VACCINE HESITANCY, TRUST, AND INSTITUTIONAL RELATIONSHIPS: AN INTERPRETIVE DESCRIPTION STUDY OF PARENTAL EXPERIENCES WITH THE IMMUNIZATION OF SCHOOL PUPILS ACT IN ONTARIO

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Abstract

Vaccine Hesitancy, Trust, and Institutional Relationships:
An Interpretive Description Study of Parental Experiences with the Immunization of School Pupils Act in Ontario

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Vaccine hesitancy continues to influence public health practice in Ontario, particularly within a system that requires parents to complete non-medical exemptions under the *Immunization of School Pupils Act, 1990*. The purpose of this study was to explore how vaccine-hesitant parents understand their decisions and navigate institutional processes during the exemption pathway. Using Thorne's (2016) Interpretive Description, seven parents from Ontario participated in semi-structured interviews focused on experiences of trust, communication, and interactions with public health. Themes developed were: mutual othering, the role of epistemic conflict, vaccine refusal and exemption as symbolic resistance and restructuring trust through relationships. These findings show that vaccine decision-making is influenced not only by beliefs about safety or access, but also by the relational and moral context in which information is delivered. The study offers insights for public health nursing practice by highlighting the importance of relational approaches, ethical communication, and trust-building within mandatory immunization systems.

Keywords: Vaccine hesitancy, institutional trust, interpretive description, immunization policy, parental decision-making, public health nursing

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List of Abbreviations

BeSD – Behavioural and Social Drivers of Vaccination

CCA – Constant Comparative Analysis

CDC – Centers for Disease Control and Prevention

COVID-19 – Coronavirus Disease 2019

HPV – Human Papillomavirus

ID – Interpretive Description

ISPA – Immunization of School Pupils Act

METI – Muenster Epistemic Trustworthiness Inventory

NACI – National Advisory Committee on Immunization

PISM – Preferences for Information via Social Media

SAGE – Strategic Advisory Group of Experts

TCPS2 – Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans

WHO – World Health Organization

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Chapter 1: Introduction

Background and Overview

Vaccine hesitancy remains one of the most persistent challenges facing public health systems in Canada, even in regions where vaccination requirements are linked to school participation (Thomas & Flood, 2020). In Ontario, the *Immunization of School Pupils Act, 1990 (*ISPA) requires that all students attending school be immunized against specified diseases unless a valid medical or non-medical exemption is submitted. While this legislation is aimed at protecting public health, the enforcement of it has also created complex relationships between parents, schools, and public health authorities. In practice, the process of compliance, exemption, or suspension under the ISPA is more than just a bureaucratic formality. It becomes an opportunity where institutional expectations meet personal values, moral judgments, and perceptions of trust.

Despite high overall vaccine coverage in Canada, national surveys indicate that approximately 15-25 percent of parents express some level of vaccine hesitancy, and a smaller proportion actively seek exemptions (Public Health Agency of Canada, 2022). Within Ontario, public health units are responsible for enforcing compliance through record review, parent notification, and walking parents through the exemption process. These interactions often happen via formal channels such as automated letters, online modules, and limited direct contact with nurses. For parents, who already question institutional authority or have experienced previous mistrust in healthcare, these processes may reinforce feelings of coercion and alienation rather than foster engagement

(Nurmi & Jaakola, 2023). Understanding how these relational dynamics unfold is vital for developing more effective and compassionate health communication strategies.

Vaccine hesitancy is often viewed in the existing literature as stemming from misinformation, cognitive biases, or a lack of confidence in science (Carrieri et al., 2023). This approach frames the hesitant individual as the problem to fix rather than someone navigating complex moral, social, and relational contexts. More recent research challenges this perspective by highlighting the social and emotional aspects of vaccine decision-making, such as trust, identity, and moral agency (Goldenberg, 2021; Larson et al., 2018). Nonetheless, there remains a gap in understanding how these concepts function within specific institutional frameworks, like Ontario's exemption process, where parents' interactions with public health are formalized and often mediated through bureaucratic tools.

As a Public Health Nurse involved in immunization programs, I have seen how these processes can challenge relationships between families and the public health system. Parents seeking exemptions often face questions not only about vaccine safety but also about integrity and respect. The tone and structure of institutional communication can either build or undermine trust. While these encounters may seem administrative, they are fundamentally relational. They show how institutional design can impact the moral and emotional dimensions of public trust.

Although vaccine hesitancy has been extensively studied, it is still framed, in much of the existing research, as a lack of knowledge. This approach has limited Public Health's capacity to engage effectively with individuals and families who question or resist vaccination. In Ontario, where childhood immunization is governed by the ISPA,

this gap becomes especially apparent. Parents seeking exemptions are often viewed through a behavioural perspective focused on persuasion and correction. However, these interactions also reveal deeper issues about how citizens experience institutional authority and relational trust.

Current provincial legislation requires parents who choose not to vaccinate their child(ren) to complete an education session or online module outlining the risks of non-immunization. While this requirement is intended to support informed decision-making, it may unintentionally reinforce mistrust. The exemption process privileges biomedical expertise while leaving little space for dialogue, emotional expression, or alternative ways of knowing. Parents' experiences within these encounters remain underexplored, particularly in relation to how they interpret and negotiate institutional authority. Understanding these processes is essential for addressing the social and ethical dimensions of vaccine hesitancy rather than treating it solely as an informational gap.

Research Aim

The aim of this study is to examine how parents in Ontario who refuse vaccines understand and manage their interactions with institutions during the ISPA exemption process. Specifically, the research looks at how parents draw on personal, moral, and experiential knowledge to support their views, and how they build and distribute trust across institutional, professional, and peer environments. By focusing on relational experiences rather than individual attitudes, the aim of this study is to reveal how trust is created, broken, and rebuilt within public health systems.

Ultimately, the aim of this research is to develop a more detailed and relational understanding of vaccine hesitancy in Ontario. By exploring how parents interpret their interactions with public health institutions, I seek to identify ways to rebuild trust and encourage respectful engagement within mandatory immunization frameworks.

Research Questions

This study was guided by three interrelated research questions that reflect its interpretive and relational focus. These questions were developed to explore how parents understand, justify, and act within the institutional and moral contexts of vaccination under Ontario's *Immunization of School Pupils Act* (ISPA). Grounded in the *Behavioural and Social Drivers of Vaccination* (BESD) model and informed by the principles of *Interpretive Description*, the questions emphasize meaning, interaction, and trust rather than prediction or measurement.

How do parents in Ontario who refuse vaccines justify their decision and navigate interactions with institutions during the ISPA exemption process?

1. **What forms of knowledge and evidence do they draw upon to support their stance?**
2. **How do they construct and allocate trust across institutions, healthcare providers, and peer networks?**

Together, these questions address the social and moral dimensions of vaccine decision-making that are often overlooked in behavioural models. They position vaccine hesitancy not as a fixed set of beliefs but as an evolving negotiation between personal conviction, social influence, and institutional interaction. By exploring how trust and

moral reasoning shape parents' experiences of exemption, the study seeks to generate insights that can inform more relational and empathetic approaches to public health engagement.

Theoretical and Conceptual Framework

This study is conceptually grounded in the World Health Organization's *Behavioural and Social Drivers of Vaccination* (BESD) framework (WHO, 2021), which identifies the individual, social, and practical factors that shape vaccination decisions (Figure 1). The BESD model highlights four interrelated domains: thinking and feeling about vaccination, social processes, motivation to vaccinate, and practical issues related to access. While this framework has become central to contemporary vaccine confidence research, it often positions hesitancy as a behavioural outcome influenced by measurable determinants. As a result, the relational and moral dimensions of trust are sometimes underexamined.

This study employs the BESD framework not as a diagnostic tool but as a lens to understand how parents interpret and navigate the institutional context of vaccination. BeSD offers a useful model for examining influences on vaccine decision-making, including cognitive, emotional, social, practical, and motivational factors (World Health Organization, 2021). Decisions are shaped by personal beliefs, social relationships, and experiences with health and education systems. Trust also plays a role in how information is interpreted and how interactions with institutions occur (Hall et al., 2001). The BeSD is used in this study to explore how Ontario parents navigate these influences during the ISPA exemption process and how broader relational and institutional contexts shape their choices.

Methodology Overview

This study is methodologically guided by Sally Thorne's Interpretive Description (ID) (Thorne, 2016), a qualitative approach rooted in applied health and nursing sciences. The aim of ID is to generate knowledge that is both theoretically grounded and practically meaningful. It recognizes that human experiences are complex and shaped by context, and that analysis should go beyond mere description to include interpretation that can inform practice. This method complements the BESD framework by prioritizing the meanings participants attach to their experiences rather than focusing solely on measurable predictors of behaviour.

