Using Social and Behavior Change to Foster Trust in Sexual and Reproductive Health

Evidence Synthesis and Recommendations

A TECHNICAL REPORT

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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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Acronyms

CCP	Johns Hopkins Center for Communication Programs
CHW	Community health worker
QI	Quality improvement
SBC	Social and behavior change
SEM	Socio-Ecological Model
SGM	Sexual and gender minorities
SRH	Sexual and reproductive health
USAID	United States Agency for International Development

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Key Definitions

Agency: Agency involves individuals or groups being aware of their ability to make choices, set individual or collective goals, and take action to reach those goals. These choices, goals, and actions are informed and affected by internal and external resources (e.g., resilience, social support) and social norms.[1]

Community health worker: Community health workers (CHWs) are health care providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors.[2]

Determinants of trust/mistrust: A factor that either leads to, enables, or acts as a barrier to trust.

Health care providers: Health care providers are individuals who provide services, products, or information with the aim of promoting, protecting, and improving health. Health care providers constitute a diverse group of individuals who operate in different settings with distinct roles and varied levels of training.[3]

Provider behavior: Provider behavior refers to the way that providers act in response to people or situations in the course of delivering health care services to clients.

Perception of care quality: Patients' (i.e., clients') view of services received and the results of the treatment.[4]

Respectful care: Care is respectful if it maintains all individuals' dignity, privacy, and confidentiality; ensures that interactions with individuals or carers enhance informed decision making, without inducement or coercion; promotes continuous support (as appropriate); is compassionate and responsive to their preferences, needs, and values; and is free from stigma, discrimination, mistreatment, and harm.[5]

Self-efficacy: Self efficacy is a concept originally proposed by the psychologist Albert Bandura and refers to an individual's belief in their capacity to act in the ways necessary to reach specific goals.[6]

Social accountability: Collective efforts of individuals and communities (i.e., rights holders) to hold service providers, government officials, and other decision makers (i.e., duty bearers) to account for the quality, effectiveness, and equitable provision of services.[7]

Social and behavior change: An evidence-driven approach to improve and sustain changes in individual behaviors, social norms, and the enabling environment. Social and behavior change (SBC) programs follow a systematic process to design and implement interventions at the individual, community, and societal levels that support the adoption of healthy practices. These programs employ a deep understanding of human behavior that draws on theory and practice from a variety of fields, including communication, social psychology, anthropology, behavioral economics, sociology, human-centered design, and social marketing.[8]

Social distance: Social distance refers to the extent to which people experience a sense of familiarity (nearness and intimacy) or unfamiliarity (farness and difference) between themselves and people belonging to different (social, ethnic, occupational, and religious) groups from their own.[9]

Background

What is the Value of Understanding Determinants and Outcomes of Trust?

The **Global Shared Agenda for Social and Behavior Change in Family Planning** identifies fostering a supportive environment for sexual and reproductive health (SRH) as a priority area.[10] Trust between communities—health facilities, clients and-**health care providers**—is a key component of a supportive environment. Trust shapes provider and client behavior both within and outside facilities and considerably impacts acceptance,[11] initiation and continued use of SRH services,[12–15] experience[16] and quality of care, and increased client satisfaction and confidence in the health system/provider.[12,17–24] Evidence shows that trust also influences both adoption and maintenance of beneficial health behaviors and positive health outcomes.[11,20,24] It can yield positive benefits for providers, such as improving work satisfaction and collaboration.[25,26]

Despite evidence supporting the positive impacts of trust in SRH service delivery, documentation is lacking on how providers incorporate trust into the planning and provision of SRH services. Furthermore, to date, little data is available on the impact of **SBC** approaches on building, fostering, and maintaining trust in SRH service delivery environments. As a result, SBC practitioners lack consensus, focus, and guidance on how to build and maintain trust in SRH using SBC approaches. Practitioners need to clearly understand what drives trust within SRH service delivery settings and how trust shapes SRH demand, client–provider and community–facility interactions, contraceptive use, and client and provider behavior. They also need pragmatic and context-relevant programmatic guidance on how to better foster trust in SRH-focused SBC programs. That understanding will equip them to design systematic and evidence-informed approaches that intentionally set up SRH service delivery settings to holistically enable, build, and sustain trust between clients, communities, health providers, and health facilities.

Breakthrough ACTION Overview

Breakthrough ACTION is an eight-year (July 2017 to July 2025) global project, funded by the USAID. The project accelerates the use of social and behavior change through state-of-the-art, evidence-based tools and processes that encourage the adoption of healthy behaviors, while addressing structural barriers and underlying social and gender norms that prevent uptake of services and positive health practices.

The project is a partnership led by Johns Hopkins Center for Communication Programs (CCP) in collaboration with Save the Children, ThinkPlace US, ideas42, Camber Collective, International Center for Research on Women, and Viamo.

To further understand this priority area and address this gap, Breakthrough ACTION conducted a literature review and led three technical consultations with SRH and SBC experts. These activities validated evidence on the determinants of trust, trust outcomes, and opportunities to use SBC to foster trust in SRH. This technical report summarizes the evidence synthesized from the literature review and technical consultations and provides recommendations for program implementers on using SBC to foster trust in SRH settings. The report also identifies gaps warranting further exploration.

Methods

Breakthrough ACTION conducted a rapid literature review to synthesize the evidence around the role of trust in fostering a supportive environment for SRH, particularly in the service delivery context. The review considered the structural components of trust (e.g., accessibility, equity, quality and continuity of care, safety of the setting, policies, health systems management) as well as intra- and interpersonal modalities, including factors related to accountability, compassion and empathy, and social and gender norms. The literature review explored the following questions:

- What are the determinants of trust between clients, communities, and providers or health facilities at different levels of SRH service delivery?
- What are the mechanisms of trust?
- How does the existence of trust impact SRH outcomes for clients, communities, and providers?
- How can trust improve between clients, communities, and providers/health institutions? What is the role of SBC in fostering or improving trust?

Project staff identified 69 articles that met the inclusion criteria. These articles were from research or programs in six regions: Europe, Asia, South America, sub-Saharan Africa, the Middle East and North Africa, and North America. In May 2023, the study team held three technical consultative workshops with 32 experts to share and validate the findings from the literature review, hear from experts' experiences, and co-develop recommendations for focusing on trust within SRH. The participants represented a diversity of perspectives, including those from francophone West Africa, Sub-Saharan Africa, Europe, Asia, and Latin America (**Appendix 1** contains more details on participants).

