Building Trust and Empathy with Young Mothers in Nutrition Programming

Context and Background

Nutrition interventions rely on a shared trust between the client and providers. Research has shown that trust shapes client and provider behavior within and outside health facilities. Client–provider interactions based on trust can enhance understanding, build true connection, create a more empathetic and supportive experience, and support positive nutrition-related behaviors. For example, an intervention by Breakthrough ACTION-Nigeria revealed how important a trusted relationship is to maximizing nutrition-related advice from community health workers (CHWs) and facility-based providers.[1]

Active listening, being vulnerable, and sharing one's own experiences as a community or facility health care worker builds a two-way relationship and sets up an experience that is more empathetic and supportive. These traits also help providers tailor their counseling to the family's situation and current behaviors. This

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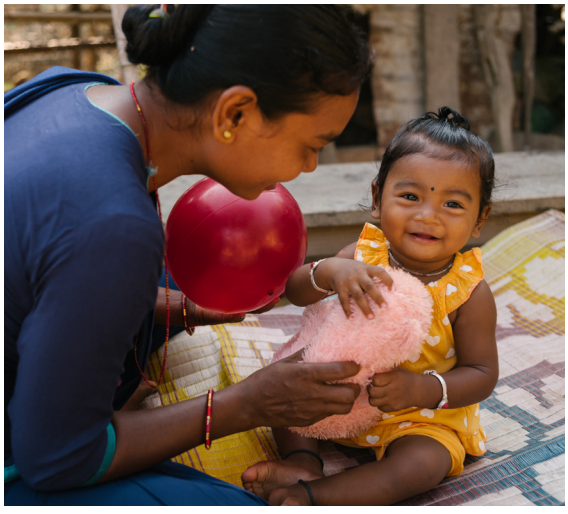
approach may be particularly important for young mothers given that many may receive less respect and attention because of providers' moral judgment of early pregnancy, having much less power than health workers, and having less agency to follow recommendations from community or facility-based health workers.

To further shared learning and highlight the importance of trust, Breakthrough ACTION conducted a literature review to answer the question: **How might we build trust and empathy within nutrition programming and with young mothers in particular?** This brief synthesizes findings and recommendations from a literature review as well as a virtual consultation. The results of the review produces recommendations for ensuring that facilities, communities, and other stakeholders prioritize trust and empathy to positively shape client–provider interactions, improve nutritional outcomes for young mothers and their children, and include as a component of health systems strengthening.



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Literature Review

A. Process

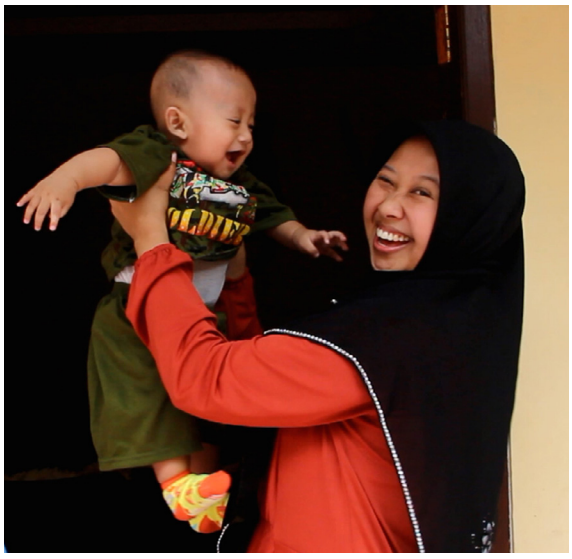
Breakthrough ACTION conducted a rapid literature review based on a web-based search of peer-reviewed and gray literature. The project used specific criteria to set the scope of the literature review and included articles from 2000 through 2023 set in low- and middle-income countries (LMICs). The search terms had four components: health area, trust, provider cadre, and population. The health area terms encompassed Medical Subject Headings and key words related to nutrition, maternal nutrition, and infant feeding practices. Breakthrough ACTION included the word "trust" as a text word in all searches. It also included terms related to provider cadres, such as those related to providers in health facilities and CHWS. Search terms used different combinations of maternal and child health (MNCH) and nutrition terms, type of provider, type of clients and trust-related search terms. Overall, the search yielded 617 unique sources across PubMed, Embase, Cumulative Index to Nursing and Allied Health Literature, and PsychINFO. Additionally, nine sources from the gray literature were included in the review. Following abstract and full text reviews, the final extraction of evidence included 53 articles.

