

TRUST STUDY

BLUEMIND FOUNDATION • OCTOBER 2026

Can trust be mental health infrastructure?

A mixed-methods study with 576 women
in hair salons in Togo.



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UNITED FOR MENTAL HEALTH IN AFRICA

About this study

Trust Study is a Bluemind Foundation publication examining the role trust may play in mental health systems in Africa. This edition looks at trust between hairdressers and their clients, emotional support, and pathways to mental health care, drawing on a study conducted in Togo.

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This study received no funding from the beauty or cosmetics industry. Data were collected by enumerators independent of and external to Bluemind Foundation.

Conflict of interest. Bluemind Foundation designs and implements the Heal by Hair innovation discussed in this report. To limit this bias, data were collected by independent enumerators, results on the programme are presented as participants' own accounts, and the report does not make causal claims about the programme's effects.

Data availability

Anonymized quantitative data and the full data-collection instruments are available from Bluemind Foundation on reasonable request for research purposes. The instruments are reproduced in the appendix.

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Executive summary

What was already known. Women confide in their hairdressers. This has been documented in the United States and Australia, and confirmed in Africa by Bluemind Foundation's 2021 survey of 714 women and 148 hairdressers in seven francophone countries, mainly in West and Central Africa. Trust is a core assumption of community mental health models, but it is rarely studied in its own right, and almost never in francophone Africa.

What this study adds. Asked who they turn to first, 30% of women surveyed name their hairdresser; fewer than 1% name a health professional. 89% of women interviewed tell their hairdresser things they say nowhere else. Trust works because the hairdresser is close, yet outside the intimate circle. Detection rests on the gap between how a client is today and how she usually is. Trust opens the way to care but does not guarantee it alone.

What it means. Access to mental health care starts before the clinic door. Trusted relationships can be equipped, without being medicalized, and must be connected to care that is available and affordable.

Keywords: trust; community mental health; trusted intermediaries; task sharing; hair salons; women's mental health; gender-based violence; pathways to care; francophone countries; West Africa; Togo.

150 million people in Africa live with a mental health condition. Fewer than 1 in 10 receive any support (WHO, 2025). Women are hit hardest: more likely to experience depression and anxiety, more exposed to violence (1 in 3 women worldwide suffer physical or sexual violence in their lifetime, WHO, 2021b), and facing the steepest barriers to care. Most women in distress will never see a mental health professional. So who do they turn to first, and can that relationship help them reach care? The answer: 30% of women surveyed name their hairdresser. Fewer than 1% name a health professional (Bluemind Foundation, Trust Study 2026). Bluemind Foundation has worked with hairdressers since 2021 through Heal by Hair. This study looks not at the programme, but at what it builds on: **trust between women and their hairdressers.**

This study examines the role that trust between women and their hairdressers may play in that pathway. It was conducted in Togo between April and June 2026 using mixed methods. The quantitative component covered **150 clients in Lomé and 290 hairdressers in Lomé, Kara, Sokodé and Dapaong.** The qualitative component comprised semi-structured interviews with 28 clients and 25 hairdressers, and five focus groups with 27 clients and 56 hairdressers. In total, 576 women took part. Data were collected by enumerators independent of Bluemind Foundation.

Confiding is already part of the relationship

79% of hairdressers say clients talk to them about personal difficulties often or sometimes, and **69% of clients** say they confide in their hairdresser often or sometimes. In interviews, 89% of clients interviewed say there are things they can discuss with their hairdresser that they do not raise elsewhere. Participants link this openness to the length and regularity of the relationship, the hairdresser's discretion and her position outside the family and close-friend circle.

Close, but outside the intimate circle

Asked whom they turn to first when going through a difficulty, clients name family (41%), **their hairdresser (30%)**, friends (11%) and health professionals (**less than 1%**); 17% say they would turn to no one first. The hairdresser is valued as accessible and largely non-judgmental. **This is the study's central finding: a certain distance, combined with familiarity, can make it easier to speak.**

Noticing that "she is not herself"

All hairdressers interviewed say they have noticed a difficulty in a client before she put it into words, and 96% of clients interviewed believe an attentive hairdresser can tell when something is wrong. Participants link this to changes in behaviour, appearance, mood or habits in clients they have known for months or years. **The signal is often the gap between how a client is today and how she usually is.** These accounts document knowledge built over time; they do not establish the clinical accuracy of such observations.

What Heal by Hair adds

The trust relationship exists with or without Heal by Hair. What differs is what hairdressers are equipped to do with it. Before training, ambassadors describe listening that was intuitive but often interrupted, judgmental or emotionally overwhelmed, with confidences sometimes repeated to others and little idea of where to refer a client. Untrained hairdressers also say they advise clients to seek help, but the study cannot say towards whom; field observations suggest this is often a religious or traditional resource. Heal by Hair ambassadors are trained to listen without judging, to keep what they hear strictly confidential, to recognize signs of distress, to respond safely, including to disclosures of violence, to know the limits of their role, and to refer to identified resources within a referral system developed with the Ministries of Health. Ambassadors report changes in how they listen, how closely they watch for signs of distress and how confident they feel about referral. Because clients themselves make non-judgmental listening a

condition of trust, these skills may also strengthen the trust on which the whole mechanism rests.

An accepted role, within clear limits

Around **90% of clients** believe salons can help women talk about their difficulties. **Almost all clients (99%) are open to a referral by their hairdresser** to a professional or a support circle: 69% say yes and 30% "maybe"; only 1% say no. Acceptance depends on an established relationship, confidentiality, and respect for the limits of the role. Clients clearly distinguish listening and referral from therapy.

What this means

The findings support the idea that trust relationships embedded in everyday life can contribute to the early stages of a mental health pathway. **Trust is part of the pathway to care: it can open the way, provided care is available and accessible. On its own, it does not replace care.** A referral is of little value if the service remains out of reach because of cost, distance or availability. This is why Bluemind Foundation also invests downstream, supporting the training of psychiatrists and health staff, working alongside public health authorities rather than in their place.

For Heal by Hair, the study clarifies the mechanism on which the programme builds. The training does not create the relationship; it makes existing practices safer, more structured and better connected to qualified resources. The findings also highlight the need to protect hairdressers' own well-being and to coordinate their role with mental health services.

This is an exploratory study based mainly on self-reported data. Client data come from women recruited in salons in Lomé; hairdresser data cover four cities. The results describe the populations studied.

Future research could follow these relationships over time, add standardized well-being measures, and test the mechanism in other countries and in other trusted relationships that share the salon's key features, starting with women who provide body care in hammams, beauticians and seamstresses. The broader question is: **under what conditions can trust become part of mental health infrastructure?**

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I. Introduction

1.1. Context

In many sub-Saharan African countries, mental health systems face serious shortages of staff, funding and services, especially in low-income countries (World Health Organization, 2025). Cost, stigma, low awareness and other social barriers add to these constraints (WHO Regional Office for Africa, 2022, 2024). As a result, a large share of mental health needs never reaches formal care.

Where formal care is hard to reach, informal emotional support exists in everyday relationships and places. For some women, these are where a personal difficulty is first voiced, before any contact with a health professional. The hair salon is one such place. Regular visits, its place in women's social and cultural life, long appointments and continuity between client and hairdresser make it a setting where personal conversations and trust can develop.

This social role of the salon is familiar to many women. It has also been documented. Cowen et al. (1979) described the place of personal exchanges between hairdressers and clients in the United States. Page et al. (2022, 2024) studied hairdressers in Australia as sources of informal social support. Health promotion programmes have also used beauty salons and barbershops to reach communities underserved by health services (Linnan & Ferguson, 2007; Victor et al., 2018).

In francophone Africa, **Bluemind Foundation made this relationship the starting point of the Heal by Hair programme**, built on the hypothesis that the existing relationship between women and their hairdressers could be an entry point into mental health support. The programme trains hairdressers to listen, to detect signs of distress and to refer clients to professionals when needed, in a role distinct from that of mental health professionals.

This rationale has since been the subject of a first experimental evaluation. Nilsson and Biyong (2025) examined Heal by Hair and the potential of hairdressers as non-medical intermediaries where access to formal mental health services is limited. They highlight that the intervention rests on a particular feature of the hairdresser-client relationship: pre-existing trust, built through regular interaction and embedded in West African social practices.

Trust is therefore a core assumption of the Heal by Hair model, but **it has not yet been studied as a research question in its own right**. How does it form? Why do some clients tell their hairdresser things they say little or nowhere else? Does the continuity of the relationship help the hairdresser notice

changes? Under what conditions can this trust support a referral to outside help?

These questions remain poorly documented, especially in francophone Africa. This study sets out to fill part of that gap.

1.2. Contribution of the study

The starting point is an observation from Bluemind Foundation's surveys and fieldwork since 2021: women already confide in hair salons. They talk about personal, emotional, family and social difficulties, sometimes before seeking any professional help. Hairdressers hear these confidences, may notice that something is wrong, and respond with whatever resources they have.

The study therefore shifts the focus from the intervention to the relationship it relies on. It asks how trust is built between hairdressers and clients, what that trust makes possible, and under what conditions it can contribute to early detection, first-line emotional support and referral. It also examines how a structured training programme, Heal by Hair, can build on these existing practices while keeping the hairdresser's role clearly distinct from that of mental health professionals.

To our knowledge, few studies have jointly examined these different dimensions in an African context using a mixed-methods approach.

This is an **exploratory, mixed-methods study**. It concerns trust relationships, reported practices and participants' perceptions. It was not designed to measure clinical outcomes or to establish a causal effect of the training.

Beyond hair salons, the study seeks to identify **the features of a pre-existing trust relationship that could inform the study of other everyday intermediaries**. The underlying question is: under what conditions can trust that already exists in certain relationships support detection, support and, when needed, access to professional care?

1.3. Part of a broader body of work

The study builds on Bluemind Foundation's first field surveys in 2021, with **714 women and 148 hairdressers in seven francophone African countries, mainly in West and Central Africa**. These surveys documented perceptions of mental health, the place of the salon in women's lives and the social role of hairdressers. They already showed that women confide in their hairdressers, as earlier studies had found in the United States and Australia. The Trust Study goes one step further: it examines the trust behind these confidences, and what that trust makes possible.

Other research on Heal by Hair evaluates the programme's effects. The Trust Study asks a different question: not whether the programme works, but what the relationship it builds on is made of.

The scope of this research, however, goes beyond the case of hair salons alone. The characteristics observed in the relationship between hairdressers and clients can now be studied in other everyday trust relationships and with other social intermediaries. Comparative research will allow us to examine what is specific to the hair salon and what pertains, more broadly, to the characteristics of pre-existing relationships likely to facilitate detection, support, or referral in mental health.