To frame the analysis and synthesis of identified determinants of trust, Breakthrough ACTION drew inspiration from various versions of the Socio-Ecological Model (SEM) (**Figure 1**).[27,28] The project used the following levels to categorize the determinants of trust: individual, interpersonal, organizational/service delivery, community, and policy/enabling environment.

FIGURE 1

The Socio-Ecological Model for Service Delivery[27,28] and also adapted from the U.S. Centers for Disease Control and Prevention.

Definitions of Socio-Ecological Model Levels

Individual: Client and provider characteristics.

Interpersonal: Clients' and providers' families, peers, and social networks. It also includes client–provider and provider–provider relationships and interactions.

Community: Relationships and interactions between organizations and people.

Organizational/service delivery: Factors that operate at the organizational, institutional, or service delivery environment level.

Policy/enabling environment: Local and national laws, public policies, and emergencies arising from conflicts or disasters.

Defining Trust and Its Components

The literature on trust is vast and multidisciplinary, with contributions from researchers in psychology, sociology, education, communication studies, political science, anthropology, and behavioral economics, among others, and each field has made a unique contribution. The lack of a single, streamlined definition for trust creates challenges for conducting programming and evaluation around trust and its determinants.

Put simply, trust refers to a firm belief in the reliability, truth, and ability or strength of someone or something.[29] Trust is dynamic and influenced by numerous social, structural, psychological, behavioral, and contextual variables which cause trust to change over time.[30] Given its complex, multi-dimensional nature, trust variables can be difficult to define and measure.

Trust takes two forms: (1) interpersonal trust and (2) impersonal trust. Interpersonal trust is the trust placed in other people and the extent to which a person ascribes credibility to other people and expects positive outcomes in the context of social interactions.[31] Interpersonal trust underlies a client's belief that service providers are credible and can be held to their word.[32]

On the other hand, impersonal trust is trust in an institution or system. It includes trust in an institutionally established relationship between professionals and clients based on the social recognition of the trustworthiness of an occupation.[33] While the two can overlap considerably, interpersonal trust is typically influenced by factors at the individual, interpersonal and community SEM levels while factors at the SEM levels of both service delivery/organization and policy/enabling environment influence impersonal trust.

Trust in the context of health service delivery has varied dimensions, including feelings about competence, responsibility, control, disclosure, and confidentiality.[34,35] Another dimension of trust is source credibility, which is the perceived reliability of a source of information assessed by expertise, knowledge, reputation, and perceived intent or reliability, among other factors.[36–38] Source credibility is particularly relevant when considering facility or service promotion efforts. Numerous determinants feed into the development and maintenance of trust.[30] These variables and their weight of importance differ between individual and community contexts and feed into how trust changes over time. This indicates that levels of trust are not static, but trust can be lost and can either increase or decrease with changing circumstances or influences.[30]

Evidence and Findings

This section details findings from the literature review and technical consultations, including the outcomes of trust and determinants at each level of the SEM. Most materials included in the review did not attempt to map determinants and outcomes of trust into the two categories of trust (interpersonal or impersonal), and findings often overlapped and intertwined. However, in general, determinants at the individual, interpersonal, and community SEM levels link to interpersonal trust, while impersonal trust typically operates more at the service delivery/organizational and policy/enabling environment SEM levels.

Insights: Outcomes and Determinants of Trust

- Evidence shows overwhelmingly that trust in the context of SRH service delivery majorly contributes to achieving service delivery goals, including helping clients choose the right contraceptive method for them and the adoption of safer sex practices by adolescents.
- The magnitude and relevance of specific trust determinants is nuanced and highly dependent on the social context as well as community/client characteristics.
- Clients' trust journeys begin before the service encounter and are influenced by the perceptions of their social networks, the communities they belong to, and their lived experience of the structural components of trust.
- Events, interactions, and the service environment clients experience and observe during utilization of SRH services can reinforce or negate their perceptions to trust/mistrust.
- CHWs are able to foster trust in ways that facility-based providers are unable to by leveraging their community ties in shaping clients' acceptance of SRH services, perceptions of care, and trust of health providers and the health system.
- Provider–provider dynamics and interactions informed by institutional power dynamics impact clients' experience of care and trust of SRH services.
- A safe space for joint priority setting and decision making between clients/communities and providers/health facilities and systems for accountability foster trust.
- Systemic mistrust arising from factors outside of SRH services—such as systemic discrimination, power imbalances, corruption and lack of accountability in government institutions, political unrest, and handling of public health emergencies—spills into perceptions of trustworthiness of SRH services.

SRH Outcomes of Trust

Trust in the SRH service delivery setting yields positive outcomes for clients, providers, and communities, including increased client confidence in and satisfaction with both community-based and facility-based health care providers and acceptance and use of SRH services. For providers, increased trust (by clients and between providers) improves their communication with clients/communities, credibility, quality of care provided, and job satisfaction.

Breakthrough ACTION identified outcomes associated with the existence of trust, as highlighted in the following examples:

- **Increased client/community use of SRH services:** Trust is a key factor facilitating utilization of SRH services. A study in Madagascar showed that trust in service providers and their skills enabled first time young parents to utilize SRH services such as skilled birth attendants.[13] Trust between client and providers can enable use of SRH services by clients who desire secrecy and

do not want to be identified as users of these services. For example, a study in Ghana showed that trust enabled covert contraceptive users (such as adolescents or women whose spouses disapproved of use) to continue to utilize modern contraceptive methods as they believed providers would maintain confidentiality about their use.[39]

