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Understanding How Community Health Workers Build Trust with Low-Income Women of Color At-Risk for Maternal Child Health Disparities: A Grounded Theory Study

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ABSTRACT

This article examines how Community Health Workers (CHWs) build trust with low-income women of color who have a historical distrust of the healthcare system, and are at risk for maternal-child health disparities. This qualitative study used a grounded theory methodology guided by Charmaz's inductive social constructivist approach. Data were collected using open-ended semi-structured interviews and focus groups with CHWs who worked in community-based and hospital-based programs in California, Oregon, Illinois, Texas, South Carolina, New York, and Maine. Thirty-two CHWs participated, with 95% of participants being of Latinx and African American ethnicity. They served women from Latinx, African American, and Migrant communities. The CHW communication strategies represent aspects of respect and client-centered care and are applied in the development of a theoretical framework. CHWs were able to build and sustain trust at the initial encounter through these specific strategies: 1) addressing immediate needs related to social determinants of health; 2) embodying mannerisms and dress; 3) speaking appropriately to the client's age, culture, and knowledge; 4) easing client's fears through locus of control, and 5) allowing for time flexibility. These findings have implications for practice through interventions to train healthcare providers to build trust with low-income women of color who have a historical distrust of the healthcare system and who are at risk for maternal-child health disparities. Future research is recommended to explore how the communication trust-building constructs also benefit all other groups at similar risk, including those with mental health disorders and infectious diseases. The findings indicate specific communication strategies through which trust can be built, beginning at the initial encounter with low-income women at risk for maternal-child health disparities and who have a historical distrust of the healthcare system.

Introduction

Establishing trust with clients is core guidance for all health professionals and a core value for healthcare systems (Birkhäuer et al. 2017; World Health Organization (WHO) 2007) . A client's initial encounter with health care providers influences how clients will ultimately trust and follow the provider's recommendations for treatment and subsequent adherence to care (Alpers, 2018; Lynn-SMcHale & Deatrick, 2000). Clients who feel emotionally and physically safe in a healthcare system are more likely to trust their provider (LoCurto & Berg, 2016). In contrast, clients are less likely to trust their providers when institutional and structural issues impede their perceptions through factors such

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as wait time, payment, perceived negative encounters with staff, and perceived discrimination (Sheppard et al., 2004).

Among low-income racial minority clients, perceived discrimination is the highest among Black, Hispanic, and Native Americans (Benkert et al., 2006; Blendon et al., 2014; Zha et al., 2020). Perceived discrimination creates barriers to access or care adherence (Maria da Conceição & Figueiredo, 2015). The historical distrust that stems from structural racism further complicates client perceptions increasing the likelihood of health disparities (Wesson et al., 2019). Studies have identified strategies such as client-centered care, community building, and respectful communication for building trust (Spencer et al., 2011; Tucker et al., 2015). Yet, these strategies do not adequately address the underlying mechanisms required to build trust with diverse groups at risk for racial/ethnic and socioeconomic health disparities.

Theoretical frameworks by Hupcey (2002) and Sheppard et al. (2004) describe institutional and health professional factors that either facilitate or impede client trust. For instance, Sheppard's framework for interpersonal communication posits that empathy and compassion build trust. Respectful communication is also necessary for building trust (Tucker et al., 2015), yet it is not included in Sheppard's framework. Preexisting trust and the role of providers in facilitating or inhibiting trust are also essential considerations (Hupcey, 2002). However, Hupcey's and Sheppard's frameworks do not precisely delineate mechanisms underlying the structural process of building trust.