Several questions guided the review:

- What are the determinants of trust between clients and providers or CHWs (in communities or facilities) at different levels of the socio-ecological model?

- What are the mechanisms of trust?
- What are the outcomes of trust for providers and clients?
- How does trust as a determinant manifest for young mothers in particular?
- How might we improve trust between clients and providers?
- What is the role of social and behavior change (SBC) in improving trust between clients and providers?

Breakthrough ACTION used definitions of trust from sociology and psychology and identified components of trust in the health context. The first component is the degree to which community members perceive facility-based providers or CHWs as caring, considerate, and attempting to provide the best care possible.[2] The second component is the idea that trust in the service delivery context, at both community and facility levels, has varied dimensions, including feelings about competence, responsibility, control, disclosure, and confidentiality.[3] The last component examines health systems as social institutions and trust across all its dimensions and types (e.g., interpersonal or public) is dynamic, both as a process and as an outcome.[4] The review delineates between two types of trust: (1) interpersonal and (2) institutional. Interpersonal trust is trust placed in other people, including the extent to which a person ascribes credibility to other people and expects positive outcomes in the context of social interactions.[5] Institutional trust is trust in an institution or system, including client trust. In other words, it is trust in an institutionally established relationship between a professional and a client, based on the social recognition of the trustworthiness of an occupation.[6] A list of key definitions is at the end of this brief.



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Following the synthesis of the literature, the project held a virtual consultation with dual, concurrent objectives: (1) reviewing the fundings to glean additional insights and identify any gaps and (2) refining recommendations for improving trust in maternal nutrition programming with a particular emphasis on young mothers. The summary of findings in section B reflects the outcomes of this process.

B. Findings

Outcomes of Trust

The literature demonstrated that trust between clients and providers resulted in positive outcomes for both. The existence of trust increased health seeking behaviors and improved health outcomes on the part of clients. Notably, providers also reaped the benefits in the form of improved work environments and increased interpersonal cooperation. Figure 1 breaks down the outcomes of the existence

Figure 1: Outcomes of Trust

CLIENT / COMMUNITY

Increased client/community use of MNCH and nutrition services[7–9]

Increased client/community confidence in health system and provider[10]

Promotion of positive health-seeking behaviors[8]

Increased community acceptance[11]

Improved client willingness to disclose information to providers[12,13]

Increased client agency and self-efficacy[12,14]

Achievement of positive health outcomes[15]

PROVIDER / HEALTH FACILITY

Improved collaboration and cooperation between providers[16–18]

Improved provider work satisfaction[19]

Improved credibility of providers[17]

Increased quality-of-care provided[20]

of trust according to client/community and provider/health facility. This section further unpacks the determinants based on evidence related to the factors needed for building and maintaining trusted relationships between clients and providers.

Determinants of Trust

The literature revealed many different factors which shape trust with the findings structured below across the levels of the socio-ecological model.

INDIVIDUAL LEVEL

This focuses on individual characteristics, such as age, sex, knowledge, attitudes, beliefs, and social class among others.