- **Increased client/community confidence in health system and provider:** Client and community confidence in providers and the larger health system is linked to trust of their competence or skills in delivering SRH services. This may stem from client positive experiences or the social recognition of trustworthiness of health professionals. For example, a study in Myanmar showed communities had increased confidence that their birthing needs would be met by CHWs because they trusted the CHWs' ability to conduct safe deliveries and administer misoprostol to control postpartum hemorrhage if needed.[17] Likewise, participants in a study in Nigeria were confident about the contraceptive services they received because they trusted service providers would only provide methods with established safety.[40]
- **Improved adoption and maintenance of beneficial health behaviors:** Trust enables adoption and maintenance of beneficial health behaviors as clients utilize SRH services that support practice of these behaviors. For example, trust in providers enables adolescent and youth engagement with SRH services and the use of safer sex practices.[20]
- **Increased client access to SRH services:** Trust increases client and community access to SRH services. Increased access is often a product of clients' improved acceptance of SRH services, which trust also supports. Additionally, trust of CHWs further enhances access, because working with a local CHW enables clients to utilize certain SRH services closer to their homes and without traveling to a health facility, overcoming possible monetary and time constraints related to traveling to a health facility. For example, a study in Zambia showed community members and adolescents are more likely to accept community-based SRH education and contraception when CHWs are trusted.[11]
- **Improved client willingness to disclose information to providers that may affect treatment decisions:** Provider decisions about course of action or care for clients are dependent to a large extent on the information they receive during provider–client interactions. Trust increases clients' willingness and comfort in disclosing information about their SRH, which can be vital for determining the best services or treatment to offer.[20,41] For example, Latina respondents to a survey in the United States indicated that those who trusted their service providers were more comfortable discussing sensitive issues and more likely to disclose important personal sexual and reproductive information to them.[41]
- **Increased client agency and self-efficacy:** Trust enhances client participation in decision making about their use of SRH services and their health which increases their agency. For example, a study of a SRH education program in the Dominican Republic found that trust enabled participants to better understand concepts being discussed and facilitated clients speaking out or asking questions for clarification as they felt safe with providers.[13]
- **Improved provider work satisfaction:** Client trust in providers and trust between different cadres of providers creates an enabling work environment for providers, which has a bearing

on their work satisfaction and motivation. For example, a study noted that community leader trust in CHWs increased CHW work satisfaction as they feel recognized and respected, which motivated them to work harder.[11] Additionally, trust between providers increases collaboration and cooperation between them which also contributes to work satisfaction.

- **Improved credibility of providers among community members:** Trust helps clients and communities view providers as credible and reliable sources of information, which can increase clients' desire to seek services and willingness to adopt and maintain healthy behaviors. Provider credibility and legitimacy is also bolstered when clients and communities perceive that respected community influencers trust providers, demonstrating some transference of trust. For example, when reliable community leaders trust and accept CHWs, community members see CHWs as more credible, which further facilitates community trust in providers and utilization of services they provide.[11]
- **Achievement of positive SRH health outcomes:** The outcomes of trust discussed above such as increased utilization of SRH services and products (e.g., contraceptives, antenatal care and skilled birth attendance) and the adoption of beneficial health behaviors feed into the achievement of positive health outcomes, such reducing unwanted pregnancies and increasing maternal and child survival due to a reduction in SRH-related mortality and morbidity.[43,44]

Consequences of Lack of Trust

Lack of client trust in SRH services is a barrier to utilization of SRH services and positive reproductive health outcomes. Both lack of trust and breaches of trust by providers or health facilities result in client and community reluctance to listen to and accept messages on SRH,[11,20] low utilization of SRH services, and concealment of medical information from providers.[20,23,41] Lack of trust can also increase the cost of accessing SRH services. For example, a study in China indicated that absence of trust in primary care facilities resulted in communities bypassing these to seek care at higher tier hospitals.[15]

Determinants of Trust

Through the literature review, Breakthrough ACTION identified factors at all levels of the SEM that influence SRH-related client–provider and community–health facility trust. Consultation participants further validated and expanded on these determinants. These are not siloed; rather, such factors interact within and across the different SEM levels and collectively impact trust.

In addition, trust in the SRH service setting is not static but can change over time. The various determinants of trust identified collectively exert influence on trust maintenance, increase, or loss. Determinants acting as enablers would maintain or increase trust while determinants which are barriers prevent the development of trust or can lead to the loss of trust.

Individual-Level Determinants

Individual-level factors for providers and clients, such as demographic factors, beliefs and biases, past experiences, and provider competence, influence trust and shape clients' perceptions of trustworthiness and experience of care (**Figure 2**).

FIGURE 2

Individual-level determinants

- **Clients' and providers' demographic characteristics, beliefs, and social status determine social distance between clients and providers, perceptions of trustworthiness, and whether trust exists in a client–provider relationship.** Several articles identified demographic characteristics of providers and clients (e.g., gender, age, ethnicity, language, race) as determinants of trust, though the exact impact on trust is determined by (1) the service delivery and community context and (2) the population receiving services. For example, adolescents and young persons prefer and are more likely to trust providers who they see as peers, who are closer to their own ages.[44–46] Older clients are more likely to trust older providers because they correlate higher competency with older age/greater years of experience[26,45] and they perceive that older providers are more respected in the community due to their age.[45,47] In some contexts, older clients expect older providers will be more discrete and less likely to talk about their clients to others.[45] In addition, demographic characteristics impact social distance, which is one of the factors determining how provider and client attributes interact and play out. In many instances, decreased social distance emanating from common client/community and provider demographics and norms increases familiarity, respect, and trust between clients and providers.[22,42]

