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TITLE PAGE

***Manuscript Title*: Role of trust in sustaining provision and uptake of Maternal and Child Healthcare: Evidence from a national programme in Nigeria**

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*Abstract

ABSTRACT

Trust is important for the effective functioning of the health system, influences health-seeking behaviours, facilitating interaction between patients and healthcare providers. However, there is limited focus on the mechanisms of how trust works within health systems in Nigeria. This paper reports how, why and in what circumstances, the implementation and subsequent termination of a maternal and child health programme affected the trust of service users and healthcare providers in Nigeria. In 2015 and 2016 key documents were reviewed, and initial programme theories of how context triggers mechanisms to produce intended and unintended outcomes were developed. These were tested, consolidated and refined through iterative cycles of data collection and analysis in 2018. Testing and validation of the trust theory utilized eight in-depth interviews with health workers, four focus group discussions with service users and household survey of 713 pregnant women and analysed retroductively. The conceptual framework adopted Hurley's perspective on 'decision to trust' and Straten et al.'s framework on public trust and social capital theory. Incentives offered by the programme triggered confidence and satisfaction among service users, contributing to their trust in healthcare providers, increased service uptake, motivated healthcare providers to have a positive attitude to work, and facilitated their trust in the health system. Termination of the programme, including withdrawal of and laying off of staff, led to most service users' dissatisfaction, and distrust reflected in the reduction in utilization of MCH services, increased staff workloads leading to their decreased performance although residual trust remained. Understanding the role of trust in a programme's positive and negative short and long-term outcomes can help policymakers and other key actors in the planning and implementation of sustainable and effective health programmes. Future research needs to explore the impact of trust in health system' performance.

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Trust is important for the effective functioning of the health system, influences health-seeking behaviours, facilitating interaction between patients and healthcare providers. However, there is limited focus on the mechanisms of how trust works within health systems in Nigeria. This paper reports how, why and in what circumstances, the implementation and subsequent termination of a maternal and child health programme affected the trust of service users and healthcare providers in Nigeria. In 2015 and 2016 key documents were reviewed, and initial programme theories of how context triggers mechanisms to produce intended and unintended outcomes were developed. These were tested, consolidated and refined through iterative cycles of data collection and analysis in 2018. Testing and validation of the trust theory utilized eight in-depth interviews with health workers, four focus group discussions with service users and household survey of 713 pregnant women and analysed retroductively. The conceptual framework adopted Hurley's perspective on 'decision to trust' and Straten et al.'s framework on public trust and social capital theory. Incentives offered by the programme triggered confidence and satisfaction among service users, contributing to their trust in healthcare providers, increased service uptake, motivated healthcare providers to have a positive attitude to work, and facilitated their trust in the health system. Termination of the programme, including withdrawal of and laying off of staff, led to most service users' dissatisfaction, and distrust reflected in the reduction in utilization of MCH services, increased staff workloads leading to their decreased performance although residual trust remained. Understanding the role of trust in a programme's positive and negative short and long-term outcomes can help policymakers and other key actors in the planning and implementation of sustainable and effective health programmes. Future research needs to explore the impact of trust in health system' performance.

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RESEARCH HIGHLIGHTS

- Incentives boosted public trust of service users and increased use of MCH services
- Training, financial rewards, facility upgrade motivated health workers positively
- Withdrawal of incentives triggered negative outcomes in use of service and trust of health workers
- Loss of public trust in the health system has a broad implication on future policy and practice
- Trust can have longer-lasting effects on programme outcomes through its residual nature

ABSTRACT

Trust is important for the effective functioning of the health system, influences health-seeking behaviours, facilitating interaction between patients and healthcare providers. However, there is limited focus on the mechanisms of how trust works within health systems in Nigeria~~low and middle income countries~~. This paper reports how, why and in what circumstances, the implementation and subsequent termination of a maternal and child health programme affected the trust of service users and healthcare providers in Nigeria. In 2015 and 2016 key documents were reviewed, and initial ~~working theories and~~ programme theories of how context triggers mechanisms to produce intended and unintended outcomes were developed. These were tested, consolidated and refined through iterative cycles of data collection and analysis in 2018. Testing and validation of the trust theory utilized eight in-depth interviews with health workers, four focus group discussions with service users and household survey of 713 pregnant women and analysed retroductively. The conceptual framework adopted Hurley's perspective ~~model~~ on 'decision to trust' and Straten et al.'s framework on public trust and social capital theory. Incentives offered by the programme triggered confidence and satisfaction among service users, contributing to their trust ~~on~~ in healthcare providers, increased service uptake, motivated healthcare providers to have a positive attitude to work, and facilitated their trust in the health system. Termination of the programme, including withdrawal of and laying off of staff, led to most service users' dissatisfaction, and distrust reflected in the reduction in utilization of MCH services, increased staff workloads leading to their decreased performance although residual trust remained. Understanding the role of trust in a programme's positive and negative short and long-term outcomes can help policymakers and other key actors in the planning and implementation of

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sustainable and effective health programmes. Future research needs to explore the impact of trust in health system' ssystems' performance.

Keywords: Nigeria, Trust, Maternal and child health services, low and middle-income countries, health system's strengthening, Realist Evaluation.

INTRODUCTION

Trust is important for the effective functioning of the health system and is crucial in facilitating interactions between patients and healthcare providers., and Due toon basis of trust, patients are willing to utilize healthcare services, share their health needs and also adhere to treatment, including prenatal and postnatal healthcare (Gilson, 2003; Peters & Youssef, 2016; Russel, 2005; Gilson, 2003). Trust is conceptualized as a reliance on a trustee, which is voluntary and with confidence (Meyer, 2015; Goudge et al., 2005; Hurley, 2006; Meyer, 2015; Riewpaiboon et al., 2005; Thiede, 2005).; Goudge et al., 2005) and is based on the assumption that health providers have the expertise to provide appropriate services to patients (Peters & Youssef, 2016). Patient-centred definitions of trust such as Lupton's (1997) point out that in medical encounters, patients' experiences with their healthcare providers are important in promoting trust. Peters & Youssef, 2016 indicate that trust is based on the assumption that health providers have the expertise to

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provide appropriate services to patients. However, aside from expertise key ~~Key~~ drivers ~~of trust~~ among pregnant women for utilizing services of Traditional Birth Attendants (TBAs) in developing countries include the feeling of confidence, security and satisfaction (Amuta-Onukagha et al., 2017; Elem & Nwaba, 2016; Ugboaja et al., 2018; ~~Amuta-Onukagha et al., 2017~~), which emanate from relational dynamics, familia~~r~~l ties and further drivers of trust. In Cambodia villagers trust public healthcare providers because they are perceived, to be honest, ~~sincere~~ and skilled; while trust in private providers is rooted in the ~~personal and~~ friendly manner they carry out their treatment ~~and the non-medical sector providers are trusted because they are easily accessible~~ (Ozawa &Walker, ~~(~~2011). Other factors that affect the use of these providers include location, accessibility, ~~cost~~ and cost of accessing care~~,~~ among others.~~quality and availability of drugs, and time constraint~~, ~~and provision of intravenous injections.~~ Ihekweazu (2016) attributes lack of trust in health workers as a key factor that contributed to the spread of Lassa fever in Nigeria and emphasizes that trust of infected and non-infected persons can only be ensured if they perceive that healthcare providers will have a positive attitude of treating them in a humane manner.

However, there is limited focus on how trust works to influence health-seeking behaviours by patients and service provision by health workers in low and middle-income countries (LMICs) (Gilson et al., 2005; Peters & Youssef, 2016). Furthermore, trust literature tends to focus ~~specifically~~ on physicians or on "the health system", neglecting the analysis of trust between healthcare users and members of healthcare teams in maternal and child health (MCH) programmes in LMICs (Sheppard et al., 2004) ~~in LMICs~~. Peters et al., (~~2016 observe~~2016) observe that in ~~In~~ the historical and institutional context of developing countries, it is necessary to draw attention to how trust can develop under challenging circumstances such as limited infrastructure

and lack of health workers ~~human resources shortage~~. The continuous nature of the prenatal to postnatal care relationship provides an ideal opportunity to examine how trust works ~~and with reference to~~regarding provision and utilization of MCH services in Nigeria. ~~develops across time~~.

This paper contributes to bridging this knowledge gap. We report our analysis of how trust works for healthcare users and providers and how it impacts their behaviours and practices ~~such as~~ in utilization and provision of maternal healthcare services in Nigeria. This is done by using ~~the theoretical perspectives of~~ Hurley's (2006) perspective on 'decision to trust' and Straten et al., (2002) framework of factors ~~that~~ influencing ~~influence~~ public ~~on~~ trust, ~~to~~ and social capital theory **(Agampodi et al., 2015, De Silva & Harpham, 2007; Szreter & Woolcock, 2004~~**~~, De Silva & Harpham, 2007~~**)** to understand ~~qualitative and quantitative~~ data gathered in our evaluation of a national Subsidy Reinvestment and Empowerment Programme (SURE-P/MCH) in Nigeria, ~~one component of~~ which focused on improving access to maternal and child health ~~(SURE-P/MCH~~). ~~We utilized social capital theory (Agampodi et al., 2015, Szreter & Woolcock, 2004, De Silva & Harpham, 2007) to interpret the sustainability of residual trust by service users after the withdrawal of SURE-P/MCH programme~~. Thereby, this paper aims to explore ~~contribute to understanding patterns and practices of trust in healthcare systems by exploring~~ how, why and under what circumstances trust influenced the uptake of maternal and child healthcare during the SURE-P/MCH programme and may influence continued MCH service uptake after the suspension of the programme.

The paper is structured as follows: ~~first,~~ we discuss ~~different~~ conceptualisations of ~~present a review of how the concept of~~ trust, ~~is understood in the literature and what this means in the context of LMIC healthcare systems and maternal care; this is followed by an overview of~~, brief information

on the organization of ~~how~~ the health system in Nigeria, ~~is organized and how MCH issues are addressed. We then present~~ the methods, results, discussion of findings, conclusions and implications for policy and practice ~~and conclusion~~.

~~***Understanding trust in healthcare systems and maternal healthcare in LMICs***~~

Types of Trust ~~***stopped***~~

~~-~~Three main types of trust (interpersonal, public and workplace) are ~~can be~~ identified in the literature. Interpersonal trust refers to the trust an individual has in another person for example between a patient and healthcare provider, while, public trust is that placed by people in an institution/system (Gilson, 2003; Gilson, 2006; Russell, 2005; van der Schee et al., 2006). Workplace trust refers to trust in colleagues, supervisors and employing organizations (Calnan & Rowe, 2006~~)~~; Gilson et al. 2005; Okello & Gilson, 2015; ~~Gilson et al. 2005~~; ~~Calnan & Rowe, 2006~~). To understand the role of trust in influencing the use of MCH services it is ~~particularly~~ important to focus on the interconnection between interpersonal and institutional levels of trust (Meyer et al., 2008) as well as the workplace. Trust, which arises at the interpersonal level (micro-level) is important to sustain public trust that occurs at the institutional/macro-level (Gilson, 2003). Workplace trust on the other hand is particularly important for staff to provide round the clock services because it positively impacts ~~on~~ the motivation of health workers (Okello & Gilson, 2015).

Nigerian health system and MCH

~~Improving MCH care is an international and national priority. The Nigerian Demographic and Health Survey (NDHS) of 2018 reports that access to skilled birth providers continues to elude many pregnant women with wide disparities according to state, rural/urban location, education and~~

~~wealth status. There was only a slight decrease in infant mortality from 69 deaths per 1,000 during the 5 years preceding the 2013 NDHS to 67 deaths per 1,000 live births in the recent 5-year period. In response to poor MCH indices in Nigeria, the Federal Government of Nigeria implemented the Subsidy Reinvestment and Empowerment Programme (SURE-P/MCH) between 2012 and 2015. The aim was to improve the lives of the most vulnerable populations (Mirzoev et al., 2016). The supply-side component aimed at expanding access to quality maternal health services and improve MCH outcomes through recruitment, training and deployment of 2,000 skilled midwives and 11,000 community health extension workers (CHEWs), supplies and medicines, infrastructure development, and activation of ward development committees (WDCs), particularly in rural communities. The demand side aimed to increase utilization of health services during pregnancy and at birth by providing conditional cash transfers (CCTs) to pregnant women who registered at public primary healthcare (PHC) facilities, where they received comprehensive MCH services.~~

Nigeria is the largest country in Sub-Saharan Africa (SSA) with the complex three-tier decentralized health system, (primary health centres, secondary (general hospitals) and tertiary (specialist and teaching hospitals),~~ typical of other LMICs~~. Private hospitals exist and are owned by individuals and organizations.~~ Disparity in the siting of health facilities between urban and rural locations started during the colonial period (Ademiluyi & Aluko-Arowolo, 2009).~~ Before the introduction of western medicine in Nigeria, pregnant women were assisted by their mothers or mothers-in-law in delivery while traditional birth attendants (TBAs) provided help if they had complications ~~(Amuta-Onukagha et al., 2017).~~ and TBAs handle about one-third of deliveries that occur outside health facilities in Nigeria. TBAs reside in ~~the~~ rural communities~~,~~ and are conversant with the cultural practices associated with delivery. Hence pregnant women are confident, feel secure and satisfied using their services (Amuta-Onukagha et al., 2017; Elem & Nwabah, 2016;

Fagbamigbe & Idemudia, 2015; Ugboaja et al., 2018).: Elem & Nwabah, 2016); They reside in the rural communities, and are conversant with the cultural practices associated with delivery. Hence pregnant women are confident, feel secure and satisfied have a feeling of security and satisfaction using their services. (Elem & Nwaba, 2016; Ugboaja et al., 2018; Amuta-Onukagha et al., 2017) Ugboaja et al., (2018)and some argue that this substantial role of TBAs also indicates lack of trust in MCH services officially provided in public in the health facilitiessystem (Ugboaja et al., 2018).

Improving MCH care in Nigeria is a national priority. The Nigerian Demographic and Health Survey (NDHS) of 2018 reports that access to skilled birth providers continues to elude many pregnant women with wide disparities according to state, rural/urban location, education and wealth status. There was only a slight decrease in infant mortality from 69 deaths per 1,000 during the 5 years preceding the 2013 NDHS to 67 deaths per 1,000 live births in the recent 5-year period. In response to poor MCH indices in Nigeria, the Federal Government implemented the SURE-P/MCH programme between 2012 and 2015. The aim was to improve the lives of the most vulnerable populations (Mirzoev et al., 2016). The supply-side component aimed at expanding access to quality maternal health services and improve MCH outcomes through recruitment, training and deployment of 2,000 skilled midwives and 11,000 community health extension workers (CHEWs), supplies and medicines, infrastructure development, and activation of ward development committees (WDCs), particularly in rural communities. The demand side aimed to increase utilization of health services during pregnancy and at birth by providing conditional cash transfers (CCTs) to pregnant women who registered at public primary healthcare (PHC) facilities, where they received comprehensive MCH services.

METHODS

Study Design

This paper reports results from a component of a broader mixed-methods study reported elsewhere (Mirzoev et al. 2016), that adopted a Realist Evaluation (RE) approach to examine the context, mechanisms and outcomes ~~effectiveness~~ of a community health workers (CHW) ~~in the SURE-P/MCH~~ programme in Anambra State, Nigeria. RE is a theory-driven approach ~~which~~ that guides the implementation of complex interventions through iterative theory development, testing and refinement (Pawson & Tilley, 1997; ~~Wong et al., 2017;~~ Robert et al., 2012; ~~Pawson & Tilley, 1997;~~ Wilson & McCormack, 2006; Wong et al., 2017~~).~~ Programme theories developed within realist studies explore which contexts trigger which mechanisms that produce intended or unintended outcome in different contexts. This enables a clear understanding of the 'whys' and the 'hows' of programme outcome within a particular context that is well suited to evaluating programmes implemented at diverse levels of the health system investigations in low-resource settings (Marchal et al., 2012). In RE, data extraction proceeds from baseline enquiries and development of programme theory to testing/refinement and consolidation of the programme theory, using empirical data (Dalkin et al., 2015).

Data Collection and analysis

The study was conducted in three phases, corresponding to the building of initial programme ~~working~~ theories (IP~~W~~Ts), testing/validation and consolidation/refinement (Manzano, 2016; Pawson & Manzano-Santaella, 2012, Pawson & Tilley, 1997) see Table 1.

