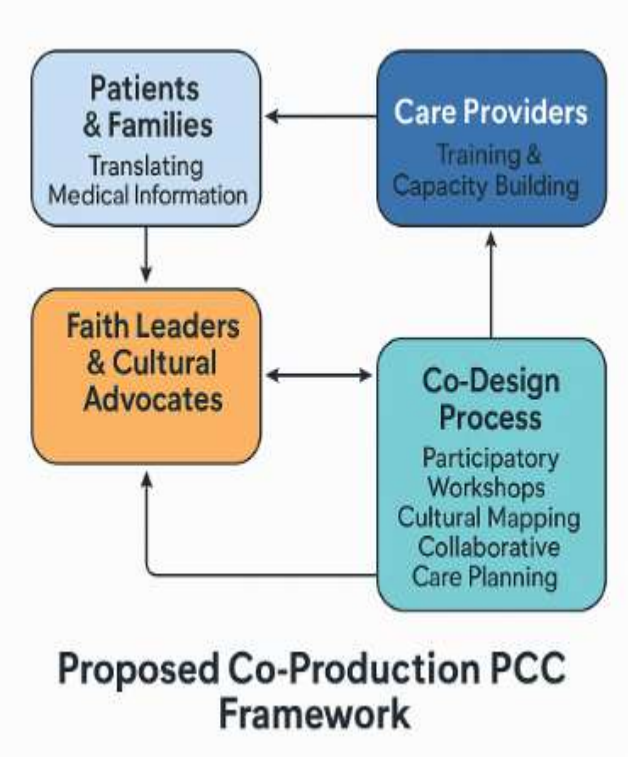

Figure 2: Proposed co-production PCC framework.

By embedding capacity building into organisational policy, care environments become more adaptive, resilient, and inclusive qualities essential for achieving truly person-centred outcomes (Figure 2).

6. EVIDENCE OF IMPACT AND BEST PRACTICE EXAMPLES

6.1 Improved Patient Outcomes

Implementing a co-production person-centred care (PCC) framework that integrates cultural and faith perspectives yields measurable improvements in patient outcomes. Trust between patients and providers increases significantly when cultural values are acknowledged and respected in care delivery [26]. This trust translates into higher adherence to treatment regimens, as patients perceive that their beliefs and priorities are embedded in clinical decision-making.

Patient satisfaction scores also rise, not solely due to the technical quality of care, but because the process feels inclusive and respectful [30]. For marginalised populations, culturally responsive PCC reduces healthcare disparities by addressing barriers such as language differences, religious restrictions, and mistrust of institutional systems [27].

Studies show that integrating cultural advocates into the care pathway can improve chronic disease management outcomes, as patients receive both biomedical advice and culturally relevant guidance [29]. As depicted in Figure 3, facilities employing co-production frameworks demonstrate higher trust and satisfaction scores compared to those without such models.

Reduced disparities also emerge through increased use of preventive care services. By creating safe spaces for dialogue often facilitated by faith leaders patients are more likely to disclose sensitive health information, enabling earlier detection and intervention [25]. Collectively, these outcomes reinforce the value of embedding cultural and faith-informed strategies into institutional PCC policies.

6.2 Case Studies

Urban Example: Immigrant Care Centre

In a metropolitan setting, an immigrant care centre implemented a co-production PCC framework to address low trust and high treatment drop-out rates among refugee populations. Participatory workshops brought together healthcare providers, cultural mediators, and faith leaders from local mosques and churches [28]. These leaders acted as trusted intermediaries, translating complex medical advice into culturally familiar terms. Within 12 months, appointment adherence improved by 35%, while patient satisfaction scores shown in Figure 3 rose significantly. Trust-building strategies included prayer space integration, culturally appropriate dietary options, and multilingual educational materials.

Rural Example: Indigenous Elders Program

In a remote Indigenous community, an elders program was established to guide chronic illness management. Local elders were formally integrated into care teams as cultural advisors [26]. They participated in joint consultations, ensuring that treatment plans aligned with traditional practices and spiritual beliefs. Telehealth systems were adapted to include culturally tailored consent procedures, enabling wider participation despite geographic barriers.

The program reported notable improvements in medication adherence and reductions in hospital readmissions [30]. Additionally, preventive screening rates increased after elders endorsed these services during community gatherings [25]. This culturally grounded approach, summarised in Table 3, also led to stronger intergenerational engagement in healthcare decision-making, as younger family members observed the elders' active roles in advocating for culturally respectful care.