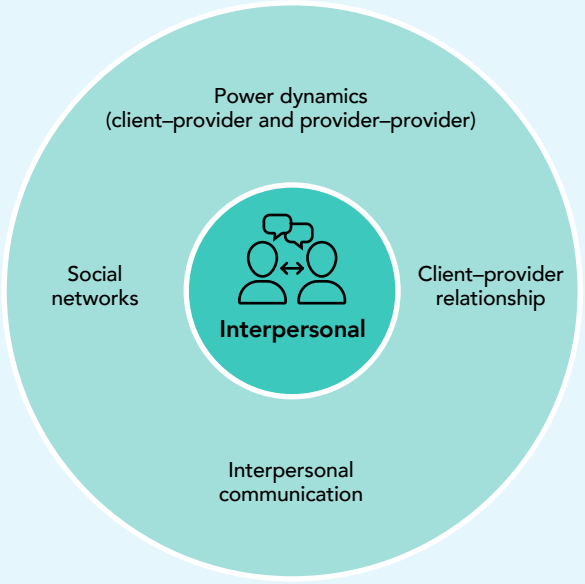
- **A positive perception of provider and institutional competence is essential for trust:** Typically, clients assume provider or institutional competence via virtue of societal recognition of training and certifications received which enables trust.[40,48] This assumption and trust is maintained when clients/communities perceive providers deliver services with competence.[40] For CHWs, linkage to and supervision by the formal sector buttresses client/community perception of competence and trust.[19] On the other hand, service encounters leading clients/communities to question provider/institutional competence is a barrier to trust. Clients' perception of provider competence is often shaped by the proxy of positive health outcomes after utilization of SRH services such as having a well baby and mother after child birth,[26,47] providers' successful management of complications,[26] years of provider experience,[26] and providers' ability to provide current health information.[21]
- **Clients' beliefs and biases about SRH and their experiences accessing SRH services frame trust.** Clients' beliefs about the trustworthiness of providers or health services may be shaped by personal and normative beliefs, including those about the inherent trustworthiness of health providers[40,48] and about beneficial or detrimental effects of health commodities such as contraceptives and vaccines,[48] religious beliefs,[49] social norms, and their personal biases based on past experiences accessing SRH services.[26,50] For example, clients who were actively listened to and attended to with respect and dignity while accessing SRH services are more trusting when they need to use SRH services again.[19] Consultation participants noted clients' observations and perceptions of interactions between providers and other clients relate to trust, as observing positive or negative interactions between other clients and providers can build or impede it.
- **Marginalized or exploited groups may have negative experiences with the health system due to systemic and structural inequities and discrimination, and this contributes to their perception of the trustworthiness of providers or health facilities.**[18,51] Distrust arises from the historically poorer treatment (by health providers and the system as a whole) of people who are marginalized, experiencing poverty or holding lower socioeconomic positions, or otherwise face discrimination and stigma due to factors such as race, tribe or ethnicity, social class, immigration status, HIV status, and level of education.[18,52] Adolescents and youth also have historically faced discrimination due to age.
- **Client trust is influenced by their perceptions of the motives and ethics of providers and health facilities.** Undergirding trusting interactions are the assumptions that providers put the best interest of clients and communities front and center and adhere to a professional code of conduct.[26,48] Trust is inhibited when clients find reasons to question these assumptions. For example, a study from Bangladesh cited public sector health workers as more trusted than those working in the private sector because community members see private sector providers as profit-oriented and more interested in financial gain.[53] Similarly, in Kenya, providers' adherence to expected codes of conduct (ethics) was cited as an enabler to client–provider trust, while acceptance of bribes or other unethical practices emerged as barriers.[26,53]

Interpersonal-Level Determinants

Interpersonal-level determinants affect the quality of provider–client relationships, client agency/decision making around SRH, and clients' experience of care (**Figure 3**).

FIGURE 3

Interpersonal-level determinants



- **Clients have expectations about how providers should treat them and the types of interactions they should experience before, during, and after accessing health services** with a provider (such as during follow-up for contraceptive side effects). Trust builds when these expectations are met and hindered when these expectations are not met. Clients' expectations for how they should be treated include the desire for high-quality, respectful care. Respectful care has several dimensions, including compassion, empathy, and confidentiality, as well as respect for clients' preferences, autonomy, and culture.[16,54,55] Expanding on this, consultation participants mentioned that other workers in the SRH setting who are not direct service providers (i.e., administrators and custodians) ability and willingness to show clients empathy and compassion in order to foster a trusting environment also affects clients' trust of providers and the system or services.
- **Familiarity formed through repetitive, client–provider connections and lasting, meaningful relationships are important to building and sustaining trust.** In the literature, familiarity with providers and the lasting, meaningful relationships that can be built through continued contact with the same providers emerged strongly as an enabler to client–provider trust. Familiarity is formed by regular contact with providers, including seeing the same provider every time, receiving home visits, and attending provider-facilitated activities in the community. Irregular contact with providers, having to see a different provider each time, or not having a positive or existing relationship with providers emerged as barriers to client–provider trust.[16,21,56,57] Similarly,

cadres that have closer contact with clients (like midwives and CHWs) are often more trusted.[49,58] In some contexts, clients trust CHWs more than facility-based providers due to their immersion and reduced social distance, because the CHWs are from the same communities and share the same language, ethnicity, culture and norms.[11,45,49] Likewise, clients with prior experience seeking and utilizing SRH services and who have developed confidence and familiarity with services are more likely to trust those services and providers, while first-time users may be hesitant to trust providers and facilities. Consultation participants also noted relatability of the provider to the client as an important determinant of trust, wherein if a client felt that the provider was relatable, they were more likely to trust them (e.g., a provider confides in a client that they use family planning and had to overcome similar misinformation themselves in order to adopt the method).

- **Power dynamics between clients are a major determinant of trust.** For clients, perceived shared agency and decision making with providers enable client–provider trust.[18] In contrast, power and wealth imbalances between clients and providers act as a barrier to trust, especially when clients feel they lack the power to advocate for their needs and preferences. Power imbalances can be exacerbated by client deference to providers' medical expertise. Even when trust of providers is low, clients may adhere to social norms around deferring to higher status or more educated individuals, especially if they are concerned about being refused services or products.[26,54]
- **Interpersonal communication skills and communication styles of providers matter in building and maintaining trust.** The literature emphasized how non-verbal communication in the form of body language, such as gestures, tone of voice, physical distance, and touch, is as important as verbal communication and shapes clients' perceptions and trust.[24] Respectful, empathetic communication signifies mutual respect, enables trust, and can be communicated by providers through active listening and attentiveness, and asking questions to get feedback. On the other hand, rushed communication, using medical jargon, or being vague/unclear in communication style are barriers to client–provider trust.[44] Lack of confidentiality during provider–client interactions is a barrier to client–provider trust, while ensuring audio-visual privacy is an enabler to client–provider trust.[41,46] Additionally, the literature shared how clients mistrust providers they feel would share their confidential information with others[41] or if their interactions with providers were interrupted by other facility providers, staff (e.g., nurses), or others.[46] Additionally, adolescents in particular were more likely to trust providers and facilities where they felt their information was kept confidential, either through provider assurance or by law.[14] Consultation participants noted communication that is sensitive to gender dynamics and equity Facilitates this sense of assurance. Additionally, consistency in SRH messaging across different providers promotes trust.
- **Clients are influenced by and often rely upon the perceptions of their social networks.** Clients often consult those within their social networks, such as family and peers, as they make decisions about using SRH services. SRH information received through these social networks can be accurate or inaccurate/based on individual knowledge and perceptions. Reliance on these networks for SRH information, including who is or is not a trusted provider in the community, influences care-seeking behaviors and trust. For example, a study in Kenya revealed that neighbors' positive experiences with or trust in providers or health facilities positively influenced trust. In the same way, negative perceptions of a provider or health facility perpetuate mistrust within social networks.[26]