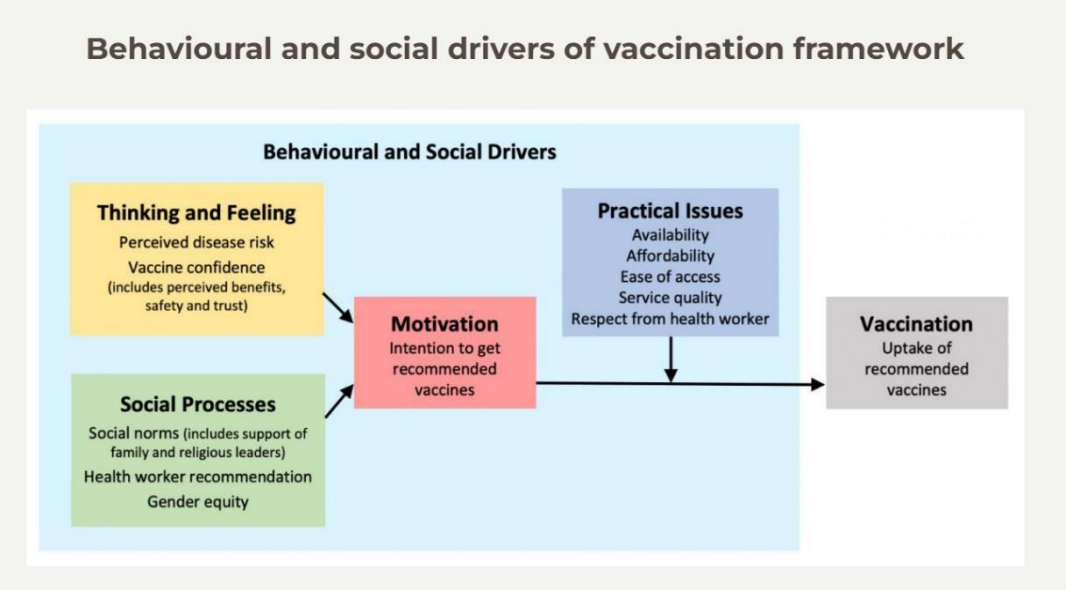
Using ID allowed for an inductive yet structured exploration of parents' narratives. The analytic process involved iterative reading, coding, and comparison to identify patterns of meaning related to trust. Findings were subsequently interpreted in the context of nursing practice to illustrate how relational dynamics influence vaccine decision-making within the ISPA setting. This dual framework enabled a balance between empirical grounding and conceptual synthesis. It also reflects the study's applied purpose: to produce knowledge that can guide public health professionals in fostering trust and understanding within mandatory immunization systems.

Together, the BESD model and Interpretive Description provide a coherent conceptual and methodological foundation for this research. The framework situates vaccine decision-making within social and institutional contexts, while the methodology supports an interpretive analysis that remains dedicated to accurately reflecting the participants' lived experiences. This integration positions the study to contribute both

theoretical insight and practical guidance for improving relational approaches to vaccine communication and public health engagement.

Figure 1

Behavioural and social drivers of vaccination framework



Retrieved from: World Health Organization. (2021). *Behavioural and social drivers of vaccination: Tools and practical guidance from the BeSD working group.* World Health Organization. https://apps.who.int/iris/handle/10665/339452

Significance and Contribution

This study contributes to the growing body of research that seeks to understand vaccine hesitancy as a relational and social phenomenon rather than an individual deficit. In Ontario, public health units are uniquely positioned at the intersection of policy enforcement, clinical care, and community engagement. Nurses and public health professionals occupy the space where institutional mandates meet personal experience, making the quality of these interactions central to both compliance and trust. By examining parents' experiences within the *Immunization of School Pupils Act* (ISPA)

exemption process, this study offers insight into how institutional practices shape not only vaccination behaviour but also the moral and emotional dimensions of public trust.

Researcher Positionality

My positionality as a Public Health Nurse working within an immunization program at an Ontario Public Health Unit (PHU) shapes the perspective I brought to this research. I have supported families through many aspects of the Immunization of School Pupils Act, including record review, clinic operations, and the vaccine exemption processes. These experiences have provided me with a detailed understanding of how policy, communication, and practice intersect in everyday encounters. They have also shown me how easily trust can be strengthened or weakened depending on the quality of these interactions. Entering this study, I carried a strong commitment to the value of vaccination and a belief in its importance for population health, along with firsthand knowledge of the pressures that shape public health decision-making.

This background provided insight into the institutional environment that participants navigated, but it also meant that I approached their stories as someone who has been part of the very systems they questioned. I am familiar with the assumptions, language, and routines that guide immunization work in Ontario, and I am aware that these can influence how I interpret the concerns parents shared. I also recognize that my professional identity may have affected how participants viewed me, how they chose to explain their decisions, and what they felt comfortable disclosing within an interview about institutional trust.

Because of this, I approached the research with a conscious awareness of power dynamics, uncertainty, and the ethical aspects of health communication. My aim was not to defend institutional practices, but to understand how parents experienced them. I conducted interviews with a focus on listening attentively, avoiding assumptions about participants' meanings, and being sensitive to the emotional significance behind their stories. Throughout the research, I strove to acknowledge the tension between my professional experiences and my desire to grasp the real experiences of those who felt ignored by the system. This approach helped me engage with the research in a way that honoured both the parents' viewpoints and experiences.

Thesis Organization

This thesis is structured into five chapters. Chapter One introduces the study's purpose, context, and conceptual basis, covering the research problem, theoretical framework, and methodological approach. Chapter Two reviews relevant literature on vaccine hesitancy, institutional trust, public health communication, and the Immunization of School Pupils Act in Ontario. Chapter Three details the methodology, including sampling, recruitment, ethical considerations, data collection, coding techniques, and interpretive analysis. Chapter Four presents the results, organized into themes that explain how parents justify their decisions, interpret interactions with institutions, and either build or withhold trust in social and professional contexts. Chapter Five offers an integrative discussion linking the findings to existing research and exploring their implications for nursing practice, public health policy, and future studies.

Chapter 2: Literature Review

The literature for this study was gathered using Trent University's Omni Search and Google Scholar, along with additional sources identified through citation chaining and reference tracking from key works. Search terms included combinations such as "vaccine hesitancy," "parental decision-making," "institutional trust," and "Ontario immunization policy," along with related concepts. Both peer-reviewed articles and grey literature from Canadian public health agencies were considered, as they offer important insights into vaccine policy and implementation in Ontario. The review aimed not to be systematic or exhaustive but to identify a broad range of literature for critical, thematic analysis. This approach enabled the inclusion of empirical studies, frameworks, and policy documents, thereby establishing a solid foundation for the current research. By integrating diverse sources, the review identifies the practical and contextual aspects of vaccine decision-making and trust, consistent with the interpretive description approach used in this research.

Vaccine Hesitancy Frameworks

Vaccine hesitancy has emerged as a significant public health concern, recognized by the World Health Organization (WHO) as one of the top ten threats to global health in 2019 (WHO, 2019). The WHO's Strategic Advisory Group of Experts (SAGE) defines vaccine hesitancy as the "delay in acceptance or refusal of vaccines despite the availability of vaccination services" (MacDonald, 2015). It is predominantly conceptualized as a spectrum of attitudes shaped by contextual factors, individual values, and perceptions, rather than a fixed position.

Several frameworks have been developed to conceptualize the drivers of vaccine hesitancy. The 3Cs model (confidence, complacency, convenience) offered a simple and influential early framework but has since been critiqued as reductionist, focusing mainly on individual attitudes and access (MacDonald, 2015). The 5Cs model (Betsch et al., 2018) added psychological nuance by incorporating "calculation" and "collective responsibility," but still emphasized individual cognition over relational and institutional forces. Similarly, the 5As model (Thomson et al., 2016) provided a useful programmatic lens (access, affordability, awareness, acceptance, activation) but conceptualized hesitancy primarily in terms of modifiable barriers. Other behavioural science frameworks, such as COM-B (Michie et al., 2011) and the Health Belief Model (Alamer, 2024), have also been widely applied. However, they risk narrowing the scope of hesitancy into preset categories, often neglecting the influence of power dynamics and institutional encounters.

More recent approaches attempt to capture this complexity. The SAGE determinants matrix provides a broad taxonomy of contextual, individual, and vaccine-specific factors, but offers limited interpretive guidance (Cadeddu, et al., 2021). The most comprehensive framework to date, the WHO Behavioural and Social Drivers of Vaccination (BeSD) model, integrates cognitive, social, and structural influences into four domains: What people think and feel, social processes, motivation, and practical issues (WHO, 2020, 2021). Crucially, BeSD places trust at the center of vaccine decision-making, recognizing that confidence in institutions, providers, and communities shapes individual vaccine choices. It has been applied across diverse contexts, from routine

immunization in low- and middle-income countries to COVID-19 vaccine uptake in high-income settings (Meng et al., 2023; Santibanez et al., 2024).

Collectively, these frameworks illustrate a shift from individualist to multidimensional perspectives on vaccine hesitancy. However, even BeSD can be used as a diagnostic checklist rather than a tool for understanding lived experience. This provides a need for interpretive qualitative research that explores how parents navigate immunization systems, negotiate institutional trust, and experience power and legitimacy. For this study, BeSD offers the most relevant conceptual foundation because of its explicit focus on trust and social processes. In the Ontario context, where exemption procedures involve direct encounters between parents and public health authorities, BeSD helps illuminate how vaccine refusal is shaped not only by access or knowledge gaps, but also by relational and institutional dynamics of trust (WHO, 2021)

Trust Literature in Canada

In the Canadian context, trust in public institutions is best understood as a relational and conditional judgement rather than a fixed attitude or generalized confidence. Within publicly funded health systems, trust is shaped by expectations that institutions will act competently, transparently, and in the public interest, while remaining accountable to the populations they serve (Trust Research Undertaken in Science and Technology [TRuST] Scholarly Network, 2024). Canadian research consistently shows that trust varies by institution and over time, particularly in response to social, political, and public health events, rather than existing as a stable or uniform characteristic (TRuST Scholarly Network, 2024).

