Can trust be started and fast-tracked in health promotion programs?

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1. The challenge of trust in health promotion

Trust is a belief in the reliability, truth, character and ability of someone or of an institution, program or government to act in the best interests of others ([1]). Trust must be earned and cannot be forced and begins with small actions of listening, social interactions, sharing interests, repetition and reciprocity that demonstrate care and support. Health promotion enables people to increase control over, and to improve their health through strategies that help people to empower themselves and that enhance their knowledge, skills and competencies ([2]). Building trust is a precursor to successful bottom-up programs, especially with vulnerable groups, to engage and to co-produce local solutions to address broader health issues such as social integration and mental health. Building trust is important when an accelerated program implementation is a high priority in order to engage people to change behaviours, utilise services and to develop disease prevention and control procedures during outbreak responses. Building trust is also important to address growing health inequalities and so now more than ever, we must make it a priority in health promotion programs.

Trust building presents a practical challenge because it is time-consuming, long-term and complicated and requires skilled workers and third sector partners that understand diverse socio-cultural contexts and have the means to work closely with communities. Trust building starts with an engagement and dialogue between an outside agent and the community to identify problem-solving solutions. The priorities of both create a partnership, a working relationship, that can lead to an inclusive, equitable, co-produced program ([3]).

1. The challenge of fast-tracking trust in health promotion

It is possible to start a program without trust because the initial engagement, dialogue, delivery of resources, services and information is usually carried out by an outside agent. Trust

can then be fast-tracked within the health promotion program by 1) engaging with influential stakeholders 2) engaging with third sector partners and health worker networks and 3) using effective bottom-up strategies including a phased approach. The benefit of fast-tracking is a timely program implementation without affecting the integrity, inclusion and sense of community ownership.

2.1 Engage with influential stakeholders

Influential stakeholders are individuals or groups that have an interest in and can affect the outcome of a program. They often have the trust of other stakeholders and can quickly inform, organise and motivate people to support health promotion activities. It is necessary that information and tools and local resources are utilised to build trust ([4]), but importantly that the stakeholders are engaged including faith leaders, peer educators, online influencers and lay health workers.

Faith leaders are important in some cultures because people listen to them and come to places of worship for a source of reliable information and social support. Faith leaders gain trust and respect through their work with informal networks, community health, social, and pastoral services. For example, faith leaders have played a transformational role by conducting modified religious practices to encourage people to comply with safe and dignified burials during disease outbreaks ([5]).

Peer educators have been successful for sex education, promoting screening and immunization services, such as with newly arrived migrants. For example, the 'Neighbourhood Mothers' project worked with migrant mothers to help those who had shared similar experiences. This helped build trust and the confidence needed to ask questions when the mothers met in small groups to discuss specific challenges such as local access to health and social care services ([6]).

2.2 Engage with third sector partners and health worker networks

Engaging with third sector partners and trusted health worker networks provide a bridge between government policy and communities to deliver information, services and resources. A network of community health workers can provide an effective means to engage and organise communities in which they live and work, often selected by the community

members, answerable to them for their activities, and have their trust. Supported by a health promotion program, community health workers can quickly promote participation to strengthen cohesiveness between individuals and to mobilise the resources necessary to support local actions, work as opinion leaders and help to fast-track trust building. Community-based organisations provide a focal point for quick access to promote local activities and to build trust, but It may be necessary to build capacity to allow them to work alongside other services. In Guinea, West Africa, for example, the use of local radio and Community Watch Committees or 'comité de veille were used in response to a national Ebola outbreak. The rapid scale-up of 2000 Committees strained trust and community-based capacities and it was estimated that only 25% of the network was functional ([7]).

2.3 Use effective bottom-up strategies

An effective bottom-up strategy is based on best practice that includes diversity, empowerment, respect, co-production and trust building. Community-Led Action ([8]), for example, encourages communities to take responsibility for local actions. The community is triggered into a collective sense of urgency to act by realising the consequences of inaction and through the development of a local action plan. The approach enables people to make their own appraisal and analysis of the situation, to build trust with the authorities by listening to community concerns and considering their needs, and to have more ownership of the outcomes.

Communities do not resist change; they resist the pressure of being made to change. Individual and community resistance can lead to non-compliant behaviours, an unwillingness to change harmful traditional practices and violence against community workers ([9]). Resistance can change overtime and in intensity. These changes can be geographically, digitally mapped to visually show where potential threats exist, between different locations. A phased approach can then be used to respectfully engage with communities to build trust and to safely implement program activities.

2.4 A phased approach

A phased approach uses three colour coded phases (Red, amber and green) to indicate to program personnel what the situation regarding safety and trust building is in a particular location, community or neighbourhood.

A phased approach

Red Phase → Not engaged, little trust Do not enter the location	Amber Phase → Engaged, trust building Enter with permission	Green Phase → Engaged, trusted Enter freely with respect
The red phase indicates that community engagement and trust building has not yet begun and personnel, other than the community engagement team, should not enter the location until an agreement has been reached with the key stakeholders in the next phase. This includes the identification of a safe space to hold facilitated dialogues to discuss local concerns/needs and future collaboration. The key outputs of the red phase are to reach an agreement with the identified representatives and to develop a plan to address community needs.	The amber phase indicates that the community representatives have agreed that trust building has begun and that the program personnel can enter the location with their permission to commence the initial activities. A community group is established to meet on a regular basis to discuss needs and the different types of cooperation. The key outputs of the amber phase are to identify the key roles and responsibilities and the training and resource gaps that are required to assist implementation.	The green phase indicates that trust has been established and personnel can enter the location to implement the program with the cooperation of the community. The key outputs of the green phase are to deliver the necessary resources, to commence training, to provide a feedback mechanism from and to the community on concerns about progress and to develop a joint evaluation framework.

1) The initial red phase indicates that community engagement and trust building has not yet begun. Personnel should not enter the location until it is safe and respectful to do so when the next phase has been achieved.
2) The second, amber phase, indicates that trust building has begun and that personnel can enter the location with the permission of the community representatives in order to commence initial program activities.
3) The final green phase indicates that trust and engagement have been established, and personnel can enter the location to implement the health promotion program with the cooperation of the community.

3. Conclusion

Now more than ever we must make trust building a priority to address growing health inequalities. In health promotion, trust is an essential element of many programs, however,

there may be insufficient time, capacity or social interaction for trust building to occur. This is especially important when an accelerated program implementation is a high priority or when using a bottom-up approach, for example, with vulnerable groups or during a disease outbreak response.

It is possible to start a health promotion program without trust through community engagement by an outside agent and then to fast-track trust building by 1) engaging with influential stakeholders 2) engaging with third sector partners and health worker networks and 3) using effective bottom-up strategies including a phased approach. The benefit is a timely program implementation without affecting the integrity, inclusion or a sense of community ownership.

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Glenn Laverack Bio

He is a social scientist with a distinguished career in international health promotion for 40 years as a practitioner, academic, researcher, and as an adviser to the UN, governmental and to third sector organisations, in more than 50 countries. He is an advocate for the value of involving communities at the centre of health promotion and has a wide range of publications including 28 books in 13 different languages. He has managed several large-scale health promotion programs including in Ghana and India and has worked as a consultant to design and evaluate many projects. He was formerly the Director of Health Promotion, at the University of Auckland, New Zealand and is currently an adjunct full professor at the United Arab Emirates University and an independent adviser and researcher.

4. References

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