colleagues so they often limit their empathy with MSM within the hospital context. MSM, trusting in the confidentiality of caregivers feel safe in the care facilities but are afraid to be seen by others. Stigmatising factors limiting access to care include : (1) fear of meeting a relative, (2) difficult relationships with technical support staff (mainly security guards), (3) HIV status disclosure and (4) potential conflicts with other MSM.

Conclusion The hospital is divided into several areas of stigmatisation. It is important to map out the MSM in their care trajectories and spaces, identify all types of staff working within them, including technical staff to enroll them in stigma reduction interventions.

Theme: Global perspectives: trust and truth in health-related settings

Day 1: Thursday 18th March – 13.35-14.55

16 UNPACKING THE 'TRUTH' ABOUT THE HEALTH GAP: DECOLONISING METHODOLOGIES, CULTURAL ARCHIVES AND THE NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PLAN 2013–2023

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Truth and authority are key concepts in settler colonial knowledge systems that inform Aboriginal health policy: 'truth' about policy 'problems' and authority in who can determine policy solutions. The growing emphasis on evidence-based policy means that policymakers increasingly draw on research and western knowledge as their sources of truth and authority. In this way, policymakers construct policy as an objective 'solution' to Aboriginal health 'problems'. However, drawing upon Foucault's notion of the 'cultural archive' or 'storehouse', Linda Tuhiwai Smith (2012) shows that western research has generated representations of, and stories about Indigenous peoples (particularly 'problems') that claim 'truth' and 'authority' but are instead embedded in white, western ways of knowing and categorising the world – and serve colonial power structures.

We used Bacchi's (2009, 2015) 'What's the problem represented to be' framework to analyse 'problems' represented within the Australian *National Aboriginal and Torres Strait Islander Health Plan 2013–2023*. The Plan acknowledges that the health and well-being of Aboriginal and Torres Strait Islander people is connected to 'trauma', 'dispossession', and the 'interruption of culture'. However, in the Plan, western knowledge, described as 'clinical' and 'evidence based', is given primacy over Aboriginal and Torres Strait Islander people's 'cultural' knowledges. What is left unproblematic in the *National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023* is the way this 'cultural' versus 'clinical' knowledge binary draws upon settler colonial hierarchies of knowledge, obscuring the ways even health policy serves settler colonial power structures. We conclude that, while positive, growing awareness of the role of colonisation in producing health disparities across settler and Indigenous populations has not translated into unsettling the knowledge systems upon

which policy is created. We provide some reflections on how decolonising research methodologies may also inform policy-makers seeking to 'unsettle' the truth and authority, particularly 'evidence', that influences policymaking.

17 AN INTERSECTIONAL ANALYSIS OF STORIES FROM COMMUNITIES IN PAKISTAN

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10.1136/bmjopen-2021-QHRN.55

As part of its strategy, the Community Engagement Centre (CEC) – a joint venture of Indus Health Network's Global Health Directorate and Interactive Research and Development, Pakistan – collects communities' stories from program catchment populations. These include challenging, life-changing incidents and narratives of agency which offer valuable insights into organic systems and barriers as well as the nuances of power and access.

Nine stories were analysed to reveal a 'catalyst'; these stories included a person or group holding the trust of community members, that demonstrated agency to act either for themselves or their communities. These catalysts may or may not have been successful in achieving the desired change, but studying these narratives revealed the lived experiences, mechanisms of trust and dynamics of power in communities: how healthcare workers, individuals, and communities interact, utilise their agency to own positions in society, and build trust to enable change – within themselves or the larger collective. We investigated the levels at which low-resourced communities experienced challenges while aspiring towards change and whether certain social categories enabled more agency than others. To examine the stories, we developed and applied an intersectional framework that was able to dissect the stories down to their elements.

Findings yielded that classism and sexism were significant barriers for communities and individuals, while trust was a powerful facilitator for agency and action. The analysis demonstrates that conducting an intersectional analysis on these stories aids in dispelling the 'symptomised' perspective of poor communities as non-agentic and helpless in the face of difficulties. Furthermore, by understanding communities' organic responses to collective problems and health concerns, programs can integrate with existing local systems for long-term solutions.

18 TRUSTED MESSAGES? EXPLORING THE ROLE OF TRUST IN MHEALTH FOR DIABETES PREVENTION IN RURAL BANGLADESH

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10.1136/bmjopen-2021-QHRN.56

Background The prevalence of type 2 diabetes is rising rapidly in Bangladesh, and there is an urgent need to engage populations in preventing and controlling diabetes. Mhealth may offer a scalable way to deliver educational advice, information and motivation for behaviour change. We conducted qualitative research to explore how a population-based mobile health

(mhealth) voice messaging intervention could be effective in this context. The intervention was tested through a cluster randomised controlled trial and, despite high coverage of messages, there was no evidence of effect. Our analysis identified the role of trust as a key mediator.