Recent Canadian research highlights the importance of differentiating trust from related concepts like reliance, confidence, or compliance (Health Data Research Network Canada, 2023). Trust develops in uncertain situations and depends on evaluating institutional intentions and integrity rather than just technical skills. Canadian scholarship on public trust in health systems and data governance emphasizes that trust must be earned through visible, trustworthy actions such as transparency, serving the public interest, and engaging the public meaningfully. Accordingly, trust isn't automatically granted by institutional authority but is constantly negotiated through institutional actions and communication (Health Data Research Network Canada, 2023).

National measures of institutional trust in Canada highlight that trust is conditional. Data from surveys like the Edelman Trust Barometer show that public confidence in government and health institutions varies over time and depends on perceptions of fairness, consistency, and moral integrity (Edelman, 2024). Although healthcare professionals and scientists generally enjoy higher trust levels than other institutions, this trust does not always apply to public systems or enforcement agencies, especially after the COVID-19 pandemic (Edelman, 2024; TRuST Scholarly Network, 2024).

For the purposes of this study, trust is conceptualized as a relational and moral process through which parents assess the credibility, intentions, and responsiveness of public health institutions. Trust is shaped by prior encounters, perceptions of fairness, and the emotional tone of institutional communication, and it plays a central role in how parents interpret and respond to mandated immunization policies. This conceptualization

foregrounds trust as something that is actively allocated, withheld, or reconfigured through interaction, rather than as a static belief in institutional authority.

Vaccine Hesitancy in Canada and Ontario

In Canada, vaccine coverage is generally high. However, hesitancy persists and is unevenly distributed across regions and populations (Chen et al, 2023). A review of the 2017 national childhood immunization coverage survey estimated that approximately 15–25% of Canadian parents harbour some degree of vaccine hesitancy, and a smaller proportion refuse vaccines outright (Public Health Agency of Canada, 2022). In Ontario, childhood immunization is governed by the *Immunization of School Pupils Act*, 1990, which requires children to be vaccinated against designated diseases to attend school, unless a valid exemption is filed (Government of Ontario, 1990). The *ISPA* mandates proof of vaccination for diphtheria, tetanus, polio, measles, mumps, rubella, meningococcal disease, pertussis, and varicella for specific age groups.

Ontario's exemption framework under the Immunization of School Pupils Act (ISPA) (1990) falls into two main categories. The first is a medical exemption, which must be signed by a physician or nurse practitioner and indicate that immunization would harm the child's health or that the child has proven immunity to the specific disease. The second is a non-medical exemption, also called a religious or philosophical exemption. Parents must submit notarized affidavits to their local public health unit for this type of exemption. Since 2017, parents requesting non-medical exemptions have also been required to attend an educational session delivered by public health staff (Government of Ontario, 2017). Parents who fail to provide proof of immunization or complete an exemption will receive a school suspension order for their child from their local public

health unit. These children may then be excluded from school until proper documentation is submitted. While the system aims to boost vaccine uptake, it can also put parents in direct, sometimes adversarial, contact with public health authorities.

Existing research on Ontario's ISPA has focused primarily on compliance rates and the effectiveness of exemption requirements (Thomas & Flood, 2020). For example, studies have shown that mandatory education sessions have reduced the number of exemptions filed in some jurisdictions, suggesting a deterrent effect (Greyson & Goh, 2023). However, these evaluations rarely examine the experiential dimension of navigating exemptions or how parents interpret affidavits warning of harm or death, or how children experience being handed suspension letters in classrooms. This omission reflects a broader tendency in vaccine hesitancy research to focus on immunization coverage rates and external predictors of hesitancy rather than on the lived experiences of students, parents, or families.

Additionally, the COVID-19 pandemic has further complicated Ontario's immunization landscape. Pandemic-era mandates, including proof-of-vaccination requirements for public venues, reshaped public discourse around coercion, consent, and autonomy (Attwell & Hannah, 2022). Parents who already perceived ISPA's exemption process as coercive may have seen COVID-19 measures as confirmation of a broader pattern of institutional overreach. As a result, hesitancy in Ontario can no longer be understood solely in terms of access or knowledge deficits. Still, it must be considered within the context of institutional trust and resistance.

While there are data available that attempts to provide insights into demographic and behavioural patterns of vaccine hesitancy (Chen et al., 2023), much of it is still inconsistent and mainly describes superficial trends. Surveys and cross-sectional studies frequently report who is hesitant, what beliefs they hold, and how coverage varies across regions or populations (Dubé et al., 2013; Aw et al., 2021). These approaches can overlook the deeper interpretive processes through which parents make sense of vaccines, navigate their encounters with institutions, and reconfigure their trust. In other words, hesitancy is typically mapped as a distribution of attitudes, but less often examined as a lived and relational experience. This gap highlights the importance of qualitative, interpretive inquiry that can move beyond descriptive categories to explore the meanings, strategies, and contestations underlying vaccine refusal in Ontario.

Vaccine Hesitancy and Institutional Trust

Trust in institutions has long been recognized as a cornerstone of effective health systems. Kaasa and Andriani (2022) argued that institutional trust is built not only on the competence of the institution, but also on accountability and the perception that institutions act in the interests of those they serve. In the domain of immunization, Larson (2018) emphasized that trust is multidimensional, encompassing confidence in the safety and effectiveness of vaccines, the reliability of health professionals who administer them, and the integrity of public health systems that recommend and regulate their use. When these dimensions of trust are fractured, vaccine programs face resistance.

Recent research has shown that declining trust in public institutions is linked to lower vaccine uptake. For example, Krastev et al. (2023) found that institutional trust was a distinct predictor of COVID-19 vaccine hesitancy in Canada, independent of

interpersonal trust. Lazarus et al. (2021) similarly reported that trust in institutions was positively associated with willingness to accept a COVID-19 vaccine across 23 countries. Rather than reflecting an outright rejection of scientific evidence, distrust often stems from perceptions of coercion, lack of transparency, and contradictory messaging in public health communication (Wang et al., 2024; de Figueiredo et al., 2020). During the COVID-19 pandemic, rapidly changing guidance and the roll-out of vaccine mandates exacerbated challenges to institutional credibility and public confidence (Han et al., 2021; Rieger & Wang, 2021).

In the Canadian context, studies have found that parents often perceive school-based immunization enforcement as punitive rather than supportive. For example, Ontario's *ISPA* requires affidavits or education sessions for exemptions, and issues suspension orders for children who are not in compliance. While these measures are intended to safeguard population health, parents frequently interpret them as stigmatizing, infantilizing, or coercive (MacDonald, 2015; Reich, 2016). The symbolic significance of receiving an affidavit acknowledging potential harm or death, or of having a suspension notice handed to a child at school, often heightens feelings of alienation from the very institutions meant to foster public trust.

Despite this evidence, much of the existing literature often treats institutional distrust as a binary predictor, framing those with "low trust" as simply more likely to refuse vaccines. Such an approach risks oversimplifying the lived experiences and nuanced ways in which distrust is felt and expressed. What may be missing is an account of how parents describe their encounters with institutions, how these interactions are infused with power and meaning, and how distrust influences their daily navigation of bureaucratic

processes like exemptions. A deeper understanding might come from looking beyond correlations to see how parents interpret and shape their relationships with institutions.

Socioeconomic and Cultural Factors Affecting Institutional Trust

Although institutional trust is often discussed in broad terms, it does not operate uniformly across all populations. Historical injustices, systemic discrimination, and ongoing inequities shape how different communities experience and evaluate institutions. In Canada, these dynamics are particularly evident among Indigenous, Black, and immigrant populations, where legacies of exclusion and differential access to healthcare contribute to distinctive patterns of vaccine hesitancy (Bagsara et al., 2021; Nguyen at al., 2023). Understanding institutional trust, therefore, requires attention to the socioeconomic and cultural contexts that mediate how parents interpret and respond to immunization policies. Exploring the interplay between socioeconomic and cultural factors and institutional trust is crucial for understanding vaccine hesitancy within Canada. Recent studies have illuminated how disparities in trust, influenced by socioeconomic status, ethnicity, and cultural background, contribute to vaccine hesitancy and have proposed strategies to build trust among diverse populations.

Marginalized communities in Canada often have lower levels of trust in institutions because of historical injustices and systemic discrimination. For example, Indigenous populations face barriers to healthcare access that stem from past unethical medical practices and ongoing inequalities. A narrative review by Nguyen et al. (2020) noted that these barriers operate at three interconnected levels. Proximal barriers include immediate factors such as negative encounters with providers, limited health literacy, and the difficulty of accessing care in geographically isolated settings. Intermediate barriers

encompass community and service-level conditions, including inadequate infrastructure, transportation challenges, and health services that are not culturally or linguistically aligned with community needs. Distal barriers involve broader structural forces, including the legacy of colonialism, systemic racism, and the exclusion of Indigenous peoples from decision-making processes. Nguyen et al. emphasize that these layers interact to create a cumulative burden that shapes how Indigenous communities experience healthcare and how trust in institutions is formed or eroded. Furthermore, vaccine hesitancy worsens healthcare inequalities, disproportionately impacting marginalized groups with limited access to trustworthy health information, such as Canada's Indigenous populations.

Bagsara et al. (2021) examined data from 2080 adults in the United States using the RAND American Life Panel survey. They found that trust in the scientific community was the strongest predictor of having received at least one COVID-19 vaccine. Asian respondents exhibited significantly higher trust in science than other racial groups, while American Indian/Alaskan Natives showed the lowest levels of institutional trust. Trust in the government's pandemic response was not significantly linked to vaccination status. This highlights the importance of institutional trust and systems in influencing vaccine hesitancy and confidence in scientific advice.