A well-documented racial disparity in maternal health care delivery and outcomes exists between Black or African American and White women. For instance, studies show that preterm birth (PTB) or low birth weight (LBW) is likely to occur with inadequate prenatal care (Gadson et al., 2017; Lu et al., 2010). Black women are twice as likely to experience preterm births and deliver LBW than White women (Hamilton et al., 2015; McLemore et al., 2018). Further, maternal mortality among African American women remains the highest at two to three times that of White women and other racial groups (Petersen et al., 2019). Preterm birth and low birth weight are linked with higher experiences of maternal stress among African American women due to chronic experiences of racism, including during their pregnancy (Paul et al., 2008). Subsequently, African American women may be reluctant to seek the necessary prenatal care (Armstrong et al., 2013). Though the perceived experience of discrimination is highest among African American women, perceived discrimination has also been reported among recent immigrant and Hispanic women (Benza & Liamputtong, 2014; National Academies of Sciences, Engineering, and Medicine, 2017; Nuru-Jeter et al., 2009).

Community programs now include trained community health workers (CHWs), known globally for their front-line work with populations at-risk (e.g., homeless, low-income women, children, and families) in a variety of settings (e.g., clinics, schools, churches). (Friedman et al., 2006; Perry et al., 2017). Studies have identified positive associations with health outcomes when CHWs promote health education, access and continuity to care, and community building (Perry et al., 2017; Spencer et al., 2011). Among MCH groups, CHWs have successfully increased breastfeeding uptake among Black women or gestational diabetic management among Hispanic women (Lassi & Bhutta, 2015). Community-based programs have expanded the CHW role to train doula companions for pregnant women through postpartum (Moore et al., 2020). As trusted community members, CHWs have successfully worked with women of color, including women at-risk for MCH disparities who harbor a historical distrust of the healthcare system. However, how CHWs build this trust, including the communication mechanisms that comprise the foundation of their work, is unknown (Jack et al., 2017; Katigbak et al., 2015).

Problem and Purpose

Current literature identifies the crucial role of trust in building effective therapeutic relationships with clients and helping achieve mutual care goals. Distrust in the healthcare system creates a barrier to care and treatment adherence, particularly among low-income women of color at risk for MCH disparities, as they may avoid seeking necessary prenatal or postnatal care. The CHWs' unique communication

strategies have successfully helped establish relationships with women in this population to navigate this barrier. Still, the existing gap in the literature is the lack of descriptions of the mechanisms or structural processes during interpersonal communication that are necessary to build client trust with all low-income racial/minority populations (Rafizadeh, 2021).

Rafizadeh's (2021) study used interviews with CHWs to explore how they build trust with low-income women of color at-risk for MCH disparities. Additionally, building on the data collected in the interviews, this article examines the themes identified in focus groups with CHWs.

Methodology

Rafizadeh's (2021) qualitative study used open-ended semi-structured interviews and focus groups applying grounded theory analysis with a social constructivist approach (Charmaz & Wright, 2015). A grounded theory's inductive, iterative data analysis process illuminates the social phenomena of interest (Glaser & Strauss, 1967) through the exploration of the social processes of the phenomena to gain an understanding that informs the resulting theoretical framework.

Recruitment

Participant recruitment included emailing flyers to state and national organizations led by CHWs and community health clinics that employed CHWs and served MCH populations. Initially, the participant sampling criteria included 1) identified as a CHW; 2) working as a CHW for a minimum of 6 months (experience was determined as more significant than education because the educational background of CHWs varies greatly); and 3) working for a program that serves low-income people of color, including MCH populations. Subsequently, purposive and snowball sampling identified CHWs appropriate for the study (Rafizadeh, 2021).

Data collection

Rafizadeh's (2021) collected data using semi-structured interviews followed by focus groups. The interviews were conducted between February 2020 and August 2020, and the focus group discussions occurred between August and September 2020. All interviews and focus groups took place through audio-recorded telephone calls or the Zoom meeting platform, apart from two in-person audiotaped interviews conducted at the Northwest Regional Primary Care Association, Migrant and Community Health Conference before COVID-19 mandates. The interviews began with broad questions about the CHW's personal and work background based on an interview guide. The interviews started with the icebreaker question, "tell me about yourself and your work as a CHW." Follow-up questions included "tell me about your work," "tell me about the most common problem that your clients talk about," "tell me about how you get your clients to trust you," and "tell me about how you help women who are pregnant or have young children," and "tell me about how you help clients who don't follow your suggestions." CHW responses eventually led to probing questions relevant to the study's purpose. Probing questions include "what does respect look like when you are talking with clients?" and "what do you mean when you say that you *'meet them where they're at*'?"

