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

Evidence Synthesis and Recommendations

A TECHNICAL BRIEF

USAID
FROM THE AMERICAN PEOPLE

Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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Acronyms

CCP	Johns Hopkins Center for Communication Programs
CHW	Community health worker
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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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.[1] Furthermore, trust between communities, clients, health facilities, and **health care providers** (at both the facility and community levels) is a key component of this supportive environment. Trust shapes provider and client behavior both within and outside facilities and considerably impacts acceptance,[2] initiation and continued use of SRH services,[2–6] experience[7] and quality of care, and increased client satisfaction and confidence in the health system/provider.[3,8–15] Evidence shows that trust also influences both adoption and maintenance of beneficial health behaviors and positive health outcomes.[2,11,15] It can yield positive benefits for providers, such as improving work satisfaction and collaboration.[16,17]

Consensus is growing within the **social and behavior change** (SBC) community that needs to understand both 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. 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 brief highlights key points synthesized from the literature review and technical consultations and provides succinct recommendations for programs on using SBC to foster trust in SRH settings. More information about these activities is available in the full report, **'Using social and behavior change to foster trust in sexual and reproductive health: A technical report'**.

Breakthrough ACTION Overview

Breakthrough ACTION is an eight-year (July 2017 to July 2025) global project, funded by 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.

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 project team identified 69 articles from programs in six regions: Europe, Asia, South America, Sub-Saharan Africa, the Middle East and North Africa, and North America. The team held three technical consultative workshops with 32 experts from these regions to share and validate the findings from the literature review, hear from experts' experiences, and co-develop recommendations for focusing on trust within SRH.

Breakthrough ACTION used the following levels of the Socio-Ecological Model (SEM) to frame the analysis and synthesis of identified determinants of trust: individual, interpersonal, community organizational/service delivery, and policy/enabling environment (**Figure 1**).[18,19]

Defining Trust and Its Components

Put simply, trust refers to a firm belief in the reliability, truth, and ability or strength of someone or something.[20] Trust is dynamic and influenced by numerous social, structural, psychological, behavioral, and contextual variables that causes it to change over time.[21] Trust is a complex and multi-dimensional construct, and as a result, variables defining trust vary widely and are based on the social and cultural context, which makes measuring difficult.[5]

Trust in the context of health service delivery has varied dimensions, including feelings about competence, responsibility, control, disclosure, and confidentiality.[25–26] 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.[27–29] Source credibility is particularly relevant when considering facility or service promotion efforts. Other definitions of key concepts related to trust are in the **Appendix**. Numerous determinants feed into the development and maintenance of trust.[21] These variables and their weight of importance differ between individual and community contexts, and feeds 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.[21]

FIGURE 1

The Socio-Ecological Model for Service Delivery[18,19] 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.

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.[22] Interpersonal trust underlies a client's belief that service providers are credible and can be held to their word.[23]

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.[24] 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.

Key Highlights and Opportunities

What follows are key highlights of findings on the determinants and outcomes of trust from Breakthrough ACTION's literature review and consultations, along with recommendations and opportunities for using SBC to foster trust in SRH for program implementers.

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.
- Community health workers (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.

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, which as highlighted in the following examples. Most papers in the review did not attempt to map determinants and outcomes of trust into the two categories of trust (interpersonal or impersonal), and the findings often overlapped and intertwined. However, in general, determinants at the individual, interpersonal and community SEM levels are linked to interpersonal trust, while impersonal trust typically operates more at the service delivery/organizational and policy/governance SEM levels.

- **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.[4] Additionally, trust between client and providers enables use of SRH services by clients who desire secrecy and do not want to be identified as users of these services.[30]
- **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 clients' positive experiences or the social recognition of trustworthiness of health professionals.
- **Increased adoption and maintenance of beneficial health behaviors health:** 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.[11]
- **Increased client access to SRH services:** Increased access to SRH services is often a product of clients' improved acceptance of SRH services, which trust also supports.[2] 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.[2]
- **Improved client willingness to disclose information to providers that may affect treatment decisions:** Trust increases clients' willingness and comfort in disclosing information about their SRH, which vitally informs how to determine the best services or treatment to offer.[11,31]
- **Increased client agency and self-efficacy:** Trust enhances client participation in making decisions about their use of SRH services and their health, increasing their agency.[4]
- **Improved provider work satisfaction:** Client trust in providers and trust between different cadres of providers creates an enabling work environment for providers, which bears on their work satisfaction and motivation.[2] 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.[2]
- **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 as reducing unwanted pregnancies and increasing maternal and child survival due to a reduction in SRH-related mortality and morbidity.[32,33]

Consequences of Lack of Trust

Lack of client trust in SRH services is a barrier to utilization of SRH services and the achievement of 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,[2,11] low utilization of SRH services, and concealment of medical information from providers.[11,14,31] 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.[6]

Determinants of Trust

Breakthrough ACTION identified determinants of trust in SRH at all levels of the SEM, which consultation participants validated and expanded. These determinants interact with one another within and across the different SEM levels and collectively impact trust. Furthermore, 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