Similarly, Black communities in Ontario face health inequities aggravated by systemic racism. The "Black Health Plan for Ontario" (Ontario Health, 2023) emphasized that addressing these disparities requires developing equitable pandemic response strategies and recovery plans for the health system. These strategies include developing approaches to ensure that Black communities receive fair and effective responses during

health crises; implementing recovery plans that prioritize the unique needs of Black populations; ensuring they benefit equally from improvements in health systems; and making fundamental changes in health and social systems to promote long-term health equity for Black communities (Ontario Health, 2023).

These examples demonstrate that institutional trust is not just an individual attitude but a relationship shaped by history. For parents in these communities, vaccine decisions often involve ongoing negotiations among recognition, representation, and trust repair.

Impact of COVID-19 Pandemic on Institutional Trust and Vaccine Hesitancy

The COVID-19 pandemic was a pivotal moment for global public health, highlighting issues of trust in institutions, scientific credibility, and moral justification in vaccine debates. For many, vaccination became more than just a routine action; it turned into a measure of institutional trustworthiness and collective morals. Studies conducted during this period revealed that people's willingness to receive the COVID-19 vaccine was influenced not only by perceptions of safety and efficacy but also by their views on how governments, health agencies, and scientists managed uncertainty (Aw et al., 2021; Lazarus et al., 2021). Trust served as a moral proxy, allowing individuals to judge whether institutions acted with integrity amid a fast-changing crisis. They looked at whether decisions were transparent, whether communications admitted doubts and new evidence, and whether authorities demonstrated competence in a manner that was perceived as accountable and fair (Aw et al., 2021). Thus, confidence in the vaccine also reflected trust in the character and actions of the institutions endorsing it.

In Canada, pandemic-era policies such as proof-of-vaccination systems, mandatory workplace vaccination, and shifting public health restrictions illustrated the tension between collective protection and personal autonomy. Although these policies successfully increased coverage in some regions, they also produced social and ethical dilemmas that extended beyond the vaccines themselves. Attwell and Hannah (2022) argue that mandates often reignited long-standing debates about coercion and state power, particularly among populations already predisposed to institutional skepticism. Based on those findings, for Ontario parents accustomed to navigating the bureaucratic processes of the ISPA, the extension of vaccination requirements into many aspects of public life may have reinforced earlier perceptions of inflexibility, surveillance, and moral judgment within public health systems.

Another defining feature of the pandemic was the visibility of scientific uncertainty. Rapidly evolving knowledge about transmission, masking, and booster schedules required authorities to communicate in real time, often revising recommendations as evidence changed. This dynamic process, while necessary, frequently conflicted with public expectations of scientific certainty. As Rieger and Wang (2021) noted, what scientists viewed as methodological transparency, many citizens perceived as inconsistency. The communicative challenge was therefore epistemic as much as logistical: maintaining trust required institutions to model uncertainty without appearing incompetent or contradictory. When these conditions were not met, public confidence weakened, particularly among those already inclined to interpret shifting guidance as evidence of unreliability.

Recent studies suggest that the effects of these ruptures have extended well beyond the pandemic. Lazarus (2024) argues that pandemic-era patterns of mistrust may have created a trust deficit that continues to influence public attitudes toward routine immunization programs. As Ontario rebuilds its school and community-based vaccination initiatives, lingering skepticism about government transparency and fairness remains a barrier to restoring pre-pandemic levels of confidence. Krastev et al. (2023) provide further evidence of this trend, finding that deficits in both institutional and interpersonal trust are associated with higher vaccine hesitancy. This distinction underscores the asymmetry of trust recovery: repairing personal relationships between clinicians and patients may be more achievable than rebuilding abstract trust in the public health system as a whole.

Equally significant is the role of digital information environments in mediating these dynamics. The pandemic accelerated the decentralization of knowledge, as individuals encountered scientific updates, personal testimonies, and misinformation side by side on social media platforms. McKinley et al. (2023) demonstrate that institutional trust acts as a moderating filter in these contexts. Individuals with higher baseline trust in government and healthcare institutions are less likely to internalize misinformation. In contrast, those with low trust are more susceptible to alternative narratives that confirm their doubts. This phenomenon illustrates how misinformation alone does not create hesitancy; instead, it interacts with pre-existing perceptions of institutional integrity.

In the Ontario context, understanding institutional trust in the aftermath of COVID-19 involves recognizing that distrust is not simply resistance, but a rational response to perceived inconsistency, inequity, or exclusion. Public health efforts to

rebuild confidence must therefore engage with the relational dimensions of trust repair, listening to parental experiences, acknowledging institutional limitations, and demonstrating accountability. Trust, as Kaasa and Andriani (2022) argue, rests on the perception that institutions act in the interests of those they serve. When this perception is damaged, technical reassurance alone is insufficient. Moral credibility, empathy, and transparency become the foundation upon which public cooperation is rebuilt.

Ultimately, the pandemic transformed the perception of vaccination from merely a biomedical issue into a test of institutional integrity. It demonstrated that confidence in vaccines is inseparable from trust in the systems that support them. The ongoing hesitancy after the pandemic indicates that institutional trust acts as both an indicator and a result of vaccination behaviour. As Ontario's public health system continues its recovery, the lessons of COVID-19 highlight the importance of sustained, open dialogue with communities whose trust has been most deeply affected. Future policies should therefore strike a balance between scientific clarity and relational sensitivity, fostering trust through mutual understanding rather than insisting on compliance.

Relational Trust and Interpersonal Care

Patterns of institutional trust are deeply tied to social and cultural contexts. When systemic inequities and histories of exclusion shape how parents experience health systems, many turn toward interpersonal and community-based relationships that feel more supportive and validating. These relationships provide not only information but also emotional recognition and a sense of belonging. Giddens (1990) distinguishes between trust in abstract systems, such as governments and health authorities, and trust in personal relations, where face-to-face encounters provide reassurance and legitimacy. When trust

in abstract systems falters, individuals often compensate by investing more heavily in relational forms of trust. This distinction is critical in understanding vaccine refusal; even when parents reject institutional authority, they frequently maintain strong trust in individual providers, alternative practitioners, or peer networks.

Relational trust in healthcare encounters is built through attentiveness, respect, and the recognition of patients or parents as whole people rather than as cases to be managed. Within the broader literature on medical trust, Hall et al. (2001) describe interpersonal trust as grounded in perceptions of fidelity, honesty, and caring, qualities that enable patients to feel valued and understood. In the context of vaccination, several studies have shown that parents' confidence is closely tied to the quality of their interactions with providers. Parents who recall positive encounters often describe being listened to without judgment, given time to ask questions, and treated as partners in decision-making (Benin et al., 2006; Leask et al., 2012). Conversely, when discussions are perceived as rushed, dismissive, or coercive, parents report diminished trust and increased ambivalence toward vaccination (Attwell & Navin, 2019; Dubé et al., 2013). Relational attentiveness, particularly the act of listening, functions not only as effective communication but as a mechanism for sustaining trust within the immunization encounter.

Alternative practitioners, such as naturopaths, chiropractors, or faith-based healers, also serve as significant nodes of relational trust. Sobo (2015) found that parents who refuse vaccines often describe these providers as more holistic, attentive, and aligned with their values than conventional physicians. This does not necessarily imply that parents reject all forms of biomedical care; instead, they selectively engage with

practitioners who demonstrate respect for parental autonomy and incorporate broader frameworks of health and well-being. Trust is therefore not absent in vaccine refusal; it is relocated to contexts where parents feel seen, respected, and empowered. In a survey of parents attending naturopathic care in Ontario, only about 50.5% reported that their children had received all recommended vaccines (Sobo, 2015). Moreover, those parents who trusted their naturopathic physician for vaccine information had significantly higher odds of having a partially vaccinated or unvaccinated child.

This literature demonstrates the importance of moving beyond binary notions of "trust" and "distrust." Vaccine refusal is not simply the result of diminished confidence in institutions but represents a reallocation of trust toward relationships, communities, and providers who align with parental worldviews (Leask et al. 2012). By examining how relational trust operates alongside institutional distrust, this study contributes to a more nuanced understanding of vaccine refusal as a process of trust fragmentation and reassignment.

Effects of Healthcare Experiences on Trust

While general institutional trust shapes public willingness to vaccinate, it is often individual healthcare encounters that determine whether that trust is strengthened or weakened. Clinicians act as translators of institutional guidance, bringing policies into personal, face-to-face relationships where tone, empathy, and confidence profoundly influence parental perceptions. Studies consistently highlight the central role of healthcare providers in shaping vaccine attitudes. Kessels et al. (2012) found that primary care physicians play a critical role in shaping intentions to receive HPV immunization, while Anandarajah et al. (2024) similarly reported that 92.4% of respondents identified

healthcare providers as their most trusted source of vaccine information. Charron et al. (2020) observed that parents who obtained information from healthcare professionals showed higher vaccine acceptance than those relying on relatives or the internet, underscoring how interpersonal communication reinforces institutional trust. Yet, this influence can also operate in reverse; Corsten et al. (2023) found that even mild expressions of hesitancy or uncertainty from clinicians could amplify parental skepticism. Recognizing that providers themselves require reliable and consistent information reinforces the importance of provider education as a foundation for public confidence in vaccination (Lin et al., 2021). Stratoberdha et al. (2022) conducted a systematic review of adult vaccination in Canada, identifying barriers such as informational gaps, limited access, safety concerns, and financial constraints. Over one-third of the included studies highlighted deficiencies in vaccine information and access, underscoring systemic issues that undermine confidence in routine immunization. Stratoberdha et al. (2022) propose that, given their accessibility and expertise, pharmacists could play a crucial role in reducing hesitancy. This also raises important questions about parents' trust in alternative healthcare providers when obtaining routine vaccines without a family doctor.