The Trust Study is thus a first empirical contribution to a broader question: **under what conditions can pre-existing trust become part of mental health infrastructure?**

II. Theoretical framework

2.1. Informal social infrastructure and community health

The idea of infrastructure, long reserved for physical and technical systems, has been extended in the social sciences to the places and organizations that shape social interaction and make certain collective functions possible (Klinenberg, 2018). Applied to community health, it draws attention to the relationships and spaces that already provide some forms of support outside health facilities: local networks, associations, community groups, places people visit regularly.

This study looks at the hair salon from this angle. It is not a place of care in the clinical sense. The salon, however, presents several characteristics relevant to the analysis: regular attendance, embeddedness in feminine social and cultural practices, continuity of relationships, and time shared between hairdresser and client. **The infrastructure examined here is not the physical salon, but the relationship built over time and what it makes possible.**

2.2. Trusted intermediaries and task sharing

A trusted intermediary is a non-specialist who already has a trust relationship with a community and who may, under certain conditions, make it easier to voice a difficulty, offer a first form of support or help someone reach an appropriate resource. These actors can be the first link in a referral chain, lowering symbolic, economic and social barriers to care. **Here, trust comes before the intermediary role: it is one of the conditions that make that role possible.**

This connects to task shifting and task sharing. The World Health Organization defines task shifting as the rational redistribution of tasks among health workforce teams (WHO, 2007). In mental health, task sharing involves non-specialists within frameworks where training, role definition, supervision and referral pathways are explicit (WHO, 2021a, 2023). The best-known African example is the Friendship Bench in Zimbabwe, where trained lay health workers deliver problem-solving therapy; a randomized trial showed reduced depressive symptoms (Chibanda et al., 2016). The Friendship Bench builds a new relationship around a trained lay worker. Heal by Hair starts from a relationship that already exists.

Heal by Hair applies this logic through graduated roles. Ambassador hairdressers are trained to detect signs of difficulty, to provide first-line listening and to refer. They do not diagnose and do not replace mental health professionals. The training curriculum

is based on the World Health Organization's mhGAP (Mental Health Gap Action Programme) materials (WHO, 2016, 2023), and ambassadors' approach follows the EROCO™* method: Écouter, Rassurer, Observer, Calmer, Orienter (Listen, Reassure, Observe, Calm, Refer). Some ambassadors receive further training to facilitate **Heal by Hair Circles**, structured spaces for group psychosocial support, still within defined skills and limits distinct from clinical care.

Task sharing does not mean everyone does the same thing or replaces specialists. It organizes different levels of response, from detection and listening to structured psychosocial support and referral, while clinical assessment, diagnosis and treatment remain with qualified professionals.

*EROCO™ is an intellectual property of Bluemind Foundation.

2.3. Relational trust: how it is built and passed on

Trust is the study's central concept. It is understood as **a relationship built over time**, through repeated interaction and accumulated experience.

Möllering (2006) stresses the role of accumulated experience and expectations about another person's future behaviour. Here, several dimensions matter: continuity, expected discretion, a non-judgmental attitude and past experience with the hairdresser.

Sociology also suggests that the people we confide in are not always the closest. Granovetter (1973) showed the value of "weak ties" that link us beyond our inner circle. Simmel's figure of "the stranger" (1908/1950) describes someone near enough to be present but distant enough to receive confidences that would be withheld from intimates. Most directly, Small (2013, 2017) found that people often discuss important personal matters with people they are not close to, partly to avoid the relational costs of confiding in intimates. The hairdresser-client relationship offers a concrete, everyday case of this pattern in an African setting.

A second question is whether trust can be passed on through a referral. A person may be more willing to see an unknown professional if someone they trust suggests it. Gilson (2003) shows more broadly that trust and interpersonal relationships are part of how health systems function.

The study tests this directly: **can trust in the hairdresser make a referral more acceptable, and under what conditions?** It does not assume that trust transfers automatically to the recommended service.

2.4. Stigma and barriers to care

Stigma is a well-documented barrier to using mental health services (Corrigan, 2004; Thornicroft et al., 2016). It shapes how people interpret their difficulties, whether they talk about them and how they expect others to react. In the African Region, stigma, cost, low awareness and inadequate services are major barriers to care (WHO Regional Office for Africa, 2022, 2024). The "pathways to care" literature shows that people pass through several filters, often informal, before reaching specialist services (Goldberg & Huxley, 1980; Gater et al., 1991). The salon may sit at the very first of these filters.

Going to the salon is not a mental health step. The client comes for an ordinary activity and the hairdresser is not seen as a health professional. A conversation about a difficulty can begin without the client having decided to seek psychological help.

Talking can come before the difficulty is labelled as a mental health problem. The salon can thus be seen as a space where neutrality lowers stigma: speaking does not mean entering a diagnostic category or crossing the threshold of a mental health service.

The study examines whether this neutral entry point lowers some barriers to speaking and, where relevant, to seeking support.

documented in Africa, and particularly in francophone Africa.

2.5. Position in the literature

Research on hairdressers' role in emotional support and mental health is limited and comes mainly from English-speaking, non-African settings. Cowen et al. (1979) were among the first to document personal exchanges between hairdressers and clients in the United States. Page et al. (2022) studied Australian hairdressers as sources of informal social support, and Page et al. (2024) the emotional labour and burnout risks associated with this role. In the United States, barbershops and beauty salons have been used for health promotion, including a trial in which pharmacists working in Black-owned barbershops achieved large reductions in blood pressure (Victor et al., 2018).

In francophone Africa, this thinking took operational form with **Heal by Hair, an innovation launched by Bluemind Foundation in 2021**. Nilsson and Biyong (2025) studied one session of the programme as part of an pilot evaluation funded by the The Fund for Innovation in Development (FID) and identified the pre-existing trust between hairdressers and clients as one of the features on which the intervention rests.

This study goes further by making the trust relationship itself the primary object of inquiry. It documents how trust develops, what it allows in conversation, how it may help in noticing difficulties and under what conditions it can support a move towards other help. It adds evidence from a field that remains under-

III. Research questions and objectives

3.1. Central question

The empirical question guiding the study is: **how can trust between a woman and her hairdresser create an entry point for early detection, first-line emotional support and referral to appropriate mental health support?** Behind it lies a broader analytical question: under what conditions can a pre-existing trust relationship become part of the pathway to mental health support and care?

The study thus examines trust starting from a specific field, the hairdresser-client relationship, while considering the broader scope of the mechanisms observed. It seeks to understand what this relationship can make possible, the conditions under which these mechanisms operate, their limits, and how a structured intervention such as Heal by Hair can support them.

3.2. Sub-questions

The central question breaks down into seven sub-questions that guided the data-collection tools and the analysis.

1. **What makes the hairdresser-client relationship conducive to confiding?** Social, relational and situational factors, distinguishing the place, the relationship and participants' experience.
2. **What difficulties come up in salon conversations?** The most frequent topics, more intimate difficulties, and subjects that remain hard to raise.
3. **What do hairdressers notice before others do?** Reported ability to detect difficulties, the signs used, and the features of the relationship that help.
4. **What can a hairdresser usefully do, and how far should she go?** Based on clients' expectations, hairdressers' practices and the Heal by Hair framework.
5. **What are the limits of the role?** Situations where hairdressers reach their limits, and the risks for clients and for hairdressers themselves.
6. **What helps or hinders the move towards outside help?** Acceptability of referral, facilitators and obstacles, and the role of trust.
7. **What does Heal by Hair training change in this relationship?** How trained ambassadors describe their listening, detection and referral practices, and how these accounts compare with those of untrained hairdressers.

3.3. Objectives

General objective: to document the role of trust in the hairdresser-client relationship and the conditions under which it can contribute to confiding, early detection, first-line emotional support and referral to appropriate mental health help, and, beyond this case, to inform the study of pre-existing trust as a possible part of mental health infrastructure.

Specific objectives:

- * document the trust mechanisms in the relationship and the relational, situational and salon-related factors behind them;
- * describe salon conversations: topics, frequency, perceived effects, and what encourages or discourages speaking up;
- * examine reported detection, listening, support and referral practices, and their limits;
- * describe how trained and untrained hairdressers report their practices, without claiming to measure the effect of training;
- * document how acceptable clients find the hairdresser's role, including referral;
- * identify what helps or hinders the move to outside help;
- * identify the features of this relationship that could be examined in other everyday trust relationships.

IV. Methodology

4.1. Design

The study uses an **exploratory, descriptive mixed-methods design** combining questionnaires, semi-structured interviews and focus groups. The questionnaires describe the scale of the phenomena (frequency of confiding, reported trust, detection and support practices, acceptability of referral). The interviews explore experiences and the factors that encourage or discourage confiding. The focus groups capture shared perceptions and social norms. Cross-referencing these sources lets us look at the extent of the phenomena, the experiences behind them and the relational logic participants describe.

The study is descriptive. It does not produce estimates representative of all Togolese hairdressers and clients, and it does not establish causal relationships.

4.2. Locations and period

The study took place in Togo between **April and June 2026**, in **Lomé, Kara, Sokodé and Dapaong**. In Lomé, client data were collected in salons in April 2026. Enumerators spent a full day in each salon to administer questionnaires. Client interviews and focus groups also took place in Lomé. Hairdressers were surveyed in all four cities; in Kara, Sokodé and Dapaong this took place in June 2026. Hairdresser interviews were conducted in Lomé and Kara, and hairdresser focus groups in Lomé.

4.3. Sample

The study covers both sides of the relationship: **hairdressers and clients**. In Lomé, Heal by Hair ambassadors were selected by random draw among eligible ambassadors. Other hairdressers took part voluntarily, without random selection. Clients were approached in salons during data collection. In Kara, Sokodé and Dapaong, hairdressers could answer with an enumerator or online.

Table 1. Sample composition by method and location

	Lomé	Kara	Sokodé	Dapaong	Total
Clients, questionnaire	150	–	–	–	150
Clients, interviews	28	–	–	–	28
Hairdressers, questionnaire	71	139	61	19	290
Hairdressers, interviews	15	10	–	–	25
Focus groups, clients (3 groups)	27	–	–	–	27
Focus groups, hairdressers (2 groups)	56	–	–	–	56
Total	347	149	61	19	576

Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026.

In Lomé, the hairdresser sample has two groups: **ambassadors**, who completed Heal by Hair training and certification; and **untrained hairdressers**, who had not received the training at the time of the survey. **In Kara, Sokodé and Dapaong, all hairdressers surveyed are untrained**, which makes the four-city sample a useful picture of everyday salon practice outside the programme.

The untrained and non-selected groups in Lomé are small (Table 2). They allow us to hear accounts from hairdressers outside the programme, but not to make statistical comparisons between groups. Differences between trained and untrained hairdressers are therefore described from interviews and from ambassadors' own accounts, not measured.

Table 2. Composition of the hairdresser sample in Lomé

	Ambassadors	Untrained and Non-selected	Total
Questionnaire	53	18	71
Interviews	9	6	15

Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026.