- **Provider–provider interactions and trust between providers affects client/community–provider/health facility relationships and trust.** Trust between providers has a positive impact on the work satisfaction of providers and helps improve client–provider trust. Several factors contribute to mistrust among providers. These include unhealthy competition, poor relationships, power dynamics, and institutional hierarchies between cadres.[19,26] These factors influence provider–provider communication and collaboration, which impacts patient care. A study in Iran reported that people perceived obstetricians as not trusting midwives' judgment, which limited midwives' agency in decision making about patients' care and their ability to provide client-centered care.[59] Another study from Kenya indicated that when clients witness discord or the use of disrespectful tones between providers, their trust in that health facility is diminished.[26]
- **Dissonance between providers' beliefs and the SRH services they offer:** Another barrier to trust is perceived disparities between a providers' beliefs and biases (which are known in the community) and the services the provider is offering clients. For example, one consultation participant cited an example from Uganda wherein Catholic clients mistrusted Catholic providers who counseled them on certain contraceptive methods because that conflicted with their shared Catholic beliefs about certain contraceptives.

Community-Level Determinants

Community norms and beliefs, community–facility dynamics, community leader support, and the collective experiences of community members with SRH services are influential in shaping community and client trust in health providers and health facilities (**Figure 4**).

FIGURE 4

Community-level determinants

- **Community leaders and other community members who hold power can influence the support, trust, and acceptance of health workers and SRH services in their communities.** When trusted and respected community leaders demonstrate support and acceptance of CHWs, this enables community members' trust in CHWs and their services. Lack of support around CHWs acts as a barrier, demonstrating the strong influence community leaders have in decision making based on trust.[11] However, this only holds true when community leaders are trusted, respected and responsive to community needs as opposed to where community leadership is weak, less cohesive and commands little or no respect from community members.[19] Also, divergent or conflicting interests between community leaders and the health facility or health workers may result in tensions and conflicting messages from leaders.
- **Community norms, beliefs, and perceptions shape trust in SRH services.** SRH is a sensitive topic in most communities. Community norms around who should be utilizing services, what services are acceptable, and whether SRH services are generally viewed positively or negatively greatly influences community trust in SRH services and providers. Community beliefs and perceptions about SRH services can be equally affected by direct positive or negative experiences with facility staff and service quality.
    - Social and gender norms and traditional beliefs may give rise to social consequences such as stigmatization of audiences using or promoting use of services. For example, norms around adolescent sexual activity might frame SRH providers as promoting risky behavior among adolescents and serve as a barrier to client–provider trust for non-youth clients.[23]
    - There can be a trust trade-off, wherein increasing provider trust with marginalized clients may reduce trust with other clients or community members. For example, communities may mistrust providers who go against social norms which discourage sexual activity in adolescent girls and provide contraceptive services to them,[23] while adolescents and youth may experience increased trust of such providers.
    - In addition, certain gender norms and roles, including community perception of women's involvement in SRH decision making and determining family power dynamics, are considered barriers to fostering trust due to both limited access to services created by these norms as well as distrust of providers who don't conform to community norms.[26]
- **Dynamics between communities and health facilities and related sub-factors such as involvement of community leaders in decision making and past successes or failures of accountability efforts in the community, and social accountability mechanisms in place can act as barriers or enablers to trust, depending on the context.** Factors that accounted for a good relationship and enabled trust included the availability of safe spaces for providers/communities to meet,[12] the involvement of community leaders and members in decision making,[11,60] and past success of accountability efforts or past positive experiences during service uptake.[26] Barriers include previous negative experiences or outcomes following the use of SRH services, unfulfilled promises, and gaps between what the community expects and what is delivered by health facilities or the health system.[12,26]

- **The extent to which communities are involved or included in decision making and priority setting about their health and health services impacts trust.** Communities want to, and should be, part of the decision-making and priority-setting process. Using multiple channels and existing groups and platforms such as community action groups and health facility committees has been effective to engage communities in decision making on health service issues and enables representation of marginalized voices and builds trust.[61] Engagement should be inclusive, accessible, and supportive of individuals and groups.
- **The distribution of power and efforts (or lack of) at addressing power imbalances between clients, communities, health providers, and facilities influences trust.** A key theme throughout the literature is the influence of power imbalances between communities and providers, and facilities' ability and willingness to address such differentials. Meaningful participation of community members in the health system must include power sharing or shifting. It also requires working with accountable community structures to understand their preferences as to how much and at what level they need to be involved.[62]

Organizational/Service Delivery-Level Determinants

The organizational/service delivery-level determinants of trust include the acceptability and accessibility of SRH services, functionality of the service environment, and the ease of navigating organizational processes when utilizing services (**Figure 5**).

FIGURE 5

Organizational/service-delivery level determinants

- **Complex pathways to accessing and referring for SRH services inhibit client trust.** Organizational processes that create burdens or barriers to accessing care act as barriers to client–provider trust. For example, long lines at payment points, voluminous paperwork, and processes that require shuttling across several service points decrease trust in that health facility.[26]
- **The service environment can act as both a facilitator and a barrier to trust.** The physical environment of a facility, including availability of resources and confidential consultation spaces, cleanliness, hygiene, and updated technology and equipment or lack thereof all build or hinder client trust. Additional service environment determinants of trust are the availability or absence of comprehensive services, client sense of physical and psychological safety, and provider workload.[15,16,43,46,48,63] The effect of the availability of comprehensive services on trust draws from client expectation or desire that providers will be able to provide all needed services leading to better health outcomes and this is more likely when comprehensive services are available.[15] For instance, respondents to a study in China had less trust for primary care health facilities as they were deemed to lack a comprehensive package of services that would meet all their health needs.[15] Heavy provider workload results in overburdened providers, leading to long wait times or rushed consultations. These produce frustration and mistrust from clients.[26] Participants in the consultations noted that the time the service is being offered, including contextual differences in terms of when it is most convenient to access care, can affect a client's experience of care and level of trust, particularly if the service is sensitive in nature. For example, covert contraceptive users may prefer to access care outside of regular clinic hours because they do not want to be recognized by anyone from their community. The inability of providers or health facilities to meet this need limits trust among this category of clients.
- **Accessibility and acceptability of channels (or modes) of SRH service delivery varies across contexts and populations, especially for marginalized and exploited persons, and this affects perception of trustworthiness.** People who are marginalized and underserved or disenfranchised by the health care system (e.g., adolescents, migrants, women with disabilities, ethnic and sexual minorities, unmarried women, and others) may experience challenges accessing SRH services because of systemic barriers and discrimination, and these harm trust.[64] For example, migrant youth and asylum seekers in Sweden with uncertain legal status found it difficult to access SRH services because of a lack of knowledge, cost, or policy restrictions, resulting in distrust of providers and the health care system.[52] This may be compounded by language and cultural differences.[52] Participants also mentioned availability (or lack) of inclusive and appropriate SBC communication materials for these groups as a determinant of trust.
- **The nature of the service itself matters.** Consultation participants also mentioned that trust is more necessary or impactful for certain types of health services. For example, family planning services are considered more sensitive than antenatal care, and therefore, trust between client and provider is more critical, including focus on determinants such as confidentiality.