Trust in healthcare professionals varies. Even brief interactions can leave lasting impressions, especially when communication feels hurried or dismissive. Parents who sense judgment or a lack of empathy during these moments may begin to question the motives or credibility of the healthcare system. Gigler et al. (2022) introduced the concept of institutional betrayal to examine how past negative healthcare experiences can impact current trust and future healthcare interactions. While various socio-demographic factors contribute to these negative experiences, Schwei et al. (2014) showed that prior

unfavourable healthcare interactions consistently influence institutional trust across racial and ethnic groups. These dynamics can create a vicious cycle where distrust in the system leads to poorer healthcare experiences, which then further reinforce that distrust.

Negative experiences within the healthcare system do not always manifest in direct interpersonal encounters. They can also occur due to the absence of care or a lack of a sustained relationship with a provider. In a study by McElfish et al. (2023), involving 1,500 adults in Arkansas, participants who had received a routine checkup within the last 2 years were nearly half as likely to express vaccine hesitancy as those who had not had a checkup in over 2 years. This could suggest that not having a regular point of contact within the healthcare system can function as a negative experience in itself. When individuals lack a trusted provider, they miss opportunities for questions to be answered and concerns to be addressed. The absence of care becomes a form of institutional silence, where people are left to navigate uncertainty alone and rely on alternative sources for healthcare information (Marshall et al., 2022).

When experiences within the healthcare system are perceived as dismissive or disempowering, many parents begin to seek alternative ways to understand and validate their concerns. These searches often extend beyond the clinical setting and into digital and social environments where new forms of knowledge and community support take shape (Sommers et al., 2025). In these spaces, parents interpret, share, and contest information about vaccination, often reconstructing their trust in ways that feel more aligned with personal experience. The following section examines how these mediated settings influence parents' understanding of expertise and authority, and how trust is rebuilt or withheld through online and peer-based interactions.

Digital Media and Trust

Social media platforms and online networks serve not only as channels of information but also as forces that shape belief formation. In many contexts, a reliance on social media as a primary source of vaccine information is associated with greater vaccine hesitancy. To reference a previously mentioned study, McKinley et al. (2023) have found that preference for information via social media (PISM) positively predicts vaccine hesitancy, while institutional trust predicts lower hesitancy, and social media's effect is often mediated through trust.

Beyond the clinical encounter, peer and community trust play a vital role in shaping vaccine decision-making. Parents often rely on peer networks to validate their choices, particularly in online spaces such as Facebook groups and parenting forums (Kata, 2012; Hoffman et al., 2019). These communities provide emotional support, alternative interpretations of scientific evidence, and a sense of solidarity in the face of institutional disapproval. Betsch et al. (2015) argue that such peer networks do not simply spread misinformation, they offer parents recognition and affirmation that they may not receive from mainstream health systems. For vaccine-refusing parents, these networks often feel more authentic and trustworthy than official public health messaging.

Furthermore, trust in social media has been linked to lower vaccination rates and higher excess mortality across various countries, even after accounting for institutional and interpersonal trust. Chen et al. (2023) demonstrate that "trust in media" is a distinct factor influencing health behaviours, suggesting that not all types of trust are beneficial for public health. Trusting social media as a source of health information may increase exposure to misinformation or non-expert opinions, thereby undermining vaccine uptake.

Social media can also amplify perceptions of risk over safety. Risk-oriented news about vaccine safety concerns and adverse events tends to have a greater effect on risk perception than safety-oriented coverage does on safety perception (Zhang et al., 2023). This asymmetry might suggest that negative narratives sometimes have a stronger influence in shaping mediated trust. However, when someone's social network is more tightly knit and information flows are dense, social media news appears to have less impact on their perceptions.

Beyond social media, mainstream news media also play a role. During the COVID-19 pandemic, vaccine coverage expanded significantly in online news sources, with shifts in sentiment polarization and coverage volume influencing public epistemic environments (Christensen et al., 2022). Accurate and transparent coverage can support legitimacy, but sensational or polarized reporting may erode trust by framing vaccination debates as conflict rather than collective public health deliberation.

Lay Knowledge, Trust in Experts, and Epistemic Resistance

A key aspect of mediated trust is how non-experts evaluate, challenge, or dismiss expert claims, often referred to as lay epistemics. Laypeople have beliefs about how medical knowledge is created, its certainty, and its authority, which influence their trust or suspicion of sources (Kienhues & Bromme, 2012).

For instance, the Muenster Epistemic Trustworthiness Inventory (METI) assesses experts' expertise, integrity, and benevolence (Hendriks et al., 2015). In mediated settings, such as online interactions, these qualities are called into question: Is the source credible, sincere, and motivated by benevolence? When official health messages are seen as

lacking transparency or humility, ordinary people might reduce their trust in the integrity or benevolence of those messages, even if they still recognize the expertise (Hendriks et al., 2015).

Furthermore, critics of mainstream medical authority often invoke what is sometimes called epistemic resistance or contestation, doing one's own "research," comparing studies, seeking alternative practitioners, or relying on lived experience as evidence. This challenges the monopoly of institutional epistemic authority. Mazanderani et al. (2020) explore how personal experience can act as epistemic evidence in health contexts, thereby shifting the balance of authority. When parents see institutional knowledge as incomplete or biased, they may favour peer networks or alternative sources that align more closely with their worldviews.

This dynamic intersects with the notion of epistemic injustice, in which certain actors, such as marginalized groups, are not afforded credibility within institutional knowledge systems. In clinical or policy encounters, parents who feel dismissed or ignored may be more receptive to mediated communities that validate their doubts (or critique dominant narratives) as a form of reparative epistemic space (Jonas et al., 2025).

Summary

This review suggests that vaccine hesitancy is not simply a matter of individual knowledge or belief but is shaped by how people negotiate belonging, legitimacy, and moral responsibility within healthcare systems. Across the literature, trust and distrust are described as interacting processes that influence how parents challenge, negotiate, or cooperate with public institutions, particularly in contexts involving mandates or

enforcement (Larson, 2018; Kaasa & Andriani, 2022; Attwell & Hannah, 2022). Approaching vaccine refusal as a relational and interpretive process, rather than solely as ignorance or defiance, may therefore offer additional insight into how institutional credibility within Ontario's public health system is built, contested, and potentially repaired.

Across both theoretical and empirical studies, trust is generally characterized as a dynamic process shaped by perceptions of competence, transparency, fairness, and moral integrity (Hall et al., 2001; Larson, 2018; TRuST Scholarly Network, 2024). The literature suggests that confidence in public health institutions may be supported when parents perceive communication as respectful, decision-making as inclusive, and enforcement practices as proportionate and legitimate. Conversely, when institutional interactions are experienced as coercive, dismissive, or inconsistent with parental values, trust may be redirected toward alternative networks, including peer communities, complementary practitioners, or online spaces that offer recognition and validation (Dubé et al., 2013; Sobo, 2015; Betsch et al., 2015).

In Ontario, where parental engagement with public health under the Immunization of School Pupils Act frequently occurs through formal documentation, education requirements, and digital communication, these relational dynamics may be particularly salient. Existing research on ISPA has largely focused on compliance outcomes and exemption rates, with comparatively limited attention to how parents experience these processes in everyday practice (Thomas & Flood, 2020; Greyson & Goh, 2023). As a result, the literature provides limited insight into how institutional encounters, moral tone, and perceptions of authority shape parental trust within legislated immunization systems.

Taken together, this body of literature positions vaccine hesitancy within a broader social field of relationships, power, and moral expectations. Trust is not consistently treated as a fixed attitude but rather as an ongoing negotiation shaped through communication, responsiveness, and perceived institutional intentions (Giddens, 1990; Kaasa & Andriani, 2022). By framing hesitancy as a relational process rather than a deficit, the literature highlights gaps in current understanding, particularly the need for interpretive research that examines how parents experience institutional authority within Ontario's legislated immunization framework. This perspective helps clarify the rationale for the present study and its focus on parents' encounters with public health systems and how these encounters may influence trust, resistance, and confidence in vaccination.

Chapter 3: Methods

Study Methodology: Interpretive Description

Thorne's (2016) interpretive description (ID) is a qualitative methodology specifically designed for use in applied health fields, particularly nursing science. It aims to overcome the limitations of traditional qualitative methods by providing a flexible and pragmatic approach that preserves interpretive depth while addressing complex real-world health experiences. Although ID integrates aspects from grounded theory, phenomenology, and ethnography, it is not confined by their philosophical or procedural expectations. Instead, it selectively adopts strategies that align with applied research goals, setting aside those that do not meet the practical needs of the study.

Interpretive description is grounded in an interpretivist epistemology, which holds that reality is socially constructed and that multiple truths can coexist (Ryan, 2018). The

methodology recognizes the value of the researcher's disciplinary background and encourages reflexivity. Rather than striving for complete objectivity, the researcher is seen as a co-constructor of meaning, whose insights, experiences, and disciplinary knowledge inform the analysis in productive ways (Thorne, 2016).

One of the key strengths of interpretive description is its methodological flexibility. Researchers are encouraged to shape their data collection and analysis methods to best serve the research question, the participants, and the disciplinary context. This included using semi-structured interviews, analytical memoing, iterative coding, and purposive sampling strategies that allow emerging findings to guide subsequent stages of inquiry. The approach supports a dynamic and responsive process that mirrors the nature of human experience.