Three client focus groups (27 participants) and two hairdresser focus groups (56 participants) were held in Lomé. The hairdresser groups included professionals not selected for Heal by Hair, to hear experiences beyond programme participants.

Recruitment bias

All clients were recruited inside salons, on the days of data collection. This has two consequences. First, regular clients are more likely to be present on any given day. Second, women who never go to salons,

or who go rarely, are absent. Hairdressers who volunteered may also be more interested in their clients' well-being than average. These biases do not undermine the study's purpose, which is to understand a mechanism where it exists, but they limit any generalization of the percentages.

4.4. Data-collection tools

Six instruments were used. The **client questionnaire** covered how often clients confide, their trust in their hairdresser, their view of the salon as a support space, their willingness to accept a referral, and how long and how often they had been visiting the salon. The **hairdresser questionnaire** covered the frequency and nature of difficulties raised, perceived trust, signs of difficulty, and support and referral practices; ambassadors were also asked about changes they attribute to training.

The two questionnaires did not offer identical answer options for every question (see section 5.4). Where wording differs, client and hairdresser answers are reported side by side but not compared directly.

Interviews with clients explored when speaking becomes possible, how clients see their hairdresser's ability to notice difficulties, what they expect and when they would accept a referral. Interviews with hairdressers covered signs observed, responses, the limits of their role and, for ambassadors, changes linked to training. **Focus groups** explored shared views on trust, confiding and the hairdresser's role. All instruments are reproduced in the appendix.

4.5. Analysis

Quantitative data were analysed descriptively (frequencies, proportions) in Excel. To show the precision of the main figures, Table 3 gives 95% confidence intervals (Wilson method) computed from the reported percentages and sample sizes. Because the samples are not random, these intervals indicate sampling precision only. No statistical tests were performed.

How percentages are reported. Percentages from questionnaires refer to 150 clients or 290 hairdressers unless stated otherwise. Percentages from interviews refer to 28 clients or 25 hairdressers interviewed and are always labelled "interviewed".

Table 3. Key quantitative indicators with sample sizes and 95% confidence intervals

Indicator	n	Reported %	95% CI
Hairdressers: clients talk about personal difficulties often or sometimes	290	79%	74-83%
Hairdressers: practising for more than 5 years	290	73%	68-78%
Hairdressers: salons can play a role in supporting women	290	96%	93-98%
Clients: confide in their hairdresser often or sometimes	150	69%	61-76%
Clients: visiting the same salon for more than a year	150	72%	64-79%
Clients: turn first to family	150	41%	33-49%
Clients: turn first to their hairdresser	150	30%	23-38%
Clients: turn first to a friend	150	11%	7-17%
Clients: turn first to no one	150	17%	12-24%
Clients: trust their hairdresser "a lot"	150	55%	47-63%
Clients: would trust a referral by their hairdresser	150	69%	61-76%
Clients: salon conversations can help women feel supported	150	91%	85-95%
Ambassadors: training changed how they listen or refer ("yes")	53	98%	90-100%

Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026. Intervals computed by the authors from reported percentages (Wilson score, 95%).

Qualitative analysis

Interviews and focus groups were transcribed and analysed thematically. The analysis followed the six phases described by Braun and Clarke (2006): familiarization, initial coding, theme development, review, definition and write-up. An initial codebook was derived from the seven sub-questions and the interview guides, then extended with codes that emerged from the data (for example "peer normalization" and "distance from the intimate circle"). Transcripts were coded by Martial Ekoa; Reporting follows the main items of the COREQ checklist (Tong et al., 2007). Quotations are anonymized and translated from French.

Finally, the analysis cross-references quantitative and qualitative data, client and hairdresser perspectives and, where the data allow, locations, to identify where sources converge and where they differ.

4.6. Ethics and safeguarding

Participation was voluntary. All participants were informed of the purpose of the study, of their right to decline or to stop at any time without consequence, and of how their data would be used; informed consent was obtained before each questionnaire, interview and focus group. No names

were recorded in the datasets, transcripts were anonymized. No financial incentive was offered.

Because the topics included family difficulties and violence, the study followed the WHO ethical and safety recommendations for research on violence against women (World Health Organization, 2001): interviews were held in private, enumerators were briefed on how to respond to distress, and participants who disclosed difficulties could be given information on support services, including the Heal by Hair referral network.

V. Results

This section combines questionnaire data, interview and focus group accounts, and observations made during data collection, and indicates the source of each finding. Quotations are anonymized.

5.1. Trust builds through repetition

The relationship studied is a long one. **73% of hairdressers have been practising for more than five years** and 49% for more than ten. **72% of clients have been going to the same salon for more than a year**, 42%

for more than three years. More than 70% visit at least two to three times a month, and nearly a third more often.

The relationship therefore rests on repeated contact over time, not on a one-off encounter. In health care, relational continuity refers to an ongoing relationship with the same person that allows knowledge of the patient to accumulate (Haggerty et al., 2003), and repeated contact is associated with greater trust and familiarity (Ridd et al., 2009).

Figure 1. Length and frequency of hairdresser-client relationships

Hairdressers: years of practice (n = 290)



Clients: time attending the same salon (n = 150)



More than 70% of clients visit their salon at least 2 to 3 times a month; nearly a third more often.

Intermediate categories derived from the reported cumulative shares (73% > 5 years, 49% > 10 years; 72% > 1 year, 42% > 3 years).



Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026.

Duration and repetition create the opportunity for trust. But duration alone does not explain confiding. Participants link the possibility of confiding to time

spent together, regular visits, the hairdresser's discretion and the circumstances of the conversation.

Table 4. Conditions associated with building and using trust in the salon

Dimension	What the data suggest
Relational continuity	Repeated visits build up knowledge of the client and her habits
Shared time	Long services leave time for conversation to settle and deepen
Expected confidentiality	Discretion is a condition for raising some topics
Salon setting	Calm, quiet moments and privacy make personal conversations easier
Women-only company	Some participants describe being among women and shared experience as helping them speak

Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026.

Table 5. Structural factors of trust, according to participants

Factor	Clients	Hairdressers
Length of service	"We spend a lot of time together, and that creates familiarity."	"Clients mostly open up during long services."
Women-only company	"Between women, we understand each other and trust each other naturally."	"Clients talk more freely when the apprentices aren't around."
Relaxed atmosphere	"The salon is calm and reassuring, a place of peace."	"The friendly atmosphere relaxes clients even before they start talking."
Regular visits	"Once it's a habit, you feel free to talk."	"What you learn about a client over time builds trust and intuition."

Source: Bluemind Foundation, Trust Study, qualitative data, Togo, 2026. Quotations translated and anonymized.

Personal conversations happen mostly during long services, when the salon is quiet, or when hairdresser and client are alone, sometimes away from apprentices. The extended time of the service thus creates the conditions for a gradual deepening of conversation.

The data suggest a useful distinction between **how trust forms** and **when it is used**. Repeated contact builds familiarity over time; the immediate conditions (time, discretion, privacy) then decide whether a confidence actually happens. The length of the relationship is an important condition for trust, but not sufficient on its own to explain confiding.

5.2. Talking before asking for help: what can be said in the salon and nowhere else

89% of clients interviewed say there are things they can discuss with their hairdresser that they do not raise elsewhere. They cite discretion, the absence of judgment, the welcome they receive and trust built up over successive visits.

A second mechanism appears in group conversations: **other clients also play a role**. Hearing other women talk about their difficulties makes problems feel more normal and lowers inhibitions. Several participants describe how another woman's story made it easier for them to speak. **One woman's words can change whether another feels her own experience can be spoken about**. This echoes research on social contact and stigma, which shows that

hearing about others' lived experience can change attitudes to mental health (Corrigan et al., 2012; Thornicroft et al., 2016).

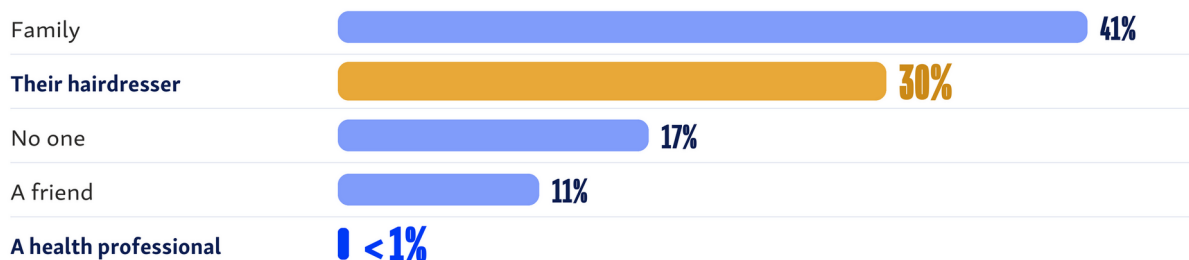
Hairdressers note that group conversations start with light topics and gradually deepen. After talking, clients describe "relief", "feeling lighter", "having put down a burden" or "feeling calm", whether or not the problem was solved. These accounts were consistently positive. This suggests that **what women value in the salon is above all being listened to, more than being given solutions**.

The study does not establish a therapeutic effect in the clinical sense. They do, however, make it possible to distinguish solving the problem from the experience of support associated with being listened to. It does show that support and problem-solving are different things: **the hairdresser's contribution does not depend on having a solution, and can start simply with hearing words that, for some women, had found no other outlet**. This is consistent with Page et al. (2022), who documented disclosures about family, health, identity and mental health, and the importance of confidentiality and safety in the relationship.

5.3. Close, yet outside the intimate circle

When going through a difficulty, clients turn first to **family (41%)** and then to **their hairdresser (30%)**, well ahead of **friends (11%)** and **health professionals (less than 1%)**. **17% say there is no one they would turn to first**.

Figure 2. Whom clients turn to first when going through a difficulty



"When you are going through a difficulty, who are you most likely to talk to first?" One answer per client (n = 150).



Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026 (n = 150).

This preference for the hairdresser is not a default choice. Clients explain it by the drawbacks they see in the alternatives.

Table 6. Sources of support and their perceived limits

Source	Perceived advantages	Perceived drawbacks
Family	Emotional closeness, lasting bond	Moral judgment, risk of betrayal, being seen differently afterwards
Friends	Complicity, shared understanding	Risk of betrayal, judgment
Health professional	Technical competence, solutions	Cost, stigma, cold and formal relationship
Hairdresser	Trust, discretion, non-judgmental listening, free of charge, knowledge built over time	Not a professional, cannot always offer a concrete solution

Source: Bluemind Foundation, Trust Study, qualitative data, Togo, 2026.

These results do not measure use of mental health services. They do show that, among the clients surveyed, the hairdresser holds an important place among the people they confide in.