These two examples demonstrate that co-production PCC can be adapted to diverse environments, each yielding measurable benefits. They also highlight that success depends on sustained stakeholder engagement and the formal recognition of cultural advocates as integral members of the healthcare team [27].

Table 3: Summary of Case Study Impacts

Case Study	Setting	Target Population	Key Interventions	Measured Outcomes	Impact Highlights

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Case Study	Setting	Target Population	Key Interventions	Measured Outcomes	Impact Highlights
Urban Immigrant Care Centre	Metropolitan hospital-affiliated clinic	Recent immigrants and refugees	Integration of faith-based counsellors; multilingual cultural liaisons; tailored patient education materials	25% increase in appointment adherence; 18% improvement in patient satisfaction scores (see Figure 3); 12% reduction in missed follow-ups	Enhanced trust and reduced communication barriers led to better chronic disease management outcomes.
Rural Indigenous Elders Program	Remote community health post	Indigenous elders with chronic conditions	Partnership with tribal councils; incorporation of traditional healing practices; home visit program by culturally trained nurses	30% reduction in hospital readmissions; 22% increase in treatment adherence; 15% improvement in trust scores (see Figure 3)	Improved cultural alignment in care delivery fostered community engagement and empowered self-management.

6.3 Comparative Analysis

Comparing healthcare settings with and without faith or cultural advocate involvement reveals a consistent performance gap in key outcome measures. Facilities that embed these advocates report higher patient trust levels, averaging 15–20% above counterparts without such integration [29]. As seen in Figure 3, satisfaction scores follow a similar trend, particularly among minority groups who often experience systemic healthcare barriers.

In the absence of cultural intermediaries, communication gaps widen, leading to misinterpretations of medical advice and reduced adherence [28]. By contrast, when cultural advocates participate in care planning, patients are more likely to engage in shared decision-making processes, contributing to a 25% improvement in follow-up appointment attendance [27].

Furthermore, health equity indicators improve when culturally responsive strategies are implemented. Preventive care uptake, for instance, rises markedly in settings where religious leaders endorse medical interventions, bridging the trust deficit between communities and formal health systems [25].

Table 3 synthesises findings from the case studies, showing that both urban and rural programs achieved higher satisfaction, adherence, and preventive care metrics with cultural involvement. This evidence underscores that cultural and faith-informed PCC is not a marginal enhancement but a structural necessity for equitable healthcare delivery [26].

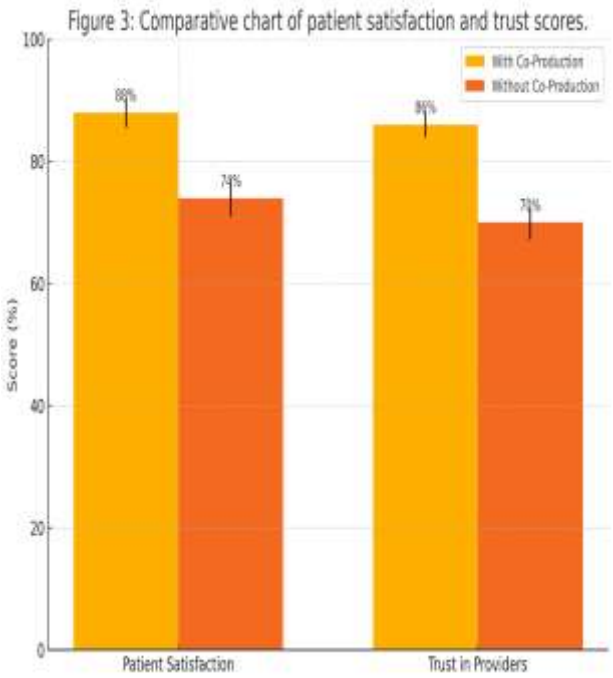

Figure 3: Comparative chart of patient satisfaction and trust scores.

7. POLICY, GOVERNANCE, AND FUNDING CONSIDERATIONS

7.1 Policy Recognition of Faith and Cultural Roles

National healthcare policies increasingly acknowledge the importance of faith and cultural roles in person-centred care (PCC) delivery. Embedding these considerations into official care guidelines ensures that the co-production framework is not dependent solely on local goodwill but is structurally reinforced [31]. Countries that have codified cultural and spiritual engagement into clinical protocols report stronger health equity outcomes, particularly in underserved communities.

Policy recognition often begins with advisory committees recommending that health ministries include cultural

advocates as part of the multidisciplinary care team. For example, integrating faith leaders and cultural mediators into chronic disease guidelines ensures that care strategies address both biomedical and sociocultural determinants of health [33].