Based on the quotation comments from the interviews, the following questions were posed during the focus groups for more discussion: 1) tell me what "meeting them where they're at" means to you?" and 2) "the concept of empowerment came up often during the interviews, could each of you talk about what this means when you are with your clients?"

Throughout the data collection and constant comparison analysis, reflexive journals and memos were used to identify and address potential researcher biases (Charmaz, 2014; Creswell & Miller, 2000). The triangulation of interview and focus group data collection also reduced threats to the data, such as researcher bias and potential participant reactivity that could influence the truthfulness of the responses because of the researcher-participant dynamic (Maxwell, 2004). Further, the research team

provided feedback during the data collection and analysis. After the data collection, memo-checking with participants over three additional zoom sessions allowed participants to confirm the findings (Rafizadeh, 2021).

Analysis

Charmaz's (2014) constant comparative data analysis and theoretical sampling approach was applied. Analysis began during the data collection by identifying initial codes, then progressed to the categorization of focused codes, with the final analysis of theoretical coding described in the resulting theoretical model. Theoretical sampling guided how the initial codes (i.e., quotations that may represent implicit or explicit meaning relevant to the study) were distilled into focused codes and, eventually, theoretical codes. Theoretical codes summarized the relationships between the focused codes and were described within the conclusive conceptual framework (Rafizadeh, 2021). See Figure 1. Atlas.ti QDA was used to annotate, code, and categorize segments.

Ethical considerations

The University of California, Davis IRB approved the study as exempt (Rafizadeh, 2021). Before each interview or focus group, the participants were informed that the communication would be audio-recorded, provided an overview of the study purpose, and invited to ask questions. The audio recordings were transferred to a qualitative data analysis (QDA) software, Atlas.ti. Interview participants received gift cards ($30 for interviews; $50 for focus groups) which amount to one to two times the average CHW hourly salary and encourage participation without coercion (Rafizadeh, 2021).

Results

CHW demographics

The majority of CHWs who participated in Rafizadeh's (2021) study were female, Hispanic, or African American, with an average age of forty. Just below 50% were married, 75% had children, 47% had CHW experience between six months and five years, and 16% had more than twenty years of experience. See Table 1.

The CHWs worked primarily in community-based organizations that served Hispanic or African American communities with women and children; 28% served Asian populations, 12.5% served Middle Eastern immigrants, including the Farsi-speaking community, and 19% served recent migrants, including Haitian and Somalian refugees. The CHWs specialized in doula companion support and housing transition from acute situations. They disseminated or provided health information (e.g., nutrition and exercise for diabetes, STD prevention, teenage pregnancy prevention), engaged in advocacy, supervised or trained other CHWs, and participated in neighborhood community building (Healthy Neighborhood). CHWs who worked in public health clinics or community nonprofit organizations served high-risk populations, including low-income adults, recent migrants, individuals with mental health problems or experiencing homelessness. CHWs who worked in hospital-based programs helped individuals who were transitioning from an acute situation through housing assistance or required chronic disease management (Rafizadeh, 2021). See Table 2.

Interviews

After analyzing the interviews, Rafizadeh's (2021) identified four hundred and seventy-four interview comments that revealed eighty-seven codes. Based on relevance, the codes were distilled into forty-seven initial codes described in gerunds (Charmaz, 2014). Among the forty-seven initial codes, twenty-seven focused codes were chosen based on relevance and were categorized into three groups: 1)