The hairdresser combines two features that might seem contradictory: she knows the client, sometimes for years, yet is usually outside her family and friend circle. **This distance, which might look like a weakness, turns out to be her main strength.** Family offers closeness but can bring judgment, gossip or a changed view of the person. Friends are accessible but can be indiscreet. Professionals have skills but are associated with cost, formality and stigma.

The hairdresser is close enough to know the client, and far enough from her private life that confiding has fewer consequences for her relationships. In the data, a degree of distance supports trust when it reduces the expected cost of speaking. This matches what Small (2017) observed in the United States: people often confide in people they are not close to, to avoid the costs of confiding in intimates. The Trust Study documents this pattern in an everyday African setting and links it to a specific, repeated, non-medical relationship.

Seven properties emerge from the data. They are summarized in Table 7 as an analytical framework that can be reused to examine other trusted relationships.

Table 7. Seven properties of the hairdresser-client relationship: an analytical framework

Property	What it means	What it makes possible
1. Familiarity without required intimacy	Known for a long time, but outside family and friends	Closeness without the obligations of intimate relationships
2. Continuity before difficulty	The relationship exists before any problem arises	Trust is already there when the person becomes vulnerable
3. Shared time	Long services, conversation is not the purpose of the visit	Ordinary talk can gradually become personal
4. Lower social cost of speaking	Confiding has fewer consequences for the client's relationships	Topics withheld from family or friends can be raised
5. Neutral entry point	The visit is about hair, not mental health	Talking can come before asking for help or naming a problem
6. Peer normalization	Other women's stories circulate in the salon	Difficulties become more "speaking" collectively
7. Longitudinal knowledge	The hairdresser knows the client's usual state	Changes can be noticed before they are put into words

Source: Bluemind Foundation, Trust Study, analytical framework derived from primary data, Togo, 2026.

Property 2 deserves emphasis: the trust available at the moment of disclosure does not have to be built when the person is already vulnerable. These seven properties are a framework drawn from this study's data, to be tested against the following results and in future work.

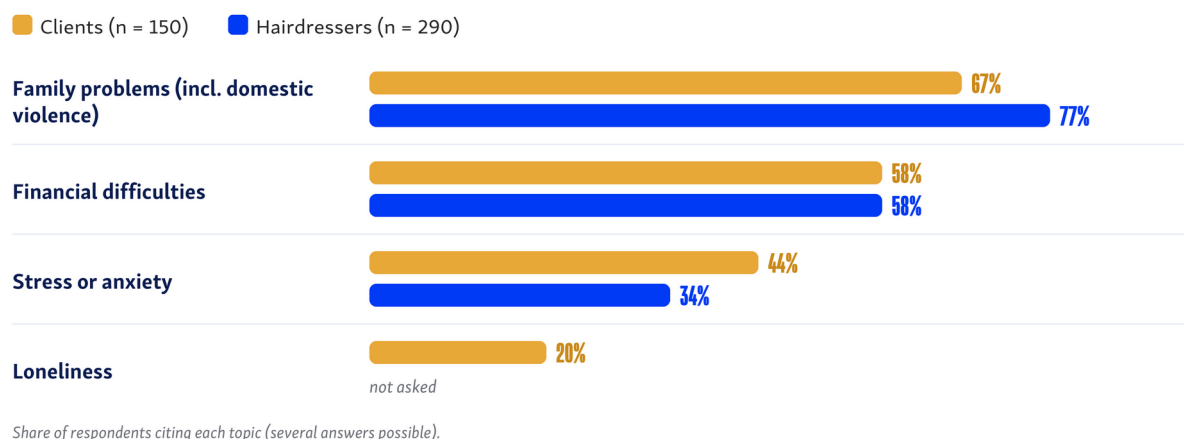
5.4. How often clients confide, and about what

Confiding is a regular part of the relationship. Among hairdressers, 40% say clients often talk to them about personal difficulties and 39% sometimes, **79% in total.** Among clients, 34% say they often confide in

their hairdresser and 35% sometimes (**69%**); about 11% say they never do.

Trust is high: **55% of clients say they trust their hairdresser "a lot,"** and fewer than 4% say they do not trust her at all.

Conversations cover a wide range of difficulties. The most frequent are **family problems**, a category that includes domestic and intra-family violence (67% of clients, 77% of hairdressers), **financial difficulties** (58% in both groups) and **stress or anxiety** (44% of clients, 34% of hairdressers). Sadness, reproductive health and **violence outside the close family circle** are also reported. 20% of clients mention loneliness and 3% other highly personal topics.

Figure 4. Topics raised in salons, clients vs hairdressers

Source: Bluemind Foundation, Trust Study, primary data, Togo, 2026.

These conversations go well beyond small talk: **they include family, financial and emotional difficulties that affect women's well-being.** The data do not allow these situations to be characterized clinically, but they show that topics directly linked to living conditions and mental health are regularly raised in the salon.

Disclosures of violence. The presence of violence among the topics raised has practical consequences. A hairdresser who hears about violence may face a situation where the client's safety is at stake, where confidentiality and protection pull in different directions, and where a poorly handled response could put the client at greater risk. Untrained hairdressers have no particular guidance for this. Heal by Hair ambassadors, by contrast, are trained to receive such disclosures calmly, to avoid actions that could expose the client, to recognize situations of immediate danger and to refer to identified support services. In Togo, these include the One Stop Centers (OSC): integrated public facilities that provide free, holistic and confidential support to survivors of gender-based violence, under the Ministry of Social Action, Solidarity, Gender, Family and Childhood Protection. Bluemind Foundation works in partnership with the Ministry of Health and the Ministry in charge of gender and social affairs. In interviews, ambassadors describe being better able to stay calm and to know where to send a client after a difficult disclosure (section 5.6). This specific contribution of hairdressers to responding to gender-based violence deserves a dedicated study.

Why do clients confide? **Trust is the reason most often given**, by 87% of hairdressers and 65% of clients. The

length of the relationship is cited by 34% of hairdressers and 36% of clients, and the salon's perceived safety by 23% and 21% respectively.

A difference emerges, however, in how the two groups explain confiding. Nearly 59% of clients mention the hairdresser's attitude, compared with 6% of hairdressers. The hairdresser's way of listening, without judging, matters as much as the duration of the relationship. Hairdressers also mention clients' need to talk more often than clients do (25% vs 8%).

Trust is therefore not only a matter of time or setting. **It also depends on how the hairdresser behaves:** repetition creates the possibility of trust; her manner helps decide whether that possibility becomes a confidence. This is precisely the dimension Heal by Hair training works on.

5.5. Early detection: noticing a change over time

Clients widely recognize their hairdresser's attentiveness. **96% of clients interviewed** believe an attentive hairdresser can notice that a client is going through a difficulty before she says so. **All hairdressers interviewed** say they have noticed a difficulty in a client before she put it into words.

Among untrained hairdressers in particular, explanations point less to a specialized ability to recognize a disorder than to **knowledge of the client built up visit after visit. The hairdresser, especially untrained, does not necessarily notice a sign because she knows its clinical meaning. She notices it because it departs from what she knows about this client.**

Table 8. Signals reported by hairdressers

Type of signal	Examples reported
Behavioural	Unusual silence, avoiding eye contact, agitation, irritability
Physical and appearance	Change in appearance, weight loss, less care for grooming
Emotional	Crying, holding back tears, visible sadness
Verbal	Indirect remarks, hints at a difficulty without saying more
Attendance	Visits becoming less frequent, withdrawal during appointments

Source: Bluemind Foundation, Trust Study, qualitative data, Togo, 2026.

The situations reported include marital or family difficulties, fatigue, changes in mood or appearance, social withdrawal and violence. These observations are not diagnoses, and their clinical accuracy cannot be validated with this study's data. They can, however, prompt a conversation, a question or closer attention.

This longitudinal detection mechanism is one of the study's main contributions. It rests on accumulated knowledge of the person that few formal systems can replicate, especially where psychiatric consultations are rare and follow-up over time almost non-existent.

Longitudinal knowledge as a detection mechanism

Repeated visits produce a **baseline**: how the client usually speaks, looks, feels, how often she comes and how she interacts. When something changes, the hairdresser implicitly compares it with this baseline. **The signal lies in the gap between how a client is today and how she usually is.**

Research on continuity of care describes the same kind of accumulated knowledge, which goes beyond what a single consultation can capture (Haggerty et al., 2003). The parallel concerns this relational property, not an equivalence of roles.

For Heal by Hair ambassadors, a second layer is added. They remain distinct from mental health professionals, but **their ability to detect no longer rests only on informal knowledge of their clients**. Trained by mental health professionals and supported for six months, they also have the knowledge, vocabulary and tools to recognize signs of difficulty, open an appropriate conversation, know the limits of their role and refer when needed.

Two forms of knowledge thus complement each other: **relational knowledge**, built through contact with the client, and **structured skills**, acquired in training. **Longitudinal knowledge makes a change visible; training helps understand it and decide on an appropriate response.**

longitudinal knowledge of the client + structured detection skills → noticing and interpreting a change → appropriate response → referral when needed

"Early detection" therefore does not mean diagnosis. It means **noticing changes early enough to open a conversation, offer initial support within the limits of the role and, when needed, facilitate a referral**. The hairdresser's role sits upstream of diagnosis. **The key question is less whether trained hairdressers notice more than others, and more what they are able to do with what they notice.**

5.6. What training changes in an existing practice

Listening, noticing changes and some forms of support exist in salons with or without the programme. But existing does not mean adequate. Before training, the ambassadors interviewed describe their listening as largely intuitive. They already listened to, advised or comforted clients, but they identify real weaknesses: interrupting, judging, being emotionally overwhelmed, missing signs of distress ("I was just listening to listen") and not knowing where to refer a client.

Confidentiality also sets trained hairdressers apart.

Accounts suggest that untrained hairdressers sometimes repeat what they have heard, while ambassadors describe a much stricter respect for confidentiality, which clients themselves make a condition of trust (Table 10). These limits are worth stating clearly. The Trust Study does not show that untrained hairdressers listen well. It shows that clients confide in them anyway, which is exactly why the quality of that listening, and what happens next, matters.

After training, the changes ambassadors report concern the quality of listening, attention to signs of difficulty, managing their own emotional reactions and their ability to refer. All ambassadors interviewed describe changes in these four dimensions.

Table 9. Changes ambassadors associate with Heal by Hair training

Dimension	Before training	After training
Quality of listening	Partial listening, frequent interruptions, judgments	Active listening without interrupting or judging, leaving room for the client
Detecting signals	Unstructured observation, signals often missed	Attention to behavioural, physical, emotional and verbal signs
Emotional stability	Emotional contagion hard to contain, crying with the client	Better able to stay present and calm after a difficult disclosure
Confidence to refer	Hesitation, not knowing available resources	Knowing the resources, able to name and recommend them

Source: Bluemind Foundation, Trust Study, Togo, 2026.