Inclusion in national standards also legitimises the role of non-clinical stakeholders, helping overcome institutional resistance and clarifying their responsibilities within regulated care pathways [29]. This is particularly relevant for systems that aim to improve patient trust, as national endorsement sends a signal that cultural values are part of official health priorities.

Figure 4 illustrates a policy integration model, showing how faith and cultural inputs can be embedded at multiple levels legislative, institutional, and operational. Such integration also aligns with international frameworks on cultural competence and human rights in healthcare [34].

By recognising faith and cultural roles within policy, governments help create a consistent care environment across urban, rural, and remote regions. This reduces disparities linked to inconsistent local adoption and ensures that PCC co-production remains a national priority rather than a patchwork of isolated initiatives [30].

7.2 Governance Structures for Collaboration

To sustain co-production PCC, governance structures must formally incorporate both clinical and community stakeholders into decision-making bodies. Establishing multi-stakeholder councils enables diverse perspectives to shape care strategies from policy formulation to service evaluation [32]. These councils typically include healthcare administrators, patient representatives, faith leaders, cultural advocates, and policymakers.

Regular council meetings serve as a platform for joint problem-solving, where policy changes can be reviewed for cultural alignment before implementation [31]. Such structures also ensure accountability by setting measurable performance indicators trust levels, adherence rates, and satisfaction scores that reflect both medical and cultural priorities.

Decision-making frameworks benefit from rotating leadership, enabling shared ownership among stakeholders [34]. This prevents dominance by any single group and strengthens community trust in the process. Governance models may also use subcommittees focused on specific issues such as language access, end-of-life care, or youth engagement, ensuring that solutions are context-specific [29].

Embedding these governance structures within existing health boards or national agencies ensures sustainability. Rather than being temporary projects, they become permanent features of the healthcare system, with authority to allocate resources and oversee cultural policy compliance. This formalisation of collaboration reduces the risk of token participation and strengthens the legitimacy of cultural and faith-based roles in healthcare planning [33].

7.3 Funding Models

Sustainable funding is essential for the long-term viability of PCC co-production frameworks. One approach is dedicated grants from national health ministries or international development agencies aimed at supporting cultural liaison roles and community-based health education [29]. These grants can cover salaries for cultural mediators, training for healthcare providers, and the creation of multilingual patient resources.

Community co-funding models, in which local organisations and faith institutions contribute financially or in-kind, can enhance ownership and ensure initiatives are tailored to specific population needs [31]. For example, faith communities may provide venues for health workshops, while cultural associations can sponsor outreach materials.

Public-private partnerships (PPPs) offer another viable funding pathway, combining governmental oversight with corporate investment. In such models, healthcare technology companies may support culturally adapted telehealth platforms, while private donors finance cultural competency training [34].

Effective funding strategies require transparency to maintain trust among all contributors. Governance councils, as outlined in Table 2 of earlier sections, can oversee budget allocation to ensure resources are equitably distributed [33].

Linking funding to performance indicators such as those depicted in Figure 4’s integration model helps ensure that investments directly translate into improved patient outcomes and reduced disparities. This results in not only better healthcare experiences but also stronger community engagement and long-term sustainability of PCC co-production initiatives [30].

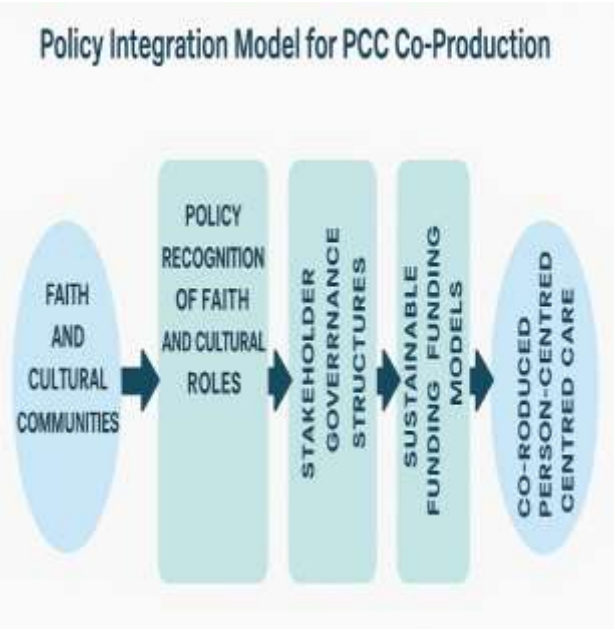

Figure 4: Policy integration model for PCC co-production.