Demographics and social distance

Social distance refers to the extent to which people experience a sense of familiarity or unfamiliarity between themselves and people belonging to different groups from their own. This includes social, ethnic, occupational, and religious groups.[21] Shorter social distance between clients and providers or CHWs is associated with greater uptake of services, including home visits.[22] Researchers in Guatemala, for example, examined an integrated health program designed to reduce maternal mortality amongst Mayan women. They found providers from the local community or those who were familiar with local culture, language, and norms were more likely to elicit honest responses from clients.[10] In other

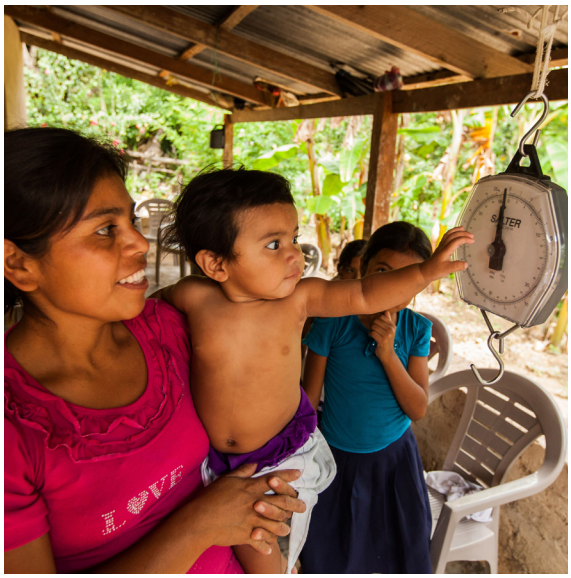
words, clients felt more comfortable with someone nearer in social distance to them.

Client beliefs and experiences

Clients' beliefs and experiences sometimes affect trust even before an interaction with a provider. In Ghana, researchers found individual beliefs among childbearing women can deter trust and use of services. "Traditional beliefs"—such as fear of witchcraft on birth outcomes or a view that childbirth was a "dangerous passage"—often prevented patients from establishing trusting relationships with providers because many women in the study knew someone who died during childbirth.[23]

Perceptions of competence and motives

Clients are more likely to trust providers and/or institutions they perceive as competent. In eastern Burma, community members implemented a mobile maternal health worker program and found the demonstration of competence key to achieving community trust.[24] Trust is underpinned by the idea that the provider has the best intentions for the client.



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When that is in question, trust erodes. For example, a study from Bangladesh cited public sector health workers as more trusted than those working in the private sector because community members viewed private sector providers as profit-oriented and more interested in financial gain.[25]

Marginalized or exploited groups

Mistrust can arise when health providers and/or health systems give relatively poor treatment to people who are marginalized, may be experiencing poverty, hold lower socioeconomic position, or otherwise face discrimination and stigma due to factors such as race, ethnicity, social class, immigration status, HIV status, and level of education.[26] In Thailand, researchers found that Hmong women, a marginalized population, suffered consistent discrimination from providers, including experiencing procedures without consent and receiving disrespectful antenatal care.[27] The minority group's negative experiences created a lack of trust within the community, which led to families and mothers commonly choosing home births rather than attending birth facilities.

INTERPERSONAL LEVEL

This encompasses one's social network, quality of relationships, and communication patterns among others.

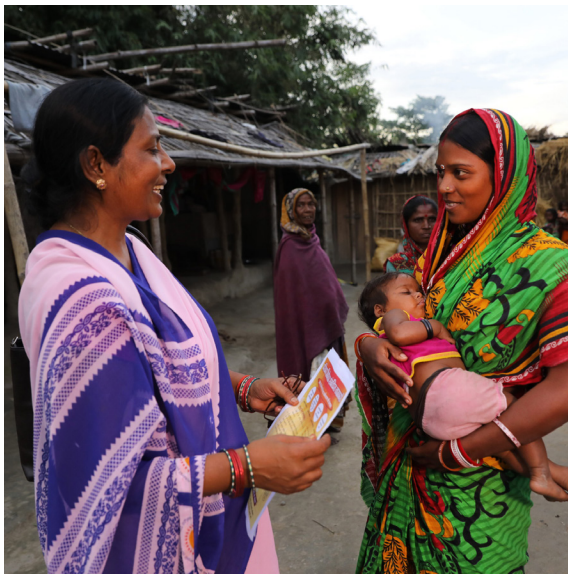
Social distance

The degree to which a client shares familiarity with a provider's social group can define the level of trust in their relationship. Proximate relationships to providers (i.e., providers living in the village where they work or belonging to the same religious or ethnic group as a client)