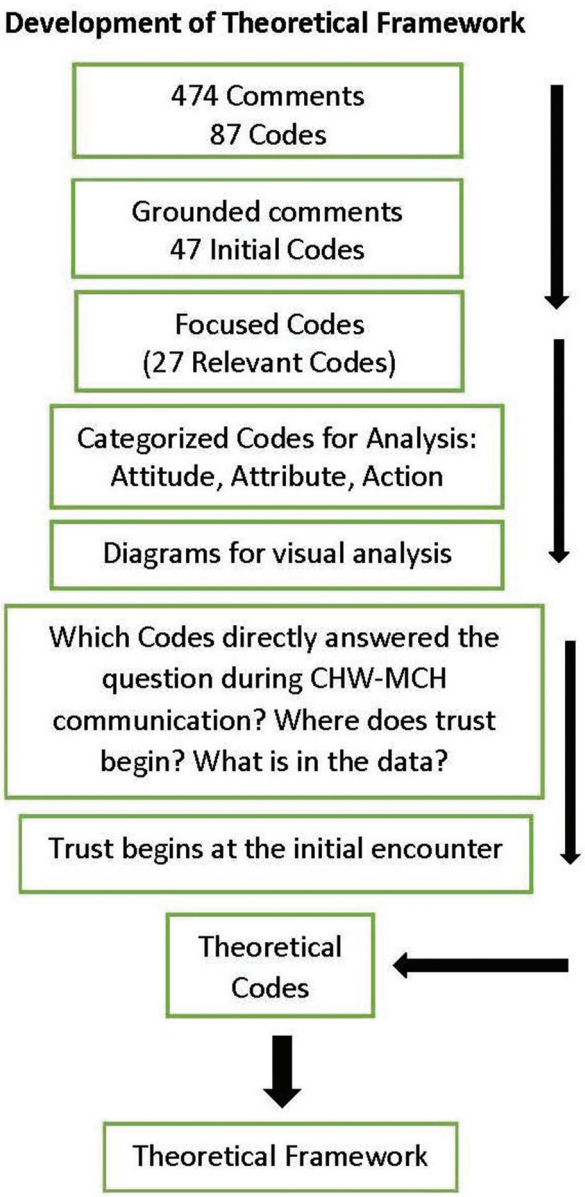

Figure 1. The development of theoretical codes and framework.

attitude, 2) attributes, and 3) action. The categories showed that trust began at the initial encounter, and three findings required further exploration: 1) a code "addressing social determinants of health (SDH) needs,;" 2) "*meeting them where they're at*,;" and 3) "empowerment." These codes were explored further in the focus groups.

Focus groups

Three focus groups were divided by the region respective of the CHW locations, Pacific Coast, Mid-U.S., and East Coast. The Pacific Coast and Mid-U.S. focus groups had six CHWs, and the East Coast had eight CHWs. The Pacific Coast and Mid-U.S. groups comprised CHWs who worked in

Table 1. CHW Socio-Demographic Characteristics ($N = 32$).

	N=32 (%) or Mean (sd)
Age	40 (11.589)
Gender	
Male	2 (6%)
Female	30 (94%)
Race/Ethnicity	
Hispanic	17 (53%)
Black	11 (34%)
Asian	1 (3%)
Native American	1 (3%)
White	2 (6%)
Marital Status	
Married	15 (47%)
Single	13 (41%)
Divorced/Separated	4 (12.5%)
Children	
Yes	24 (75%)
No	8 (25%)
CHW Years of Experience	
6 months-5 years	15 (47%)
6–10 years	8 (25%)
11–20 Years	4 (12.5%)
>20 years	5 (15.6%)

Table 2. Characteristics of CHW roles and target communities.