Table 1: Showing the three phases of methods of data collection

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Phases	Features	Methods of data collection
Phase 1	The building of initial programme working theories (IPWTs) and programme theories	(i)Review of key documents (SURE-P/MCH programme implementation manual, relevant federal and state-level policies) (June – September 2015) (ii)IDIs with stakeholders: 10 policymakers, 11 programme officers, 16 health workers/PHC staff, and 15 facility managers at Federal and state levels (12 PHCs and 3 General hospitals) (May-November 2016) (iii) FGDs with 8 VHWs, 12 WDCs, 12 service users and 12 family members of the service users. (May –November 2016)
Phase 2	Testing and validation of the trust theory	i) 8 IDIs with health workers and 4 FGDs with service users (August- September 2018) ii)Quantitative method: a household survey of 713 women (May- June 2018)
Phase 3	Theory refinement and consolidation of results into the final trust theory	Use of CMO template to visualize CMO configuration with empirical data (December 2018)

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In phase 1, we reviewed key SURE-P/MCH programme documents and relevant MCH Federal and state policies, between June and September 2015, to understand the programme architecture and design (Ebenso et al., 2019). Initial qualitative interviews were held (May -November 2016)

with purposefully- identified 96 stakeholders comprising IDIs with 10 policymakers, 11 programme officers, 16 health workers/PHC staff, and 15 facility managers at federal and state levels. Focus Group discussions (FGDs) were held with 8 VHWs, 12 WDCs, 12 service users (pregnant women) and 12 family members of service users. Different numbers of interviewees reflect the three phases of our research and different engagements with the Trust theory. The selection of all these different numbers of respondents was done ~~in order~~ to explore their views about the SURE-P/MCH programme. These data facilitated the development of 8 programme theories for the main study (Mirzoev et al. 2016).

In phase 2, which entailed data testing and validation of trust theories, qualitative and quantitative ~~qualitative~~ methods were utilized. Data were collected in twelve PHCs and three general hospitals purposively selected to reflect the implementation of the SURE-P/MCH programme in Anambra state, ~~South-eastern,~~ Nigeria. These facilities were clustered into three, each cluster comprised one general hospital and four PHCs. The focus on the clusters just reflect the setup of the SURE-P/MCH programme- by the government Two of the clusters benefitted from the SURE-P/MCH intervention, while the third cluster without SURE-P/MCH intervention was used as a control. This was relevant to enable us to determine if there are any differences in MCH service utilization by service users in the clusters that benefited from the intervention ~~(SURE-P/MCH)~~ compared to the control cluster. ~~that did not benefit from the intervention.~~ For the qualitative methods, 8 IDIs with health workers and 4 FGDs with service users were conducted (August- September 2018).

The IDIs and FGDs were guided by a semi-structured question guide which was designed around the different versions of initial programme ~~working~~ theories and included questions for testing and validating the different components of the programme theories for the main study. The FGD

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interviews were conducted in the Igbo language, while the IDIs were conducted in both Igbo and English languages depending on respondents' preference. All IDIs and FGDs were conducted face-to-face and were audio-recorded with respondents' consent, transcribed and translated into English as necessary. Female researchers ~~Researchers~~ (NE, (Sociologist), UE, (Health Economist), UO and EE (Medical doctors)

trained in realist interviewing undertook the data collection ~~,~~while NE, UE, UO, TE(male Health economist), EE and AM (female Sociologist) were involved in data analysis.

Qualitative data collection was complemented by data from a quantitative household survey. The survey was based on a community listing of all households in the project cluster areas that had a birth in the last 6 years; covering a period before, during and after the SURE-P/MCH programme. A stratified random sample of 713 women were selected for quantitative interview across the three project areas. A questionnaire was administered, which collected information on maternal health-seeking behaviour to the care given and socioeconomic information on the household between May and June 2018.

In phase 3, we refined and modelled the complex relations between the actors, context, intervention processes and mechanisms, and its outcomes (December 2018). Using the Context-Mechanism-Outcome (C-M-O) configuration, we examined the emerging data on trust to make inferences about the relationships between contexts, mechanisms and outcomes (Figure 1). We examined the quantitative data critically to explore the effect of the intervention on various sub-groups of women and to identify sub-period variation in outcome relative to the period before, during and after the withdrawal of the programme. Patterns across data sets were identified by accumulation (the same factor was present within a set and across sets) and causal relationships

were established with further support of the theoretical literature and our qualitative data set. This enabled us to refine and consolidate our programme theory on trust which states as follow:

> *In the context of improved staff attitude, upgraded health facilities and functioning WDCs achieved during the implementation of the SURE-P/MCH programme, pregnant women who receive sustained financial and non-financial incentives to use MCH services (Context), are likely to develop and maintain a sense of improved trust (including confidence and satisfaction) with health facilities and staff (Mechanism), ultimately leading to the improved likelihood of repeated and regular utilization of MCH services from these health facilities (Outcome).*

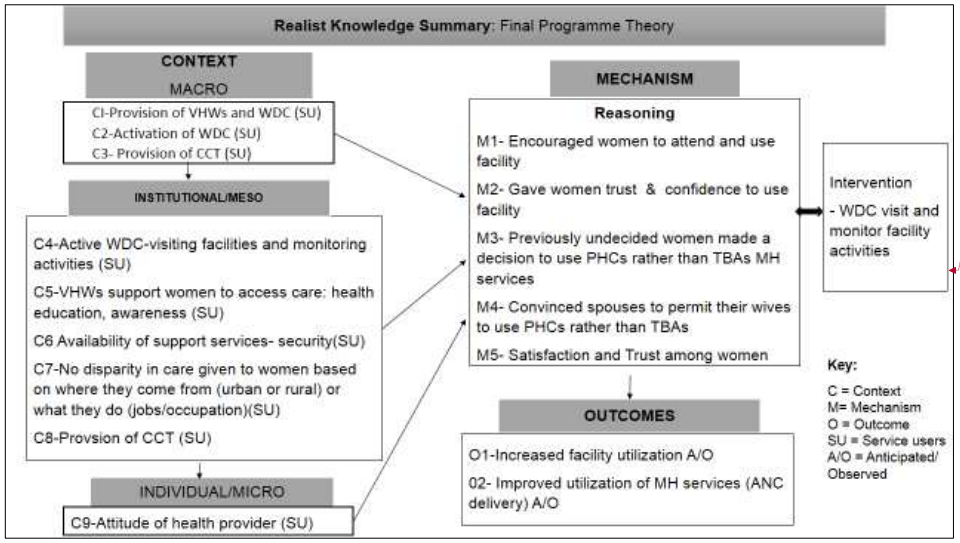

Figure1: CMO template visualizing the causal linkages among contexts (Cs), Mechanisms (Ms) and Outcomes (Os).

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Theoretical Framework

To explain how trust works, we drew upon Hurley's (2006) perspective ~~model~~ on 'decision to trust' and Straten et al., (2002) framework of factors that influence public trust in the Dutch healthcare system. We also utilized social capital theory (Agampodi et al., 2015; ~~,~~ Bourdieu, 1986; De Silva & Harpham, 2007; ~~Putnam 1995;~~ Szreter & Woolcock, 2004, ~~De Silva & Harpham, 2007~~) in our interpretation of the sustainability of trust during SUREP/MCH Programme and existence residual trust by service users after the withdrawal of SURE-P/MCH programme.

Elements of Hurley's (2006) perspective relevant to explaining trust in LMIC context include security; the number of similarities between the trustee and truster; if the trustee shows benevolent concerns, trustee's capability to do their work.

Straten et al., (2002) ~~also~~ provide a useful framework in the explanation of factors ~~that~~ influencing~~e~~ public trust at micro, meso and macro levels~~. exploring eight dimensions of public trust namely: "trust in the patient focus of healthcare providers"; "trust that policies at the macro level will be without consequences for the patient"; "trust in the expertise of healthcare providers"; "trust in the quality of care"; "trust in information supply and communication by care provides"; "trust in the quality of cooperation"; "trust in the time spent on patients"; and "trust in the availability of care~~

~~(Straten et al., 2002: 230).~~ They specify that at the micro-level people are more concerned about the behaviour of the healthcare providers, whether they will listen to them and handle their problems appropriately. At the meso level, peoples' concern is whether the health providers are cooperating among themselves; at the macro level, people tend to be worried about impacts of interventions accompanying development process in the society on their access to, as well as the quality of healthcare. This framework is relevant in the analysis of trust in LMICs. Peters & Youssef (2016) discuss the role of trust at micro and macro levels in LMICs. At the micro-level, they indicate that based on trust, the interaction between the doctor and patient can become more effective and consequently will enhance the patient's satisfaction and compliance with treatment. At the macro level, the importance of trust is seen in the impact it makes in ~~the~~ society by influencing efforts being made to meet societal expectations. Studies on trust in Nigeria, (~~Ugboaja et al., 2018;~~ Amuta-Onukagha et al., 2017; Babalola & Fatusi, 2009; Fagbamigbe & Idemudia, 2015;~~-~~Ugboaja et al., 2018) ~~Babalola & Fatusi, 2009~~) reinforce the relevance of articulating factors at the micro, meso, and macro levels in analysis of trust in health systems. ~~While home birth alone or with the help of relatives and/or traditional birth attendants is the norm in many LMICs, delay to seek appropriate MCH is a key factor in child mortality. However, the focus on promoting facilities based health systems in LMICs for obstetric care (WHO, 2005) often ignores how poorly functioning, inaccessible and prohibitive this type of facility based care (Teela et al., 2009) is for low income women.~~

Social capital is conceptualized ~~with reference to~~regarding entitlements to resources including information, financial benefits as well as favours and services ~~which~~ individuals get through membership to a community and participation in networks. It also implies expectation of reciprocity concerning an individual's relationship with other members of the networks (Bourdieu,

1986; ~~Putnam 1995; Szreter & Woolcock, 2004;~~ De Silva & Harpham, 2007; Szreter & Woolcock, 2004). Hence Social capital is perceived as 'tangible' and 'intangible' resources that members of a group have access to on account of their membership to the group (De Silva & Harpham, 2007).

Three types of ties namely '~~-~~bonding', 'bridging', (Gittell & Vidal, 1998) and 'linking' social capital (Szreter and Woolcock, 2004) ~~arehave been~~ identified. Bonding social capital refers to relationships of trust and cooperation, with strong ties among people who have shared identity such as race, social class, age and place of residence. The bonding ties serve as means through which individuals seek help and get support from members of the network (Erickson 2011). Bridging social capital derives from respect and mutual relationships in networks that are not homogeneous but still serve as sources of resources and information (~~Putnam 2000;~~ Erickson 2011; Gittell & Vidal 1998; ~~-~~Putnam 2000~~Erickson 2011~~). Linking social capital, on the other hand, refers to "vertical" ties existing among people who belong to different levels of power in the society (Erickson, 2011; Szreter and Woolcock 2004).

Three dimensions of social capital are structural, cognitive and relational social capital. Structural capital refers to the existence of social networks through which people have access to resources and people; and what people do including roles, rules and procedures (Bourdieu 1986). Cognitive social capital refers to the perceptions of people and their interpretations of the shared relationships in the networks. The relational social capital deals ~~with reference to~~concerning the nature of personal relationships existing among people through interaction in the social system as well as feelings of trust in the network (Claridge 2018; Harpham et al., 2002; ~~Nahapiet & Ghoshal 1998; Harpham et al 2002; Claridge 2018~~). ~~Some authors Putnam (1993) and~~ Szreter (2002) considers trust as a precondition that facilitates ~~cooperation or~~ the existence of shared norms in networks.

~~(Putnam 1993; Szreter 2002).~~ However, Woodcock (2001) views trust as an outcome of social capital arising from repeated interaction.

Although social capital theory has its origin ~~from~~in developed countries, it has been successfully used in the analysis of health behaviour and outcomes in some LMICs including Nigeria (~~Ozawa et al.,2016; Fantahun et al., 2007~~; Agampodi et al., 2017; Fantahun et al., 2007; Lau LL, et al. 2020; Ozawa et al.,2016; Semali et al.,2015; Ware et al 2009~~13; Lau LL, et al. 2020~~). Social capital theory demonstrates that health outcomes are dependent o~~f~~n income inequality levels with greater impact on communities where inequality is higher and safety nets lower (~~Vincens et al, 2018;~~ Rodgers et al. 2019; Vincens et al, 2018) ~~as, which is the case~~ in most LMICs. Therefore, social capital ~~T~~ plays a vital role in increasing the levels of trust in the analysis of health behaviour and outcomes in some LMICs and is ~~are~~ relevant to our study in Nigeria.

~~he ten trust factors outlined by Hurley (2006) in his model are: risk tolerance; the level of adjustment; relative power; security; the number of similarities between the trustee and truster; the degree of alignment of the interests of the parties; if the trustee shows benevolent concerns, trustee's capability to do their work, shows predictability and integrity; and if the parties have good communication. Straten et al., (2002) also provide a useful framework in explanation of factors that influence public trust at micro, meso and macro levels, utilizing an instrument to measure eight dimensions of public trust. These include: "trust in the patient-focus of healthcare providers"; "trust that policies at the macro level will be without consequences for the patient"; "trust in the expertise of healthcare providers"; "trust in the quality of care"; "trust in information supply and communication by care provides"; "trust in the quality of cooperation"; "trust in the time spent on patients"; and "trust in the availability of care (Straten et al., 2002: 230). They specify that at the micro level people are more concerned about the behaviour of the healthcare providers, whether~~

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they will listen to them and handle their problems appropriately. At the meso level, peoples' concern is whether the health providers are cooperating among themselves; at the macro level, people tend to be worried about impacts of interventions accompanying development process in the society on their access to, as well as the quality of healthcare. This framework is relevant in the analysis of trust in LMICs. Peters & Youssef (2016) discuss the role of trust at micro and macro levels in LMICs. At the micro level, they indicate that based on trust, the interaction between the doctor and patient can become more effective and consequently will enhance the patient's satisfaction and compliance with treatment. At the macro level, the importance of trust is seen in the impact it makes in the society by influencing efforts being made to meet societal expectations. Studies on trust in Nigeria, (Ugboaja et al., 2018; Amuta-Onukagha et al., 2017; Fagbamigbe & Idemudia, 2015; Babalola & Fatusi, 2009) reinforce the relevance of articulating factors at the micro, meso, and macro levels in analysis of trust in health systems. While home birth alone or with the help of relatives and/or traditional birth attendants is the norm in many LMICs, delay to seek appropriate MCH is a key factor in child mortality. However, the focus on promoting facilities based health systems in LMICs for obstetric care (WHO, 2005) often ignores how poorly functioning, inaccessible and prohibitive this type of facility based care (Teela et al., 2009) is for low-income women.

Social capital theory deals with the relationship among people or groups and resources they get through the relationship (Bourdieu, 1986; Szreter & Woolcock, 2004; De Silva & Harpham, 2007). It also entails the expectation of reciprocity concerning their relationship with other members of the networks. Social capital has ''bonding', bridging', (Gittell & Vidal, 1998.) and 'linking' components (Szreter &Woolcock, 2004). Bonding refers to relationships of trust and cooperation, with strong ties among people who have shared identity. Bonding ties serve as "a source of help

~~and support among members" (Erickson 2011:3). Bridging social capital derives from respect and mutual relationships in networks that are not homogeneous but still serve as sources of resources and information (Putnam 2000; Gittell & Vidal 1998; Erickson 2011). Linking social capital refers to "vertical ties between people in different formal or institutionalized power hierarchies" (Erickson, 2011: 5). The bonding social capital is particularly relevant for the discussion of residual trust experienced in our study.~~

RESULTS

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Two broad themes were identified following analysis of qualitative and quantitative datasets: trust during the SURE-P/MCH programme; and distrust following the withdrawal of government support and funding to the SURE-P/MCH programme. The first theme of trust during the SURE-P/MCH programme is further subdivided into trust by service users, and trust by health workers; whereas the second theme of withdrawal of support and distrust due to withdrawal of services is subdivided into distrust by service users and distrust among health workers. The themes and corresponding sub-themes are presented next.

Trust during the SURE- P MCH programme

Trust by service users

The household survey which investigated how women's trust in the health system changed when SURE-P/MCH was introduced shows that 25% of those living in SURE-P/MCH areas and 55% of those living in CCT areas said that their trust in the health system increased as a result of the resources provided through the SURE-P/MCH programme (Figure 2).