Policy/Enabling Environment-Level Determinants

Factors operating at the policy/enabling environment-level such as policies governing SRH services, existence and handling of natural disasters/emergencies, track records of government, accountability, and the political environment influence whether clients feel they can trust providers and health institutions (**Figure 6**).

FIGURE 6

Policy/enabling environment-level determinants

- **Policies governing SRH services are a major determinant of trust.** Effective and transparent policies which ensure SRH services are equitable and accessible are essential for creating and maintaining client trust. When there are laws that protect patient–provider confidentiality and when the provision of free or subsidized services removes financial barriers to utilization, clients are enabled to trust SRH service providers.[14,26] Consistency in these policies and communication around them assures trust-building. Policies can become a barrier when their interpretation is ambiguous[26] and when they restrict access and utilization of SRH services for certain populations, such as adolescents.[14] Additionally, consultation participants noted how a lack of clear policies and guidance on a number of service-related factors can hinder trust. For example, the lack of laws protecting SRH rights for certain populations and policies governing access to technology are barriers to trust.
- **Systemic mistrust during emergencies and disasters easily spills into SRH services.** Natural or human-made disasters and emergencies such as pandemics, war, and community clashes may seed distrust in providers and the health system broadly, which cascades into SRH services.[21,65]

Some of this may emanate from a fear of lack of safety, in which case visibility of measures to protect clients from harm enables trust. For example, a study in Sierra Leone post-Ebola showed that community knowledge of infection prevention measures such as the use of personal protective equipment and institutionalizing Ebola screening and seeing these measures in practice at health facilities enabled trust.[65] Another factor which fuels distrust is poor communication of risks and uncertainties during public health emergencies. For example, a study in rural India showed pregnant women lost trust in health workers who could not answer their questions about the effect of COVID-19 on the fetus.[21] This, coupled with temporary shutdown of non-emergency services in the public health sector such as SRH services and high cost of the private sector, resulted in decreased access to SRH services and an erosion of trust in the health sector.[21]

- **The track record of government and social institutions matters.** The performance of government or social institutions, including past successes or failures and corruption or lack of transparency in the use of finances and allocation of resources, are important trust determinants.[26,64] Clients are more likely to trust providers when governmental policies and promises are consistent overtime and not just linked to one administration, are seen to be implemented and are adapted to meet the community's needs, as well as when clients perceive they receive a quality of care that is worth their investment (i.e., providers are held accountable to provide good care). Providers are able to develop trust amongst one another when facilities are properly staffed through regulation, and provider feedback is received and acted upon by official systems and processes.[26]
- **The political environment can influence trust, and who is in power or in opposition influences trust in providers and the health system.**[66] Similarly, religious norms and practices ingrained in political platforms can be barriers to trust. For example, when religious or cultural norms around SRH are ingrained into SRH services or enforced by political platforms in power, communities and clients with different norms or views encounter a barrier to trust.

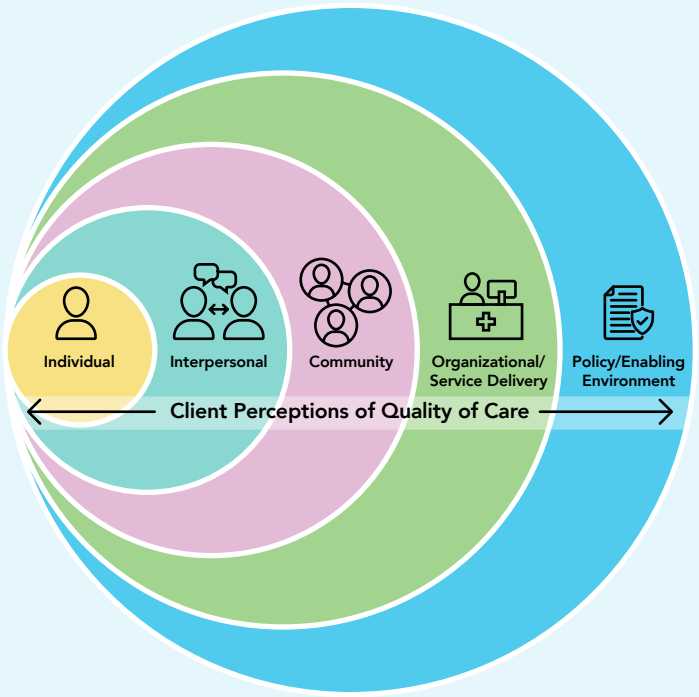
Cross-Cutting Determinants: Perceptions of Quality of Care

The literature review and subsequent consultation brought to the fore the complexity and nuances of trust as some determinants were identified to be crosscutting and influenced by factors at different levels of the SEM.

Of particular note is client perceptions of quality of care. These perceptions are driven by determinants across SEM levels, including the service delivery environment and processes (e.g., adequacy of commodities, availability or lack of human resources, wait time for services, financial barriers to care), community norms and beliefs, individual beliefs, interpersonal communication between clients and providers, and the extent to which clients are involved in decision making about care. The determinants feeding into the perception of quality of care interact with each other and the weight each carries in influencing perceptions varies across clients and contexts (**Figure 7**).

FIGURE 7

Client Perceptions of Quality of Care Across the SEM



Adolescents and Youth

The review particularly focused on adolescents due to the sensitive nature in many contexts of providing adolescents with SRH services and meeting their specific needs. Trust in providers and the health system enables adolescents to seek SRH services, even though care-seeking may be stigmatized or perceived negatively.[11]

Key determinants to adolescent trust include provider behavior (interpersonal), provider communication (interpersonal), facility environment (organization/service delivery), and policies around confidentiality and accessibility (policies/enabling environment). Negative provider behavior towards adolescents—driven by social norms around sexuality, moral values, and generational differences between adolescents and providers,[67] community misconceptions about motives of providers,[23] and policies limiting adolescent access to SRH services[14]—can all lead to distrust and limit adolescents' ability to access SRH services.