CHW's Program and Population Served	All $N = 32\%$)
Type of Program	
Community-based	25 (78%)
Hospital-based	7 (22%)
Program Target Population	
Women only	5 (18.7%)
Women and children (families)	11 (28.1%)
Students (14-24yo)	4 (12.5%)
Homeless women and children	2 (9.4%)
Adults without MCH encounter	10 (31%)
Population served*	
African American (AA)	22 (69%)
Hispanic	30 (94%)
Asian	9 (28%%)
Refugee/Migrant**	6 (19%)
Middle-Eastern	4 (12.5%
White	7 (29%)
Services ***	
Health Educator	14 (44%)
Advocacy	13 (41%)
Housing Specialist	3 (9%)
Outreach/Resource	23 (72%)
Doula	3 (9%)
Case Management Assist	2 (6.2%)

*All populations are low-income. Some programs have primary target populations of Black/Hispanic.
**Migrant Hispanic, Somalian, Haitian,
***Services overlap. Each service, as described by CHW

a community-based program. In contrast, the East Coast group equally included CHWs from hospital and community-based programs (Rafizadeh, 2021).

In explaining the code "addressing social determinants of health needs," CHWs stated clients required help to access resources for their children's essential needs. The necessities included but were

not limited to transportation, safe housing, and food or infant care needs. By meeting these needs, CHWs began to build trust (Rafizadeh, 2021).

The code "meeting them where they're at" was distilled to "communicating in client's familiar environment," "assessing client's readiness," "respecting individual's choices," and "addressing client's illness, pain, and situation." When they used these strategies, CHWs found that clients were more likely to engage in future conversations or visits (Rafizadeh, 2021).

The emphasis was on helping clients through "building skills" to access care or help clients see that they were already empowered. The code "building empowerment skills" was merged with "learning from each other," and the code "organizational role" dropped from the categorization for focused coding as it was deemed not relevant to the inquiry. The organizational role was an external influence that can help facilitate trust but was not specific to the query about how CHWs build trust in the context of interpersonal communications. As described by the CHWs, the organizational role included supporting CHW work through training and being reputable in the community. CHWs agreed that reputable organizations helped facilitate trust when clients realized the CHW worked for a respected organization. See Figure 1, which describes Rafizadeh's (2021) theoretical code development.

Theoretical codes findings

Addressing social determinants of health immediate needs

The SDH needs of the MCH clients, as identified by CHWs, included food, housing, infant needs (diapers), childcare, necessary educational material for the younger children, environmental safety, and transportation. Some CHWs had diapers or transportation vouchers; however, most CHWs offered resources where the mothers could call or visit to address their specific needs. When public education moved to virtual due to the pandemic, two CHWs described helping mothers to find public computers with Wi-Fi access and training them to use the computers. Two CHWs were housing specialists, but they also had clients who were mothers and needed additional support with transportation, food, and childcare. During the focus groups, other CHWs confirmed that they also had to navigate these situations.

> CHW33 "Because, like, if we have a family, and I'm going in with a mom, trying to educate her, and she has other issues like housing, food is concerned, you really have to be sensitive and stop the education, and focus on that."

> CHW14 "With pregnant moms, it really was a lot of social determinants of health and a lot of things done to them . . . And when, uh, a mom sees that you're really invested in their child, well, okay, so we can start build this relationship, and we have taken formulas, pampers."

Embodying mannerisms and dress

The quotation comments describe how CHWs used facial expression, dress, and posture strategies, particularly in their first encounter with a client. For instance, a CHW who worked with high school students wore jeans and a sweatshirt, as students would be more inclined to approach them. Others described avoiding clothing that might intimidate clients, such as lab coats. Another strategy was avoiding postures of dominance, such as standing over the client but instead remaining at eye level. As a result, CHWs stated that their clients were more likely to engage in conversations that allowed them to begin to build trust.

> CHW8 "And if that respect is based on socioeconomic level, formal education level, the way people dress, the way people present themselves, first presentation, and if there's a lack of respect based on that, based on superficial factors, people sense that and definitely more reluctant to go back and do follow up with that provider. But that respect has got to be there on a human level, human, human. You know, I've spoken with some providers who say that they rather not wear their white jacket, not wear a tie, and dress down so people won't feel intimidated and feel the respect that the provider wants them to feel. The look in the eye, and the provider, I keep focusing on the provider because they're the lead, they're the lead in this relationship."