Although flexible, interpretive description maintains a strong emphasis on rigour and credibility. Thorne (2016) outlines clear expectations for systematic analytic procedures, including transparency in decision-making, careful attention to patterns and relationships in the data, and integration with existing knowledge in the field. The aim is to move beyond basic description to produce insights that are grounded in the evidence and relevant to practice.

This approach integrates elements from other qualitative traditions, differing in meaningful ways that make it particularly well-suited for this study. Grounded theory, for example, is oriented toward generating theory from empirical data (Urquhart et al., 2010). While this is valuable in contexts where new theoretical models are the intended outcome, grounded theory's focus on abstract concepts does not align with the applied

aim of this project, which is to generate practice-relevant insights into how vaccine-hesitant parents engage with healthcare and institutions.

Phenomenology, by contrast, emphasizes uncovering the essence of lived experience (Levasseur, 2003). One of its strengths lies in its commitment to bracketing the researcher's disciplinary knowledge, allowing for a focus solely on participants' perspectives on lived experience. However, in applied nursing research, this bracketing can limit the productive use of professional expertise during analysis. Given my disciplinary background in public health nursing, setting aside professional knowledge would be both impractical and counter to the goals of this study, which aims to inform practice by integrating participant experiences with professional insights.

Ethnography also offers relevant strategies, particularly its attention to social context and cultural meaning-making. Yet ethnography is primarily designed to map the shared practices of cultural groups, typically requiring extended field immersion (Hammersley, 2018). The present study does not aim to construct a cultural portrait of vaccine-hesitant communities, but rather to interpret individual parents' experiences with healthcare and their perceptions of institutional trust. For this reason, while ethnographic tools such as attention to context are valuable, the methodology as a whole extends beyond the intended scope.

While interpretive description differs from grounded theory, phenomenology, and ethnography, it also incorporates some of their strengths. It adopts systematic coding and pattern development from grounded theory, emphasizes attention to lived experience and the meanings participants assign from phenomenology, and appreciates social context and norms shaping behaviour from ethnography. What sets interpretive description ap+art is

its flexibility to use these tools without being bound by each tradition's philosophical assumptions. Instead of focusing on theory creation, essential meanings, or cultural mapping, it allows researchers to fluidly switch between description and interpretation, maintaining a practical focus.

Interpretive description is especially well-suited to health-related inquiries where the goal is to understand experience in a way that can inform care, policy, or service delivery. Unlike methodologies that aim to generate theory or purely descriptive accounts, ID seeks to develop applied knowledge that has the potential to shape future responses. In the context of this study, which explores how parental experiences with the healthcare system and levels of institutional trust influence vaccine decisions, ID provides an appropriate framework for capturing the complexity of participants' perspectives while also producing findings that can inform public health efforts. In recent years, ID has been increasingly adopted in nursing and other applied health disciplines because it provides a pragmatic framework for generating findings that are both conceptually rigorous and directly applicable to clinical practice (Chiu et al., 2023; Mudd et al., 2023)

Role of the Researcher within Interpretive Description

Within interpretive description, the researcher is understood as a knowledgeable participant in the analytic process rather than a detached observer. Thorne (2016) emphasizes that researchers working in applied disciplines bring professional insight that can deepen the analysis when used thoughtfully. This perspective positions disciplinary expertise not as a source of bias to be bracketed, but as a legitimate and often necessary interpretive resource. In the context of this study, my background in public health nursing

shaped how I understood the institutional, clinical, and policy environments that parents described. This knowledge provided context for interpreting how participants navigated immunization encounters, understood risks, and made decisions within the ISPA framework.

Interpretive description also expects the researcher to remain aware of how their professional lens influences the analytic process. Rather than eliminating that influence, the aim is to use it deliberately and transparently. This involves recognizing how a nursing perspective can illuminate certain aspects of the data while potentially obscuring others. By approaching the analysis with disciplined attentiveness to these influences, the researcher can draw on their expertise to enrich the interpretation while ensuring that participant accounts remain the central source of meaning-making. In this way, the role of the researcher in interpretive description is both informed and accountable, contributing to an analysis that is grounded in practice yet faithful to the experiences shared by participants.

Critiques of Interpretive Description

Although ID provides notable flexibility and practical usefulness, it has faced criticism for potential methodological ambiguity. Since ID selectively integrates techniques from grounded theory, phenomenology, and ethnography without strictly adhering to their philosophical foundations, it may be viewed as lacking the procedural clarity or theoretical rigour of these more established methods (Hunt, 2009). This flexibility, intended to respond effectively to complex health issues, also increases the researcher's responsibility to clearly explain analytic choices and ensure that interpretations remain firmly rooted in the data. Additionally, the focus on applied

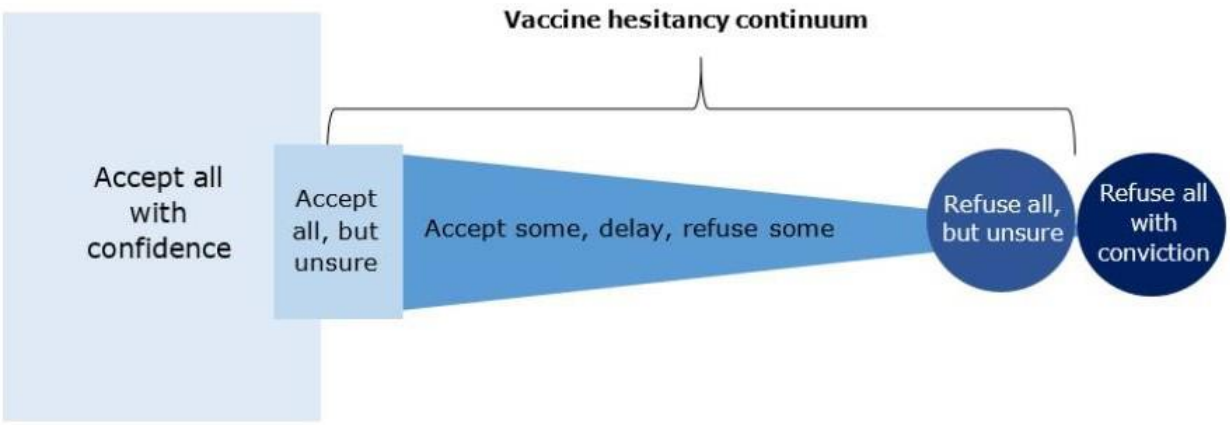
outcomes might lead to concerns that findings could be overly influenced by the researcher's disciplinary biases rather than participants' perspectives. To address these issues, I have enhanced the study's rigour by maintaining detailed audit trails, documenting analytic decisions, and practicing reflexivity to identify potential biases (Carcary, 2021). These steps aim to ensure the credibility and trustworthiness of the results while preserving the methodological flexibility that makes interpretive description particularly suitable for nursing research.

Study Setting and Sampling

The aim of this study is to understand the experiences of trust in parents who are hesitant about immunizations. To do so, I recruited participants who had completed non-medical exemptions under the *Immunization of School Pupils Act, 1990.* This group was deliberately chosen to gain a deeper understanding of individuals who are closer to vaccine refusal on the vaccine hesitancy continuum (see Figure 2) (Public Health Agency of Canada, 2023). This line of inquiry follows Krastev et al.'s (2023) study of 1541 Canadians that found that those with higher vaccine hesitancy scores also showed significantly lower levels of institutional trust. Therefore, to better understand the link between vaccine hesitancy and institutional trust, it was essential to target a population with higher levels of vaccine hesitancy.

Figure 2

The Vaccine Hesitancy Continuum



From Public Health Agency of Canada. (2023). Addressing vaccine hesitancy in the context of COVID-19: A primer for health care providers. Government of Canada. https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/vaccines/vaccine-hesitancy-primer.html

Purposive sampling methods were used to reach vaccine-hesitant parents. Recruitment strategies included posting digital flyers (Appendix A) on Facebook within groups where vaccine hesitancy was known to be discussed. I have deliberately not identified the specific groups in this thesis, as many were private communities that required permission to be a member. While I was transparent with group administrators and participants about the purpose of the study, I also made clear that neither individual members nor specific groups would be identified in any reporting. This approach balanced transparency in recruitment with the ethical obligation to protect the privacy of online communities. Additionally, physical flyers were posted in locations frequented by vaccine-hesitant parents, such as primary care offices, arenas, and clerks' offices, where ISPA affidavits are often notarized. It should be noted that no participants were recruited to this study through the use of physical flyers. Snowball sampling was utilized by requesting that participants share information regarding the study with contacts who had

also undergone the ISPA exemption process. Snowball sampling was considered particularly suitable for this study, as I targeted a population with low institutional trust, including in post-secondary institutions. Utilizing established relationships with high levels of interpersonal trust helped to overcome potential obstacles related to mistrust in post-secondary institutions or the researcher (Emerson, 2015).

Effectively reaching vaccine-hesitant parents who have completed exemption processes required tailored strategies that addressed their potential skepticism of research and institutions. Public outreach efforts were carefully crafted to avoid language that could provoke resistance, such as overly medical terminology or judgmental messages. Similarly, other research highlights the importance of culturally and contextually sensitive recruitment methods when engaging vaccine-hesitant groups (Bedford et al., 2018). In some instances, engaging with community gatekeepers such as administrators within specific Facebook groups was necessary to ensure ethical outreach was maintained. This will be discussed further in the thesis's discussion chapter.