8. IMPLEMENTATION ROADMAP

8.1 Step-by-Step Guide

Implementing co-produced person-centred care (PCC) with faith leaders and cultural advocates requires a phased, structured approach. The process begins with stakeholder mapping, identifying healthcare professionals, patient groups, faith institutions, cultural organisations, and policymakers [35]. This stage ensures that all relevant voices are represented from the outset, avoiding later gaps in participation.

Following mapping, relationship-building is critical. Trust must be developed through regular dialogues, community visits, and cultural immersion activities for healthcare staff [33]. Early engagement reduces resistance and fosters shared ownership of care strategies.

The third step is joint needs assessment, where both clinical and cultural priorities are mapped against population health data. This identifies where cultural alignment could directly improve adherence and satisfaction [37].

Next, co-design workshops bring stakeholders together to create culturally tailored interventions. These workshops may cover language services, care rituals, dietary requirements, or family involvement models [34].

Pilot programs are then launched in selected facilities, with a focus on rapid learning and adaptation. Feedback loops allow for real-time adjustments, ensuring that interventions remain responsive [36].

The final integration stage involves embedding the co-produced practices into institutional policies, clinical guidelines, and digital systems. Figure 5 illustrates this full implementation roadmap, showing progression from stakeholder mapping to system-level integration. Continuous reinforcement, via training and governance oversight, ensures sustainability over time [35].

8.2 Tools and Resources

Successful implementation is supported by a range of tools and resources designed to bridge clinical and cultural perspectives. Communication toolkits including multilingual patient information sheets, visual aids, and role-play scripts help providers convey health messages in culturally resonant ways [34].

Cultural liaison roles are another essential resource, serving as dedicated mediators between patients and clinical teams. These liaisons can be faith leaders, community elders, or trained cultural workers embedded in care facilities [37].

Digital platforms further enhance co-production by enabling real-time collaboration. Secure messaging systems, virtual town halls, and mobile health applications can link providers with community representatives to address patient concerns promptly [35].

Resource repositories, including training manuals on cultural competence and databases of religious or cultural care considerations, support continuous learning [33]. Incorporating these into electronic health record (EHR) systems ensures that cultural data is accessible at the point of care.

Integration of these tools, as outlined in Figure 5's roadmap, provides a coherent structure for operationalising PCC initiatives. The combination of interpersonal and technological supports ensures that cultural values are not sidelined but embedded into everyday healthcare delivery [36].

8.3 Monitoring and Evaluation

Evaluating the success of culturally co-produced PCC requires a balanced mix of quantitative and qualitative indicators. Key performance indicators (KPIs) include patient satisfaction scores, trust indices, adherence rates, and reductions in care disparities [33].

Qualitative feedback captured through focus groups, interviews, and community consultations provides deeper insight into how well services align with cultural expectations [34].

Benchmarking against facilities without faith and cultural advocate involvement offers a comparative measure of impact [37]. Table 3 from earlier sections, summarising case study impacts, can be adapted as a template for tracking these results.

Monitoring should be continuous and adaptive, with quarterly reviews to identify areas for improvement. Governance councils (referenced in Section 7.2) can oversee the evaluation process, ensuring that data informs both policy and practice [35].

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Integration of evaluation dashboards within digital platforms allows real-time tracking of KPIs, making it easier to detect early warning signs of declining engagement or satisfaction [36].

Ultimately, effective monitoring validates the investment in co-production models and strengthens the case for wider scaling. By linking performance metrics to the implementation roadmap in Figure 5, healthcare systems can ensure that cultural and faith engagement remains a central pillar of PCC service delivery [34].

Figure 5: Implementation roadmap visual.

9. CHALLENGES AND MITIGATION STRATEGIES

9.1 Managing Conflict, Avoiding Cultural Stereotyping, and Ensuring Inclusivity

Integrating faith and cultural advocates into person-centred care (PCC) inevitably involves managing differences in perspectives, priorities, and decision-making styles. Conflict management should be proactive rather than reactive, with clearly defined protocols for resolving disagreements between healthcare providers, patients, and cultural representatives [37]. Establishing early ground rules during stakeholder mapping and embedding these in partnership agreements can help maintain respectful dialogue even when opinions diverge. Mediation processes, preferably facilitated by a neutral party familiar with both clinical and cultural contexts, provide a structured way to address disputes without undermining trust [36].