In the questionnaire, **98% of ambassadors surveyed (n = 53)** answered "yes" when asked whether the training had changed how they listen to and refer clients, and 2% answered "a little". None answered "no". These are self-assessments by programme participants and may be influenced by social desirability (section 8.1).

The training does not create a skill from nothing. **It structures, secures and strengthens an existing disposition** in two ways: technically, by giving a framework for listening, detecting and referring; and personally, by giving hairdressers the legitimacy to act in this role. And because clients make non-judgmental listening a condition of trust (Table 10), better listening may in turn strengthen the trust itself.

Table 10. Clients' expectations and limits of the hairdresser's role

What clients expect and accept	What clients reject or fear
Listening without judging or interrupting	Moral judgment on the client's choices
Comfort and presence	Making decisions for the client
Suggesting gentle options or a referral	Prescribing radical solutions
Strict confidentiality	Repeating confidences to other clients or outsiders
Recognizing feelings, empathy	Minimizing feelings or mocking a difficulty
Referral to a resource if needed	Making the client feel guilty or overstepping her role

Source: Bluemind Foundation, Trust Study, qualitative data, Togo, 2026.

Trust is the non-negotiable condition. "Trust" is the word most often used in both groups, and the prerequisite for everything else. **Clients do not expect their hairdresser to become a therapist.** They value an intermediary role: listening, discretion, support and, when needed, suggesting another resource.

Interviews also reveal strong resistance to consulting mental health professionals, at once economic, symbolic and social. Some participants still equate seeing a professional with admitting to a mental illness, which can delay or prevent help-seeking. The data cannot estimate how widespread these views are in Togo, but they are among the obstacles participants mention when describing the move from an informal conversation to professional help.

5.7. An accepted role, within limits

Clients and hairdressers largely agree on the salon's potential as a support space. **Around 90% of clients believe salons can help women talk about their difficulties, and 91% believe salon conversations can help women feel less alone or better supported.** Among hairdressers, 96% believe salons can play a role in supporting women.

This acceptance has conditions. **Clients have clear expectations of what the hairdresser should and should not do**, which matter for how the model is designed and presented.

5.8. From trust to referral: not automatic

Can the trust that makes confiding possible also make it easier to seek other help?

77% of hairdressers say they have already advised a client to seek outside help. This shows that suggesting outside help is a common reflex. But the survey does not record **where** untrained hairdressers send their clients, so this cannot be equated with referral to qualified mental health services. Field observations suggest that, without training, the advice often points to religious or traditional resources.

This is where the training makes a clear difference. In Heal by Hair, referral is not just telling a client to "get help". Ambassadors are trained to recognize the limits of their role and to refer, when needed, **to mental health professionals and to resources identified in the programme's referral system, developed in partnership with the Ministries of Health.** The training

therefore acts not only on the willingness to refer, but on **who the client is referred to and whether that referral is appropriate**.

On the client side, **almost all clients (99%) are open to a referral by their hairdresser** to a support circle or a professional: 69% would trust it outright and 30% "maybe"; about 1% say no. The principle of a referral by the hairdresser is therefore widely accepted, even if, for nearly a third of clients, this acceptance remains conditional. These answers say nothing about whether clients actually go, or whether trust holds once they meet someone they do not know.

What helps

Trust in the hairdresser is the first condition: when it is established, clients say they are ready to follow her advice, even towards organizations they do not know. A second facilitator is the hairdresser's own positive experience of the professionals or support circles she recommends. Reported willingness, recommendation and actual use must be kept distinct.

What gets in the way

Obstacles reinforce each other: **the cost** of professional care, **stigma** and the fear of being seen as "sick", **fear of the unknown** and doubts about **confidentiality** in formal institutions.

5.8.1. Can trust be passed on?

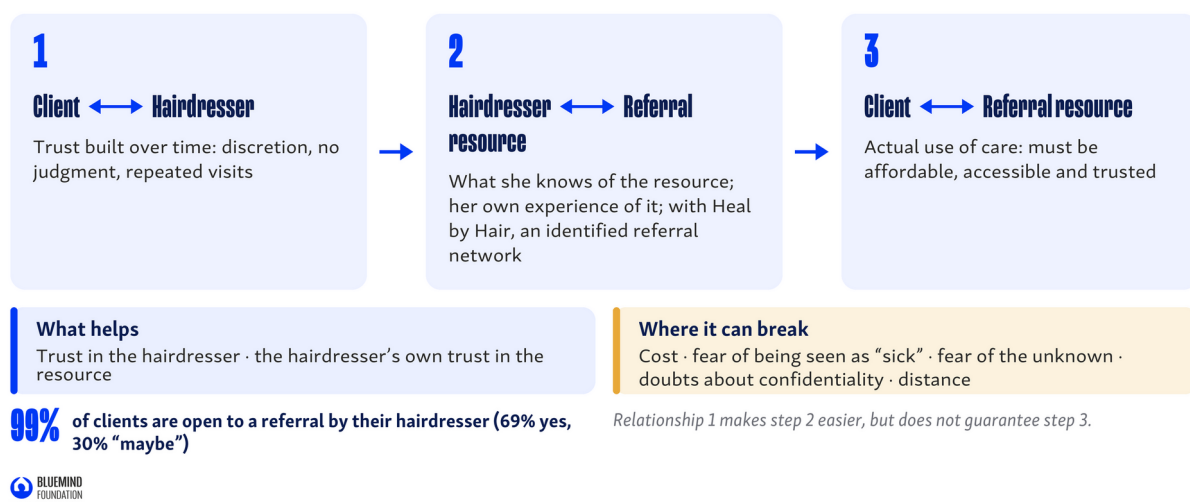
What makes a referral credible to clients? Trust in the hairdresser is important but not enough. Participants also mention **the hairdresser's own trust in the resource she recommends. Trust does not pass automatically from the hairdresser to any institution she recommends**. It depends on her relationship with that resource, what she knows of it and how she can vouch for it.

Three relationships are involved:

client ↔ hairdresser | hairdresser ↔ referral resource
client ↔ referral resource

The first can make the second step easier, but does not guarantee the third.

Figure 5. The referral chain: three relationships and where it can break



Source: Bluemind Foundation, Trust Study, analytical framework derived from qualitative data, Togo, 2026.

5.8.2. Where the referral chain breaks

The results distinguish **the relational ability to open a referral** from **the material and social possibility of following it through**. A client may trust her hairdresser, accept her advice and still not reach the service. **Trust can lower barriers at the start of the pathway. It does not remove the obstacles at the end.**

5.9. The conceptual model

Taken together, the results suggest a conceptual model. It is not a path every client follows, but the main steps the data identify between an existing trust relationship and possible use of support or care.

The model starts with **a relationship that exists before any mental health intervention**. Length of relationship,

repeated contact, shared time, discretion, the hairdresser's attitude and the neutrality of the salon create conditions for trust and for speaking. This continuity also produces **longitudinal knowledge of the client**, which can make a change visible before it is put into words.

Heal by Hair works on this existing relational infrastructure. It gives ambassadors knowledge and tools to structure listening, the detection of distress, the response and, when needed, referral to an identified resource. It does not create the relationship, but it changes what the hairdresser can do with it.

Referral is a separate step. Clients say they are willing to consider a recommendation from a hairdresser they trust, but this guarantees neither acceptance of any resource nor actual use. The transition also depends on the credibility of the

resource, its accessibility, its cost and attitudes to mental health.

The model distinguishes what the relationship makes possible, what training can structure, and what the care system must make accessible.

Figure 3. Conceptual model: from trust to support and possible access to care



Source: Bluemind Foundation, Trust Study, conceptual model derived from primary data, Togo, 2026.

Table 11 breaks trust down into the distinct functions identified in the study. These functions

follow one another but are not automatic: each can occur without the next.

Table 11. Trust broken down into distinct functions

Function	What trust (and continuity) make possible	What Heal by Hair training adds	What it does not guarantee
1. Speaking	A difficulty can be voiced, sometimes for the first time	Listening without interrupting or judging	That the difficulty is understood or named
2. Support	Relief from being heard, less isolation	Emotional stability, safe responses, including to disclosures of violence	Resolution of the problem
3. Detection	A change is noticed against the client's usual state	Vocabulary and reference points to interpret signs and open a conversation	A diagnosis (detection is not diagnosis)
4. Referral	Seeking help becomes conceivable	Knowing who to refer to, when, and within which limits, via an identified network	That the client goes, or that the service is accessible and affordable

Source: Bluemind Foundation, Trust Study, analytical framework derived from primary data, Togo, 2026.

VI. Discussion

This section relates the results to the literature, separates what pre-exists any intervention from what training adds, and returns to the broader question: **under what conditions can a pre-existing trust relationship become part of mental health infrastructure?**

6.1. Trust as relational infrastructure upstream of care

The salon is more than a place of women's sociability. It brings together several conditions that appear to favour speaking about personal difficulties and receiving a first form of support, before any contact with care. No single feature explains this; **it results from the combination of a place, a rhythm and a relationship.**

The salon is first a **third place**: an ordinary activity with no medical connotation, distinct from home and family, yet socially familiar. Long services, regular visits, women-only company and the atmosphere of personal care create particular conditions for conversation. The group also plays a part: hearing another client's experience can lead a woman to recognize her own situation and speak up. **The salon is a place where stories circulate, where other women's experiences make difficulties feel more normal and less isolating.**

Our results extend the observations of Cowen et al. (1979) and Page et al. (2022) by specifying the relational conditions behind these exchanges. **Trust is neither a property of the salon nor automatically attached to the profession.** It is built over time, as discretion, absence of judgment and predictability are confirmed visit after visit. Not every hairdresser-client relationship becomes a trust relationship, and not every salon offers the same conditions.

The hairdresser's position is the clearest lesson: **she is close without belonging to the intimate circle, familiar without being involved in the situation described.** This qualifies the idea that closeness is always the best condition for confiding. **A degree of distance, combined with familiarity, continuity and discretion, can protect speech as much as closeness enables it.** This is consistent with the sociology of weak ties and of "the stranger" (Granovetter, 1973; Simmel, 1908/1950) and with Small's (2017) finding that people often confide in those they are not close to. The contribution here is to show this pattern in a specific, repeated, everyday relationship in Africa, and to connect it to detection and referral.

Clients also describe relief and calm after confiding, even when nothing was resolved. **Being able to speak and be heard is itself described as support.** One contribution of the study is thus to make visible **the**

space between living with a difficulty in silence and turning to a formal service. This space is not empty: places, relationships and practices exist in which a difficulty becomes speakable, recognizable and shareable, before it is ever labelled as a mental health matter.