Figure 2: Change in trust once SURE-P was introduced (% of women)

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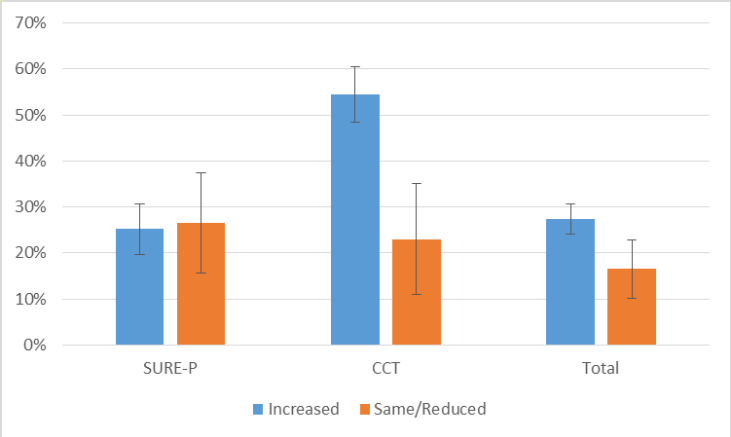

Note: Error bars represent 95% confidence intervals

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To interpret these ~~quantitative findings~~ quantitative findings, our qualitative data showed that the availability of skilled birth attendants~~,~~ and drugs seemed to enhance trust and service utilization. These combined with a positive attitude of the staff towards the patients, triggered service users'

satisfaction and confidence in health workers and contributed to interpersonal trust between the staff and service users and also increased public trust in the health system, ultimately leading to increased utilization of the facilities, during the programme. "*I would trust the health centre and come because the nurses were good and would give you good drugs. When they have treated your child and seen that they are effective, you would advise other people to come here "(*FGD - Service users, Trader, aged 27). This illustrates aspects of Hurley's (2006) factors such as "confidence and satisfaction" which enable people to decide to trust as well as aspects of Straten et al., (2002) dimensions of trust such as "trust in the patient-focus of healthcare providers"; "trust in the expertise of healthcare providers"; and "trust in the quality of care". This finding also depicts relational social capital, highlighting the interpersonal trust existing between the service users and the healthcare providers due to the positive attitude of the latter. At the same time, the existence of this relational social capital emanated from the public trust the service users had in the health system because of the tangible resources they were accessing such as good drugs provided free by SURE-P/MCH.

In the Nigerian context ~~where the cost of drugs~~ are ~~is costly~~high, ~~private markets and a proliferation are prevalent and~~ a lack ~~of regulation of counterfeit drugs~~ exists. ~~Loss~~Loss ~~in~~ of confidence in healthcare systems (Onwujekwe et al., 2009) has been linked to the non-availability of high-quality drugs and this has ~~an even~~ more significant role in MCH (Amadi &Tsui, 2018). Our data demonstrate that the provision of subsided services including some drugs triggered a sense of removal of the financial barrier which is a major impediment to accessing healthcare, thus contributing to increased public trust of service users in the health system, increased access to care and enhanced utilization of MCH services.

...We received drugs here during the SURE P MCH programme free..., they didn't collect money from us because the drugs were free then (FGD - Service user, farmer, aged 35).

...I come here based on my trust that they don't give fake drugs and so I have 100% trust in them..." and for the safety of the child: *...I come to give birth safely..."* (FGD - Service user, poultry farmer, aged 27).

Service users received some monetary and non-monetary incentives during ANC registration, ~~focused~~ antenatal care (ANC) and postnatal care (PNC). CCT payments ranging from N1000 to N5000 (about USD 30) were given to pregnant women who met the required programme conditions. Also, "Mama Kits" ~~which~~ containing toiletries were given to pregnant women during or after delivery. These financial and non-financial incentives ~~provided for the women, affordably~~ facilitated access to services that ~~combined with the supply side improvement~~ built the trust of women in the system. These mechanisms contributed towards increased and repeated utilization of MCH services. "*The incentives were good, it raised people's spirit up..., so the trust of people increased as well as the number of people who came to the health centre"* (FGD - Service users, t~~T~~rader, aged 27).

The programme established and recruited members of WDCs in ~~each community where it was implemented~~ and trained them on sensitizing their target beneficiaries about the programme ~~and on the need to utilize the services provided~~. It also recruited, trained and incentivized VHWs on ~~the role and responsibility of~~ creating awareness of the programme and ~~the services in communities~~, getting ~~the~~ pregnant women and children under the age of five to enrol and utilize the services. ~~The use of WDCs and incentivization of the VHWs enabled programme awareness creation, mobilization and support of women in the communities to utilize MCH services~~. This led

to bonding social capital between the women in the communities and VHWs, which triggered pregnant women's utilization of the PHC facilities. The provision of monetary and non-monetary incentives to pregnant women who accessed MCH services in the PHC facilities enhanced their confidence in the health system as well as satisfaction among the service users.

…from the period of SURE- P … they had people who went from house to house who informed us about the health centre… they would encourage women to go to the health centre and see for themselves, they came around to help out at the clinic … (FGD - Service users, farmer and trader, aged 32).

Why I am confident coming here is that sometime last year, my child was sick and then a woman encouraged us to come here we did and they took good care of him (FGD - Service users, tailor, trader, farmer aged 37).

Trust by health workers

The programme recruited, and trained midwives and CHEWs to provide MCH services. These health providers were deployed to all the implementing health facilities and the national government was responsible for their remuneration. The programme staff were reported to be paid their monthly salaries regularly. ~~Regular staff payment by SURE-P/MCH was a trigger for motivation considering that many trained nurses were previously unemployed as reported elsewhere (Ebenso et al. 2020).~~ Consequently, ~~the~~ staff were highly motivated and this triggered workplace trust, which made them available, leading to improved quality round-the-clock services, while also ensuring the availability of skilled birth attendants. Regular staff payment by SURE-P/MCH was a trigger for motivation considering that many trained nurses were previously

unemployed as reported elsewhere (Ebenso et al. 2020). Other factors such as the provision of incentives for service users and free drugs which enhanced utilization of MCH services, as well as equipment, accommodation, increased staff strength and training as well as intrinsic joy in having patients to attend to contributed to the motivation of health workers. ~~Training and regular payment of healthcare staff salaries motivated them to have a positive attitude to work and triggered public trust among the staff in the health system.~~ This is exemplified by the quote from a health worker in charge of a facility.

"*When you talk about staffing, Sure-P made the standard of the workers to be superb. You'd see all mix of staff; midwives, CHEWs… and everybody will be in their uniform while working… apart from thato Sure-P brought water, they sank boreholes that use solar and not electricity everywhere …Sure-P also brought drugs. The poor people …~~who cannot afford their three square meal~~ can now come to the facility*. (IDI, Health worker,/ Officer in charge, PHC~~of a facility~~)

Withdrawal of support and distrust due to withdrawal of services

Distrust among health workers

Withdrawal of the programme brought about laying off of all SURE-P/MCH staff ~~which reduced staff support including staff~~ including staff- training and supervision. At the individual level, the remaining staff experienced ~~loss of colleagues, lack of training/supervision and loss of source of income.~~ i~~I~~ncreased workloads, inability to meet financial obligations and lack of motivation, which triggered poor health workers' attitude, ~~sense of~~ frustration and unwelcome attitude toward the patients~~, leading to loss of trust in the health system~~. These ultimately contributed to poor service delivery and reduction in utilization of MCH services across the implementing facilities.

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A health worker narrated that,

…when staff are demoralized, they won't come to work when they are supposed to come. …Wwhen you come to the health facility, you won't see them because they are not appreciated, and you will now discover that people may come to access healthcare services without seeing anybody that will attend to them (IDI, health worker/Community Health Officer, PHC).

The discouragement experienced by health workers affected their attitude to service users. "*... sometimes you would meet hostile nurses who use abusive words on pregnant women"* (FGD - Service users, Teacher, aged 34).

Distrust by service users

At the organizational level, the withdrawal of the programme incentives triggered a reduction in the supply of medicines and other commodities, re-introduction of user fees., and deterioration of MCH services. Qualitative data show that withdrawal of incentives triggered dissatisfaction, decreased sense of financial security leading to distrust in the health system and subsequent reduction in utilization of MCH services. *"As of then, (during SURE-P programme) the clinic was filled with people due to the incentives but now, everyone has run away"* (FGD - Service users, Farmer aged 29).

Some users began to visit other service providers, including TBAs while the few that utilized the facilities resorted to purchasing medicines outside the health facilities. This trend was highlighted by a health worker;

Those things that we need (e.g. drugs and mama kits…. which SURE-P used to supply) made people come to the health facility, but now that there is no SURE-P, they are not so motivated ~~because of lack of all these~~, … Now when they come and see that the price is high, it makes them to either go to the market or do self-treatment… ~~which can lead to death or other complications~~

(IDI, health worker/Community Health Officer, PHC).

The fact that the withdrawal of incentives and consumables resulted in a reduction in utilization of PHC facilities by pregnant women led to the loss of public trust in the health system is consistent with some studies from Nigeria that barriers to utilization of skilled care in formal healthcare facilities include the cost of seeking healthcare and lack of trust in the health system among others (Amuta-Onukagha et al., 2017; Fagbamigbe & Idemudia 2015; Ugboaja et al., 2018)~~the framework of Straten et al., (2002) that at the micro-level people are more concerned about the behaviour of the healthcare providers, and whether they will handle their healthcare needs appropriately. However there were others who kept using the facilities because of positive attitude of the health workers.~~

~~"*For me it wasn't because of the incentives but the fact that if I am sick they would treat me well but there are those that lost trust because the incentives had stopped so they were going somewhere else*(FGD, service user, fruit trader 29 years)~~

~~This buttresses Straten et al., (2002) perspective that at the micro-level people are more concerned about the behaviour of the healthcare providers, and whether they will handle their healthcare needs appropriately.~~

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Quantitative data show that when women were asked to indicate their level of trust in the health system two years after SURE-P//MCH was ended, of those women that said their trust had increased as a result of SURE-P/MCH, around 33% said their trust in the system had eroded while the remaining 66% said their trust remained the same or had even increased (Figure 3).

Figure 3: Change in trust when SURE-P was withdrawn

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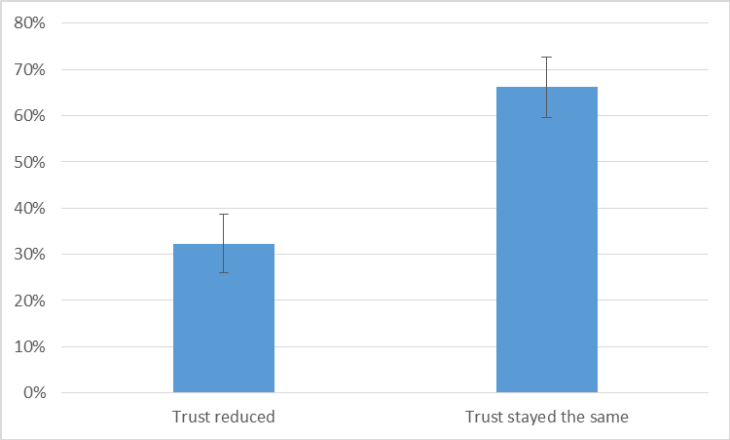

Note: Of women indicating that their trust in the system increased when SURE-P was introduced

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Residual trust by service users

However, despite the withdrawal of the programme and its incentives, both quantitative and qualitative data show that some service users still have confidence in the health system and maintained unwavering trust in health providers due to their satisfaction and the level of

interpersonal trust previously built on the health providers. *"…. Some of them (service users) that came in during SURE-P/MCH continued maybe because they were pleased with what they saw, then convincing others to come in while the SURE-P had already closed, but some still trust them and come"* (IDI, health worker/ Nurse-Midwife, PHC).

"For me, it wasn't because of the incentives but the fact that if I am sick they would treat me well but there are those that lost trust because the incentives had stopped so they were going somewhere else(FGD, service user, fruit trader 29 years)

This buttresses Straten et al., (2002) perspective that at the micro-level people are more concerned about positive ~~the~~ behaviour of the healthcare providers, and whether they will handle their healthcare needs appropriately.

FGD responses also highlight the relevance of social capital theory in the explanation of the existence of residual trust experienced in our study.

The residual trust depicted in both qualitative and quantitative data conform to ~~with~~ social capital theory about how 'bonding' and linking social capital lead~~s~~ to trust. ~~Most of the healthcare providers reside in the communities studied and share similar cultural and social identities with the service users.~~ The bonding ties serve as a means of enabling service users to seek help from the healthcare providers to pay for treatment in insta~~l~~lments which is not usually applicable in other health facilities ~~"a source of help and support among members" (Erickson 2011:3).~~ Bonding and linking social capital consequently ~~The existence of shared norm~~s enhance~~s~~ interpersonal trust

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between healthcare providers and service users and consequently results in the residual trust identified in our study. ~~after the withdrawal of the programme.~~

DISCUSSION

In this paper, we ~~have~~ explored how, why and in what circumstances, the implementation and subsequent termination of the SURE-P/MCH programme affected the trust of service users and health service providers in Nigeria. Specific issues in the findings related to sustainability of trust in the health system due to services and incentives provided during SURE-P/MCH and lack of trust which resulted due to the withdrawal of services and incentives are discussed.

Sustainability of trust in the health system

SURE-P/MCH programme ushered in staff training and re-training; provision of monetary and non-monetary incentives; subsidization of MCH services, including drugs; facility upgrade; and improved staff remuneration. ~~This development led to the provision of quality care by well-motivated staff and contributed to increased utilization of services and building of interpersonal trust in health workers and public trust in the health system by service users.~~ Health providers are motivated when there is institutional support through the provision of resources such as equipment, upgrading of health facilities ~~in terms of renovation/building of new structures, provision of water supply, good working environment~~ and in-service training, and regular remuneration as occurred during the programme This facilitated the development of health providers' public trust in the health system and workplace trust. This development led to the provision of quality care by well-motivated staff and contributed to increased utilization of services and building of interpersonal trust in health workers and public trust in the health system by service users. This finding

corroborates the reports– ~~which are critical for job performance and satisfaction~~. ~~Some scholars (Gilson et al., (2005) and Nwabueze et al., (2011) report~~ of an integral relationship between positive staff attitude and patient-provider interpersonal trust, service users' satisfaction and utilization of health facility services (Gilson et al., 2005; Gopichandran & Chetlapalli 2013; Nwabueze et al., 2011). . ~~This was corroborated in our study as the positive staff attitude during the programme contributed to increased interpersonal trust between the service users and health providers, which in turn sustained utilization of MCH services. Gopichandran & Chetlapalli (2013) show that service providers' behaviour influenced the level of trust the service users apportion to them. Russell (2005) also report that trust is a driver of health seeking behaviour among patients in hospital settings in some countries such as Colombo, and Sri Lanka. We attribute the increased utilization of MCH services amongst users in our study to a high level of trust on providers and the health system as patients with lower levels of trust are less expected to seek services, have repeated utilization, and more likely to avoid healthcare (Armstrong et al., 2006).~~

Provision of financial and non-financial incentives ~~and subsidized services such as drugs,~~ resulted in increased utilization of MCH services amongst users due to the development of trusting behaviour in the health system. This reflects ~~corroborates~~ literature on the impact of incentives on the utilization of MCH services. ~~Thomson et al., (2014) show that the use of incentive has the potential for reducing inequalities by enabling the poor and vulnerable have access to items they would not be able to afford.~~ Ekezie et al., (2017) report that incentives enable women to take care of barriers arising due to user-fees that are burdensome and motivate them to seek healthcare and in turn improve their standard of living. The use of WDCs and incentivization of the VHWs enabled programme awareness creation, mobilization and support of women in the communities to utilize MCH services. This led to trust in the health system as well as satisfaction among the

service users. This corroborates Thomson et al., (2012) report that incentives promote interpersonal relationship between providers and consumers.

Withdrawal of support and distrust due to withdrawal of services

The termination of the SURE-P/MCH programme was accompanied by a withdrawal of programme incentives and re-introduction of user fees. Withdrawal of access to free drugs by the SURE-P/MCH programme poses a serious concern for service users as it predisposes them to the risk of using TBAs for MCH services (Elem & Nwabah, 2016; Okonofua et al., 2018) and counterfeit drugs. Access to genuine drugs in Nigeria is a major health challenge due to the proliferation of counterfeit drugs (Akinyandenu, 2013). Withdrawal of these programme incentives compromised the quality of care due to the deterioration of MCH services. This triggered dissatisfaction, ~~decreased sense of financial security,~~ consequently leading to distrust in the health system and subsequent reduction in utilization of MCH services. ~~It could also be possible that people who were coming from other facilities because of the SURE-P/MCH programme, are no longer bothered and they moved back to the facilities where they were receiving services before.~~ Kang & James (2004) and Graham et al., (2015) report that good quality services are associated with the possibility of retaining existing clients and attracting new ones. Our study shows that the withdrawal of drugs and other support services led to the loss of public trust in the health system which, resulted in reduced utilization of MCH services, as service users could no longer rely on the health providers and the health system with confidence. Our data reflect other studies (~~Whetten, 2006; Riewpaiboon et al., 2005;~~ Ugboaja et al 2018) that distrust in the health system is a barrier to service utilization and results in poor health outcomes. Baba-Ari et al., (2018) demonstrate that although CCTs influenced the uptake of MCH interventions by beneficiaries in North Central

Nigeria, that lack of trust was one of the factors that constrained uptake of the programme by non-beneficiaries.