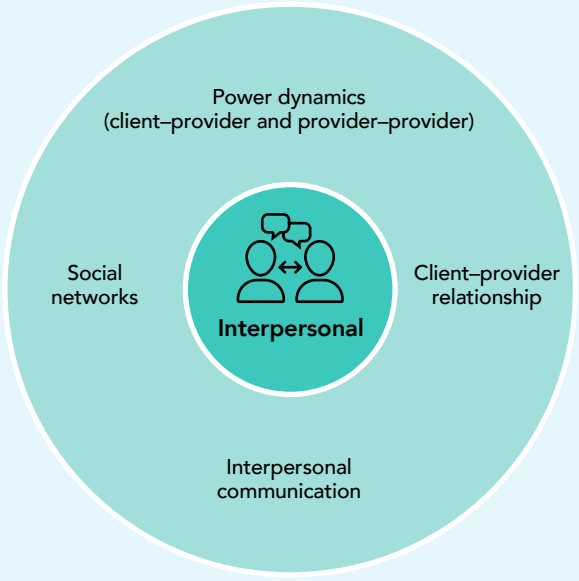
- **Clients' and providers' demographic characteristics, beliefs, and social status determine social distance between clients and providers, perceptions of trustworthiness, and whether trust exists or not in a client–provider relationship.**
- **Clients trust providers they perceive to be competent and skillful.**
- **Clients' beliefs and biases about SRH and their experiences accessing SRH services frame trust.** 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.[10]
- **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.**[9] These individuals may include youth, migrants, women, sexual and gender minorities (SGM), and people experiencing poverty or holding lower socioeconomic positions.
- **Clients' trust is influenced by their perceptions of the motives and ethics of providers and health facilities.**

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 follow-up care with a provider for contraceptive side effects). Trust builds when these expectations are met and hindered when 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.
- **Other workers in the SRH setting who show clients empathy and compassion foster a trust of both providers and the health system.** This includes personnel who are not direct service providers, such as administrative staff and custodians.
- **Familiarity formed through repetitive, client–provider connections and lasting, meaningful relationships are important to building and maintaining trust.**
- **Power imbalances between clients and providers are a major determinant of trust.** 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 they are concerned about being refused services or products.[17]
- **Interpersonal communication skills and communication styles of providers matter in building and maintaining trust.** Additionally, consistency in SRH messaging across different providers promotes trust.
- **Clients are influenced by and often adopt or reflect the perceptions of their social networks.**
- **Provider–provider interactions and trust between providers affects client and community trust in health providers and facilities and their relationships.** If clients perceive or observe that providers are at odds or do not treat each other well, this impacts their trust of those providers and of the facility in general. For example, one study from Kenya indicated that when clients witness discord or hear disrespectful tones between providers, their trust in that health facility is diminished.[17]
- **Perceived disparities between a providers' beliefs and biases (which are known in the community) and the services the provider is offering can cause dissonance and distrust.**

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 gatekeepers (e.g., community volunteers) can influence the support, trust, and acceptance of health workers and SRH services in their communities.**
- **Community norms, beliefs, and perceptions shape trust in SRH services.** Community norms around who should be utilizing SRH services, what services are acceptable, and whether SRH services are generally viewed positively or negatively greatly influence community trust in SRH service providers.
- **Dynamics between communities and health facilities and related sub-factors, such as the 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.**
- **The extent to which communities are involved or included in decision making and priority setting about their health and health services impacts trust.**
- **The distribution of power and efforts (or lack of) at addressing power imbalances between clients, communities, health providers, and facilities influences trust.**

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

- **The service environment can act as both a facilitator and a barrier to trust.** Trust is enabled when there is enough space for client audio-visual privacy when receiving services while inadequate commodities or equipment to meet service needs is a barrier to trust.
- **Complex pathways to accessing and referring for SRH services inhibit client trust.** Organizational processes that create burdens or barriers to accessing care are barriers to client–provider trust.
- **Accessibility and acceptability of channels (or modes) of SRH service delivery varies across contexts and populations, especially for marginalized and exploited persons or groups, which affects perception of trustworthiness.** People who are underserved or disenfranchised by the health care system such as migrant refugees may experience challenges accessing SRH services because of systemic barriers (e.g., lack of resources or restrictive policies) and discrimination, which influences their trust of providers and facilities.[34,35] This may be compounded by language and cultural differences influencing their perception of service acceptability.[35]

- **The nature of the service matters.** Consultation participants mentioned trust is more impactful for certain types of health services. For example, family planning services are considered more sensitive than antenatal care, and therefore, service outcomes depend even more on establishing trust between client and provider, through factors like 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. Consistency in these policies and communication around them also assures trust-building.
- **Systemic mistrust during emergencies and disasters easily spills into SRH services.** General mistrust of health providers and the health system during emergencies and disasters, such as pandemics, wars, and community clashes, easily cascades into SRH services. This can result from fear for one's safety as well as temporary shutdown of non-emergency public health services.[12,36]