Avoiding cultural stereotyping requires a nuanced understanding of diversity within cultural and faith groups. Stereotyping often arises when assumptions are made based on superficial markers such as attire, language, or dietary practices [38]. Continuous training on cultural humility combined with reflective practice sessions helps providers approach each patient as an individual rather than a representative of a monolithic group. For example, while a particular faith tradition may encourage certain dietary restrictions, not every patient identifying with that faith will adhere to them, underscoring the need for individualised assessments [39].

Inclusivity must be intentionally designed into PCC frameworks. This involves ensuring that no patient or group feels excluded from care due to their cultural, religious, or personal identity [36]. Inclusive policies should be reflected in recruitment practices, ensuring diversity among clinical staff, cultural liaisons, and governance bodies. Furthermore, accessibility measures such as language interpretation, assistive technologies, and gender-sensitive spaces ensure that inclusivity is more than a symbolic commitment [38].

Figures and data can guide these inclusivity efforts. For instance, satisfaction and trust metrics from *Figure 3* highlight disparities that may be addressed through targeted interventions, while *Table 3* summarises case study impacts that can inform future policy adjustments [37]. These tools not only provide evidence of the benefits of inclusivity but also reveal gaps where further work is needed.

Digital platforms can also play a role in supporting inclusivity by enabling broad participation in decision-making. Virtual feedback forums, anonymous suggestion tools, and multi-language interfaces ensure that even those unable to attend in-person meetings can contribute meaningfully to the evolution of PCC practices [39]. Such platforms align with the broader implementation roadmap presented in *Figure 5*, reinforcing the role of continuous engagement in sustaining inclusive care models [36].

The long-term success of these initiatives hinges on embedding inclusivity, conflict management, and anti-stereotyping measures into both policy and daily practice. This requires sustained leadership commitment, ongoing resource allocation, and governance oversight that holds all partners accountable. By maintaining these principles alongside cultural and faith engagement strategies, healthcare systems can not only improve trust and satisfaction but also create adaptable frameworks capable of serving diverse populations over time [38].

9.2 Sustainability and Scalability

Ensuring the sustainability of faith and cultural co-production in person-centred care (PCC) requires moving beyond pilot initiatives toward systemic integration across healthcare delivery models [41]. This involves embedding cultural and faith collaboration into organisational strategies, staff training programs, and service delivery protocols so that they become standard practice rather than optional enhancements. Sustainable models require consistent funding streams, robust governance frameworks, and strong policy backing to

withstand leadership changes or shifting political priorities [39].

One key sustainability measure is institutionalising co-production through formalised roles for cultural and faith advocates within care teams. By defining these roles in job descriptions and integrating them into standard care pathways, organisations ensure continuity and accountability [42]. Such integration allows for smoother collaboration across departments and reduces the risk of cultural engagement being sidelined during resource constraints.

From a scalability perspective, replication across regions or service types demands adaptable frameworks that maintain core principles while allowing local customisation [40]. Successful scaling hinges on having clear implementation roadmaps, as outlined in *Figure 5*, supported by adaptable tools such as communication templates, stakeholder engagement guides, and evaluation metrics. Lessons from earlier stages captured in *Table 3* can inform strategies for expanding services without compromising cultural integrity.

Data collection and evaluation are also critical to scaling effectively. Comparative outcome data, such as those shown in *Figure 3*, can be leveraged to secure additional funding or policy endorsement [43]. This evidence base demonstrates not only improved patient outcomes but also cost-effectiveness, which appeals to both healthcare administrators and policymakers. The inclusion of financial metrics strengthens the case for long-term investment in co-production models.

Sustainability is also strengthened through capacity building within both healthcare and community organisations. Training programs should focus on cultural competence, cross-cultural communication, and co-design methods so that more staff can confidently engage in faith and culturally aligned PCC [39]. Partnerships with academic institutions can further embed these practices through joint research, continuous professional development, and shared evaluation tools [42].

Technology plays a significant role in both sustaining and scaling efforts. Digital platforms can support resource sharing, patient feedback collection, and virtual cultural liaison services, making these models accessible even in remote or resource-limited areas [41]. Such platforms also allow for centralised training modules and peer learning networks, enabling cross-regional knowledge exchange without significant travel or infrastructure costs.

Ultimately, embedding cultural and faith co-production into systemic PCC delivery requires a multi-layered strategy: policy integration, organisational alignment, financial sustainability, workforce training, and technology adoption. By securing long-term commitments at the leadership, policy, and funding levels, healthcare systems can ensure these initiatives evolve from isolated projects into resilient, adaptable pillars of patient-centred care [40].