Factors associated with the withdrawal of the SURE-P/MCH programme namely reduced staff strength; increased workloads; lack of training and supervision; and reduced income made service providers ~~to~~ lose trust in the health system. This manifested as poor staff attitude towards patients. Okello & Gilson (2015) report that low remuneration and inadequacy of resources trigger workplace distrust and demotivates health workers in LMICs.

However, we also observed that majority of household survey respondents who had indicated that the programme increased their trust also said that withdrawal made no difference. This suggests that for many households, the trust built up during the programme persisted well beyond the end of formal financial support. Similarly, some of the service users had unwavering trust towards the service providers despite the withdrawal of the SURE-P/MCH programme and its accompanying incentives. The existence of this residual trust ~~found in our study~~ could be attributed to unchanged staff positive attitude in those facilities. This highlights relational social capital, depicting the interpersonal trust existing between the service users and the healthcare providers due to the health workers' positive attitude to their work and care of their patients. It also corroborates the perspective of ~~argument of~~ Straten et al., (2002) that at the micro-level people are more concerned about the behaviour of the healthcare providers, focusing on whether they will handle their needs appropriately. ~~The existence of the residual trust due to patient-provider interpersonal trust ,trust, This also reflects findings of Gilson et al., (2005) in South Africa, that the key concern of primary care service users is that healthcare providers have a positive attitude which includes being respectful and providing good quality care.~~

Furthermore, the residual trust could be attributed to the existence of 'bonding' and linking social capital between the healthcare providers and the service users. Most of the healthcare providers reside in the communities studied and share similar cultural and social identities with the service users. So, the bonding and linking social capital enable service users to seek help and support from the healthcare providers as demonstrated in requests for instal~~l~~lment payment for treatment by some service users. ~~ties serve as "a source of help and support among members" (Erickson 2011:3).~~ The existence of bonding and linking social capital ~~shared norms~~ is also attributed to trust that was established as a result of repeated interaction (Szreter, 2002~~:655)~~. This in turn enhanced interpersonal trust between healthcare providers and service users and consequently triggered ~~resulted in~~ the residual trust identified after the withdrawal of the programme.

STRENGTHS AND LIMITATIONS

- RE methodology has been useful in evaluating the SURE-P/MCH programme. This facilitated the development of initial programme theories and enabled us to explore how and why and in what circumstances the context of SURE-P/MCH programme implementation triggered mechanisms that generated anticipated and unanticipated outcomes within the system.

Limitations: ~~The~~The theoretical framework ~~used in this paper~~ is based ~~i~~on theories developed in Western rich and industrialised countries (Gilmore, 2019) and potentially may miss to apprehend the contextual systemic factors embedded in LMIC and Nigeria. Social capital theory, however, is based on the notion of actor-based capital to understand mechanisms of inequality which are fundamental in understanding LMICs health systems.

- ~~Q~~questions in the qualitative interview guide did not directly address 'trust' but 'factors' that determine trust such as confidence and satisfaction. That might have affected the

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comprehensiveness of the responses. Since the interviews were conducted after the withdrawal of the SURE-P/MCH programme, the time lag could have affected the recall of experiences of the interviewees. Moreover, trust and confidence are inter-related in the sense that both have an underlining notion of expectation. While we regard satisfaction as an outcome of trust conceptually, different respondents saw trust and satisfaction as being inter-related.

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Implications for policy and practice

Based on the findings presented in this paper, we recommend that government and policymakers need to ~~do the following:~~ build-in sustainable structures in policy designs to mitigate sudden programme withdrawal and its subsequent effects on service users and service providers; provide free drugs in PHCs to enable the poor and vulnerable ~~to~~ have access to quality drugs rather than being exposed to the risk of cheap counterfeit drugs; provide regular and adequate remuneration to health workers to motivate them to have a positive attitude to their work and service users. This would enhance interpersonal trust between the health workers and service users as well as public trust in the health system by health providers and service users, and workplace trust for health providers.

Conclusion

The SURE-P/MCH programme was beneficial due to subsidized services and drugs, financial and non-financial incentives. This encouraged service users to trust the healthcare providers and the

health system and increased service utilization. Ultimately, it removed financial barriers to accessing MCH services. However, withdrawal of the programme led to distrust in the healthcare providers and the health system and reduced utilization of MCH services. Findings from this study ~~as stated in the preceding paragraph,~~ will be useful to government and policymakers in designing policies and practices for implementing health programmes that will enhance interpersonal~~-~~ trust ~~between~~between health~~-~~ providers and service users; and public trust in the health system by health providers and service users, and workplace trust for health providers. This in turn will trigger the provision of quality healthcare services and increased utilization of health facility services in Nigeria. ~~Due to the paucity of research on trust in LMICs and particularly in Nigeria, our findings will boost the interest of researchers to explore the impact of trust in effectiveness and sustainability of health intervention programmes and health system.~~

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ABSTRACT

Trust is important for the effective functioning of the health system, influences health-seeking behaviours, facilitating interaction between patients and healthcare providers. However, there is limited focus on the mechanisms of how trust works within health systems in Nigeria. This paper reports how, why and in what circumstances, the implementation and subsequent termination of a maternal and child health programme affected the trust of service users and healthcare providers in Nigeria. In 2015 and 2016 key documents were reviewed, and initial programme theories of how context triggers mechanisms to produce intended and unintended outcomes were developed. These were tested, consolidated and refined through iterative cycles of data collection and analysis in 2018. Testing and validation of the trust theory utilized eight in-depth interviews with health workers, four focus group discussions with service users and household survey of 713 pregnant women and analysed retroductively. The conceptual framework adopted Hurley's perspective on 'decision to trust' and Straten et al.'s framework on public trust and social capital theory. Incentives offered by the programme triggered confidence and satisfaction among service users, contributing to their trust in healthcare providers, increased service uptake, motivated healthcare providers to have a positive attitude to work, and facilitated their trust in the health system. Termination of the programme, including withdrawal of and laying off of staff, led to most service users' dissatisfaction, and distrust reflected in the reduction in utilization of MCH services, increased staff workloads leading to their decreased performance although residual trust remained. Understanding the role of trust in a programme's positive and negative short and long-term outcomes can help policymakers and other key actors in the planning and implementation of sustainable and effective health programmes. Future research needs to explore the impact of trust in health system' performance.

Keywords: Nigeria, Trust, Maternal and child health services, low and middle-income countries, health system's strengthening, Realist Evaluation.

INTRODUCTION

Trust is important for effective functioning of the health system and is crucial in facilitating interactions between patients and healthcare providers. Due to trust, patients are willing to utilize healthcare services, share their health needs and also adhere to treatment. (Gilson, 2003; Peters & Youssef, 2016; Russel, 2005 ;). Trust is conceptualized as a reliance on a trustee, which is voluntary and with confidence (Goudge et al., 2005; Hurley, 2006; Meyer, 2015; Riewpaiboon et al., 2005; Thiede, 2005).). Patient-centred definitions of trust such as Lupton's (1997) point out that in medical encounters, patients' experiences with their healthcare providers are important in promoting trust. Peters & Youssef, 2016 indicate that trust is based on the assumption that health providers have the expertise to provide appropriate services to patients. However, aside from expertise key drivers among pregnant women for utilizing services of Traditional Birth Attendants (TBAs) in developing countries include the feeling of confidence, security and satisfaction (Amuta-Onukagha et al., 2017; Elem & Nwaba, 2016; Ugboaja et al., 2018;), which emanate from relational dynamics, familial ties and further drivers of trust. In Cambodia villagers trust public healthcare providers because they are perceived, to be honest, and skilled; while trust in private providers is rooted in the friendly manner they carry out their treatment (Ozawa &Walker, 2011).

Other factors that affect the use of these providers include location, accessibility, and cost of accessing care among others., Ihekweazu (2016) attributes lack of trust in health workers as a key factor that contributed to the spread of Lassa fever in Nigeria and emphasizes that trust of infected and non-infected persons can only be ensured if they perceive that healthcare providers will have a positive attitude of treating them in a humane manner.

However, there is limited focus on how trust works to influence health-seeking behaviours by patients and service provision by health workers in low and middle-income countries (LMICs) (Gilson et al., 2005; Peters & Youssef, 2016). Furthermore, trust literature tends to focus on physicians or on "the health system", neglecting the analysis of trust between healthcare users and members of healthcare teams in maternal and child health (MCH) programmes in LMICs (Sheppard et al., 2004). Peters et al., (2016) observe that in the historical and institutional context of developing countries, it is necessary to draw attention to how trust can develop under challenging circumstances such as limited infrastructure and lack of health workers. The continuous nature of the prenatal to postnatal care relationship provides an ideal opportunity to examine how trust works regarding provision and utilization of MCH services in Nigeria. .

This paper contributes to bridging this knowledge gap. We report our analysis of how trust works for healthcare users and providers and how it impacts their behaviours and practices in utilization and provision of maternal healthcare services in Nigeria. This is done by using Hurley's (2006) perspective on 'decision to trust' and Straten et al., (2002) framework of factors influencing public trust, and social capital theory **(Agampodi et al., 2015, De Silva & Harpham, 2007; Szreter & Woolcock, 2004)** to understand data gathered in our evaluation of a national Subsidy Reinvestment and Empowerment Programme (SURE-P/MCH) in Nigeria, which focused on

improving access to maternal and child health).. Thereby, this paper aims to explore how, why and under what circumstances trust influenced the uptake of maternal and child healthcare during the SURE-P/MCH programme and may influence continued MCH service uptake after the suspension of the programme.

The paper is structured as follows: we discuss conceptualisations of trust, brief information on the organization of the health system in Nigeria, the methods, results, discussion of findings, conclusions and implications for policy and practice.

Types of Trust

Three main types of trust (interpersonal, public and workplace) are identified in the literature. Interpersonal trust refers to the trust an individual has in another person for example between a patient and healthcare provider, while, public trust is that placed by people in an institution/system (Gilson, 2003; Gilson, 2006; Russell, 2005; van der Schee et al., 2006). Workplace trust refers to trust in colleagues, supervisors and employing organizations (Calnan & Rowe, 2006; Gilson et al. 2005; Okello & Gilson, 2015 ;). To understand the role of trust in influencing the use of MCH services it is important to focus on the interconnection between interpersonal and institutional levels of trust (Meyer et al., 2008) as well as the workplace. Trust, which arises at the interpersonal level (micro-level) is important to sustain public trust that occurs at the institutional/macro-level (Gilson, 2003). Workplace trust on the other hand is particularly important for staff to provide round the clock services because it positively impacts the motivation of health workers (Okello & Gilson, 2015).

Nigerian health system and MCH

Nigeria is the largest country in Sub-Saharan Africa (SSA) with the complex three-tier decentralized health system, (primary health centres, secondary (general hospitals) and tertiary (specialist and teaching hospitals),. Private hospitals exist and are owned by individuals and organizations. Before the introduction of western medicine in Nigeria, pregnant women were assisted by their mothers or mothers-in-law in delivery while traditional birth attendants (TBAs) provided help if they had complications and TBAs handle about one-third of deliveries that occur outside health facilities in Nigeria. TBAs reside in rural communities and are conversant with the cultural practices associated with delivery. Hence pregnant women are confident, feel secure and satisfied using their services (Amuta-Onukagha et al., 2017; Elem & Nwabah, 2016; Fagbamigbe & Idemudia, 2015; Ugboaja et al., 2018). Ugboaja et al., (2018) argue that this substantial role of TBAs also indicates lack of trust in MCH services officially provided in public health facilities

Improving MCH care in Nigeria is a national priority. The Nigerian Demographic and Health Survey (NDHS) of 2018 reports that access to skilled birth providers continues to elude many pregnant women with wide disparities according to state, rural/urban location, education and wealth status. There was only a slight decrease in infant mortality from 69 deaths per 1,000 during the 5 years preceding the 2013 NDHS to 67 deaths per 1,000 live births in the recent 5-year period. In response to poor MCH indices in Nigeria, the Federal Government implemented the SURE-P/MCH programme between 2012 and 2015. The aim was to improve the lives of the most vulnerable populations (Mirzoev et al., 2016). The supply-side component aimed at expanding access to quality maternal health services and improve MCH outcomes through recruitment, training and deployment of 2,000 skilled midwives and 11,000 community health extension workers (CHEWs), supplies and medicines, infrastructure development, and activation of ward development committees (WDCs), in rural communities. The demand side aimed to increase

utilization of health services during pregnancy and at birth by providing conditional cash transfers (CCTs) to pregnant women who registered at public primary healthcare (PHC) facilities, where they received comprehensive MCH services.

METHODS

Study Design

This paper reports results from a component of a broader mixed-methods study reported elsewhere (Mirzoev et al. 2016), that adopted a Realist Evaluation (RE) approach to examine the context, mechanisms and outcomes of a community health workers (CHW) programme in Anambra State, Nigeria. RE is a theory-driven approach that guides the implementation of complex interventions through iterative theory development, testing and refinement (Pawson & Tilley, 1997; Robert et al., 2012; Wilson & McCormack, 2006; Wong et al., 2017Programme theories developed within realist studies explore which contexts trigger which mechanisms that produce intended or unintended outcome in different contexts. This enables a clear understanding of the 'whys' and the 'hows' of programme outcome within a particular context that is well suited to evaluating programmes implemented at diverse levels of the health system investigations in low-resource settings (Marchal et al., 2012). In RE, data extraction proceeds from baseline enquiries and development of programme theory to testing/refinement and consolidation of the programme theory, using empirical data (Dalkin et al., 2015).

Data Collection and analysis

The study was conducted in three phases, corresponding to the building of initial programme theories (IPTs), testing/validation and consolidation/refinement (Manzano, 2016; Pawson & Manzano-Santaella, 2012, Pawson & Tilley, 1997) (see Table 1 in supplementary file for tables).

In phase 1, we reviewed key SURE-P/MCH programme documents and relevant MCH Federal and state policies, between June and September 2015, to understand the programme architecture and design (Ebenso et al., 2019). Initial qualitative interviews were held (May -November 2016) with purposefully identified 96 stakeholders comprising IDIs with 10 policymakers, 11 programme officers, 16 health workers/PHC staff, and 15 facility managers at federal and state levels. Focus Group discussions (FGDs) were held with 8 VHWs, 12 WDCs, 12 service users (pregnant women) and 12 family members of service users. Different numbers of interviewees reflect the three phases of our research and different engagements with the Trust theory. The selection of all these different numbers of respondents was done to explore their views about the SURE-P/MCH programme. These data facilitated the development of 8 programme theories for the main study (Mirzoev et al. 2016).

In phase 2, which entailed data testing and validation of trust theories, qualitative and quantitative methods were utilized. Data were collected in twelve PHCs and three general hospitals purposively selected to reflect the implementation of the SURE-P/MCH programme in Anambra state, Nigeria. These facilities were clustered into three, each cluster comprised one general hospital and four PHCs. The focus on the clusters just reflect the setup of the SURE-_P/MCH programme by the government Two of the clusters benefitted from the SURE-P/MCH intervention, while the third cluster without SURE-P/MCH intervention was used as a control. This was relevant to enable us to determine if there are any differences in MCH service utilization by service users in the clusters

that benefited from the intervention compared to the control cluster. For the qualitative methods, 8 IDIs with health workers and 4 FGDs with service users were conducted (August- September 2018).

The IDIs and FGDs were guided by a semi-structured question guide which was designed around the different versions of initial programme theories and included questions for testing and validating the different components of the programme theories for the main study. The FGD interviews were conducted in the Igbo language, while the IDIs were conducted in both Igbo and English languages depending on respondents' preference. All IDIs and FGDs were conducted face-to-face and were audio-recorded with respondents' consent, transcribed and translated into English as necessary. Female researchers (NE, (Sociologist), UE, (Health Economist), UO and EE (Medical doctors) trained in realist interviewing undertook the data collection while NE, UE, UO, TE (male Health economist), EE and AM (female Sociologist) were involved in data analysis.

Qualitative data collection was complemented by data from a quantitative household survey. The survey was based on a community listing of all households in the project cluster areas that had a birth in the last 6 years; covering a period before, during and after the SURE-P/MCH programme. A stratified random sample of 713 women were selected for quantitative interview across the three project areas. A questionnaire was administered, which collected information on maternal health-seeking behaviour to the care given and socioeconomic information on the household between May and June 2018.