Aim To analyse the role of trust as a causal mechanism in mhealth messaging.

Methods We conducted non-participant observation while messages were being received, and four focus group discussions (FGDs) with men and women who had subscribed to messages, and one key informant interview. We conducted descriptive content analysis in Nvivo as a team.

Results Mass messaging for advertising was common in the study context, and despite efforts to identify messages, this may have affected receipt. The Diabetic Association of Bangladesh was a well-known and trusted institution which meant that mhealth messages were believed and trusted, and therefore it was beneficial to establish this early in message content. We found that many felt the messages were irrelevant as they did not feel at risk of diabetes. Messages being delivered by a trusted organisation was of limited use for diabetes prevention, because this framed messages within a disease paradigm which many felt that they didn't fit into.

Conclusion Trust was a mediator of intervention effect, but association with diabetes may have made the intervention less attractive for populations who believe themselves not to be at risk. Participatory design of mhealth messaging may be equally as important as the trustworthiness of the implementing organisation.

Day 2: Friday 19th March – 14.50-15.50

19 THE ROLE OF TRUST IN GLOBAL RESOURCE ALLOCATION DECISIONS FOR VACCINE PREVENTABLE DISEASES

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Background Evidence on disease burden and the impact of interventions are instrumental in vaccine related investment decisions. It is imperative to understand what the facilitators and barriers of evidence use are to ensure the most effective vaccine investment decisions for public health at global and national level are made.

Aims Overall, this research aims to understand if, and how, mathematical models are used to inform resource allocation decisions for vaccine-preventable diseases in low-and middle-income countries. Here we focus on exploring the role of trust in the potential use of evidence from mathematical models.

Methods Twelve semi-structured interviews were conducted with mathematical modelers (evidence producers) and employees at international organizations, who are involved in decision-making processes (evidence consumers) at a global level. Information was collected on stakeholders' experiences and perceptions of the use of mathematical models at global and at national level. All mathematical modelers were purposively sampled by their extensive vaccine modelling

experience at a global and/or national level. Data from interviews were coded and mapped to a theoretical framework, which identified the spectrum of evidence use by policy and decision makers.

Expected results This presentation will describe how mathematical models are being used in global level resource allocation decisions, and more specifically, how trust is understood by both model consumers and producers. Preliminary findings suggest trust is both an integral facilitator and barrier for evidence use and heavily influenced by model producer's research environments and length of relationships with model consumers. Amongst consumers the concept of trust is most notable in the context of methodologies, data transparency and stakeholder relationships.

Conclusion This research suggests that the use of evidence and perceptions of evidence differ among stakeholders. Trust among evidence producers and consumers is an integral component in evidence informed decision-making that can be a barrier or facilitator.

20 SOCIAL JUSTICE AND DISEASE ERADICATION: UNDERSTANDING THE 'TRUST GAP' IN POLIO'S FINAL STRONGHOLDS

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10.1136/bmjopen-2021-QHRN.58

Background The global effort to eradicate polio has reduced cases by 99% globally. However, delivering the program to the world's hardest-to-reach populations, who continue to receive inequitable access to health resources and services has impelled distrust and refusal of the program.

Aim This study explores key determinants for building and sustaining public trust in global disease control programs.

Methods STRIPE (Synthesis and Translation of Research and Innovations from Polio Eradication) is a collaboration seeking to map, synthesise, and disseminate lessons learned from polio eradication in Afghanistan, Bangladesh, the DRC, Ethiopia, India, Indonesia, and Nigeria. We conducted 194 key informant interviews with policymakers, government and program officials, and frontline workers across the global, national, and sub-national levels. Here, we draw on interviews from Afghanistan and Nigeria.

Results Public trust in the polio eradication effort has been progressively deteriorating, especially among the marginalised and disenfranchised populations. At the country level, repeated and aggressive mass vaccination campaigns, de-emphasis of routine immunisation and other essential health services, and gender dynamics, have combined in critical ways to influence community response to program activities.

Informants highlight the importance of community knowledge and experience, socio-cultural norms and local area issues, access to essential health services, and transparent and consistent communications as key determinants of trust and acceptance of the polio program and vaccine.

Conclusion Early polio eradication efforts singularly focused on eradication strategies, failing to acknowledge community priorities or account for other essential services, including water, sanitation and hygiene, maternal and childcare, etc., reinforcing existing inequities among the vulnerable populations, and resulting in refusals and resistance. The Global Polio Eradication Initiative has more recently taken steps to