The hair salon here provides the empirical ground from which this mechanism can be observed. The analytical scope of this finding, however, goes beyond the salon itself. It leads us to ask whether other configurations combining social accessibility, repeated interactions, trust built over time, knowledge of the person, and a position relatively outside the intimate circle could fulfill comparable functions in the early steps of a mental health pathway.

6.2. Longitudinal knowledge as a detection mechanism

All hairdressers interviewed report having detected a difficulty before it was put into words, and 96% of clients interviewed believe an attentive hairdresser can sense a difficulty before it is expressed. These self-reports do not establish the accuracy (sensitivity or specificity) of such detection. Their value is to identify a plausible mechanism.

Repeated contact does two different things. It builds trust, which may make confiding easier. And it builds **knowledge of the person**, which may make changes visible: an unusual silence, a change in appearance, new irritability or less frequent visits stand out **against an individual baseline built up over the relationship.**

This describes a community-watch function. The hairdresser does not replace the health professional, and relational detection is not clinical assessment. But she has a resource formal services rarely have: **regular access to a person in an ordinary setting, and the ability to compare how she is today with how she usually is.** Where much of the population has little, late or no contact with mental health services, this deserves attention.

For ambassadors, training adds structured skills to this longitudinal knowledge: recognizing signs, naming them, opening a conversation, knowing the limits of the role, knowing when to refer. **The first gives a baseline (she can see that a client "is not herself"); the second gives a framework for responding.** The value of a trusted intermediary may therefore lie not only in her accessibility or in the trust placed in her, **but in the combination of relational continuity and a structured ability to handle, carefully, the changes that continuity makes visible.**

This hypothesis merits examination beyond the hairdressing sector. Other professions, social roles, or relationships characterized by repeated interaction, accumulated knowledge of individuals, and sufficient trust could be studied, to identify which relational properties may support detection, support, or referral and under what safeguards. The salon thus becomes more than a particular object of study: it constitutes an empirical case from which more general hypotheses about the properties of relational trust infrastructures can be formulated and tested.

6.3. Heal by Hair: from existing access to a structured capacity to act

The results separate what Heal by Hair **finds** in the existing relationship, what it **structures** and what it **adds**.

The programme builds on existing relational capital: trust, confiding, knowledge of clients and some listening and advice practices are reported by hairdressers whether or not they took part. **The programme does not create the relationship or the access; it works with them.** But the existence of these practices says nothing about their quality. Ambassadors' own accounts of their practice before training (interrupting, judging, disclosing, being overwhelmed, not knowing where to refer) show that confiding can happen without the listener being equipped for it.

The training acts on three levels:

- * **Practice:** a framework for what was intuitive: listening without interrupting, limiting judgment, staying emotionally steady, recognizing signals and knowing when a handover is needed.
- * **Interpretation:** it does not create knowledge of the client, but gives reference points that change how changes are noticed, understood and acted on. A change that would once just have been observed can now lead to closer attention, a conversation or a referral.
- * **Posture:** ambassadors describe greater confidence to listen, engage and refer within defined limits. **An intuitive, uncertain practice becomes an identified, equipped and bounded role.**

Referral shows the difference most clearly. 77% of hairdressers say they have advised a client to seek help, so the reflex exists without training. But where untrained hairdressers send clients is not documented and may often be religious or traditional resources, and cannot be equated with referral to qualified services. In Heal by Hair, ambassadors refer within the limits of their role to identified resources. **The training's contribution is not mainly to create the wish to refer, but to qualify the referral: to whom, when, within which limits and to which recognized resources.** On the client side, 99% are open to a

referral from their hairdresser (69% yes, 30% maybe). But some say this depends on what their hairdresser knows about the resource or her own experience of it. The data suggest **less a transfer of trust than a mediation:** trust in the hairdresser reduces uncertainty about an unfamiliar resource and makes using it conceivable, but does not replace that resource's own credibility, accessibility or the trust it must earn.

The programme is therefore not just about adding mental health skills to an accessible profession. **It connects an existing relational infrastructure, where trust and support already exist, with qualified support and care.** In settings where many mental health needs remain outside formal services, the challenge is not only to extend services but to understand which trust relationships already exist upstream of care, what they already do, how they can be strengthened without medicalizing them, and how they can make appropriate use of the formal system more accessible and acceptable. It is in this articulation that the results of this study invite us to locate the potential of trust as a component of mental health infrastructure.

6.4. Limits and operating conditions of the model

6.4.1. Trust cannot be presumed

Trust cannot be created by decree, or assumed simply because someone is a hairdresser. It is built through repeated contact, tested discretion and absence of judgment. Not every client confides in her hairdresser, not every relationship reaches the same closeness, and not every salon offers the same conditions. In addition, 17% of clients say there is no one they would turn to first when facing a difficulty, a group the salon alone may not reach.

Training a hairdresser does not automatically produce a trusted intermediary. Training adds skills to an existing relationship; it cannot replace the relational history that makes them usable. Hairdresser-client relationships are not alike everywhere. Patterns of sociability, salon visits and trust vary across contexts, and the model will need to adapt accordingly as it scales.

6.4.2. Can formalization damage the relationship?

If part of Heal by Hair's value lies in the ordinary, non-medical nature of the relationship, **how far can it be formalized without losing what makes it accessible?** Over-medicalizing the hairdresser's role, presenting her as a substitute for a professional, or making the technical intervention too visible could alter how the salon is perceived; and, with it, the conditions for confiding. **The aim is to strengthen the hairdresser's capacity to act within an existing relationship without changing its nature.** The line between structuring and medicalizing is thus an important question for the

model's future development and for the study of other trusted intermediaries.

6.4.3. A role that also exposes hairdressers

Hairdressers hear accounts of violence, bereavement, emotional distress and serious family difficulties, in a job never designed as psychosocial support. Ambassadors report that training changes how they receive these accounts, notably by reinforcing confidentiality, reducing emotional contagion, and clarifying the limits of their role. It does not remove the burden of repeated exposure to others' distress (Page et al., 2024). **One risk of relying on accessible community actors is to turn their availability into a new, invisible burden.** Sustainability requires explicit limits to the role, the possibility of handing over, supervision, and support for hairdressers themselves when they need it.

6.4.4. Detection is not diagnosis

Noticing that someone seems different, recognizing signs of difficulty and knowing how to start a conversation do not amount to a clinical diagnosis. Training equips ambassadors to recognize signs of distress, use non-stigmatizing language, and identify when more attention or a referral may be needed - not to diagnose. This boundary is a safety condition: the value of relational trust infrastructure lies in acting **upstream of, or alongside, care**, without shifting clinical responsibilities onto non-specialists.

6.4.5. Trust is not enough if the referral chain breaks

The most structural limit appears at the point of handover. Clients' willingness to accept a referral guarantees neither the existence nor the accessibility of an appropriate resource. **A relational infrastructure can only facilitate access to care if it connects to care that is available, accessible and trustworthy.** The chain can break at many points: no accessible professionals, cost, distance, waiting times, stigma, an unsuitable resource, or a loss of trust at the point of entry into the formal system. **Improving detection without improving the response could create a dead end: more needs become visible, with nowhere to go.**

This is less a limit of Heal by Hair than a limit of trust itself as an access mechanism. Trust has two functions: a **relational** one (a difficulty can be expressed, recognized and discussed) and a **mediating** one (moving to an outside resource becomes less uncertain and more acceptable). The second depends on the quality and accessibility of the resource. **In short, trust is part of the pathway to care and can open the way to it, provided care is available and accessible; on its own, it does not replace care.**

This is why Bluemind Foundation does not work only upstream. Through it supports the training of African psychiatrists and health staff. This is not a substitute for the role of public authorities, which remains theirs, but a responsibility the Foundation takes on

alongside them: a referral is only as good as the service at the other end.

6.4.6. What the data say about the properties of trust

The findings go beyond the general observation that trust matters.

- ★ **Trust is cumulative.** It builds over repeated contact. Duration does not act alone: it provides the occasions on which discretion, consistency and absence of judgment can be tested.
- ★ **Trust is positional, not only interpersonal.** It depends on the hairdresser's position (known, accessible, yet outside the intimate circle) as much as on her qualities. **Maximum intimacy is not necessarily the best condition for confiding.**
- ★ **Trust is situated.** An ordinary activity, no health label, time, regular visits and other women's stories give it room to form and be used.
- ★ **Trust is distinct from the knowledge that accompanies it. Trust makes speaking possible; continuity can, even without words, make detection possible.**
- ★ **Trust supports several distinct functions** (speaking, support, detection, referral; Table 11) that should not be conflated and are not always activated together.
- ★ **Trust is necessary but not sufficient** to move towards outside help: it removes neither cost nor stigma, nor the need for the next resource to be credible and accessible.

Across these properties, **the value of the relationship may lie less in the hairdresser's profession than in the configuration she brings together.** The study does not show that each property is necessary or sufficient in a causal sense, nor that they would combine the same way elsewhere. It does provide a set of observable properties precise enough to be studied and tested in other relationships. The question becomes: **which configurations of trust enable which functions, at which point in the pathway, and under what conditions?**

VII. Implications

If access to care depends not only on services but also on the social paths through which a difficulty becomes speakable, noticeable and eventually referable, then **the architecture of mental health care does not start at the door of the health system**. It can start upstream, in the relationships and ordinary places where people already talk about their difficulties, are known over time, and trust someone enough to consider other help. This does not mean ordinary relationships should replace care systems, but that systems can recognize, preserve and, where relevant, link these existing relational resources to qualified support.

7.1. For mental health systems

Where specialists are scarce, strengthening mental health systems is usually framed in terms of supply: number of professionals, facilities, funding, geographic coverage, integration into primary care. These remain essential. The study adds another component: **the relational architecture of access to care**.

A difficulty is not necessarily voiced for the first time to a professional. It may have been lived in silence, noticed by someone who has known the person for years, confided within a trust relationship, or given a first form of support. For some, this precedes care; for others, it is the only place the difficulty is ever expressed.

This changes the questions we ask. **Not only "where is the service?", but also: whom do people talk to when a difficulty arises? Who is in a position to notice a change? Whom do they trust enough to accept a recommendation? Through which relationships do they pass before reaching, or never reaching, the health system?**

The challenge is not necessarily to create new places with a mental health function, but to identify the relationships that already perform useful functions and decide **which can be linked to the system, for what, and with what safeguards. What should be structured is not the trust relationship itself**, whose value partly lies in its ordinary, non-institutional character, but the skills used when certain situations arise, the limits of the role, handover procedures, supervision and links with qualified resources.

This is not a response to under-investment in mental health services. A trust relationship does not treat a disorder and does not make up for a lack of services. The upstream and the downstream must be strengthened together. Bluemind Foundation's support for training psychiatrists and health staff, and its intention to support care structures alongside public authorities, follows from this: there is no point making needs visible if there is nowhere to refer

them. **Access to mental health care depends not only on a service being available, but on a socially possible path to it.**

7.2. For public policy

First, broaden the map of resources relevant to mental health. Alongside professionals, facilities, primary care and recognized community actors, there are social intermediaries with existing trust capital. Their relevance should not be assumed from their profession; the properties identified here (Table 7) offer more precise criteria to assess it.