In phase 3, we refined and modelled the complex relations between the actors, context, intervention processes and mechanisms, and its outcomes (December 2018). Using the Context-Mechanism-Outcome (C-M-O) configuration, we examined the emerging data on trust to make inferences about the relationships between contexts, mechanisms and outcomes (Figure 1). We examined the quantitative data critically to explore the effect of the intervention on various sub-groups of women and to identify sub-period variation in outcome relative to the period before, during and after the withdrawal of the programme. Patterns across data sets were identified by accumulation (the same factor was present within a set and across sets) and causal relationships were established with further support of the theoretical literature and our qualitative data set. This enabled us to refine and consolidate our programme theory on trust which states as follow:

> *In the context of improved staff attitude, upgraded health facilities and functioning WDCs achieved during the implementation of the SURE-P/MCH programme, pregnant women who receive sustained financial and non-financial incentives to use MCH services (Context), are likely to develop and maintain a sense of improved trust (including confidence and satisfaction) with health facilities and staff (Mechanism), ultimately leading to the improved likelihood of repeated and regular utilization of MCH services from these health facilities (Outcome).*

Figure1: CMO template visualizing the causal linkages among contexts (Cs), Mechanisms (Ms) and Outcomes (Os). (See Figure 1 in supplementary file for figures)

Theoretical Framework

To explain how trust works, we drew upon Hurley's (2006) perspective on 'decision to trust' and Straten et al., (2002) framework of factors that influence public trust in the Dutch healthcare system. We also utilized social capital theory (Agampodi etal., 2015; Bourdieu, 1986; De Silva & Harpham, 2007; Szreter & Woolcock, 2004,) in our interpretation of the sustainability of trust during SUREP/MCH Programme and existence residual trust by service users after the withdrawal of SURE-P/MCH programme.

Elements of Hurley's (2006) perspective relevant to explaining trust in LMIC context include security; the number of similarities between the trustee and truster; if the trustee shows benevolent concerns, trustee's capability to do their work.

Straten et al., (2002) provide a useful framework in the explanation of factors influencing public trust at micro, meso and macro levelsThey specify that at the micro-level people are more concerned about the behaviour of the healthcare providers, whether they will listen to them and handle their problems appropriately. At the meso level, peoples' concern is whether the health providers are cooperating among themselves; at the macro level, people tend to be worried about impacts of interventions accompanying development process in the society on their access to, as well as the quality of healthcare. This framework is relevant in the analysis of trust in LMICs. Peters & Youssef (2016) discuss the role of trust at micro and macro levels in LMICs. At the micro-level, they indicate that based on trust, the interaction between the doctor and patient can become more effective and consequently will enhance the patient's satisfaction and compliance

with treatment. At the macro level, the importance of trust is seen in the impact it makes in society by influencing efforts being made to meet societal expectations. Studies on trust in Nigeria, (Amuta-Onukagha et al., 2017; Babalola & Fatusi, 2009; Fagbamigbe & Idemudia, 2015;Ugboaja et al., 2018)) reinforce the relevance of articulating factors at the micro, meso, and macro levels in analysis of trust in health systems. Social capital is conceptualized regarding entitlements to resources including information, financial benefits as well as favours and services individuals get through membership to a community and participation in networks. It also implies expectation of reciprocity concerning an individual's relationship with other members of the networks (Bourdieu, 1986; De Silva & Harpham, 2007; Szreter & Woolcock, 2004). Hence Social capital is perceived as 'tangible' and 'intangible' resources that members of a group have access to on account of their membership to the group (De Silva & Harpham, 2007).

Three types of ties namely 'bonding', 'bridging', (Gittell & Vidal, 1998) and 'linking' social capital (Szreter and Woolcock, 2004) identified. Bonding social capital refers to relationships of trust and cooperation, with strong ties among people who have shared identity such as race, social class, age and place of residence. The bonding ties serve as means through which individuals seek help and get support from members of the network (Erickson 2011). Bridging social capital derives from respect and mutual relationships in networks that are not homogeneous but still serve as sources of resources and information (Erickson 2011; Gittell & Vidal 1998; Putnam 2000). Linking social capital, on the other hand, refers to "vertical" ties existing among people who belong to different levels of power in the society (Erickson, 2011; Szreter and Woolcock 2004).

Three dimensions of social capital are structural, cognitive and relational social capital. Structural capital refers to the existence of social networks through which people have access to resources and people; and what people do including roles, rules and procedures (Bourdieu 1986). Cognitive

social capital refers to the perceptions of people and their interpretations of the shared relationships in the networks. The relational social capital deals concerning the nature of personal relationships existing among people through interaction in the social system as well as feelings of trust in the network (Claridge 2018; Harpham et al., 2002). Szreter (2002) considers trust as a precondition that facilitates the existence of shared norms in networks. However, Woodcock (2001) views trust as an outcome of social capital arising from repeated interaction.

Although social capital theory has its origin in developed countries, it has been successfully used in the analysis of health behaviour and outcomes in some LMICs including Nigeria (; Agampodi et al., 2017; Fantahun et al., 2007; Lau LL, et al. 2020; Ozawa et al.,2016; Semali et al.,2015; Ware et al 2009). Social capital theory demonstrates that health outcomes are dependent on income inequality levels with greater impact on communities where inequality is higher and safety nets lower (Rodgers et al. 2019; Vincens et al, 2018) in most LMICs. Therefore, social capital plays a vital role in increasing the levels of trust in the analysis of health behaviour and outcomes in some LMICs and is relevant to our study in Nigeria.

RESULTS

Two broad themes were identified following analysis of qualitative and quantitative datasets: trust during the SURE-P/MCH programme; and distrust following the withdrawal of government support and funding to the SURE-P/MCH programme. The first theme of trust during the SURE-P/MCH programme is further subdivided into trust by service users, and trust by health workers; whereas the second theme of withdrawal of support and distrust due to withdrawal of services is

subdivided into distrust by service users and distrust among health workers. The themes and corresponding sub-themes are presented next.

Trust during the SURE- P MCH programme

Trust by service users

The household survey which investigated how women's trust in the health system changed when SURE-P/MCH was introduced shows that 25% of those living in SURE-P/MCH areas and 55% of those living in CCT areas said that their trust in the health system increased as a result of the resources provided through the SURE-P/MCH programme (Figure 2). See figure 2 in supplementary file for figures

To interpret these quantitative findings, our qualitative data showed that the availability of skilled birth attendants and drugs seemed to enhance trust and service utilization. These combined with a positive attitude of the staff towards the patients, triggered service users' satisfaction and confidence in health workers and contributed to interpersonal trust between the staff and service users and also increased public trust in the health system, ultimately leading to increased utilization of the facilities, during the programme. "*I would trust the health centre and come because the nurses were good and would give you good drugs. When they have treated your child and seen that they are effective, you would advise other people to come here "(*FGD - Service users, Trader, aged 27). This illustrates aspects of Hurley's (2006) factors such as "confidence and satisfaction" which enable people to decide to trust as well as aspects of Straten et al., (2002) dimensions of trust such as "trust in the patient-focus of healthcare providers"; "trust in the expertise of healthcare providers"; and "trust in the quality of care". This finding also depicts relational social capital,

highlighting the interpersonal trust existing between the service users and the healthcare providers due to the positive attitude of the latter. At the same time, the existence of this relational social capital emanated from the public trust the service users had in the health system because of the tangible resources they were accessing such as good drugs provided free by SURE-P/MCH.

In the Nigerian context a lack of confidence in healthcare systems (Onwujekwe et al., 2009) has been linked to the non-availability of high-quality drugs and this has more significant role in MCH (Amadi &Tsui, 2018). Our data demonstrate that the provision of subsided services including some drugs triggered a sense of removal of the financial barrier which is a major impediment to accessing healthcare, thus contributing to increased public trust of service users in the health system, increased access to care and enhanced utilization of MCH services.

…We received drugs here during the SURE P MCH programme free…, they didn't collect money from us because the drugs were free then (FGD - Service user, farmer, aged 35).

…I come here based on my trust that they don't give fake drugs and so I have 100% trust in them…" and for the safety of the child: *…I come to give birth safely…"* (FGD - Service user, poultry farmer, aged 27).

Service users received some monetary and non-monetary incentives during ANC registration, antenatal care (ANC) and postnatal care (PNC). CCT payments ranging from N1000 to N5000 (about USD 30) were given to pregnant women who met the required programme conditions. Also, "Mama Kits" containing toiletries were given to pregnant women during or after delivery. These financial and non-financial incentives facilitated access to services that built the trust of women in the system. These mechanisms contributed towards increased and repeated utilization of MCH services. "*The incentives were good, it raised people's spirit up…, so the trust of people increased*

as well as the number of people who came to the health centre" (FGD - Service users, trader, aged 27).

The programme established and recruited members of WDCs in and trained them on sensitizing their target beneficiaries about the programme. It also recruited, trained and incentivized VHWs on creating awareness of the programme and, getting pregnant women and children under the age of five to enrol and utilize the services. This led to bonding social capital between the women in the communities and VHWs, which triggered pregnant women's utilization of the PHC facilities. The provision of monetary and non-monetary incentives to pregnant women who accessed MCH services in the PHC facilities enhanced their confidence in the health system as well as satisfaction among the service users.

…from the period of SURE- P … they had people who went from house to house who informed us about the health centre… they would encourage women to go to the health centre and see for themselves, they came around to help out at the clinic … (FGD - Service users, farmer and trader, aged 32).

Why I am confident coming here is that sometime last year, my child was sick and then a woman encouraged us to come here we did and they took good care of him (FGD - Service users, tailor, trader, farmer aged 37).

Trust by health workers

The programme recruited, and trained midwives and CHEWs to provide MCH services. These health providers were deployed to all the implementing health facilities and the national

government was responsible for their remuneration. The programme staff were reported to be paid their monthly salaries regularly. Consequently, staff were highly motivated and this triggered workplace trust, which made them available, leading to improved quality round-the-clock services, while also ensuring the availability of skilled birth attendants. Regular staff payment by SURE-P/MCH was a trigger for motivation considering that many trained nurses were previously unemployed as reported elsewhere (Ebenso et al. 2020). Other factors such as the provision of incentives for service users and free drugs which enhanced utilization of MCH services, as well as equipment, accommodation, increased staff strength and training as well as intrinsic joy in having patients to attend to contribute to the motivation of health workers. .This is exemplified by the quote from a health worker in charge of a facility.

"*When you talk about staffing, Sure-P made the standard of the workers to be superb. You'd see all mix of staff; midwives, CHEWs… and everybody will be in their uniform while working… apart from that… Sure-P brought water, they sank boreholes that use solar and not electricity everywhere …Sure-P also brought drugs. The poor people … can now come to the facility*. (IDI, Health worker,/ Officer in charge, PHC)

Withdrawal of support and distrust due to withdrawal of services

Distrust among health workers

Withdrawal of the programme brought about laying off of all SURE-P/MCH staff including staff training and supervision. At the individual level, the remaining staff experienced increased workloads, inability to meet financial obligations and lack of motivation, which triggered poor health workers' attitude, frustration and unwelcome attitude toward the patients. These ultimately

contributed to poor service delivery and reduction in utilization of MCH services across the implementing facilities.

A health worker narrated that,

...when staff are demoralized, they won't come to work when they are supposed to come. ..., and you will now discover that people may come to access healthcare services without seeing anybody that will attend to them (IDI, health worker/Community Health Officer, PHC).

The discouragement experienced by health workers affected their attitude to service users. "*... sometimes you would meet hostile nurses who use abusive words on pregnant women"* (FGD - Service users, Teacher, aged 34).

Distrust by service users

At the organizational level, the withdrawal of the programme incentives triggered a reduction in the supply of medicines and other commodities, re-introduction of user fees.. Qualitative data show that withdrawal of incentives triggered dissatisfaction, decreased sense of financial security leading to distrust in the health system and subsequent reduction in utilization of MCH services. *"As of then, (during SURE-P programme) the clinic was filled with people due to the incentives but now, everyone has run away"* (FGD - Service users, Farmer aged 29).

Some users began to visit other service providers, including TBAs while the few that utilized the facilities resorted to purchasing medicines outside the health facilities. This trend was highlighted by a health worker;

Those things that we need (e.g. drugs and mama kits…. which SURE-P used to supply) made people come to the health facility, but now that there is no SURE-P, they are not so motivated, … Now when they come and see that the price is high, it makes them to either go to the market or do self-treatment… (IDI, health worker/Community Health Officer, PHC).

The fact that the withdrawal of incentives and consumables resulted in a reduction in utilization of PHC facilities by pregnant women led to the loss of public trust in the health system is consistent with some studies from Nigeria that barriers to utilization of skilled care in formal healthcare facilities include the cost of seeking healthcare and lack of trust in the health system among others (Amuta-Onukagha et al., 2017; Fagbamigbe & Idemudia 2015; Ugboaja et al., 2018)

Quantitative data show that when women were asked to indicate their level of trust in the health system two years after SURE-P//MCH was ended, of those women that said their trust had increased as a result of SURE-P/MCH, around 33% said their trust in the system had eroded while the remaining 66% said their trust remained the same or had even increased (Figure 3).

See Figure 3 in supplementary file for figures:

Residual trust by service users

However, despite the withdrawal of the programme and its incentives, both quantitative and qualitative data show that some service users still have confidence in the health system and maintained unwavering trust in health providers due to their satisfaction and the level of interpersonal trust previously built on the health providers. *"…. Some of them (service users) that came in during SURE-P/MCH continued maybe because they were pleased with what they saw,*

then convincing others to come in while the SURE-P had already closed, but some still trust them and come" (IDI, health worker/ Nurse-Midwife, PHC).

"*For me, it wasn't because of the incentives but the fact that if I am sick they would treat me well but there are those that lost trust because the incentives had stopped so they were going somewhere else*(FGD, service user, fruit trader 29 years)

This buttresses Straten et al., (2002) perspective that at the micro-level people are more concerned about positive behaviour of the healthcare providers, and whether they will handle their healthcare needs appropriately.

FGD responses also highlight the relevance of social capital theory in the explanation of the existence of residual trust experienced in our study.

The residual trust depicted in both qualitative and quantitative data conform to social capital theory about how 'bonding' and linking social capital lead to trust. The bonding ties serve as a means of enabling service users to seek help from the healthcare providers to pay for treatment in instalments which is not usually applicable in other health facilities Bonding and linking social capital consequently s enhance interpersonal trust between healthcare providers and service users and consequently results in the residual trust identified in our study.

DISCUSSION

In this paper, we explored how, why and in what circumstances, the implementation and subsequent termination of the SURE-P/MCH programme affected the trust of service users and health service providers in Nigeria. Specific issues in the findings related to sustainability of trust

in the health system due to services and incentives provided during SURE-P/MCH and lack of trust which resulted due to the withdrawal of services and incentives are discussed.

Sustainability of trust in the health system

SURE-P/MCH programme ushered in staff training and re-training; provision of monetary and non-monetary incentives; subsidization of MCH services, including drugs; facility upgrade; and improved staff remuneration. Health providers are motivated when there is institutional support through the provision of resources such as equipment, upgrading of health facilities and in-service training, and regular remuneration as occurred during the programme This facilitated the development of health providers' public trust in the health system and workplace trust.This development led to the provision of quality care by well-motivated staff and contributed to increased utilization of services and building of interpersonal trust in health workers and public trust in the health system by service users. This finding corroborates the reports of an integral relationship between positive staff attitude and patient-provider interpersonal trust, service users' satisfaction and utilization of health facility services (Gilson et al., 2005; Gopichandran & Chetlapalli 2013; Nwabueze et al., 2011). .

Provision of financial and non-financial incentives resulted in increased utilization of MCH services amongst users due to the development of trusting behaviour in the health system. This reflects literature on the impact of incentives on the utilization of MCH services. Ekezie et al., (2017) report that incentives enable women to take care of barriers arising due to user-fees that are burdensome and motivate them to seek healthcare and in turn improve their standard of living. The use of WDCs and incentivization of the VHWs enabled programme awareness creation, mobilization and support of women in the communities to utilize MCH services. This led to trust

in the health system as well as satisfaction among the service users. This corroborates Thomson et al., (2012) report that incentives promote interpersonal relationship between providers and consumers.

Withdrawal of support and distrust due to withdrawal of services

The termination of the SURE-P/MCH programme was accompanied by a withdrawal of programme incentives and re-introduction of user fees. Withdrawal of access to free drugs by the SURE-P/MCH programme poses a serious concern for service users as it predisposes them to the risk of using TBAs for MCH services (Elem & Nwabah, 2016; Okonofua et al., 2018) and counterfeit drugs. Access to genuine drugs in Nigeria is a major health challenge due to the proliferation of counterfeit drugs (Akinyandenu, 2013). Withdrawal of these programme incentives compromised the quality of care due to the deterioration of MCH services. This triggered dissatisfaction, consequently leading to distrust in the health system and subsequent reduction in utilization of MCH services. Kang & James (2004) and Graham et al., (2015) report that good quality services are associated with the possibility of retaining existing clients and attracting new ones. Our study shows that the withdrawal of drugs and other support services led to the loss of public trust in the health system which, resulted in reduced utilization of MCH services, as service users could no longer rely on the health providers and the health system with confidence. Our data reflect other studies (Ugboaja et al 2018) that distrust in the health system is a barrier to service utilization and results in poor health outcomes. Baba-Ari et al., (2018) demonstrate that although CCTs influenced the uptake of MCH interventions by beneficiaries in North Central Nigeria, that lack of trust was one of the factors that constrained uptake of the programme by non-beneficiaries.