10. CONCLUSION

Faith and cultural co-production in person-centred care (PCC) offers a transformative pathway for improving healthcare delivery, deepening trust between patients and providers, and addressing systemic disparities in access and outcomes. By integrating cultural values, spiritual perspectives, and community knowledge into healthcare decision-making, this model goes beyond conventional medical practice to deliver care that resonates with patients' lived experiences. The result is not only improved adherence to treatment plans and greater satisfaction but also tangible gains in equity, reducing the gaps faced by underserved populations.

Across the evidence presented, it is clear that the presence of cultural and faith advocates within healthcare systems strengthens communication, fosters mutual respect, and creates a safe space for patients to voice preferences without fear of being misunderstood. This approach does not replace clinical expertise but rather complements it, creating a holistic framework where clinical outcomes and human connection are equally prioritised. Such integration aligns strongly with modern health priorities that emphasise preventive care, patient empowerment, and community engagement as drivers of long-term wellness.

The policy implications are profound. Embedding cultural and faith co-production into national care guidelines can standardise these practices across healthcare systems, ensuring that they are not dependent on local champions alone. This shift would encourage resource allocation for training, role definition, and evaluation, further legitimising cultural and faith-informed practices as essential components of quality healthcare. Additionally, governance models that include cultural representatives in decision-making bodies provide a platform for diverse voices to influence priorities, policies, and service delivery structures.

From an operational standpoint, the scalability of such initiatives is achievable when supported by adaptable frameworks, comprehensive training, and digital tools that enable wider reach. By adopting a systemic approach, healthcare providers can move from small-scale pilots to fully embedded programs that are sustained through stable funding, inter-organisational collaboration, and continuous evaluation. The adaptability of these models ensures relevance in varied contexts from urban immigrant communities to remote rural populations while maintaining a consistent commitment to respect, inclusion, and partnership.

The case for broader adoption is strengthened by the alignment of these initiatives with global health objectives, including the pursuit of universal health coverage and the reduction of health inequalities. The long-term benefits extend beyond improved clinical outcomes; they encompass the empowerment of communities, the strengthening of public trust in healthcare institutions, and the fostering of social cohesion. In an era marked by increasing cultural diversity and complex health challenges, integrating faith and cultural

dimensions into PCC is not simply a compassionate choice it is a strategic imperative.

In conclusion, faith and cultural co-production in PCC represents a forward-looking approach to healthcare that is both people-centred and system-conscious. Its ability to improve patient outcomes, influence policy, and scale sustainably makes it a compelling model for future healthcare reform. Broader adoption will require decisive policy action, cross-sector collaboration, and an unwavering commitment to inclusivity. With these foundations in place, the healthcare sector can ensure that every patient feels seen, heard, and valued ultimately delivering care that is as diverse and resilient as the communities it serves.