- **The track record of government and social institutions matters, including their past successes and failures.** Clients are more likely to trust providers when governmental policies and promises are implemented and are adapted to meet the community's needs, as well as when patients perceive they receive a quality of care that is worth their investment (i.e., providers are held accountable to provide good care).
- **The political environment can influence trust, and who is in power or in opposition influences trust in providers and the health system.**

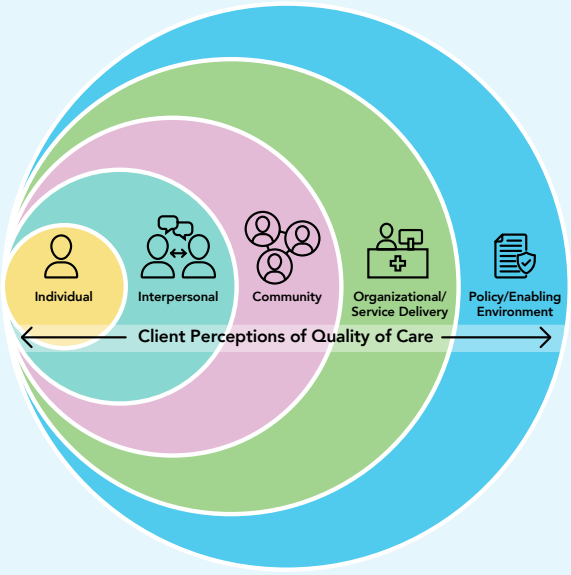
Cross-Cutting Determinants: Perceptions of Quality of Care

The literature review and subsequent consultations 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 (**Figure 7**).

A cross-cutting determinant that came out strongly in the literature is client perceptions of quality of care. While these are a determinant of trust, such perceptions are also driven by other determinants across different SEM levels, such as 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 formed varies across clients and contexts.

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 of providing adolescents with SRH services and meeting their specific needs in different contexts.

Key determinants identified as related to adolescent trust include provider behavior (interpersonal), provider communication (interpersonal), facility environment (organization/service delivery), and policies around confidentiality (policies, legislation/enabling environment). Negative provider behavior towards adolescents—driven by social norms around sexuality, moral values, and generational differences between adolescents and providers,[37] community misconceptions about motives of providers,[14] and policies limiting adolescent access to SRH services[5]—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,[9,38] as well as if they have access to service channels that allow anonymity such as online consultations,[39] they have access to providers they consider as relatable or peers,[39] and providers communicate to them in simple language devoid of medical jargon.[32]

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

Breakthrough ACTION identified various opportunities from the literature and consultations and developed recommendations for various audiences working in SRH. Practitioners working in SRH should consider what is relevant and feasible in their given context before adapting a recommendation.

Key to these recommendations is the need to be patient and treat trust as a process. Trust in health providers and in health institutions builds over time. 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 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 instead of an afterthought.

Design and implement multi-level trust-fostering interventions that cut across the SEM. When planning SBC interventions intended to foster or improve trust, practitioners need to 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.

Recommendations for Program Implementers Working on Service Delivery

Elevate the importance of client-centered and respectful care. Client-centered and respectful care are crucial determinants of trust at all levels of the SEM. 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 are available in the technical report.

Ensure capacity building and 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-building 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 building should also 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.

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. For example, social networks heavily influence how a client both interacts with their provider and processes health information. 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. Two-way dialogue that promotes social accountability and platforms such as the community scorecard[40] and Partnership Defined Quality toolbook[41] 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 quality

improvement 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. This process enables health providers to strengthen their capacity to communicate this information to health facility management and community members.

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 SGM. However, practitioners must assess the credibility and accessibility of such platforms in any given context. Additionally, the literature shows 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.[42]

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 set ups 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 and 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 or experience discrimination face additional barriers to patient-centered and respectful care, and SRH resources and services may not always account for their unique needs, which affects trust. Developing or fostering systems that are inclusive to 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.

Conclusion

The literature review and consultations underscored trust as an essential component of a supportive SRH environment, and increasing and fostering trust in SRH environments contribute to positive outcomes for both clients and providers. These activities also highlighted influential determinants as well as gaps in understanding the determinants of trust and their interactions at different levels of the SEM. Various determinants play out at different levels of the SEM which influence trust between clients, communities, health providers, and institutions. This brief provides 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.

Based on gaps in the literature, opportunities for further research can be found in the full report, **'Using social and behavior change to foster trust in sexual and reproductive health: A technical report'.**

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Appendices

APPENDIX 1

Consultation Participants

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Ketan Chitnis, Chief, SBC, UNICEF Mozambique

Marie-Claude Mbuyi, Democratic Republic of the Congo Country Director, Pathfinder International

Martha Silva, Associate Professor, Tulane University

Mercy Manoranjini, Knowledge Management Lead, Center For Catalyzing Change

Nahida Akari, Midwife, Amel

Nyane Nonyana, Senior Monitoring, Evaluation and Learning Advisor, Jhpiego

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APPENDIX 2

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]

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