Factors associated with the withdrawal of the SURE-P/MCH programme namely reduced staff strength; increased workloads; lack of training and supervision; and reduced income made service providers lose trust in the health system. This manifested as poor staff attitude towards patients. Okello & Gilson (2015) report that low remuneration and inadequacy of resources trigger workplace distrust and demotivates health workers in LMICs.

However, we also observed that majority of household survey respondents who had indicated that the programme increased their trust also said that withdrawal made no difference. This suggests that for many households, the trust built up during the programme persisted well beyond the end of formal financial support. Similarly, some of the service users had unwavering trust towards the service providers despite the withdrawal of the SURE-P/MCH programme and its accompanying incentives. The existence of this residual trust could be attributed to unchanged staff positive attitude in those facilities. This highlights relational social capital, depicting the interpersonal trust existing between the service users and the healthcare providers due to the health workers' positive attitude to their work and care of their patients. It also corroborates the perspective of Straten et al., (2002) that at the micro-level people are more concerned about the behaviour of the healthcare providers, focusing on whether they will handle their needs appropriately. Furthermore, the residual trust could be attributed to the existence of 'bonding' and linking social capital between the healthcare providers and the service users. Most of the healthcare providers reside in the communities studied and share similar cultural and social identities with the service users. So, the bonding and linking social capital enable service users to seek help and support from the healthcare providers as demonstrated in requests for instalment payment for treatment by some service users. The existence of bonding and linking social capital is also attributed to trust that was established as a result of repeated interaction (Szreter, 2002. This in turn enhanced interpersonal trust between

healthcare providers and service users and consequently triggered the residual trust identified after the withdrawal of the programme.

STRENGTHS AND LIMITATIONS

- RE methodology has been useful in evaluating the SURE-P/MCH programme. This facilitated the development of initial programme theories and enabled us to explore how and why and in what circumstances the context of SURE-P/MCH programme implementation triggered mechanisms that generated anticipated and unanticipated outcomes within the system.

Limitations:

- The theoretical framework is based on theories developed in Western rich and industrialised countries (Gilmore, 2019) and potentially may miss to apprehend the contextual systemic factors embedded in LMIC and Nigeria. Social capital theory, however, is based on the notion of actor-based capital to understand mechanisms of inequality which are fundamental in understanding LMICs health systems.

- Questions in the qualitative interview guide did not directly address 'trust' but 'factors' that determine trust such as confidence and satisfaction. That might have affected the comprehensiveness of the responses. Since the interviews were conducted after the withdrawal of the SURE-P/MCH programme, the time lag could have affected the recall of experiences of the interviewees. Moreover, trust and confidence are interrelated in the sense that both have an underlining notion of expectation. While we regard satisfaction as an outcome of trust conceptually, different respondents saw trust and satisfaction as being interrelated.

Implications for policy and practice

Based on the findings presented in this paper, we recommend that government and policymakers need to build-in sustainable structures in policy designs to mitigate sudden programme withdrawal and its subsequent effects on service users and service providers; provide free drugs in PHCs to enable the poor and vulnerable have access to quality drugs rather than being exposed to the risk of cheap counterfeit drugs; provide regular and adequate remuneration to health workers to motivate them to have a positive attitude to their work and service users. This would enhance interpersonal trust between the health workers and service users as well as public trust in the health system by health providers and service users, and workplace trust for health providers.

Conclusion

The SURE-P/MCH programme was beneficial due to subsidized services and drugs, financial and non-financial incentives. This encouraged service users to trust the healthcare providers and the health system and increased service utilization. Ultimately, it removed financial barriers to accessing MCH services. However, withdrawal of the programme led to distrust in the healthcare providers and the health system and reduced utilization of MCH services. Findings from this study will be useful to government and policymakers in designing policies and practices for implementing health programmes that will enhance interpersonal trust between health providers and service users; and public trust in the health system by health providers and service users, and workplace trust for health providers. This in turn will trigger the provision of quality healthcare services and increased utilization of health facility services in Nigeria.

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ABSTRACT

Trust is important for the effective functioning of the health system, influences health-seeking behaviours, facilitating interaction between patients and healthcare providers. However, there is limited focus on the mechanisms of how trust works within health systems in low and middle-income countries. This paper reports how, why and in what circumstances, the implementation and subsequent termination of a maternal and child health programme affected trust of service users and healthcare providers in Nigeria. In 2015 and 2016 key documents were reviewed, and initial working theories and programme theories of how context triggers mechanisms to produce intended and unintended outcomes were developed. These were tested, consolidated and refined through iterative cycles of data collection and analysis in 2018. Testing and validation of the trust theory utilized eight in-depth interviews with health workers, four focus group discussions with service users and household survey of 713 pregnant women and analysed retroductively. The conceptual framework adopted Hurley's model on 'decision to trust' and Straten et al.'s framework on public trust and social capital theory. Incentives offered by the programme triggered confidence and satisfaction among service users, contributing to their trust on healthcare providers, increased service uptake, motivated healthcare providers to have a positive attitude to work, and facilitated their trust in the health system. Termination of the programme, including withdrawal of and laying off of staff, led to most service users' dissatisfaction, and distrust reflected in the reduction in utilization of MCH services, increased staff workloads leading to their decreased performance although residual trust remained. Understanding the role of trust in a programme's positive and negative short and long-term outcomes can help policymakers and other key actors in the planning and implementation of sustainable and effective health programmes. Future research needs to explore the impact of trust in health systems' performance.

Keywords: Nigeria, Trust, Maternal and child health services, low and middle-income countries, health system's strengthening, Realist Evaluation.

INTRODUCTION

Trust is important for the effective functioning of the health system and is crucial in facilitating interactions between patients and healthcare providers, and on basis of trust, patients are willing to utilize healthcare services, share their health needs and also adhere to treatment including prenatal and postnatal healthcare (Peters & Youssef, 2016; Russel, 2005; Gilson, 2003). Trust is conceptualized as a reliance on a trustee, which is voluntary and with confidence (Meyer, 2015; Hurley, 2006; Riewpaiboon et al., 2005; Thiede, 2005; Goudge et al., 2005) and is based on the assumption that health providers have the expertise to provide appropriate services to patients (Peters & Youssef, 2016). Patient-centred definitions of trust such as Lupton's (1997) point out that in medical encounters, patients' experiences with their healthcare providers are important in promoting trust. However, there is limited focus on how trust works to influence health-seeking behaviours by patients and service provision by health workers in low and middle-income countries (LMICs) (Gilson et al., 2005; Peters & Youssef, 2016). Furthermore, trust literature tends to focus specifically on physicians or on "the health system", neglecting the analysis of trust between healthcare users and members of healthcare teams in maternal and child health (MCH) programmes (Sheppard et al., 2004) in LMICs. In the historical and institutional context of developing countries, it is necessary to draw attention to how trust can develop under challenging circumstances such as limited infrastructure and human resources shortage. The continuous nature of the prenatal to postnatal care relationship provides an ideal opportunity to examine how trust works and develops across time.

This paper contributes to bridging this knowledge gap. We report our analysis of how trust works for healthcare users and providers and how it impacts their behaviours and practices such as utilization and provision of maternal healthcare services in Nigeria. This is done by using the theoretical perspectives of Hurley (2006) and Straten et al., (2002) on trust, to understand qualitative and quantitative data gathered in our evaluation of a national Subsidy Reinvestment and Empowerment Programme (SURE-P/MCH) in Nigeria, one component of which focused on improving access to maternal and child health (SURE-P/MCH). We utilized social capital theory (Agampodi et al., 2015, Szreter & Woolcock, 2004, De Silva & Harpham, 2007) to interpret the sustainability of residual trust by service users after the withdrawal of SURE-P/MCH programme. Thereby, this paper aims to contribute to understanding patterns and practices of trust in healthcare systems by exploring how, why and under what circumstances trust influenced the uptake of maternal and child healthcare during SURE-P/MCH programme and may influence continued MCH service uptake after the suspension of the programme.

The paper is structured as follows: first, we present a review of how the concept of trust is understood in the literature and what this means in the context of LMIC healthcare systems and maternal care; this is followed by an overview of how the health system in Nigeria is organized and how MCH issues are addressed. We then present the methods, results, discussion of findings, implications for policy and practice and conclusion.

Understanding trust in healthcare systems and maternal healthcare in LMICs

Three main types of trust (interpersonal, public and workplace) can be identified in the literature. Interpersonal trust refers to the trust an individual has in another person for example between a patient and healthcare provider, while, public trust is that placed by people in an institution/system

(Gilson, 2003; Gilson, 2006; Russell, 2005; van der Schee et al., 2006). Workplace trust refers to trust in colleagues, supervisors and employing organizations (Okello & Gilson, 2015; Gilson et al. 2005; Calnan & Rowe, 2006). To understand the role of trust in influencing use of MCH services it is particularly important to focus on the interconnection between interpersonal and institutional levels of trust (Meyer et al., 2008) as well as workplace. Trust, which arises at the interpersonal level (micro-level) is important to sustain public trust that occurs at the institutional/macro-level (Gilson, 2003). Workplace trust on the other hand is particularly important for staff to provide round the clock services because it positively impacts on the motivation of health workers (Okello & Gilson, 2015).

Nigerian health system and MCH

Improving MCH care is an international and national priority. The Nigerian Demographic and Health Survey (NDHS) of 2018 reports that access to skilled birth providers continues to elude many pregnant women with wide disparities according to state, rural/urban location, education and wealth status. There was only a slight decrease in infant mortality from 69 deaths per 1,000 during the 5 years preceding the 2013 NDHS to 67 deaths per 1,000 live births in the recent 5-year period. In response to poor MCH indices in Nigeria, the Federal Government of Nigeria implemented the Subsidy Reinvestment and Empowerment Programme (SURE-P/MCH) between 2012 and 2015. The aim was to improve the lives of the most vulnerable populations (Mirzoev et al., 2016). The supply-side component aimed at expanding access to quality maternal health services and improve MCH outcomes through recruitment, training and deployment of 2,000 skilled midwives and 11,000 community health extension workers (CHEWs), supplies and medicines, infrastructure development, and activation of ward development committees (WDCs), particularly in rural communities. The demand side aimed to increase utilization of health services during pregnancy

and at birth by providing conditional cash transfers (CCTs) to pregnant women who registered at public primary healthcare (PHC) facilities, where they received comprehensive MCH services.

Nigeria is the largest country in Sub-Saharan Africa (SSA) with the complex three-tier decentralized health system, (primary health centres, secondary (general hospitals) and tertiary (specialist and teaching hospitals), typical of other LMICs. Private hospitals exist and are owned by individuals and organizations. Disparity in the siting of health facilities between urban and rural locations started during the colonial period (Ademiluyi & Aluko-Arowolo, 2009). Before the introduction of western medicine in Nigeria, pregnant women were assisted by their mothers or mothers-in-law in delivery while traditional birth attendants (TBAs) provided help if they had complications (Amuta-Onukagha et al., 2017). TBAs handle about one-third of deliveries that occur outside health facilities in Nigeria (Fagbamigbe & Idemudia, 2015); reside in the rural communities, and are conversant with the cultural practices associated with delivery. Hence pregnant women are confident and have a feeling of security and satisfaction using their services (Elem & Nwaba, 2016; Ugboaja et al., 2018; Amuta-Onukagha et al., 2017) and some argue that this substantial role of TBAs also indicates lack of trust in MCH services in the health system (Ugboaja et al., 2018).

METHODS

Study Design

This paper reports results from a component of a broader mixed-methods study that adopted a Realist Evaluation (RE) approach to examine the effectiveness of community health workers in the SURE-P/MCH programme in Anambra State, Nigeria. RE is a theory-driven approach which guides the implementation of complex interventions through iterative theory development, testing and refinement (Wong et al., 2017; Robert et al., 2012; Pawson & Tilley, 1997; Wilson &

McCormack, 2006). Programme theories developed within realist studies explore which contexts trigger which mechanisms that produce intended or unintended outcome in different contexts. This enables a clear understanding of the 'whys' and the 'hows' of programme outcome within a particular context that is well suited to evaluating programmes implemented at diverse levels of the health system investigations in low-resource settings (Marchal et al., 2012). In RE, data extraction proceeds from baseline enquiries and development of programme theory to testing/refinement and consolidation of the programme theory, using empirical data (Dalkin et al., 2015).

Data Collection and analysis

The study was conducted in three phases, corresponding to the building of initial working theories (IWTs), testing/validation and consolidation/refinement (Manzano, 2016; Pawson & Manzano-Santaella, 2012, Pawson & Tilley, 1997) see Table 1.

Table 1: Showing the three phases of methods of data collection

Phases	Features	Methods of data collection
Phase 1	The building of initial working theories (IWTs) and programme theories	(i)Review of key documents (SURE-P/MCH programme implementation manual, relevant federal and state-level policies) (June – September 2015) (ii)IDIs with stakeholders: 10 policymakers, 11 programme officers, 16 health workers/PHC staff, and 15 facility managers at Federal and state levels (12 PHCs and 3 General hospitals) (May-November 2016) (iii) FGDs with 8 VHWs, 12 WDCs, 12 service users and 12 family members of the service users. (May –November 2016)

Phase 2	Testing and validation of the trust theory	i) 8 IDIs with health workers and 4 FGDs with service users (August- September 2018) ii)Quantitative method: a household survey of 713 women (May- June 2018)
Phase 3	Theory refinement and consolidation of results into the final trust theory	Use of CMO template to visualize CMO configuration with empirical data (December 2018)

In phase 1, we reviewed key SURE-P/MCH programme documents and relevant MCH Federal and state policies, between June and September 2015, to understand the programme architecture and design (Ebenso et al., 2019). Initial qualitative interviews were held (May -November 2016) with purposefully-identified 96 stakeholders comprising IDIs with 10 policymakers, 11 programme officers, 16 health workers/PHC staff, and 15 facility managers at federal and state levels. Focus Group discussions (FGDs) were held with 8 VHWs, 12 WDCs, 12 service users (pregnant women) and 12 family members of service users. These data facilitated the development of 8 programme theories for the main study.

In phase 2, which entailed data testing and validation of trust theories, qualitative and qualitative methods were utilized. Data were collected in twelve PHCs and three general hospitals purposively selected to reflect the implementation of SURE-P/MCH programme in Anambra state, South-eastern, Nigeria. These facilities were clustered into three, each cluster comprised one general hospital and four PHCs. Two of the clusters benefitted from the SURE-P/MCH intervention, while the third cluster without SURE-P/MCH intervention was used as a control. For the qualitative methods, 8 IDIs with health workers and 4 FGDs with service users were conducted (August-September 2018).

The IDIs and FGDs were guided by a semi-structured question guide which was designed around the different versions of initial working theories and included questions for testing and validating the different components of the programme theories for the main study. All IDIs and FGDs were conducted face-to-face and audio-recorded with respondents' consent, transcribed and translated into English as necessary. Researchers trained in realist interviewing undertook the data collection.

Qualitative data collection was complemented by data from a quantitative household survey. The survey was based on a community listing of all households in the project cluster areas that had a birth in the last 6 years; covering a period before, during and after the SURE-P/MCH programme. A stratified random sample of 713 women were selected for quantitative interview across the three project areas. A questionnaire was administered, which collected information on maternal health-seeking behaviour to the care given and socioeconomic information on the household between May and June 2018.

In phase 3, we refined and modelled the complex relations between the actors, context, intervention processes and mechanisms, and its outcomes (December 2018). Using the Context-Mechanism-Outcome (CMO) configuration, we examined the emerging data on trust to make inferences about the relationships between contexts, mechanisms and outcomes (Figure 1). We examined the quantitative data critically to explore the effect of the intervention on various sub-groups of women and to identify sub-period variation in outcome relative to the period before, during and after the withdrawal of the programme. Patterns across data sets were identified by accumulation (the same factor was present within a set and across sets) and causal relationships were established with further support of the theoretical literature and our qualitative data set. This enabled us to refine and consolidate our programme theory on trust which states as follow:

In the context of improved staff attitude, upgraded health facilities and functioning WDCs achieved during the implementation of the SURE-P/MCH programme, pregnant women who receive sustained financial and non-financial incentives to use MCH services (Context), are likely to develop and maintain a sense of improved trust (including confidence and satisfaction) with health facilities and staff (Mechanism), ultimately leading to the improved likelihood of repeated and regular utilization of MCH services from these health facilities (Outcome).