increases trust with those providers.[28] The converse is also true: distance (i.e., the provider is not from a shared community) can decrease trust from clients and the community. Furthermore, providers who are familiar with the local culture, language, and norms are more likely to elicit honest responses to questions from clients. This trust can serve as the basis for the client to continue engage in positive health seeking behaviors and future return visits. A study in Guatemala demonstrates how programs built on respect and caring that leverage former clients can leverage trusted members of the community to build trust.[10]

Perceived motives

Clients perceive providers' motives either as trustworthy and well-intentioned or in a more negative light. In one study on the influence of trust on maternal vaccine acceptance, some pregnant women preferred doctors at facilities rather than CHWs because they couldn't assess where CHWs came from, who sent them, or what their motives were.[29] The same women mentioned respect and approachability colored their perception of providers and affected whether they would come in for return visits or not. This demonstrates that, to build trust, providers need to establish their well-intentioned motives with the client from the start.



Provider cadre

A provider's specialty or cadre may also affect how trusting a client is. Many women prefer midwives over a doctor because midwives are preceived to be more likely to provide a higher level of personal care, better continuity of care, and more emotional support.[30] One study in Iran found that midwives may be better at implementing respectful care to mothers because they consistently showed empathy to clients, provided women-centered care, and spoke kindly to women using respectful language.[31]

Familiarity

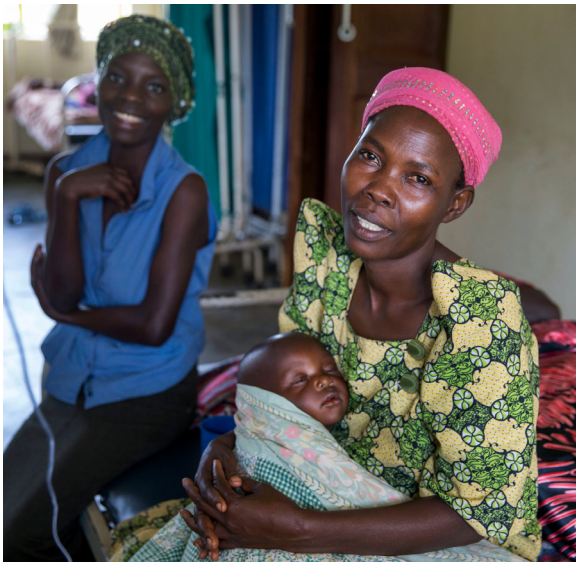
Familiarity with a provider and meaningful relationships built through sustained contact with the same provider can enable client–provider trust. Familiarity is formed by regular contact with the same provider, including seeing the same provider often, receiving home visits, and attending provider-facilitated activities in the community. Irregular contact with providers, seeing a new provider each time, and not having a positive or existing relationship with the provider emerged as barriers.[32–34] In Kenya, both clients and providers agreed, "the quality of prior care experience at a facility influences trust" in maternity care.[16] Another study in South Africa indicated that women who received a home visit from a CHW, in addition to the standard of care in a health facility, built trust with their CHW and were more likely to exclusively breastfeed at three months.[15]

Power dynamics

A client's trust grows through perception of shared agency and decision making with providers.[35] In contrast, power imbalances between clients and providers are a barrier to trust, especially when MNCH clients feel they lack the power to advocate for their needs and preferences and are exacerbated by differences in wealth, education, and client deference to providers' medical expertise.[16,31] This may be especially relevant for young mothers who may have less education, wealth, and power than a health care provider.