CHW20 "So you try to read the person and try to give them the same body language that they're giving you. So, you're facing them in a chair, you are not really standing over them, and when you're talking to them, you're not standing over the patient's head. You're like over them; just look like you're comfortable and you're not in a rush. You don't want to make the person feel rushed."

Speaking appropriate to age, culture, and knowledge

Spoken language refers to the contextual meaning of CHW interactions, not the client's dialect or the language specific to their race, ethnicity, or culture (Burns et al., 1996, pp. 31-32). CHWs spoke about sharing their own experiences with clients. Thus, the women they served were likely to engage in conversation and disclose information about their needs. CHWs described paying attention to their tone of voice while being conscious of the client's age, educational level, and culture.

CHW22 "Well, my strategy, personally, is I always have my clients warm up to me. I'll go in, have them ask questions, things like that, and I just make them feel comfortable. You always have to address, to me, with respect. You know, like yes, ma'am, or no ma'am, because the older generation, especially the African Americans, that's what they're used to, you know. So, when you go in and show them that kind of respect, then they're more likely to, like, "oh, okay," you know. 'She comes from a good upbringing because she shows a level of respect."

CHW10 "And if I have the opportunity, I try to explain to them how it works. So, it depends on many factors. Eh, their age, their education factor, the technology access, so if I'm aware of all those factors, I can better help them to understand."

CHW15 "I'm sorry, like when I used to do home visits, and I visit Indian families, I'd take a pair of socks because they expected me, their home was sacred, right, they expect everyone to enter to take off their shoes. And that's a form of respect. So, I knew I had to bring socks, or an extra sock, out of respect for the culture."

Acknowledging discomfort through locus of control

CHWs described that meeting their client in familiar environments – such as coffee shops, home, or the children's school – helped the client be more open and communicative. CHWs who worked in neighborhoods would encounter mothers at community events, such as school events, or when providing community health education on diabetes or obesity. Sometimes a mother with specific needs may not approach the CHW because of fear until a friend tells the CHW about the mother, prompting the CHW to find a way to approach the mother without causing alarm.

CHW7 "I would try to be in a setting that's very comfortable. I had a little office in the school, so I tried not to be in the little office, and if community members wanted assistance, I would ask them where they would like to meet, like at the coffee shop or would they like to meet at the library. A lot of parents would take the kids to the school bus, and they wouldn't even be able to meet at the office at the school If they (parents) need to meet me, I would tell them, I could meet them at a place that's closer to you."

CHW20 "And sometimes they're just weary about coming out to you, and sometimes you just have to meet them where they're at, at their homes, in the park, or, recreation center, where they're comfortable at."

Allowing for time flexibility

Initially, when clients were unwilling to engage with CHWs or participate in recommended interventions, CHWs' maintained open communication as the client's situation changed, and they may reach out to the CHW for help. The CHWs reported that texting and telephone calls with their clients increased during the COVID social distancing mandates. Texting was typical, though clients could also communicate with the CHW by e-mail or telephone. This flexibility in CHW contact mode was important for mothers and teenage women who may have immediate needs that need to be addressed outside of the regular 8 am to 5 pm work schedule.

CHWs who worked in programs focused on community building engaged with community members in their neighborhoods. For instance, they attended school functions, community events

and shopped in the neighborhood stores. CHWs stated that as the women became familiar with their "face" and "presence," they were more likely to approach them in situations that required CHWs' help.

> CHW26 "With moms, like I said, it helped me a lot to show up to be there constantly. So, I have not been the person where they see one time, and they don't see me again. I start by being steady participating activities in the schools. And even going to the shows for their kids, like that, so I can be present for them or their kids."

> CHW27 "So because I'm older, they start treating me like a grandma. And I love it. And that's what it came out to be. The presence, the being there, the showing up every day. So that's when they start confiding in you. So, if I think if that went one or two times, I don't think the friendship, it wouldn't have happened. It took me a good year to be there every day for them to come forward to me."