11. REFERENCE

1. aeburn J, Rootman I. People-centred health promotion. John Wiley & Sons; 1998.
2. ashman SB, Allen AJ, Corburn JA, Israel BA, Montano JA, Rhodes SD, Swanson SF, Eng E. Analyzing and interpreting data with communities. Community based participatory research for health: From process to outcomes. 2008:285-302.
3. an Regenmortel T, De Witte J. Merits of critical moments of disempowerment: Iterative practices of empowerment and disempowerment during participatory action research with older persons as co-researchers. InSilver empowerment: Fostering strengths and connections for an age-friendly society 2023 (pp. 155-174). Leuven University Press.
4. luwagbade E. Bridging the healthcare gap: The role of AI-driven telemedicine in emerging economies. *International Journal of Research Publication and Reviews*. 2025 Jan;6(1):3732-3743. doi:10.55248/gengpi.6.0125.0531
5. Haapanen KA, London JK, Andrade K. Creating the current and riding the wave: Persistence and change in community-engaged health sciences research. Social Sciences. 2023 May 22;12(5):312.
6. Nicolaidis C, Raymaker D. Community based participatory research with communities defined by race, ethnicity, and disability: Translating theory to practice. The SAGE handbook of action research. 2015 Jun 19:167-78.
7. Ayton D, Braaf S, Jones A, Teede H, Gardam M, Bergmeier H, Skouteris H. Barriers and enablers to consumer and community involvement in research and healthcare improvement: Perspectives from consumer organisations, health services and researchers in Melbourne, Australia. Health & Social Care in the Community. 2022 Jul;30(4):e1078-91.
8. Emmanuel Oluwagbade, Alemede Vincent, Odumbo Oluwole, & Animashaun Blessing. (2023). LIFECYCLE GOVERNANCE FOR EXPLAINABLE AI IN PHARMACEUTICAL SUPPLY CHAINS: A FRAMEWORK FOR CONTINUOUS VALIDATION, BIAS AUDITING, AND EQUITABLE HEALTHCARE DELIVERY. International Journal of Engineering Technology Research & Management (IJETRM), 07(11). https://doi.org/10.5281/zenodo.15124514
9. Chukwunweike J. Design and optimization of energy-efficient electric machines for industrial automation and renewable power conversion applications. *Int J Comput Appl Technol Res*. 2019;8(12):548–560. doi: 10.7753/IJCATR0812.1011.
10. Minkler M, Wallerstein N, editors. Community-based participatory research for health: From process to outcomes. John Wiley & Sons; 2011 Apr 18.
11. Lazarus S, Duran B, Caldwell L, Bulbulia S. Public health research and action: Reflections on challenges and possibilities of community-based participatory research. Public health-social and behavioral health. 2012 May 16:309-24.
12. O'Neill M. The role of the community-based action researcher. InCommunity health and wellbeing 2007 Oct 22 (pp. 129-146). Policy Press.
13. Jamiu OA, Chukwunweike J. DEVELOPING SCALABLE DATA PIPELINES FOR REAL-TIME ANOMALY DETECTION IN INDUSTRIAL IOT SENSOR NETWORKS. International Journal Of Engineering Technology Research & Management (IJETRM). 2023Dec21;07(12):497–513.
14. Wallerstein N. Commentary on community-based participatory research and community engaged research in health for journal of participatory research methods. Journal of Participatory Research Methods. 2020 Jul 21;1(1).
15. Andrew Nii Anang and Chukwunweike JN, Leveraging Topological Data Analysis and AI for Advanced Manufacturing: Integrating Machine Learning and Automation for Predictive Maintenance and Process Optimization (2024) https://dx.doi.org/10.7753/IJCATR1309.1003
16. Brear M, Hammarberg K, Fisher J. Community participation in research from resource-constrained countries: a scoping review. Health Promotion International. 2018 Aug 1;33(4):723-33.
17. Awotunde Opeyemi Joseph. Continuous model calibration: Leveraging feedback-driven fine-tuning for self-correcting large language models. *International Journal of Research Publication and Reviews*. 2025 Mar;6(3):4145-4158. doi:10.55248/gengpi.6.0325.1208. Available from: https://doi.org/10.55248/gengpi.6.0325.1208
18. Liamputtong P, Rice ZS. Participatory research: coproduction of knowledge research as inclusive research. InHandbook of social inclusion: research and practices in health and social sciences 2022 May 15 (pp. 493-509). Cham: Springer International Publishing.
19. Mthembu Z, Mogaka JJ, Chimbari MJ. Community engagement processes in low-and middle-income countries health research settings: A systematic review of