Provider interpersonal communication skills

A study in India examined the effects of respectful interpersonal communication (of which trust was a component) on feeding practices and found that about half of the mothers had better recall of health messages and that interactions that were more respectful were associated with a greater likelihood of adopting most child-feeding behaviors.[36]



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Peer groups and social networks

Clients also often consult those within their social networks, such as family and peers, as they make decisions about using MNCH and nutrition-related services. MNCH information received through these social networks may or may not be accurate, but reliance on these networks, including who is or is not a trusted provider in the community, influences care-seeking behaviors and trust. For example, a study in Kenya focused on maternity care revealed that neighbors' positive experiences with providers or health facilities positively influenced trust.[16] A study in Bangladesh found that pregnant adolescents who received advice and emotional support from older women in their family or trusted circle were more likely to adopt healthy eating practices and attend more antenatal care appointments.[37]

COMMUNITY AND HEALTH SYSTEMS LEVELS

This level focuses on the social, cultural, and physical environment.

Community leader buy-in

Community leaders can make or break a community's trust in maternal and child health services. Their support can facilitate trust and acceptance and holds true when community leaders are trusted themselves.[20] For example, the use of recognized community leaders in Mozambique increased community engagement.[38] Community leaders not only affect the trustworthiness of a program but can also mobilize people towards that health initiative. According to a study in Tanzania, engaging community leaders can increase male participation in MNCH services, leading to an increase in service

uptake related to prevention of mother-to-child-transmission of HIV.[39]

Community norms

Social and gender norms may give rise to community distrust for certain services or be a facilitator towards uptake. A study in Kenya found that community norms shape perceived risk of seeking maternity services at health facilities that are not trusted whereby women travel further distances to find a facility a community deems more trusted and of higher quality.[16] In Guatemala, researchers considered gender norms when encouraging male partners to become advocates for quality maternal health services resulting in greater uptake of services.[10]

Community involvement in decision making

Communities want to be part of decision-making and priority-setting processes. Using multiple channels and existing groups and platforms such as community action groups and health facility committees have been effective engaging communities in decision making on health service issues and enables representation of marginalized voices and builds trust.[40] As an example, participant responses in a study in Indonesia indicated that, "If village leaders are transparent, community members will trust them and be actively involved in the local development process."[16] Engagement should be inclusive, accessible, and supportive of individuals within nutrition-related programs with young mothers in particular, given they may often be left out of such decision making. Doing so could positively impact their trust in nutrition and MNCH services.

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Relationships between health system and community

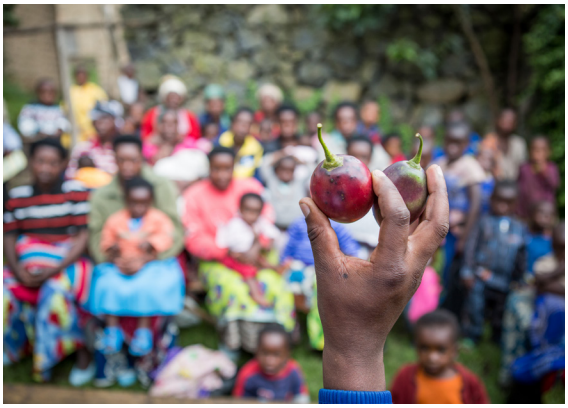
The relationship between communities and the health systems that serve them can be complex. If a community has had a negative relationship with a facility (e.g., from poor care, long wait times, or discrimination), they may be less likely to seek care there. Conversely, a positive relationship may create trust and lead to a greater uptake in services as do social accountability efforts.[41] Feedback from the community about the health system is vital to creating a strong basis of trust between the two.[2,42] A study in Uganda, for example, summarized community perceptions of health facilities into report cards and shared them with the facilities, leading community members and staff to develop an action plan to improve services. Within a year, service quality and uptake increased as the positive feedback loop led to greater trust within the community and better health outcomes, including a 33% reduction in under-five mortality.[43]

Service environment

The physical environment of a facility, including availability of resources, confidential consultation spaces, cleanliness, hygiene, technology, and

equipment all foster 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 in both family and community service delivery settings.[10,29,31,32] Heavy provider workload results in overburdened providers, leading to long wait times or rushed consultations.[16]