Adolescents are enabled to trust providers and the health system when they either receive assurance of confidentiality or legislation protects it,[14] as well as if they have access to service channels that allow anonymity such as online consultations,[39,68] they have access to providers they consider as relatable or peers, and providers communicate to them in simple language devoid of medical jargon.[44]

Opportunities for Using SBC to Foster Trust in SRH Service Delivery Settings

This section summarizes recommendations and opportunities for using SBC to build or maintain trust in SRH service delivery settings. These recommendations highly depend upon context but emerged as key themes. Practitioners should consider what is relevant and feasible in their given context before adapting a recommendation.

Key to all recommendations is the need to be patient. Trust in health providers and impersonal trust in health institutions builds over time and can be a long process. SBC programming in SRH aiming for scalability and sustainability should build upon existing structures of trust, incorporate new trust concepts, and evaluate and maintain trust over time. It should also adapt as necessary to ensure trust is rebuilt (when lost) or maintained.

General Recommendations

Elevate the importance of trust in SRH, making fostering trust central to SRH services.
Elevate trust as a key component of larger SBC-related interventions, including those focused on provider behavior change, community engagement, and quality improvement (QI). This requires that program implementers understand and are intentional about addressing the determinants of trust that exist at all levels of the SEM.

Design and implement multi-level trust-fostering interventions that cut across the SEM.
Collaborative and participatory SBC programs that consider the interactions between the determinants of trust at different levels of the SEM and the larger health system are likely to be more effective than interventions that do not use a multi-level approach. When planning or designing a particular SBC intervention to foster or improve trust, consider all determinants of trust at different levels of the SEM, as these interplay and reinforce each other to influence client perceptions of quality of care in that particular context. SBC programs which consider the relationships between multiple determinants at multiple levels—such as individual's beliefs and biases, interpersonal communication between the client and provider, provider competence, and community norms, as well as the larger service delivery environment determinants of trust, such as adequacy of resources and facility processes—have the potential to have more impact on reaching trust goals than programs which solely focus on one determinant or one level of the SEM.

Recommendations for Program Implementers Working on Service Delivery

Elevate the importance of client-centered and respectful care.
The literature shows and the consultations reinforced the importance of client-centered and respectful care as a crucial determinant of trust at all levels of the SEM. Therefore, program implementers and others involved in planning for or providing SRH services should strive to

incorporate respectful care in order to foster and maintain trust. This requires action at multiple levels; illustrative examples at various levels are highlighted in **Appendix 2**, with suggestions of tools to help achieve this in **Appendix 3**.

Ensure capacity strengthening for providers is empathy-based and comprehensive in its scope.
There is no one way to build and maintain trust; instead, it requires cross-cutting skills and approaches. Capacity-strengthening interventions for health care providers may include, for example, integrating an empathy-based approach into pre-service training of health care providers, emphasis on motivational interviewing techniques, building confidence in providing multiple services, trust-building activities, and informal, participatory learning approaches. Capacity strengthening should include building providers' awareness of how social distance from clients and other sociodemographic factors influence the building of client–provider trust and how they can be intentional about addressing trust during client interactions. For example, providers can reflect on and be intentional about being relatable and actively listening, inquiring about client preferences, and soliciting for feedback or questions during interactions with clients where the social distance between client and provider is wide because of language or other barriers.

Advocate for the space for clients to make a choice of receiving services from a preferred provider.
Program implementers can advocate for SRH service delivery setups which allow clients to be seen by a provider of their preference or one they are more comfortable with. This could include ensuring clients can be seen by the same provider over time, because familiarity or relationship building endears trust. Consideration and planning are needed to implement this to prevent work imbalances or overburdening of some providers due to higher patient preference to see them compared to colleagues in the same workspace.

Implement a holistic approach to building trust throughout a client's journey of utilizing care.
A holistic approach considers what factors may be at play before a service encounter, during service delivery, and after service delivery. These approaches also consider influences such as friends, family members, and peers. While client–provider interactions are generally located at the interpersonal level of the SEM, they are influenced by other factors at other levels. For example, how a client interacts with their provider and processes health information is heavily influenced by their social network(s). Trust can be fostered by identifying factors that influence before, during, and after a service interaction; identifying social networks and influential individuals at all SEM levels; and finding ways to consider and address their influence on trust.

Include trust-building as an actionable step in quality assurance and improvement processes.
Platforms such as the community scorecard[69] and Partnership Defined Quality toolbook[70] provide ways for communities and health providers to jointly agree upon issues affecting use and demand for health services, and work in unison to address them through defined processes. These approaches have been integrated in quality assurance processes. Health facilities could consider setting trust-specific targets in their QI initiatives and using social accountability approaches in collaboration with communities, including those most vulnerable and marginalized, to foster trust, improve client–

provider relationships, improve provider behavior, and provide adequate documentation and lessons learned. Through this process, health providers can strengthen their capacity to communicate this information to health facility management and community members.

Include measures of trust as an indicator in monitoring and evaluation efforts.
Given how trust helps achieve SRH outcomes such as the utilization of modern contraception, incorporating measures of trust as indicators in SRH and quality of care programs is valuable. SRH implementers can consider how to adapt existing trust scales such as the trust in physician scale[32] for SRH services and ideal points to collect this information.

Strengthen and sustain regular dialogue between community members and providers.
Program implementers should engage with community leaders and groups to understand their priorities regarding SRH services, health messages, and policies. These dialogues should include addressing community expectations regarding standards, provider training, and certifications. Program implementers can work with communities to strengthen their capacity to communicate this information to health facility management and community members. This can be achieved through established platforms such as community health committees.

Utilize community structures, influencers, and social networks in the diffusion of information on SRH services.
Community structures such as women's groups and religious bodies are important collaborators as they are already trusted within communities and influence priority groups for SRH services.