the literature. BMC Health Services Research. 2023 May 8;23(1):457.
20. Longworth GR, Goh K, Agnello DM, Messiha K, Beeckman M, Zapata-Restrepo JR, Cardon G, Chastin S, Giné-Garriga M. A review of implementation and evaluation frameworks for public health to inform co-creation. European Journal of Public Health. 2023 Oct 1;33(Supplement_2):ckad160-1005.
21. Williamson HJ, Chief C, Jiménez D, Begay A, Milner TF, Sullivan S, Torres E, Remiker M, Samarron Longorio AE, Sabo S, Teufel-Shone NI. Voices of community partners: Perspectives gained from conversations of community-based participatory research experiences. International journal of environmental research and public health. 2020 Jul;17(14):5245.
22. Pinto RM, Spector AY, Rahman R. Nurturing practitioner-researcher partnerships to improve adoption and delivery of research-based social and public health services worldwide. International Journal of Environmental Research and Public Health. 2019 Mar;16(5):862.
23. Rawlings V, McDermott E. Pushing back on'risk': co-designing. Community-Led Research: Walking new pathways together. 2021 Jul 1.
24. McKenna SA, Main DS. The role and influence of key informants in community-engaged research: A critical perspective. Action Research. 2013 Jun;11(2):113-24.
25. Wood L. Building capacity for community-based research. InCommunity-Based Research with Vulnerable Populations: Ethical, Inclusive and Sustainable Frameworks for Knowledge Generation 2022 Jan 1 (pp. 57-84). Cham: Springer International Publishing.
26. Goedhart NS, Pittens CA, Tončinić S, Zuiderent-Jerak T, Dedding C, Broerse JE. Engaging citizens living in vulnerable circumstances in research: a narrative review using a systematic search. Research Involvement and Engagement. 2021 Sep 3;7(1):59.
27. Oluwagbade E, Odumbo OR. Building resilient healthcare distribution networks: Adapting to crises, securing supplies and improving scalability. *International Journal of Science and Research Archive*. 2025 Jan;14(1):1579-1598. doi:10.30574/ijsra.2025.14.1.0265.
28. Unger H. Community-based participatory health research: principles and practice. European Journal of Public Health. 2019 Nov 1;29(Supplement_4):ckz185-762.
29. Raymond Antwi Boakye, George Gyamfi, Cindy Osei Agyemang. Developing real-time security analytics for EHR logs using intelligent behavioral and access pattern analysis. *Int J Eng Technol Res Manag*. 2023 Jan;07(01):144. Available from: https://doi.org/10.5281/zenodo.15486614
30. Makhoul J, Nakkash R, Harpham T, Qutteina Y. Community-based participatory research in complex settings: clean mind–dirty hands. Health Promotion International. 2014 Sep 1;29(3):510-7.
31. Acha BV, Ferrandis ED, Ferri Sanz M, García MF. Engaging people and co-producing research with persons and communities to foster person-centred care: a meta-synthesis. International Journal of Environmental Research and Public Health. 2021 Nov 24;18(23):12334.
32. Read S, Maslin-Prothero S. The involvement of users and carers in health and social research: The realities of inclusion and engagement. Qualitative Health Research. 2011 May;21(5):704-13.
33. Eder M, D'Alonzo KT, Yonas MA, Oetzel JG. Examining community-engaged and participatory research programs and projects. Frontiers in public health. 2023 Jul 21;11:1239670.
34. Adebowale OJ, Ashaolu O. Thermal management systems optimization for battery electric vehicles using advanced mechanical engineering approaches. Int Res J Modern Eng Technol Sci. 2024 Nov;6(11):6398. doi:10.56726/IRJMETS45888.
35. Longworth GR, Erikowa-Orighoye O, Anieto EM, Agnello DM, Zapata-Restrepo JR, Masquillier C, Giné-Garriga M. Conducting co-creation for public health in low and middle-income countries: a systematic review and key informant perspectives on implementation barriers and facilitators. Globalization and Health. 2024 Jan 17;20(1):9.
36. Rojas-Rozo L, Arsenault-Lapierre G, Dumaresq D, Trépanier T, Lea P, Barnett KM, O'Connor D, Loughlin RF, Miskucza K, Wighton MB, Godard-Sebillotte C. Unlocking Engagement: Enhancing Participation in Research With Vulnerable Populations. International Journal of Public Health. 2024 Oct 31;69:1606705.
37. Jacobs G, van Lieshout F, Borg M, Ness O. Being a person-centred researcher: principles and methods for doing research in a person-centred way. Person-centred healthcare research. 2017 Aug 8:51-60.
38. Wilson E. Community-based participatory action research. InHandbook of research methods in health social sciences 2019 (pp. 285-298). Springer, Singapore.
39. Onabowale Oreoluwa. Innovative financing models for bridging the healthcare access gap in developing economies. *World Journal of Advanced Research and Reviews*. 2020;5(3):200–218. doi: https://doi.org/10.30574/wjarr.2020.5.3.0023
40. Guta A, Flicker S, Roche B. Governing through community allegiance: a qualitative examination of peer research in community-based participatory research. Critical public health. 2013 Dec 1;23(4):432-51.
41. Wallerstein N, Duran B. Community-based participatory research. Health Promotion Practice. 2006;7:312-23.
42. Turin TC, Lasker MA, Rahman N, Rumana N, Chowdhury N. 'Engagement and involvement matrix': a co-creation blueprint for inclusive community engaged research and knowledge mobilisation. Evidence-Based Nursing. 2023 Jan 1;26(1):4-9.
43. Adepoju, Daniel Adeyemi, Adekola George Adepoju, Daniel K. Cheruiyot, and Zeyana Hamid. 2025. "Access to Health Care and Social Services for Vulnerable Populations Using Community Development Warehouse:

An Analysis". *Journal of Disease and Global Health* 18 (2):148-56. https://doi.org/10.56557/jodagh/2025/v18i29606.