Sample Size Justification

The study involved seven participants, which aligns with qualitative research guidelines that prioritize depth and richness of data over quantity. In interpretive description, sample adequacy isn't based on fixed numbers but on "information power" (Malterud, Siersma, & Guassora, 2016). This concept suggests that the more relevant information each participant provides regarding the research focus, the fewer participants are required. Considering the specific focus on parents in Ontario who have sought vaccine exemptions under the Immunization of School Pupils Act, this sample size was

sufficient to reflect diverse experiences while allowing for a detailed exploration of each narrative.

Following the iterative nature of interpretive description, data collection and analysis were conducted simultaneously, allowing me to assess the adequacy of the sample as interviews progressed. The experiences shared by each participant were highly complex, and it became evident that conducting dozens more interviews would not necessarily result in "saturation" in the traditional qualitative sense. In fact, data saturation is not the goal of interpretive description, as the richness of human experience cannot be exhausted through repetition (Thorne, 2016). Instead, the focus is on generating sufficient depth and variation in the data to support meaningful interpretation and applied insights. After seven interviews, the recurring patterns and relationships observed across narratives provided adequate information power to address the study's research questions, while still preserving the individuality of each participant's perspective.

Additionally, the study's limited sample size highlighted its focus on capturing complexity and contextual details rather than generalizable results. Each participant provided in-depth descriptions of their healthcare experiences, trust in institutions, and decision-making processes surrounding vaccines, providing sufficient insight to fulfill the study's goals.

Data Collection

Semi-structured interviews served as the primary data source for this study. The interview process followed the guide outlined in Appendix B, which provided a consistent structure while allowing flexibility for participants to explore topics they felt

were important. Questions were asked in an open-ended and responsive manner so that participants could shape the direction of the conversation.

Participants contacted the researcher through phone, email, or Facebook Messenger and were offered their preferred interview format: in-person, by phone, or through video conferencing. Providing multiple format options supported accessibility and accommodated participant preference. Seven interviews were conducted in total, and the length of the interviews ranged from 20 to 58 minutes. A consent form (Appendix C) approved by the Trent University Research Ethics Board (Appendix D) was provided in advance, and either written or verbal consent was documented prior to each interview. Participants were informed of their right to withdraw at any time.

Demographic information was collected voluntarily through a brief form (Appendix E) that asked about age category, gender, ethnic background, highest level of education, household income, and access to a primary care provider. These questions were used only to describe the participant sample. All interviews were audio-recorded with consent and transcribed verbatim for analysis. Throughout data collection, neutral prompts and clarification questions were used to support depth and ensure that participants could elaborate on their experiences in ways that were comfortable for them.

Rationale for Semi-Structured Interviews

Semi-structured interviews were selected as the main data collection method because they offer the flexibility to explore participants' unique experiences while maintaining consistency across sessions (Kallio et al., 2016). Unlike structured interviews, which can limit responses, or unstructured ones, which may lead to

difficulties in comparison, semi-structured interviews find a balance between depth and guidance. This approach enabled me to focus on specific topics, such as parental experiences with the healthcare system and institutional trust, while also providing participants with the opportunity to raise unexpected yet relevant issues.

In interpretive description, it is crucial to follow participants' narratives openly and responsively. This approach enables researchers to explore the contextual and nuanced ways in which experiences influence decision-making (Thorne, 2016). Semi-structured interviews aid this process by allowing probing and clarification, especially when participants share complex or emotionally sensitive views. This is particularly important in the context of vaccine decision-making, where participants might feel judged or defensive. Additionally, this method supports building rapport, which is vital for obtaining genuine accounts in qualitative health research (DiCicco-Bloom & Crabtree, 2006).

Additionally, the semi-structured approach was well-suited to the practical aspects of this study, as participants had the option to conduct interviews in person, by phone, or via video calls. Guiding questions ensured coverage of all essential topics across different modes, while allowing participants the freedom to communicate in a manner that felt genuine and comfortable. This method supported both the interpretive description epistemology and the practical aim of gathering detailed, relevant insights.

Researcher-Participant Relationship within Semi Structured Interviews

In qualitative research, particularly within interpretive description, the relationship between the researcher and participant is viewed as an active, evolving

connection rather than a neutral exchange (Lim, 2025; Thorne, 2016). The researcher is not merely an objective observer but a co-creator of meaning, engaging with participants in ways that influence both the data collected and the interpretations made. Therefore, efforts were made to build rapport, reduce power disparities, and foster an environment where participants felt comfortable sharing their experiences and viewpoints openly. For example, I began each interview with an informal conversation about daily life, emphasizing that there were no “right” or “wrong” answers, and framed participants as experts in their own experiences. When parents expressed hesitation or apologized for their views, I reassured them that their perspectives were valuable to the study, which often helped reduce tension and encouraged more open sharing.

This approach followed interpretive description principles, focusing on participants' voices and acknowledging the researcher's interpretive role. Ultimately, the relationship between researcher and participant functioned as a collaborative space where participants shared their experiences, and the researcher listened attentively, posed insightful questions, and interpreted their stories responsibly.

Data Analysis

Interpretive description required an iterative approach to data analysis that occurred concurrently with data collection (Thompson Burdine et al., 2021). Olsen et al. (2013) highlight the benefits of utilizing Glaser and Strauss's (1967) approach of constant comparative analysis (CCA) as its iterative and flexible nature aligned well with the goals of ID to generate practical and contextually grounded insights. CCA allowed researchers to continuously compare and contrast data segments, facilitating the identification of patterns, themes, and categories that emerged from the participants' experiences. This

iterative process was essential in ID, as it supported the development of a nuanced understanding of complex phenomena. For example, after early interviews revealed strong themes of distrust toward school-based immunization enforcement, I adjusted subsequent probes to explore this issue more deeply, illustrating how analysis and data collection informed one another. Refining categories and themes through constant comparison helped ensure that the resulting interpretations were deeply rooted in the data, reflecting the participants' lived experiences. Olsen et al. (2013) showed that CCA involves the following six steps:

Step 1: Data immersion

Step 2: Development of an initial thematic template

Step 3: Organization of collected data based on a thematic template.

Step 4: Condensing and refining of identified themes.

Step 5: Comparing and contrasting data within related categories

Step 6: Comparing and contrasting data with dissimilar categories.

Taguette data analysis software was utilized for data transcription, coding, and thematic analysis. During data analysis, collaborative discussions occurred with the supervisory committee to ensure all nuances and deeper meanings within the data were captured. This approach identified common themes and created a narrative that described the experiences of the sample population. These collaborative reviews served as a form of peer debriefing, challenging me to justify my coding decisions and thereby strengthening the credibility of the analytic process. This information has the potential to shape nursing policy and practice by enhancing nurses' understanding of the experiences of vaccine-

hesitant parents in Ontario. This better prepared nurses for conversations and interactions with this population regarding vaccines.

Rigour

Thorne's (2016) expectations for rigour in Interpretive Description focus on keeping the study's methods and interpretations aligned with its underlying assumptions, staying close to participants' accounts, and making the analytic process clear and defensible. This involves maintaining coherence between the research question, analytic decisions, and disciplinary perspective; representing participants' experiences in a way that reflects both common patterns and important variation; and demonstrating a logical, transparent path from data to interpretation. Thorne also emphasizes the importance of interpretive authority, which requires reflexivity and careful attention to how meaning is constructed. While she does not outline a strict checklist, she supports the use of established qualitative standards when they align with the aims of ID. With this in mind, the following section draws on Lincoln and Guba's (1985) trustworthiness criteria, including credibility, dependability, confirmability, and transferability, to describe how rigour was supported in this study.

Credibility was maintained through the use of verbatim transcripts, preserving participants' words as central to the analysis. During interviews, probing questions were employed to prompt elaboration and clarify meanings, ensuring interpretations were grounded in participants' own accounts rather than assumptions. Reflexive journaling and memoing throughout the analysis process helped document initial impressions and refine insights, promoting transparency in the development of interpretations. Additionally, discussions with the supervisory committee acted as peer debriefing sessions, where

coding choices and emerging themes were critically reviewed to ensure they aligned with the data.

Dependability was ensured by establishing a comprehensive audit trail that documented every phase of the research. This included process notes explaining the reasons behind methodological decisions, raw transcripts, coded datasets, and reflexive notes that captured analytic choices and changes over time. Utilizing Taguette software improved organization by providing a systematic approach to storing, retrieving, and comparing codes. This method enables others to follow the reasoning behind the findings, thereby reinforcing dependability.

Confirmability was maintained through continuous reflexive practices aimed at reducing researcher bias and emphasizing participants' perspectives. Reflexive journaling helped examine how my role as a public health nurse might influence data interpretation. Analytic memos differentiated between participants' accounts and my professional assumptions, while supervisory discussions offered external validation of interpretations. This combination of reflexive practices and supervisory oversight strengthened the grounding of findings in participants' stories, rather than relying on the researcher's preconceptions.

Transferability was facilitated by offering detailed, contextual descriptions of participants' experiences and the Ontario vaccine policy landscape, including how the Immunization of School Pupils Act is enforced. By framing findings within this wider social and institutional context, readers can assess their relevance to other public health scenarios. Although the results are not intended to be statistically generalizable, this

approach ensures the findings are still meaningful and potentially useful beyond the specific study setting.

Together, these strategies facilitated a thorough and reliable research process that conformed to interpretive description principles, ensuring that the results accurately reflected participants' experiences and were valuable for nursing practice.

Reflexivity

Reflexivity was an essential part of maintaining rigour throughout this study. Because my background includes professional experience within Ontario's immunization system, it was important to examine how this knowledge shaped my interpretations during data collection and analysis. Interpretive description recognizes that disciplinary expertise is a valuable resource, but it also expects researchers to be attentive to how familiar ways of thinking can influence what stands out in the data and how meaning is constructed.