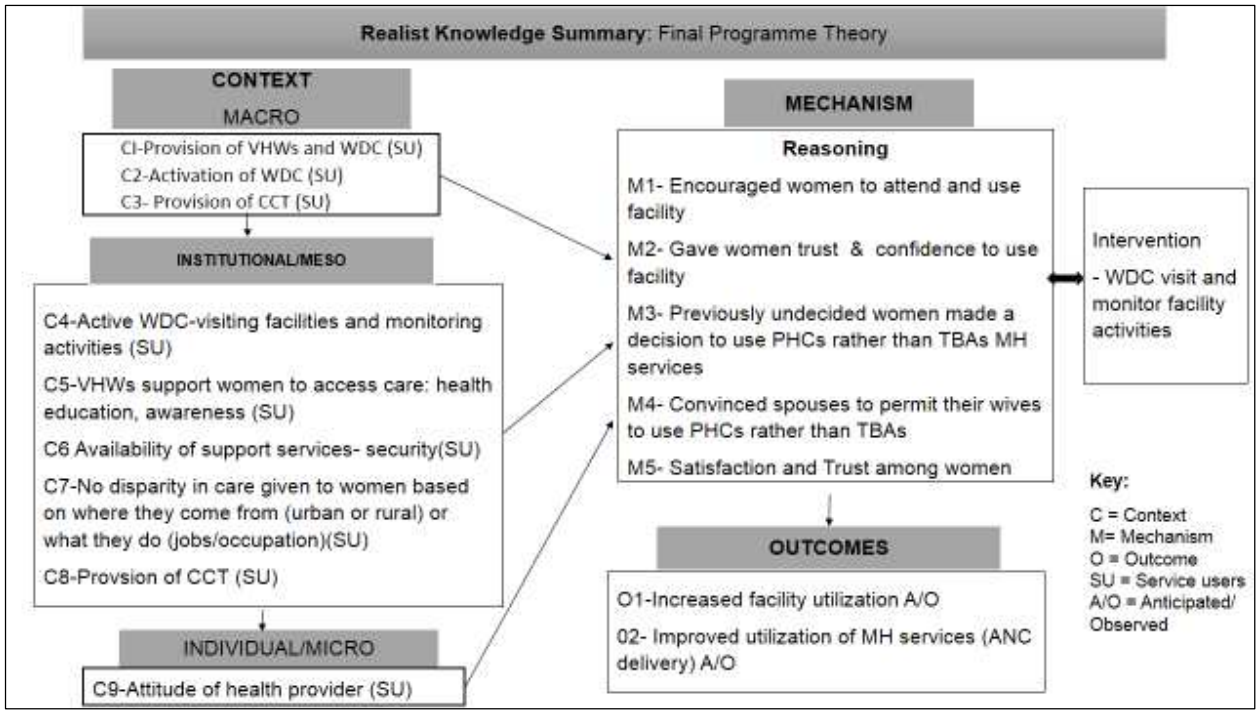


Figure1: CMO template visualizing the causal linkages among contexts (Cs), Mechanisms (Ms) and Outcomes (Os).
(No colour for figure1 in print)

Theoretical Framework

To explain how trust works, we drew upon Hurley's (2006) model on 'decision to trust' and Straten et al., (2002) framework of factors that influence public trust in the Dutch healthcare system. We also utilized social capital theory (Agampodi et al., 2015, Szreter & Woolcock, 2004, De Silva & Harpham, 2007) in our interpretation of the sustainability of residual trust by service users after the withdrawal of SURE-P/MCH programme.

The ten trust factors outlined by Hurley (2006) in his model are: risk tolerance; the level of adjustment; relative power; security; the number of similarities between the trustee and truster; the degree of alignment of the interests of the parties; if the trustee shows benevolent concerns, trustee's capability to do their work, shows predictability and integrity; and if the parties have good communication. Straten et al., (2002) also provide a useful framework in explanation of factors that influence public trust at micro, meso and macro levels, utilizing an instrument to measure eight dimensions of public trust. These include: "trust in the patient-focus of healthcare providers"; "trust that policies at the macro-level will be without consequences for the patient"; "trust in the expertise of healthcare providers"; "trust in the quality of care"; "trust in information supply and communication by care provides"; "trust in the quality of cooperation"; "trust in the time spent on patients"; and "trust in the availability of care (Straten et al., 2002: 230). They specify that at the micro-level people are more concerned about the behaviour of the healthcare providers, whether they will listen to them and handle their problems appropriately. At the meso level, peoples' concern is whether the health providers are cooperating among themselves; at the macro level, people tend to be worried about impacts of interventions accompanying development process in the society on their access to, as well as the quality of healthcare. This framework is relevant in the analysis of trust in LMICs. Peters & Youssef (2016) discuss the role of trust at micro and macro

levels in LMICs. At the micro-level, they indicate that based on trust, the interaction between the doctor and patient can become more effective and consequently will enhance the patient's satisfaction and compliance with treatment. At the macro level, the importance of trust is seen in the impact it makes in the society by influencing efforts being made to meet societal expectations. Studies on trust in Nigeria, (Ugboaja et al., 2018; Amuta-Onukagha et al., 2017; Fagbamigbe & Idemudia, 2015; Babalola & Fatusi, 2009) reinforce the relevance of articulating factors at the micro, meso, and macro levels in analysis of trust in health systems. While home birth alone or with the help of relatives and/or traditional birth attendants is the norm in many LMICs, delay to seek appropriate MCH is a key factor in child mortality. However, the focus on promoting facilities-based health systems in LMICs for obstetric care (WHO, 2005) often ignores how poorly functioning, inaccessible and prohibitive this type of facility-based care (Teela et al., 2009) is for low-income women.

Social capital theory deals with the relationship among people or groups and resources they get through the relationship (Bourdieu, 1986; Szreter & Woolcock, 2004; De Silva & Harpham, 2007). It also entails the expectation of reciprocity concerning their relationship with other members of the networks. Social capital has ‘’bonding’, bridging’, (Gittell & Vidal, 1998.) and ‘linking’ components (Szreter &Woolcock, 2004). Bonding refers to relationships of trust and cooperation, with strong ties among people who have shared identity. Bonding ties serve as “a source of help and support among members” (Erickson 2011:3). Bridging social capital derives from respect and mutual relationships in networks that are not homogeneous but still serve as sources of resources and information (Putnam 2000; Gittell & Vidal 1998; Erickson 2011). Linking social capital refers to “vertical ties between people in different formal or institutionalized power hierarchies”

(Erickson, 2011: 5). The bonding social capital is particularly relevant for the discussion of residual trust experienced in our study.

RESULTS

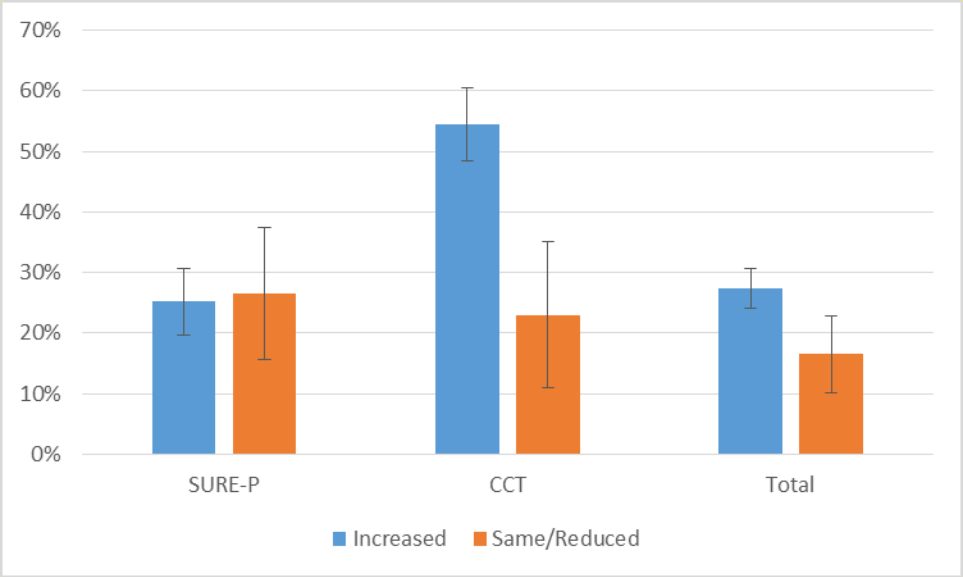
Two broad themes were identified following analysis of qualitative and quantitative datasets: trust during the SURE-P/MCH programme; and distrust following the withdrawal of government support and funding to the SURE-P/MCH programme. The first theme of trust during the SURE-P/MCH programme is further subdivided into trust by service users, and trust by health workers; whereas the second theme of withdrawal of support and distrust due to withdrawal of services is subdivided into distrust by service users and distrust among health workers. The themes and corresponding sub-themes are presented next.

Trust during the SURE- P MCH programme

Trust by service users

The household survey which investigated how women's trust in the health system changed when SURE-P was introduced shows that 25% of those living in SURE-P/MCH areas and 55% of those living in CCT areas said that their trust in the health system increased as a result of the resources provided through the SURE-P/MCH programme (Figure 2).

Figure 2: Change in trust once SURE-P was introduced (% of women)



Note: Error bars represent 95% confidence intervals

(Retain colour for print in figure 2)

To interpret these quantitative findings, our qualitative data showed that availability of skilled birth attendants, and drugs seemed to enhance trust and service utilization. These combined with a positive attitude of the staff towards the patients, triggered service users' satisfaction and confidence in health workers and contributed to interpersonal trust between the staff and service users and also increased public trust in the health system, ultimately leading to increased utilization of the facilities, during the programme. "*I would trust the health centre and come because the nurses were good and would give you good drugs. When they have treated your child and seen that they are effective, you would advise other people to come here "(*FGD - Service users, Trader, aged 27). This illustrates aspects of Hurley's (2006) factors such as "confidence and satisfaction" which enable people to decide to trust as well as aspects of Straten et al., (2002) dimensions of

trust such as "trust in the patient-focus of healthcare providers"; "trust in the expertise of healthcare providers"; and "trust in the quality of care".

In the Nigerian context where the cost of drugs is high, private markets and a proliferation are prevalent and lack of regulation of counterfeit drugs. Loss in confidence in healthcare systems (Onwujekwe et al., 2009) has been linked to non-availability of high-quality drugs and this has an even more significant role in MCH (Amadi &Tsui, 2018). Our data demonstrate that the provision of subsided services including some drugs triggered a sense of removal of the financial barrier which is a major impediment to accessing healthcare, thus contributing to increased public trust of service users in the health system, increased access to care and enhanced utilization of MCH services.

…We received drugs here during the SURE P MCH programme free…, they didn't collect money from us because the drugs were free then (FGD - Service user, farmer, aged 35).

…I come here based on my trust that they don't give fake drugs and so I have 100% trust in them…" and for the safety of the child: *…I come to give birth safely…"* (FGD - Service user, poultry farmer, aged 27).

Service users received some monetary and non-monetary incentives during ANC registration, focused antenatal care (ANC) and postnatal care (PNC). CCT payments ranging from N1000 to N5000 (about USD 30) were given to pregnant women who met the required programme conditions. Also, "Mama Kits" which contain toiletries were given to pregnant women during or after delivery. These financial and non-financial incentives provided for the women, affordably facilitated access to services that combined with the supply side improvement built the trust of women in the system. These mechanisms contributed towards increased and repeated utilization of MCH services. "*The incentives were good, it raised people's spirit up…, so the trust of people*

increased as well as the number of people who came to the health centre" (FGD - Service users, Trader, aged 27).

The programme established and recruited members of WDCs in each community where it was implemented and trained them on sensitizing their target beneficiaries about the programme and on the need to utilize the services provided. It also recruited, trained and incentivized VHWs on the role and responsibility of creating awareness of the programme and the services in communities, getting the pregnant women and children under the age of five to enrol and utilize the services. The use of WDCs and incentivization of the VHWs enabled programme awareness creation, mobilization and support of women in the communities to utilize MCH services. This led to confidence in the health system as well as satisfaction among the service users.

…from the period of SURE- P … they had people who went from house to house who informed us about the health centre… they would encourage women to go to the health centre and see for themselves, they came around to help out at the clinic … (FGD - Service users, farmer and trader, aged 32).

Trust by health workers

The programme recruited, and trained midwives and CHEWs to provide MCH services. These health providers were deployed to all the implementing health facilities and the national government was responsible for their remuneration. The programme staff were reported to be paid their monthly salaries regularly. Consequently, the staff were highly motivated and this triggered workplace trust, which made them available, leading to improved quality round-the-clock services,

while also ensuring the availability of skilled birth attendants. Training and regular payment of healthcare staff salaries motivated them to have a positive attitude to work and triggered public trust among the staff in the health system.

Withdrawal of support and distrust due to withdrawal of services

Distrust among health workers

Withdrawal of the programme brought about laying off of all SURE-P/MCH staff which reduced staff support including staff-training and supervision. At the individual level, the remaining staff experienced loss of colleagues, lack of training/supervision and loss of source of income. Increased workloads, inability to meet financial obligations and lack of motivation triggered poor health workers' attitude, sense of frustration and unwelcome attitude toward the patients, leading to loss of trust in the health system. These ultimately contributed to poor service delivery and reduction in utilization of MCH services across the implementing facilities.

A health worker narrated that,

...when staff are demoralized, they won't come to work when they are supposed to come when you come to the health facility, you won't see them because they are not appreciated, and you will now discover that people may come to access healthcare services without seeing anybody that will attend to them (IDI, health worker/Community Health Officer, PHC).

The discouragement experienced by health workers affected their attitude to service users. "... *sometimes you would meet hostile nurses who use abusive words on pregnant women"* (FGD - Service users, Teacher, aged 34).

Distrust by service users

At the organizational level, the withdrawal of the programme incentives triggered a reduction in the supply of medicines and other commodities, re-introduction of user fees, and deterioration of MCH services. Qualitative data show that withdrawal of incentives triggered dissatisfaction, decreased sense of financial security leading to distrust in the health system and subsequent reduction in utilization of MCH services. *"As of then, (during SURE-P programme) the clinic was filled with people due to the incentives but now, everyone has run away"* (FGD - Service users, Farmer aged 29).

Some users began to visit other service providers, including TBAs while the few that utilized the facilities resorted to purchasing medicines outside the health facilities. This trend was highlighted by a health worker;

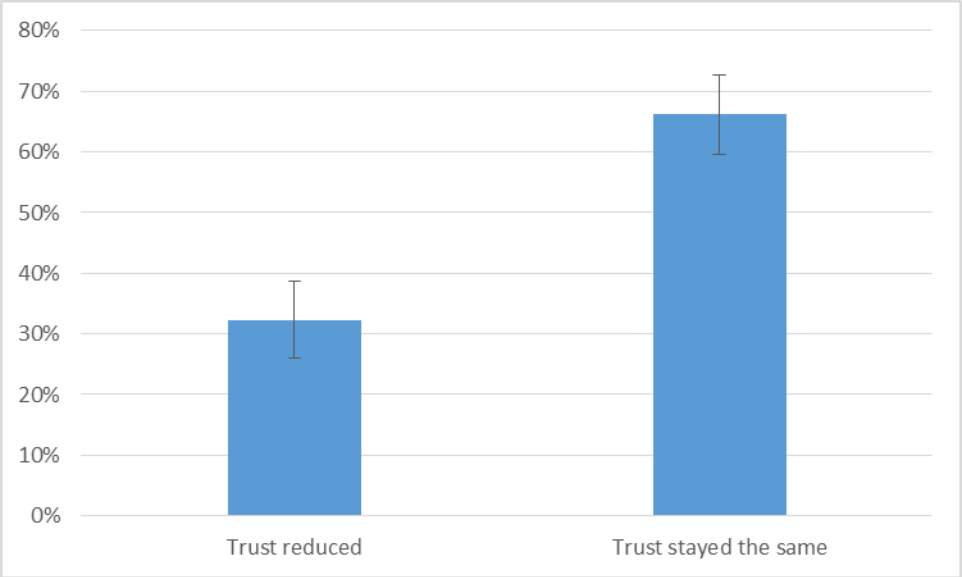
Those things that we need (e.g. drugs and mama kits…. which SURE-P used to supply) made people come to the health facility, but now that there is no SURE-P, they are not so motivated because of lack of all these, … Now when they come and see that the price is high, it makes them to either go to the market or do self-treatment which can lead to death or other complications (IDI, health worker/Community Health Officer, PHC).

The fact that the withdrawal of incentives and consumables led to the loss of public trust in the health system is consistent with the framework of Straten et al., (2002) that at the micro-level people are more concerned about the behaviour of the healthcare providers, and whether they will handle their healthcare needs appropriately**.**

Quantitative data show that when women were asked to indicate their level of trust in the health system two years after SURE-P//MCH was ended, of those women that said their trust had

increased as a result of SURE-P/MCH, around 33% said their trust in the system had eroded while the remaining 66% said their trust remained the same or had even increased (Figure 3).