The work environment can dictate health care worker' job satisfaction, including that of other community cadres, and their motivation to engage in respectful care and provide quality services, all of which directly affects trust in a client–provider relationship.[19] Midwives in Mozambique, for example, found several barriers to providing quality perinatal care including an inadequate number of beds, equipment, and human resources as well as unnecessary and complicated processes to receive care.[44] The midwives also cited the hierarchical management structures as an inhibitor to quality care. All told, the environment led to unhappy staff and clients, eroding the trust between clients and the health system itself. This effect potentially worsens among young mothers who may be navigating some of these services for the first time. Thus, these mothers may refrain from seeking future services altogether.



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Complex pathways to accessing and referring

Organizational processes that create burdens to accessing care also act as barriers to client–provider trust. For example, long lines at payment points, extensive paperwork, and processes that require moving between several service points decrease trust in a health facility.[24] These barriers delay service delivery and place an unnecessary burden on patients, making them less likely to seek care.

POLICY/ENABLING ENVIRONMENT LEVEL

This level focuses on broader structural, political, and economic systems.

Policies governing MNCH services

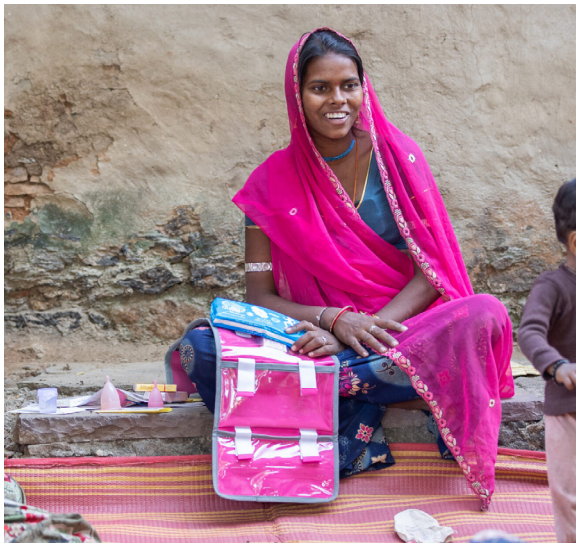
Effective and transparent policies and services are vital for building and maintaining client trust. Clients are more likely to trust service providers when laws exist that protect patient–provider confidentiality. Trust also increases when free or subsidized services remove financial barriers to client utilization.[16,33] While policies to address maternal nutrition to prevent developmental delays and disabilities already exist in many LMICs—and these policies usually include guidelines on nutrition education, maternal diet, weight gain during pregnancy, and antenatal and postnatal services—improved health outcomes depend on instituting even more comprehensive guidance and regulation in these areas.[45]

Mistrust during emergencies

Natural disasters and emergencies such as pandemics, war, and community clashes may seed distrust in providers and the health system broadly.[34] 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.[31] Following the Ebola outbreak in Sierra Leone, research revealed that communities viewed health workers as potential contaminants, and trust in health providers fell, possibly resulting in poor maternal health outcomes.[46]

Track record of government and social institutions

Government performance—including past successes or failures, corruption, and lack of transparency in the allocation of resources—serve as useful determinants of trust. Clients are more likely to trust providers when governments are consistent and implement and adapt services to meet community needs, and clients perceive such services as offering a high quality of care. Providers develop trust amongst one another when facilities have proper staffing, and official systems receive and act upon provider feedback.[16] However, that trust may deteriorate if the government creates a plan to improve services and/or service quality and then fails to follow through.[2,47]



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Opportunities to Foster Trust

Figure 2 highlights an illustrative list of opportunities to further foster trust within maternal health and nutrition programming at both the health facility and community level. Elevating trust as a key component of interventions at multiple levels will likely have greater impact if done as a holistic approach. Practitioners should consider the ideas below and others they can best suit to their context. Given young mothers are often underserved and subject to discrimination, program implementers should engage with them in co-designing any potential interventions to ensure their unique needs are met.