> CHW34 "It (trust) definitely takes time. Some of them, uh, you know the clients, they like to text, so they'll text you, and that takes time as well. And before COVID, we were seeing them once a week, so we had a pretty good, you know, a lot of texts, so that's how we develop trust with them, we're seeing them a lot, and even though we were seeing them, they were texting us throughout the week as well. So just having those texts in builds trust."

Figure 2 is the theoretical framework with the Trust Building Mechanisms

Discussion

The theoretical framework describes Rafizadeh's (2021) understanding of how CHWs build trust with low-income women of color at risk for MCH disparities and with a history of health system distrust based on socioeconomic disadvantage or racial/ethnic discrimination. The study expanded on existing literature by showing how CHWs develop trust in diverse populations, further supporting the literature that highlights the success of CHWs as trusted members of the community who "bridge the gap" between at-risk low-income racial/ethnic clients and the health care system (Friedman et al., 2006). CHWs demonstrated how they "bridge gaps in healthcare" by building trust through non-verbal communication, respectful communication, and client-centered care strategies.

The framework relied on the client's perceptions during their encounters with the CHW, beginning with their first impressions, and continuing through intervention. Further, the findings emphasize that clients treated with respect are included in their treatment decision-making and do not perceive being stereotyped due to bias, confirming past studies on the role of respect in building trust (Tucker et al., 2015). The historical racism in healthcare has compounded experiences of distrust, underscoring the importance of respectful communication with clients who have previously experienced discrimination (Sheppard et al., 2004). As a result, when CHWs build trusting relationships, there is an improvement in client adherence to treatment, improved health outcomes, and reduced health disparities.

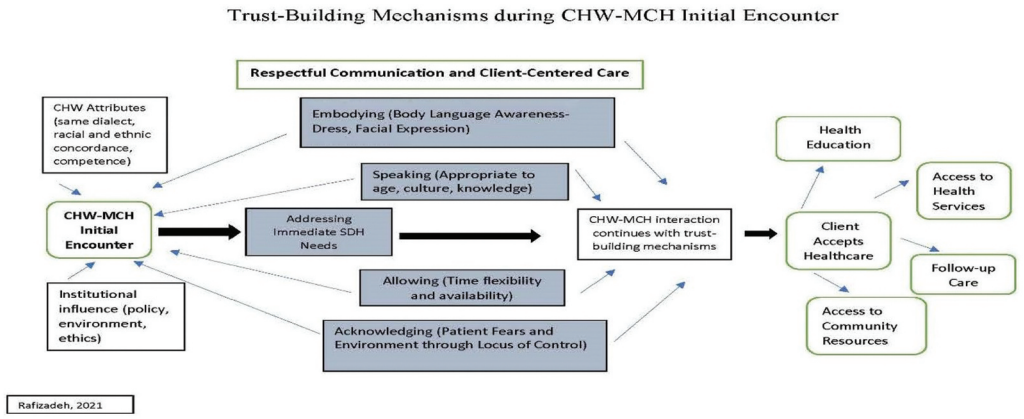

Figure 2. Trust-building mechanisms during CHW-MCH encounter model.

Rafizadeh's (2021) expands on the conceptual frameworks of healthcare trust by Hupcey (2002) and Sheppard et al. (2004)by describing how trust is facilitated. In Hupcey's framework, client trust is identified in the client pathway from preexisting perspectives, how these perspectives influence their interactions within the health care system, including with providers, and the client's final evaluation of the interaction based on facilitating and inhibiting behaviors. This framework, however, does not identify the specific facilitating behaviors, as shown in the current study results.

Sheppard's et al. (2004) framework describes broad mechanisms influencing client trust, including institutional factors, physician communication, continuity of care, compassion/caring for the client, and competence. Rafizadeh's (2021) study expands this framework by uncovering how respectful communication that represents caring and compassion is conveyed during client communication. Consistent with the literature, respectful communication is essential for client trust. Further, Rafizadeh's study expands on Hupcey's (2002) and Sheppard's et al. (2004) work to include community settings.