Figure 3: Change in trust when SURE-P was withdrawn



Note: Of women indicating that their trust in the system increased when SURE-P was introduced

(No colour for figure 3 in print)

Residual trust by service users

However, despite the withdrawal of the programme and its incentives, both quantitative and qualitative data show that some service users still have confidence in the health system and maintained unwavering trust in health providers due to their satisfaction and the level of interpersonal trust previously built on the health providers. *"…. Some of them (service users) that came in during SURE-P/MCH continued maybe because they were pleased with what they saw,*

then convincing others to come in while the SURE-P had already closed, but some still trust them and come" (IDI, health worker/ Nurse-Midwife, PHC).

The residual trust depicted in both qualitative and quantitative data conform with social capital theory about how 'bonding' social capital leads to trust. Most of the healthcare providers reside in the communities studied and share similar cultural and social identities with the service users. The bonding ties serve as "a source of help and support among members" (Erickson 2011:3). The existence of shared norms enhances interpersonal trust between healthcare providers and service users and consequently results in the residual trust identified in our study after the withdrawal of the programme.

DISCUSSION

In this paper, we have explored how, why and in what circumstances, the implementation and subsequent termination of the SURE-P/MCH programme affected the trust of service users and health service providers in Nigeria. Specific issues in the findings related to sustainability of trust in the health system due to services and incentives provided during SURE-P/MCH and lack of trust which resulted due to the withdrawal of services and incentives are discussed.

Sustainability of trust in the health system

SURE-P/MCH programme ushered in staff training and re-training; provision of monetary and non-monetary incentives; subsidization of MCH services, including drugs; facility upgrade; and improved staff remuneration. This development led to the provision of quality care by well-motivated staff and contributed to increased utilization of services and building of interpersonal

trust in health workers and public trust in the health system by service users. Health providers are motivated when there is institutional support through the provision of resources such as equipment, upgrading of health facilities in terms of renovation/building of new structures, provision of water supply, good working environment and in-service training, and regular remuneration as occurred during the programme This facilitated the development of health providers' public trust in the health system and workplace trust which are critical for job performance and satisfaction. Some scholars (Gilson et al., 2005; Nwabueze et al., 2011) report an integral relationship between positive staff attitude and interpersonal trust, satisfaction and utilization of health facility services. This was corroborated in our study as the positive staff attitude during the programme contributed to increased interpersonal trust between the service users and health providers, which in turn sustained utilization of MCH services. Gopichandran & Chetlapalli (2013) show that service providers' behaviour influenced the level of trust the service users apportion to them. Russell (2005) also report that trust is a driver of health-seeking behaviour among patients in hospital settings in some countries such as Colombo, and Sri Lanka. We attribute the increased utilization of MCH services amongst users in our study to a high level of trust on providers and the health system as patients with lower levels of trust are less expected to seek services, have repeated utilization, and more likely to avoid healthcare (Armstrong et al., 2006).

Provision of financial and non-financial incentives and subsidized services such as drugs, resulted in increased utilization of MCH services amongst users due to the development of trusting behaviour in the health system. This corroborates literature on the impact of incentives on the utilization of MCH services. Thomson et al., (2014) show that many of their study participants perceive that the use of incentive has the potential for reducing inequalities by enabling the poor and vulnerable have access to items they would not be able to afford. Ekezie et al., (2017) report

that incentives enable women to take care of barriers arising due to user-fees that are burdensome and motivate them to seek healthcare and in turn improve their standard of living. The use of WDCs and incentivization of the VHWs enabled programme awareness creation, mobilization and support of women in the communities to utilize MCH services. This led to trust in the health system as well as satisfaction among the service users. This corroborates Thomson et al., (2012) report that incentives promote interpersonal relationship between providers and consumers.

Withdrawal of support and distrust due to withdrawal of services

The termination of the SURE-P/MCH programme was accompanied by a withdrawal of programme incentives and re-introduction of user fees. Withdrawal of access to free drugs by SURE-P/MCH programme poses a serious concern for service users as it predisposes them to risk of using TBAs for MCH services (Elem & Nwabah, 2016; Okonofua et al., 2018) and counterfeit drugs. Access to genuine drugs in Nigeria is a major health challenge due to the proliferation of counterfeit drugs (Akinyandenu, 2013). Withdrawal of these programme incentives compromised quality of care due to deterioration of MCH services. This triggered dissatisfaction, decreased sense of financial security, consequently leading to distrust in the health system and subsequent reduction in utilization of MCH services. It could also be possible that people who were coming from other facilities because of the SURE-P/MCH programme, are no longer bothered and they moved back to the facilities where they were receiving services before. Kang & James (2004) and Graham et al., (2015) report that good quality services are associated with the possibility of retaining existing clients and attracting new ones. Our study shows that the withdrawal of drugs and other support services led to the loss of public trust in the health system which, resulted in reduced utilization of MCH services, as service users could no longer rely on the health providers

and the health system with confidence. Our data reflect other studies (Whetten, 2006; Riewpaiboon et al., 2005; that distrust in the health system is a barrier to service utilization and results in poor health outcomes. Baba-Ari et al., (2018) demonstrate that although CCTs influenced the uptake of MCH interventions by beneficiaries in North Central Nigeria, that lack of trust was one of the factors that constrained uptake of the programme by non-beneficiaries.

Factors associated with the withdrawal of the SURE-P/MCH programme namely reduced staff strength; increased workloads; lack of training and supervision; and reduced income made service providers to lose trust in the health system. The loss of public trust by the service providers towards the health system manifested as poor staff attitude towards patients. Okello & Gilson (2015) report that low remuneration and inadequacy of resources trigger workplace distrust and demotivates health workers in LMICs. However, we also observed that majority of household survey respondents who had indicated that the programme increased their trust also said that withdrawal made no difference. This suggests that for many households, the trust built up during the programme persisted well beyond the end of formal financial support. Similarly, some of the service users had unwavering trust towards the service providers despite the withdrawal of the SURE-P/MCH programme and its accompanying incentives. The existence of this residual trust found in our study could be attributed to unchanged staff positive attitude in those facilities, although the withdrawal of incentives and consumables led to loss of public trust in the health system. This corroborates the argument of Straten et al., (2002) that at the micro-level people are more concerned about the behaviour of the healthcare providers, focusing on whether they will handle their needs appropriately. This also reflects findings of Gilson et al., (2005) in South Africa, that the key concern of primary care service users is that healthcare providers have a positive attitude which includes being respectful and providing good quality care.

Furthermore, the residual trust could be attributed to the existence of 'bonding' social capital between the healthcare providers and the service users. Most of the healthcare providers reside in the communities studied and share similar cultural and social identities with the service users. So, the bonding ties serve as "a source of help and support among members" (Erickson 2011:3). The existence of shared norms is also attributed to trust that was established as a result of repeated interaction (Szreter, 2002:655). This in turn enhanced interpersonal trust between healthcare providers and service users and consequently resulted in the residual trust identified after the withdrawal of the programme.

STRENGTHS AND LIMITATIONS

- RE methodology has been useful in evaluating the SURE-P/MCH programme. This facilitated the development of initial programme theories and enabled us to explore how and why and in what circumstances the context of SURE-P/MCH programme implementation triggered mechanisms that generated anticipated and unanticipated outcomes within the system.
- Limitations: The questions in the qualitative guide did not directly address trust but factors that determine trust such as confidence and satisfaction. That might have affected the comprehensiveness of the responses. Since the interviews were conducted after the withdrawal of the SURE-P/MCH programme, the time lag could have affected the recall of experiences of the interviewees.

Implications for policy and practice

Based on the findings presented in this paper, we recommend that government and policymakers need to do the following: build-in sustainable structures in policy designs to mitigate sudden programme withdrawal and its subsequent effects on service users and service providers; provide

free drugs in PHCs to enable the poor and vulnerable to have access to quality drugs rather than being exposed to the risk of cheap counterfeit drugs; provide regular and adequate remuneration to health workers to motivate them to have a positive attitude to their work and service users. This would enhance interpersonal trust between the health workers and service users as well as public trust in the health system by health providers and service users, and workplace trust for health providers.

Conclusion

The SURE-P/MCH programme was beneficial due to subsidized services and drugs, financial and non-financial incentives. This encouraged service users to trust the healthcare providers and the health system and increased service utilization. Ultimately, it removed financial barriers to accessing MCH services. However, withdrawal of the programme led to distrust in the healthcare providers and the health system and reduced utilization of MCH services. Lessons learnt from this study as stated in the preceding paragraph, will be useful to government and policymakers in designing policies and practices for implementing health programmes that will enhance interpersonal trust between health providers and service users; and public trust in the health system by health providers and service users, and workplace trust for health providers. This in turn will trigger the provision of quality healthcare services and increased utilization of health facility services. Due to the paucity of research on trust in LMICs and particularly in Nigeria, our findings will boost the interest of researchers to explore the impact of trust in effectiveness and sustainability of health intervention programmes and health system.

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Supplementary file of Figures

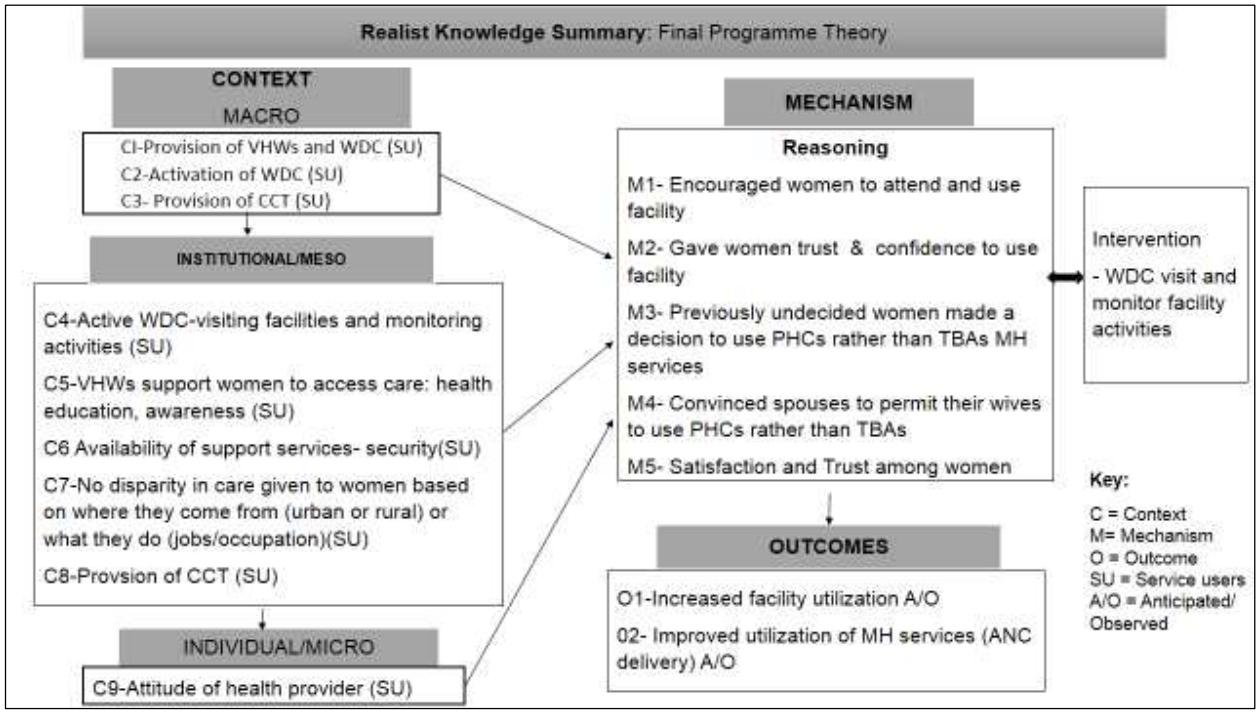

Figure1: CMO template visualizing the causal linkages among contexts (Cs), Mechanisms (Ms) and Outcomes (Os).

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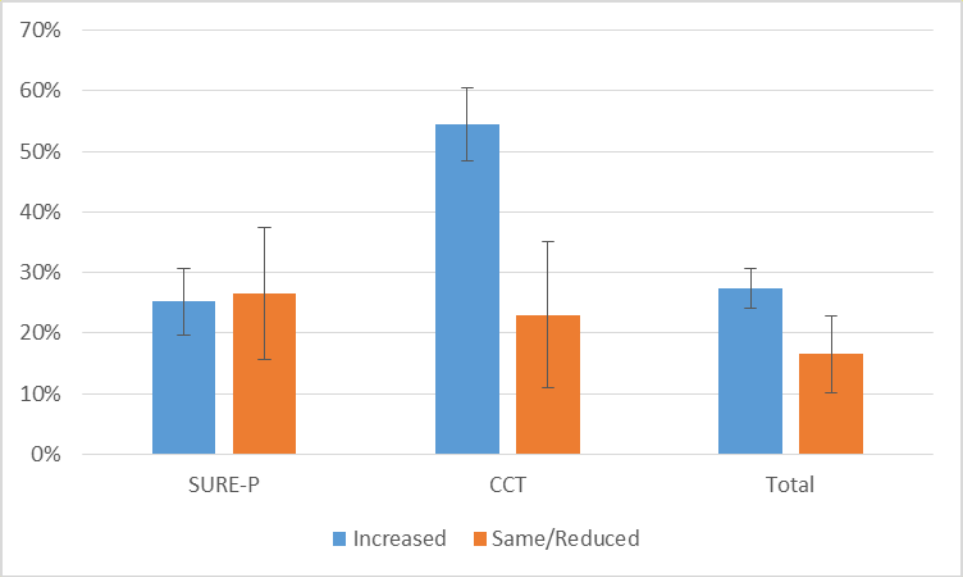
Figure 2: Change in trust once SURE-P was introduced (% of women)



Note: Error bars represent 95% confidence intervals

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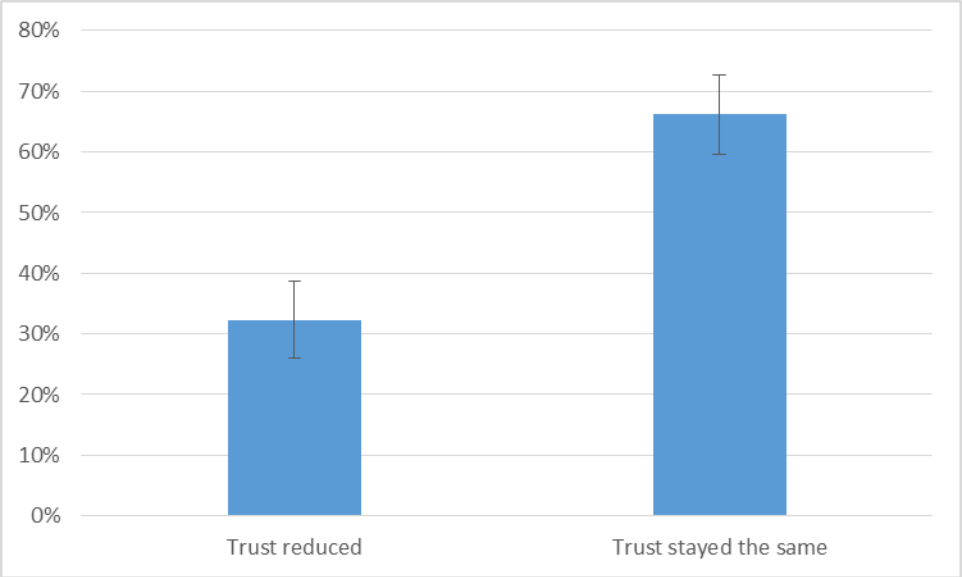
Figure 3: Change in trust when SURE-P was withdrawn



Note: Of women indicating that their trust in the system increased when SURE-P was introduced

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Supplementary File of Tables

Table 1: Showing the three phases of methods of data collection

Phases	Features	Methods of data collection
Phase 1	The building of initial programme theories (IPTs) and programme theories	(i)Review of SURE-P/MCH programme implementation manual, relevant federal and state-level policies) (June – September 2015) (ii)IDIs with stakeholders: 10 policymakers, 11 programme officers, 16 health workers/PHC staff, and 15 facility managers at Federal and state levels (12 PHCs and 3 General hospitals) (May-November 2016) (iii) FGDs with 8 VHWs, 12 WDCs, 12 service users and 12 family members of the service users. (May –November 2016)
Phase 2	Testing and validation of the trust theory	i) 8 IDIs with health workers and 4 FGDs with service users (August- September 2018) ii)Quantitative method: a household survey of 713 women (May- June 2018)
Phase 3	Theory refinement and consolidation of results into the final trust theory	Use of CMO template to visualize CMO configuration with empirical data (December 2018)

Credit Author Statement

NOT APPLICABLE