Second, integrate without institutionalizing.

Recognizing a trusted intermediary does not mean institutionalizing the relationship that gives her value. Policy can preserve its ordinary, non-medical nature while securing training, clear responsibilities, supervision, safeguarding protocols and access to qualified resources.

Third, fund the other end of the referral.

A recommendation from a trusted person makes outside help conceivable, but only if the next resource is available, affordable and credible. Relying on community intermediaries without strengthening the system's capacity to receive referrals would make needs visible without any effective response.

Fourth, use neutral spaces against stigma. Some conversations begin precisely because they happen in a place not associated with mental health. **This neutral entry point** can serve prevention and awareness policies: talking about mental health in ordinary places, without requiring people to see themselves as patients first.

Fifth, connect mental health and responses to gender-based violence. Salons are places where violence is disclosed. Trained hairdressers can be a safe first point of contact and a bridge to specialized services, provided referral networks for survivors exist and are coordinated with mental health services. This is relevant to actors working on gender equality and violence against women, and to coordinated initiatives in this field.

Sixth, address the francophone gap. Evidence on community mental health in francophone Africa remains scarce. Francophone development cooperation actors (for example the Agence Française de Développement and Expertise France) and francophone ministries of health have a particular interest in models designed and documented in these settings.

The policy challenge is not only to multiply formal access points, but to understand how people make their way to them, and which trust relationships can make

that journey possible without being turned into health services.

7.3. For research: towards a science of relational trust infrastructure

The main scientific contribution may be to shift the question. Not only "can hairdressers play a role in community mental health?", but: **which properties of a trust relationship enable which functions in a mental health pathway, at what point, and under what conditions?**

The study proposes observable dimensions: repeated contact, trust tested over time, longitudinal knowledge, discretion, absence of judgment, familiarity combined with distance from the intimate circle, a neutral entry point and the possibility of mediation. These do not all serve the same function. Repetition builds trust and knowledge; discretion and non-judgment are linked to speaking; accumulated knowledge to detection; existing trust to the acceptability of referral, without guaranteeing that trust passes to the resource.

Future research can therefore move beyond asking whether a trusted intermediary "works", and **break the mechanism down**: which properties are associated with confiding, detection, support and mediation? Which combinations are needed for each? Where does the chain break?

If the functions observed depend partly on the properties of the relationship rather than on hairdressing itself, comparable mechanisms could be found in other trusted relationships. Not all are equal. Ranked against the properties identified in this study (shared time, privacy, repeated contact, distance from the intimate circle, a neutral entry point, women-only company and the visibility of changes over time), three groups emerge:

- * **Closest to the salon, and untested:** for example women who provide scrubs, massage and body care in hammams; beauticians; and seamstresses. All combine long or repeated private sessions, women-only settings and close attention to the body, where changes, fatigue or signs of violence become visible; seamstresses also accompany key life events (weddings, pregnancies, mourning). **To our knowledge, no programme anywhere trains hammam body-care workers or seamstresses in mental health.** Beauty professionals have been trained to recognize domestic violence in the United States and the United Kingdom (for example "Cut It Out" and "Shear Haven"), but not, to our knowledge, in mental health support in Africa.
- * **Already tested elsewhere, to adapt:** barbers, the male equivalent of hairdressers, are trained as mental health advocates in the United States and the United Kingdom (The Confess Project;

Leeds Mind's Barber Talk); pharmacy staff and clergy are common targets of gatekeeper training; and traditional and faith healers have worked with primary care in an effective collaborative model for psychosis in Ghana and Nigeria (Gureje et al., 2020). Faith communities offer deep trust, but sit inside the community, where confiding may carry a higher social cost and distress may be framed in spiritual terms.

- * **Relays rather than confidants:** moto-taxi drivers, market traders and mobile money agents have frequent contact but brief, public, transactional exchanges with little confidentiality. They lack the conditions that make confiding possible. They can help in other ways, such as transporting people to care (as moto-taxi drivers already do for maternal health and survivors of violence in East Africa) or displaying information, but not as primary listeners.

The aim is not to transpose Heal by Hair to other trades as it stands, but to test whether certain ordinary relationships can act as relational infrastructure for mental health, and which properties determine what they can reasonably do. If they can, this opens a path to scale that does not depend on creating new relationships: **training people who are already trusted could reach many more people, potentially at lower cost, because the relationship does not need to be built.** This hypothesis, and its cost, remain to be tested.

A larger study would allow these questions to be answered with the additional rigour they deserve: several countries and types of trusted intermediaries, random or quota sampling of clients, longitudinal follow-up of relationships, standardized measures of well-being and mental health (such as the WHO-5 or PHQ-9), and follow-up of referrals through to actual use of services. Research funders in global mental health could make such a study possible, building on the framework proposed here.

Comparative research would also clarify what is specific to the salon (its place in women's self-care, long appointments, its group dynamic) and what belongs to relational properties found elsewhere. This agenda could move from a single case, the hairdresser–client relationship in Togo, **towards a testable theory of relational trust infrastructure in mental health.**

7.4. For Heal by Hair

Heal by Hair builds on a relational infrastructure that predates it. It does not create salon visits, continuity, confiding or trust. Its contribution is to make certain functions within that relationship **safer and more structured**: listening, noticing signs of difficulty, understanding the limits of the role, responding safely to disclosures, including of violence, and referring to qualified resources. The trust exists with

or without the programme; what the programme changes is what hairdressers can do with it, and where clients are sent.

Heal by Hair's main asset is not to have created a new point of contact with women, but to have identified an existing one early, and to have built an intervention around the properties of the relationship already formed there.

Supervision and ongoing support for hairdressers are conditions for sustainability. The model's coherence depends not only on training but on the quality and accessibility of referral resources, the protection of ambassadors' well-being and a clear boundary between community support and clinical responsibility.

Finally, the programme should preserve what may be its most important feature: **not medicalizing the relationship that gives it access to women**. Its value lies in adding skills and connections to an existing relationship without turning the salon into a health facility or the hairdresser into a substitute for a professional, **while still contributing to clients' mental well-being**. Women describe relief, calm and feeling less alone after being listened to by their hairdresser; trained ambassadors aim to make that support safer and, when needed, to open the way to mental health care.

On a programme level, three dimensions call for particular attention: **the quality and continuity of support for ambassadors; the definition and protection of their role; and the quality of the link with the support and care services to which clients are referred.**

The beauty and cosmetics industry, whose networks reach many salons, could in future help disseminate such approaches, provided this does not compromise the neutrality of the salon that makes confiding possible. This study received no funding from that sector.

VIII. Limitations and scope

This study is exploratory and descriptive. Its aim is to document the properties and functions of an existing trust relationship and how it may contribute to the early stages of a mental health pathway. It was not designed to measure clinical outcomes, establish the effectiveness of Heal by Hair or produce estimates representative of Togo. The limitations below define **what can and cannot be inferred from the results**.

8.1. Mainly self-reported data

The results rest on what clients and hairdressers report about their relationships, confidences, detection, support and referral, not on direct observation of interactions. As with any self-reported data, answers may be affected by memory, interpretation or social desirability. This applies particularly to ambassadors, who may report favourably on a training they took part in, and to some acceptability questions put to clients.

The convergence between questionnaires, interviews and focus groups, and between clients' and hairdressers' perspectives, strengthens the coherence of the mechanisms identified, without removing these limits.

8.2. No causal effects

The study describes how trained and untrained hairdressers report their practices. **These differences are descriptive and are not estimates of the effect of Heal by Hair training.** They may reflect participants' prior characteristics, experience, motivation or other unmeasured factors. The untrained and non-selected groups in Lomé were too small for statistical comparison (Table 2).

This limit concerns only part of the results. It does not apply in the same way to findings on confiding, the features of the trust relationship, longitudinal knowledge or the conditions of referral, which answer descriptive questions. The effect of Heal by Hair is a separate question, addressed by other research.

8.3. A snapshot of relationships built over time

The study observes relationships that often go back several years, but at a single point in time. It cannot show how trust appears, grows, weakens or disappears. Since repetition and longitudinal knowledge are central to the mechanism, following relationships over time would show how they relate to trust and to the different functions (confiding, detection, support, referral), and whether changes ambassadors report after training last.

8.4. Geographic scope and recruitment

Data were collected in Lomé, Kara, Sokodé and Dapaong, but not evenly. **All client data come from Lomé**, while hairdresser data cover all four cities, where hairdressers outside Lomé are all untrained. The results should not be read as representative of Togolese clients or hairdressers. They describe mechanisms within the populations studied. Whether the properties identified (repetition, longitudinal knowledge, discretion, non-judgment, closeness combined with distance from the intimate circle, neutral entry point) are found elsewhere, and in what combination, remains to be established.

8.5. What the study measures and what it does not

The Trust Study concerns the trust relationship and the mechanisms of confiding, detection, support and referral. It was not designed to measure symptoms or psychological well-being. The absence of standardized measures such as the WHO-5 or PHQ-9 is therefore not a limitation for its main question, but it bounds what can be said about reported effects: when a client describes relief or calm, the study records this experience; it cannot infer clinical improvement. Adding such measures in future would allow a complementary question: when trust relationships support speaking, support or access to help, are they also associated with measurable changes in well-being or mental health?

8.6. From a case to a broader hypothesis

The study concerns one relationship, between hairdressers and clients, in West Africa, Togo. It identifies properties associated with the functions observed, but cannot show that they would produce the same mechanisms in other professions, relationships or cultures. This is also its main opening: the results provide dimensions precise enough to compare. **At this stage, the relevant generalization is analytical, not statistical:** the study proposes mechanisms and properties whose presence, combination and functions can now be tested elsewhere.

Conclusion

This study started from a specific question: how can trust between a woman and her hairdresser create an entry point for early detection, first-line emotional support and referral to mental health support? Evidence from 150 clients and 290 hairdressers in Togo, with interviews and focus groups, gives a first answer: **trust is not just a general quality of the relationship. It rests on a particular configuration and supports several distinct functions before a person reaches formal care.**

Three lessons stand out.