Besides having similar racial and ethnic concordance with their clients, the CHWs were also mothers, which allowed them to convey that they understood the bias and discrimination their clients may have experienced. Because of these shared experiences, CHWs understood the social norms of the client's culture and the challenges of being a mother with limited economic means. Although these shared attributes and experiences helped to initiate trust at the first meeting, the CHWs emphasized that the process was complex, multi-layered in verbal and non-verbal communication, and ongoing through their relationships with their clients.

The CHWs in Rafizadeh's (2021) study worked for institutions and organizations that supported their work, as evidenced by the time flexibility that permitted them to develop relationships with their clients. These institutions paid for their phones, allowing them to text with their clients, an additional strategy identified as helpful for open communication and building client trust.

Respectful communication

The CHWs' multi-level approach to building trust included understanding the socioeconomic dynamic conveyed during the first impression through means such as dress, posture, and self-awareness of how they spoke and behaved (Rafizadeh, 2021). Although many CHWs might share racial/ethnic and/or language concordance with their clients, they often represented institutions or agencies that engendered distrust by members of low socioeconomic and specific racial/ethnic communities. CHWs emphasized the importance of conveying respect by speaking informally and conversationally to ease any fear or discomfort. The CHWs also used non-verbal and spoken communication to align with their client's cultural norms, age, and level of education, as any unintentional message could raise communication barriers (Rafizadeh, 2021).

Client-centered care

In Rafizadeh's (2021) study, the CHWs who worked with MCH clients were distinguished from those who worked with other populations by addressing their client's immediate needs for tangible resources, often related to social determinants of health. In meeting these needs, the CHWs earned the trust of their clients enough to engage in further conversation to address more pressing health concerns, including follow-up medical appointments that may have been avoided due to health system distrust.

Trust-building mechanisms sustained during interventions

The trust-building mechanisms CHWs applied during the initial encounter continued throughout their client interventions (Rafizadeh, 2021). The consistent communication style throughout all interactions sustains the trust established, allowing CHWs to help their client gain health knowledge, access care, and facilitate acceptance of formal social support. Also, when CHWs share their

knowledge and skills, they serve as role models for their clients to learn how to navigate a complicated healthcare system and develop strategies for communicating with healthcare providers. The CHWs shared common experiences – such as being new mothers with limited income and resources, which also helped them facilitate trust. As a result, women in the community approached the CHWs for assistance in schools and neighborhood environments and even sustained communication after the intervention (Rafizadeh, 2021).

Limitations

The findings from Rafizadeh's (2021) study must be viewed considering its limitations. Although the sample included thirty-two CHWs from eight states in the Pacific, Central, and Eastern regions of the United States, the findings cannot be generalized to all CHWs. CHWs who work in acute care settings may not be able to meet clients in the community, a locus of control strategy CHWs use when meeting clients for the first time.

Another limitation is that the study does not account for the perceptions of the recipients of CHW care. Future studies with CHW clients are recommended to understand their perspectives and confirm congruence with CHW perspectives (Rafizadeh, 2021).

Recommendations

Non-verbal communication between the client and CHW is key to building trust. Rafizadeh's (2021) study shows that client trust in their CHWs begins at the first encounter and continues through the intervention. The study also identified CHW attributes, attitudes, and actions that promoted trust – some reflected in other conceptual frameworks and some new contributions to the literature.

Future research is also needed to investigate if other health professionals can adopt similar trust-building mechanisms. Indeed, respectful communication and accountability training may benefit all healthcare providers who interact with clients, particularly those at risk for health disparities and who mistrust the healthcare system. Healthcare policy that requires communication training is essential, as the growth of diverse populations poses ongoing challenges to meeting the healthcare needs of people of color who have experienced discrimination at multiple levels. "Such policies can contribute to the foundational components needed to build client trust in healthcare. Ultimately, institutional values that encourage trusting therapeutic relationships reflect the best interest of the clients served" (Rafizadeh, 2021).

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