Figure 2: Opportunities to Foster Trust in Maternal Health

INDIVIDUAL LEVEL

- Minimize social distance between providers and their clients (both at the family and community levels).
- Approach interactions with empathy and compassion; adopt a "listen first, respond second" approach.
- Understand and acknowledge clients' beliefs around and past experiences with the health system.

INTERPERSONAL LEVEL

- Address power dynamics between providers and clients and between providers themselves.
- Encourage respectful care best practices and improved interpersonal communication.

COMMUNITY LEVEL

- Foster community engagement and shared decision making.
- Apply social accountability approaches.
- Create and sustain mother's groups to build intergenerational dialogue.

HEALTH SYSTEMS

- Establish provider–client commitment pacts.
- Support health workers and community cadres in applying empathy-based approaches that build trust and reduce social distance.
- Include trust building as an actionable step in quality improvement.
- Allow clients to see the provider of their choice to develop relationships over time.
- Leverage social accountability approaches.
- Improve facility environments.

POLICY/ENABLING ENVIRONMENT

- Cultivate clear, transparent, and truthful communication with governments and social institutions.
- Increase funding for health services, training, and supportive supervision for providers (facility and community).
- Harness technology through mass and digital media to demonstrate providers who care while ensuring flexibility and confidentiality through trusted platforms.
- Increase home visits to engage young mothers.

Conclusion

While the mechanism of trust is not always clear, and the measurement of trust is an imperfect practice lacking uniformity across the studies reviewed, trust remains an essential factor, given its role in shaping client and provider behavior in health facilities and communities.

Based on the literature, trust builds through familiarity with providers, interpersonal communication, and positive perceptions of provider motives, among many other pathways. By increasing trust, positive health outcomes improve, follow up visits increase, client and provider satisfaction is higher, and health outcomes improve. If providers, facilities, and health systems fail to build trust or loses it, clients are less likely to visit or complete their appointments, health behaviors may stagnate or worsen, and communities may develop a negative perception of providers, health facilities, and the health system. Moving forward, this field needs more research to determine how best to build trust with young mothers to support nutrition-related behaviors.

The synthesis of evidence aimed to explore how the nutrition community may further build trust and empathy across its programming, and with young mothers in particular. While few of the studies reviewed specifically focus on young mothers, the findings highlight trust as an essential factor influencing care-seeking behavior and health outcomes. Trusted relationships have the potential to maximize nutrition-related advice from CHWs and facility-based providers, highlighting the need for nutrition programs to consider trust as a factor of maternal and child health outcomes more intentionally and invest in additional research in this area.

Appendix 1: Key Definitions

Agency: Agency means that individuals or groups are aware of their autonomy, can set individual or collective goals, and take action to reach said goals.[48]

Community health worker: Community health workers (CHWs) are health care providers who live in the community they serve and traditionally receive lower levels of formal education and training than professional health care workers such as nurses and doctors.[49]

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.[50]

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

Perception of care quality: Patients' (i.e., clients') view of services received and the results of the treatment.[51]

Respectful care: Care is respectful if it is provided to all individuals in a manner

that maintains their dignity, privacy, and confidentiality; is free from stigma, discrimination, mistreatment, and harm; enables informed choice and continuous support; and responds to individuals' and their families' preferences, needs, and values.[52]

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.[53]

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.[54]

Social and behavior change: An evidence-driven approach to improve and sustain changes in individual behaviors, social norms, and the enabling environment. 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.[55]

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.[21]

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Acknowledgements

This work builds on earlier efforts under Breakthrough ACTION led by Heather Hancock and Oluwakemi Akagwu focused on fostering trust related in sexual and reproductive health services, which laid the foundation for this literature review. The team extends thanks to Saori Ohkubo as well for carrying out the literature search and to Rebecca Pickard and Marcela Aguilar for support in copyediting and layout of this brief.

This case study is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Breakthrough ACTION and do not necessarily reflect the views of USAID or the United States Government.