First, trust is built over time. Repeated contact lets clients test the hairdresser's discretion, consistency and absence of judgment. It also builds knowledge of the client, making changes in behaviour, appearance, mood or attendance easier to notice. **Trust makes speaking possible; longitudinal knowledge can make a difficulty visible before it is put into words.**

Second, the hairdresser's position matters. She is familiar without belonging to the intimate circle, known over time without being involved in family life, and met in an ordinary place not labelled as mental health. **Emotional closeness is not the same as ease of confiding.**

Third, trust enables several functions, but not automatically. It can make speaking easier, provide a first form of support, open a conversation when a change is noticed and make a referral more acceptable. It does not guarantee trust in the recommended resource, or make that resource accessible. **Trust is part of the pathway to care and can support the move towards it; on its own, it does not replace care.**

Heal by Hair is best understood within this mechanism. The relationship exists without the programme, and so do confiding and some forms of detection and support. But the quality of that listening, and where clients are sent, are another matter. Ambassadors' accounts suggest that training structures practices that were intuitive: listening without interrupting or judging, recognizing signs of difficulty, staying steady, knowing the limits of the role and referring to identified resources. These findings are descriptive and do not support causal claims, but they show **what a structured intervention can strengthen within an existing trust relationship.**

This does not mean every trust relationship is mental health infrastructure, or that what happens in salons transfers unchanged elsewhere. It leads to a testable question: **which configurations of trust enable which functions in a mental health pathway, at what stage, and under what conditions?**

For mental health systems, the implication is broader. **Access does not necessarily begin at the door**

of a service. It can begin upstream: in the relationships where a difficulty first becomes speakable, in the knowledge that lets someone see that a woman "is not herself", and in the trust that makes outside help conceivable.

If mental health systems are usually described from the point of service onwards, this study invites us to look at what comes before: **the trust relationships in which a difficulty may first become speakable, noticeable and open to referral.**

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Appendices

Appendix A. Quantitative questionnaires

A.1. Client questionnaire

- How long have you been coming to this salon? ☐ Less than 6 months ☐ 6–12 months ☐ 1–3 years ☐ More than 3 years
- How often do you come here? ☐ Once a month or less ☐ 2 to 3 times a month ☐ More often
- Do you ever talk about personal difficulties with your hairdresser? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often
- How much do you trust your hairdresser? ☐ Not at all ☐ A little ☐ A lot ☐ Completely
- What topics can be discussed in salons? (several answers possible) ☐ Stress / anxiety ☐ Sadness ☐ Financial difficulties ☐ Family problems ☐ Violence ☐ Reproductive health ☐ Loneliness ☐ Other
- When you are going through a difficulty, who are you most likely to talk to first? ☐ Family ☐ Friend ☐ Hairdresser ☐ Health professional ☐ No one
- Do you think hair salons can help women talk about their difficulties? ☐ Yes ☐ No ☐ I don't know
- If your hairdresser referred you to a support circle or a professional, would you trust her? ☐ Yes ☐ Maybe ☐ No
- Why do you talk to your hairdresser? (several answers possible) ☐ Because I trust her ☐ Because we have known each other for a long time ☐ Because she listens ☐ Because I feel safe in the salon ☐ Because I need to talk to someone ☐ Other
- Can conversations in salons help women feel less alone or better supported? ☐ Yes ☐ No ☐ I don't know

A.2. Hairdresser questionnaire

- Status ☐ Heal by Hair ambassador ☐ Untrained ☐ Applied but not selected
- How long have you been practising? ☐ Less than 2 years ☐ 2–5 years ☐ 5–10 years ☐ More than 10 years
- How often do clients talk to you about personal difficulties? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often
- What topics come up most often? (several answers possible) ☐ Stress / anxiety ☐ Sadness ☐ Financial difficulties ☐ Family problems ☐ Violence ☐ Reproductive health ☐ Bereavement ☐ Other

- In your view, why do clients talk to you? (several answers possible) ☐ Because they trust me ☐ Because we have known each other for a long time ☐ Because the salon is a safe place ☐ Because they need to talk ☐ Because they feel less judged ☐ Other
- Have you ever advised a client to seek help? ☐ Yes ☐ No
- If you are an ambassador: has the training changed how you listen to or refer clients? ☐ Yes ☐ No ☐ A little
- Do you think salons can play a role in supporting women? ☐ Yes ☐ No ☐ I don't know

Appendix B. Interview guides

B.1. Client interview guide

Block 1. The relationship with the hairdresser

- How long have you been coming to this salon / to this hairdresser?
- How often do you come here?
- How would you describe your relationship with your hairdresser? ☐ Very poor ☐ Poor ☐ Neutral ☐ Good ☐ Very good
- When you come here, what do you usually talk about? (several answers possible) ☐ Stress / anxiety ☐ Sadness ☐ Financial difficulties ☐ Family problems ☐ Violence ☐ Reproductive health (pregnancy, motherhood, fertility, etc.) ☐ Bereavement ☐ Hair and beauty ☐ General topics (news, media, films, etc.) ☐ Nothing much, we don't talk a lot ☐ Other (please specify)
- What makes you feel most comfortable with your hairdresser? ☐ Time spent together ☐ Her discretion ☐ The way she talks ☐ The way she listens ☐ She has known you for a long time ☐ Other (please specify)

Block 2. Relevance

- Do you ever talk about personal matters with your hairdresser? ☐ Yes ☐ No
- Is it easier to talk about personal matters with your hairdresser? ☐ Yes ☐ No (if no, go to question 11)
- Why is it sometimes easier to talk in a hair salon than elsewhere?
- What makes the salon different from other places for talking?
- Why can talking to a hairdresser be easier than talking to (a) your family, (b) a friend, (c) a health professional?

11. Are there things a woman can tell her hairdresser that she would not say elsewhere? Why?

Block 3. Early detection

12. In your view, what does a hairdresser sometimes notice in a client before other people do? ☐ Sadness ☐ Fatigue ☐ Silence ☐ Irritability ☐ Change in mood ☐ Change in appearance ☐ Other
13. Have you ever talked to your hairdresser about a difficulty before talking to anyone else? ☐ Yes ☐ No. If yes, why her first?
14. Do you think a hairdresser can tell that a woman is not doing well, even if she does not say so clearly? Why?

Block 4. Support and referral

15. When a woman tells her hairdresser about a difficult problem, what does she expect from her first?
16. In your view, what can a hairdresser usefully do in this situation?
17. In your view, what should a hairdresser not do?
18. If your hairdresser referred you to a support circle or a professional, what would give you the confidence to go?
19. What could stop you from going?

Block 5. Emotional effect and outlook

20. How do you feel after talking to someone in a salon who truly listens to you?
21. Can talking to a hairdresser already help a woman, even before seeing a professional? Why?
22. What could make it even easier for women to talk about their difficulties in salons?
23. What would make it easier for women to go to a support service or a professional if their hairdresser referred them?
24. In your view, can hair salons play a role in supporting women in your community? Why?

B.2. Hairdresser interview guide

Block 1. Experience in the profession

- How long have you been practising this trade?
- About how many clients do you see per day?
- About how many clients do you see per week?

Block 2. Conversations in the salon

- How often do clients talk to you about personal difficulties?
- What kinds of difficulties do clients raise most often? Prompts: ☐ Stress ☐ Household and family problems ☐ Financial difficulties ☐ Violence ☐ Sadness ☐ Reproductive health

(pregnancy, motherhood, fertility, etc.) ☐ Bereavement ☐ Other (please specify)

- In your view, why do clients choose to talk to you?

Block 3. The trust mechanism

- In your work, what builds trust with your clients?
- In your view, why do clients confide in their hairdresser?
- Do you think some clients talk because they have known you for a long time? ☐ Yes, please explain ☐ No, please explain ☐ No firm opinion
- When do clients talk most easily? ☐ When the salon is calm and quiet ☐ During long services (colouring, relaxing, braiding) ☐ When they are alone with me ☐ At the end of the appointment, when they are more relaxed ☐ At the start, with light topics that then develop ☐ Any time, depending on what they need ☐ Other. Why?
- Do you think some clients talk because they feel less judged here than elsewhere? ☐ Yes ☐ No

Block 4. Detection

- What signs make you think a client is not doing well, even if she does not say so? ☐ She is quieter than usual ☐ Her appearance has changed (neglect, visible fatigue) ☐ She cries or holds back tears ☐ She avoids eye contact or seems absent ☐ She often cancels or postpones appointments ☐ She makes indirect remarks about her situation ☐ She is unusually agitated or tense ☐ Other
- Have you ever noticed a difficulty before the client mentioned it? ☐ Yes ☐ No
- In your view, what does a hairdresser see or hear earlier than others? ☐ Physical changes ☐ Changes in mood and behaviour ☐ Family or marital tensions mentioned over several visits ☐ Accumulated fatigue, stress or exhaustion ☐ Signs of violence or abuse ☐ How often she comes to the salon ☐ Gradual social isolation ☐ Other

Block 5. Response and limits

- When a client tells you about a serious problem, what do you most often do? ☐ I listen without interrupting or judging ☐ I ask gentle questions to understand better ☐ I reassure her and show my support ☐ I tell her about resources or people who can help ☐ I share a similar experience if I have one ☐ I feel overwhelmed and don't know what to do ☐ I change the subject so as not to intrude ☐ I say nothing ☐ I apply the EROCO™ method (Écouter, Rassurer, Observer, Calmer, Orienter: Listen, Reassure, Observe, Calm, Refer)
- What is hardest for you in these situations? ☐ Not knowing what to say or how to react ☐

Managing my own emotions ☐ Finding the right balance between listening and referring ☐ Knowing whether to tell someone or keep it confidential ☐ Carrying on working normally after a difficult disclosure ☐ Not having training for these situations ☐ Feeling responsible without the tools to really help

17. In your view, what are the limits of a hairdresser's role?

18. In which cases should a client absolutely be referred to another form of help?

Block 6. Effect of the training (ambassadors only)

19. Has Heal by Hair training changed how you listen? Can you give an example?

20. Has it helped you detect certain situations better? Can you give an example?

21. Has it changed how you reassure, calm or refer clients? Can you give an example?

22. Has it given you more confidence to refer a client? Can you give an example?

Block 7. Outlook

23. Do you think salons and hairdressers can play a role in supporting women? Why?

24. In your view, what would make it easier for women to get help when they need it?

25. If salons were better connected to support services, what would be important for this to work well?

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Appendix C. Focus group guides

C.1. Clients

1. In general, what role does a hair salon play in the lives of women in your community?
2. Why do women sometimes talk about very personal things at the salon?
3. What makes someone feel comfortable (or not) talking in a salon?
4. What can a hairdresser usefully do when a woman is not doing well?
5. What should she not do?
6. If a hairdresser referred a woman to a support circle or a professional, what would inspire confidence?
7. Could salons play a bigger role in supporting women? Why?

C.2. Hairdressers

1. In your experience, why do clients confide in their hairdresser?

2. What kinds of difficulties come up most often?
3. What makes a hairdresser trustworthy in clients' eyes?
4. What does a hairdresser see or hear before other people do?
5. How far can a hairdresser go in listening and support?
6. When should a referral be made?
7. What would help hairdressers play this role better without overstepping their limits?

Mental health is health.