Harness the power of new technologies and alternative methods of service delivery, such as self-care approaches.
The literature shows mobile and digital health technologies may be promising in fostering community trust in the health care system and its various components. The place of digital health technologies was reinforced during the COVID-19 pandemic, where use of telehealth rapidly increased and helped improve access to SRH services when traditional service delivery points were closed. Furthermore, digital platforms may serve as trusted channels for SRH information for populations who desire a high degree of anonymity or confidentiality, such as adolescents and sexual and gender minorities (SGM). However, practitioners must assess the credibility and accessibility of such platforms in any given context. Additionally, the literature shows that clients prefer confidentiality and agency over care decisions, including flexibility in times they access services. The role of alternative, non-traditional health service delivery methods, such as self-care, in fostering or increasing trust should be explored, as self-care offers an avenue for clients to have more control over their SRH and a more active role in decision making.[71]

Explore and address how power dynamics and provider–provider relationships in communities and facilities impact client trust.
SBC implementers can support managers to provide opportunities for reflection and dialogue between providers to uncover and address power imbalances which fuel mistrust among providers.

This can include providing opportunities for providers to give feedback about team setups and policies which influence intercollegial work relationships.

Recommendations for Program Implementers Working on Policy and Normative Issues

Advocate for institutionalization of social accountability approaches for setting priorities, monitoring SRH services and utilization of funds.

Social accountability fosters trust by providing a safe and neutral space for dialogue between clients/communities and health providers/facilities. The process allows for joint prioritization of action planning to improve issues related to use of and demand for quality health services in a two-way manner and can improve empathy between providers and clients/communities. Implementers can push for systemic adoption and wider implementation of social accountability approaches by advocating for their inclusion as part of service delivery policies, especially related to client–provider interaction, provider behavior, and client's rights.

Advocate for systems that are inclusive of the needs and desires of underserved or marginalized groups (e.g., people with disabilities, adolescents, migrant women, SGM).

Populations that are often underserved such as adolescents, or subject to discrimination, such as people with disabilities or SGM face additional barriers to patient-centered and respectful care, and their unique needs may not always be accounted for in SRH resources or services, which affects trust. Developing or fostering systems that are inclusive of the needs and autonomy of these populations will enable and maintain trust.

- Advocate for initiatives that make SRH materials more accessible to people living with disabilities and other groups who lack access.
- Advocate for policies that protect the rights and confidentiality of populations who are underserved or are subject to discrimination.

Build on existing dialogues and interventions around social norms.

Social norms are highly contextual, and implementers need to engage with communities to fully understand which social norms impact trust in SRH, the strength of the impact, and how they might impact planning and delivery of SRH services and norms shifting interventions.

Opportunities for Further Research

The literature review and consultation brought to the fore gaps in understanding the determinants of trust and their interactions at different levels of the SEM. The SBC in SRH field needs further research in the following areas:

- How supervisor behavior and relationships with providers influence trust and the client–provider relationship at the organizational and service delivery level.
- Understanding the trust journey and pathways to rebuilding trust when trust is lost, including barriers and enablers to rebuilding trust.
- Mechanisms of trust, particularly across multiple levels of the SEM; different factors like client self-efficacy, agency, and empowerment; and how these factors affect a client's trust journey.
- How norms related to trust are diffused among clients and providers and what factors determine whether they abide by them.
- How individual level factors which are social determinants of health, such as race, gender and socioeconomic status, affect trust and its determinants/outcomes at the global and country levels.
- Whether institutional trust in the health system or interpersonal trust in the provider has more impact on client/community trust.
- Measuring trust more explicitly, answering the question of how to measure changes in trust (increased or decreased trust) and its impact on SRH outcomes.
- Understanding how different levels/modes of service delivery—such as facility versus community-level service delivery and public versus private service delivery—constitute enablers or barriers to trust, depending on the context.
- Trust theories from disciplines outside of public health and how they can be utilized in understanding and building trust in SRH service delivery.
- Monitoring trust in and use of Generative AI or machine learning applications such as chatbots or AI-powered virtual assistants for clients or providers in AI-provided treatment recommendations (e.g., on drug interactions or other updated medical information).

Conclusion

Trust is an essential component of a supportive SRH environment, and increasing and fostering trust in SRH environments contributes to positive outcomes for both clients and providers. Various determinants play out at different levels of the SEM which influence trust between clients, communities, health providers, and institutions. This technical report provides SBC practitioners with an overview of the determinants of trust in SRH and outlines opportunities for using SBC to address key barriers and enablers to trust within SRH services.

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Appendices

APPENDIX 1

Consultation Participants

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APPENDIX 2

Illustrative Interventions Towards Elevating Practice of Client Centered and Respectful Care

SEM LEVEL	ILLUSTRATIVE EXAMPLES
Individual and Interpersonal	• Develop models with concrete examples of ideal provider behaviors to share with providers. • Host active listening sessions with clients, providers, and facility management for clients to provide feedback to providers. • Forums and activities for providers to build their interpersonal communication skills and practice approaches (including showing compassion/empathy). • Using group mentorship models or empathy checklists. • Develop and implement client empowerment initiatives towards achieving client awareness of rights and agency.
Organizational/ service delivery	• Develop and implement a checklist for respectful care for providers and their supervisors and ensure there are accountability mechanisms in place. Examples of accountability mechanisms include integrating these checklists into supportive supervision visits or as part of career advancement processes. • Utilize environmental cues: Written cues, such as pacts or promises in facilities, can show clients that their rights are being respected and help to foster trust.
Community	• Strengthen and support existing community/facility linkages, such as community health committees and community participation in quality improvement or social accountability activities. • Facilitate visioning processes with providers and community members to co-create a shared vision and solutions for respectful care and other identified priorities. • Utilize social accountability approaches to identify shared priorities and keep client/community–provider/health facility feedback loops open.
Policy/enabling environment	• Institutionalize continued mentorship initiatives for providers focused on trust building and respectful care including components addressing compassionate and empathetic communication.

APPENDIX 3

Suggested Tools and Resources to Help Build and Include Trust in Reproductive Health

This appendix presents a collection of SBC-related resources and tools which were curated with and by consultation participants that can be adapted for the purpose of incorporating trust components in SRH programming.

- Achieving a Positive Experience of Care in Health Facilities for Women, Newborns, Children, and Their Families in Sub-Saharan Africa: **French**
- Empathways for Empathy-Building Activities Between Providers and Clients: **English** and **French**
- **Provider Behavior Change Toolkit For Family Planning**
- **Community Action Cycle to Engage with Communities Around Their Own Priorities: Using the Community Action Cycle to Build Trust in Guinea**
- **Partnership Defined Partnership Approach to Engage Community and Facility Representatives in Dialogue**
- Social accountability approaches
    - **Community Score Card**
    - **iDARE Methodology**

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