To support this awareness, I used structured reflexive practices over the course of the project. Reflexive journaling provided a place to record assumptions, expectations, and moments where my professional lens shaped my initial reactions. This included noting places where I felt aligned with participants' experiences and places where my instinctive interpretations reflected established public health thinking rather than the participant's intended meaning. Analytic memoing complemented this process by helping me trace emerging patterns in the data and distinguish insights grounded in participant accounts from those shaped by disciplinary habits or prior experience.

Regular supervisory discussions added an additional layer of accountability. These meetings required me to articulate the reasoning behind analytic choices, consider alternate interpretations, and revisit assumptions that might otherwise go unquestioned. By documenting these reflections and engaging with them throughout the study, I worked to ensure that my professional background informed but did not overshadow the analysis. This reflexive process supported transparency and contributed to the overall trustworthiness of the study by helping ensure that interpretations remained grounded in participants' stories rather than guided by institutional assumptions.

A recurring tension within the research process involved balancing my professional training with a commitment to remain open to perspectives that differed from public health norms. My background in nursing means that certain explanations or concerns may initially evoke familiar clinical interpretations. When this occurred during interviews, I used my reflexive journal to document my immediate reactions and examine how they might shape the direction of questioning or the framing of emerging insights. This process helped me slow down my interpretive response and consider how my assumptions could influence the analysis. Rather than evaluating participants' comments through a clinical lens, I worked to treat each account as a meaningful expression of experience. By returning to these reflections during the analytic phase, I was able to monitor the influence of my disciplinary perspective and ensure that the final interpretation was grounded in participants' narratives. This approach supported the methodological aims of interpretive description by encouraging an analytic stance that was both informed by professional knowledge and accountable to the data.

Ethical Considerations

This study received approval from the Trent University Research Ethics Board (File No. 29145). All procedures adhered to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) (Canadian Institute of Health Research, 2022). In particular, the principles of respect for persons, concern for welfare, and justice outlined in TCPS2 were actively applied to ensure participants' autonomy, minimize potential harm, and promote fairness in recruitment and reporting. Given that vaccine decision-making can be a highly sensitive and value-laden topic, particular attention was paid to protecting participants' autonomy, privacy, and well-being throughout the research process.

Informed consent was obtained from all participants before the commencement of interviews. Participants were provided with a written consent form that outlined the purpose of the study, expectations for participation, potential risks and benefits, and their right to withdraw at any stage without consequence. Verbal consent was then recorded at the start of each interview to ensure comprehension and voluntary participation. Care was taken to use non-technical language when reviewing the consent process, given that some parents expressed skepticism of medical or institutional authority.

Confidentiality was safeguarded by assigning each participant a pseudonym and removing any identifying information from transcripts and analytic materials. Audio recordings and consent forms were stored on password-protected, encrypted files, accessible only to the researcher. Transcripts were stored on secure university servers in compliance with institutional data protection policies. Any quotations included in

reporting or presentations were carefully reviewed to ensure that contextual details could not inadvertently identify participants.

Because the study engaged with a group often characterized by low institutional trust, building rapport and minimizing potential harm were central ethical priorities. Interview questions were framed to avoid judgmental or leading language, and participants were reminded that there were no “right” or “wrong” answers. During interviews, if participants expressed strong emotions such as frustration, defensiveness, or mistrust, these were acknowledged respectfully and without correction. This approach reflected both ethical obligations and the interpretive description methodology, which emphasizes co-constructing meaning in a manner that honours participants’ lived experiences.

Finally, measures were taken to ensure that participants did not feel coerced or pressured into participating in the study. Recruitment materials avoided authoritative institutional branding and were written in neutral, accessible language. In recognition of the time and personal experiences shared, participants were provided with a $25 honorarium, which was offered regardless of whether they completed or withdrew from the study. This practice is consistent with standard approaches to participant recruitment and ensures that appreciation for participants’ contributions is conveyed without creating undue influence. Collectively, these ethical practices ensured that the study was conducted with integrity, transparency, and sensitivity to the unique vulnerabilities of the participant population. These safeguards not only protected participants but also enhanced the credibility and trustworthiness of the study by ensuring that findings were developed within a respectful, transparent, and ethically sound framework.

Chapter 4: Findings

The purpose of this chapter is to represent the voices of the parents who participated in this study and to explore how their experiences shed light on decision-making within Ontario's required immunization legislation. The analysis focuses on parents who sought exemptions under the *Immunization of School Pupils Act* (ISPA), examining how they described their interactions with public health and how those experiences shaped their confidence in institutional authority. Rather than evaluating the correctness of parents' choices, this chapter focuses on how everyday encounters with the healthcare system influence meaning, trust, and moral reasoning.

The findings in this chapter are presented through four themes that reflect the patterns identified across participant interviews. These themes illustrate how parents understood their interactions with public health, how they made sense of information, and how they navigated institutional processes related to the Immunization of School Pupils Act. Each theme stands alone, but together they show a broader relational process that shaped trust, decision-making, and experiences of authority.

Participants and Context

Seven parents of school-aged children took part in the study, including five mothers and two fathers from across Ontario. Demographic information forms (Appendix D) were utilized to collect information upon participant consent. Five of the seven participants consented to the collection of demographic information. The remaining two participants declined. They did not offer a reason, and I did not ask for one in order to respect their comfort and support a positive rapport during the interview process. Given the sensitivity of the topic and the importance of maintaining trust with participants who

may already feel cautious about institutional processes, it was important to allow them to opt out without pressure or further inquiry. Participants ranged in age from their late twenties to mid-fifties and represented a range of family structures, including single-parent and two-parent households. One participant described strong religious ties. Occupations included working in healthcare, education, trades. Four of the five participants reported access to a primary care practitioner. Most participants had completed or attempted an ISPA exemption for at least one child. One participant chose not to complete the ISPA exemption process and had their child serve the entire 20-day suspension for incomplete immunization information. The highest level of education completed ranged from a High School Diploma (two participants) to a bachelor's degree (two participants) to a master's degree (one participant). Interviews ranged from 20 to 70 minutes, six were conducted via telephone and one was conducted via zoom. Conversations were open but influenced by the interview guide found in Appendix B. Despite different personal contexts, most parents described fatigue, defensiveness, and mistrust that shaped their experience of communication with public health.

Derivation of Themes

Across interviews, early patterns began to take shape as participants described moments that challenged their trust in public health and healthcare systems. Several parents recalled interactions where tone, language, or body posture made them feel judged or dismissed, which shaped how they interpreted later encounters. Others focused on the struggle to reconcile their own experiences or observations with the certainty expressed by institutions, which contributed to ongoing questions about credibility and intent. Many also described frustrations with administrative processes or expectations that

felt rigid, rushed, or poorly explained. At the same time, participants spoke about seeking support from people or platforms where they felt understood, which often played a significant role in shaping how they navigated decision-making. These recurring patterns provided an early sense of the relational, moral, and institutional tensions that appear throughout the four themes presented below.

These conceptual clusters were refined through iterative documentation and comparison, progressing from surface-level descriptions to relational interpretations. Four final themes emerged that captured both the emotional tone and natural logic underpinning participants' experiences:

1. *Mutual Othering* (How they are positioned) - how parents and institutions come to view each other as unreasonable or illegitimate through recurring experiences of moral judgment and defensiveness.

2. *Epistemic Conflict* (How they know) - how participants challenge institutional expertise and construct alternative frameworks of knowledge and evidence.

3. *Vaccine Refusal and Exemption as Symbolic Resistance* (How they act) - how parents frame non-compliance as an act of moral agency and protection rather than ignorance or neglect.

4. *Restructuring trust through relationships* (How they trust)- how trust shifts from systems to individual actors, peers, or alternative practitioners perceived as more authentic and respectful.

While each theme is distinct, they are best understood as interconnected. Mutual Othering captures the breakdown of dialogue; Epistemic Conflict traces how that rupture

develops into a contestation of institutional authority; Symbolic Resistance explores how parents assert autonomy within coercive structures; and Relational Trust shows how confidence is reconstructed in more personal, emotionally grounded ways. Together, these themes demonstrate how vaccine hesitancy is not an individual belief problem but a relational process shaped by institutional encounters.

Theme 1: Mutual Othering (How they are Positioned)

The first central theme, Mutual Othering, illustrates how parents and institutions perceived each other with distrust, judgment, and moral distancing. Instead of a single conflict, this pattern was repeated throughout interactions with public health, schools, and healthcare providers. Parents usually approached these encounters seeking understanding or to share their reasoning, but expressed that they often felt dismissed, misunderstood, or judged. Consequently, their frustration and defensiveness were met with institutional responses that amplified these feelings, perpetuating this cycle of alienation.

What emerged across the interviews was a relational struggle experienced by parents who felt their decision-making was being questioned. Participant 2 described being positioned as “anti-vaxx” in the case, and participant 7 stated she was labelled as “irresponsible” when her choices diverged from public health expectations. Many perceived institutional processes, such as exemption education or suspension notices, as efforts to assert control rather than to engage in dialogue. As participant 3 stated, “You’re a joke if you think it’s about anything other than them trying to control you”. These experiences led parents to defend their values and credibility, framing their actions as protective and principled rather than oppositional. This theme displays how vaccine hesitancy, within the ISPA framework, is shaped not only by beliefs about vaccines but

also by how parents experience and interact within institutional settings. The following section explores how participants, in their own words, articulated this dynamic of alienation and defensive identity.

Across interviews, parents described how their interactions with public health and healthcare workers often left them feeling dismissed and disrespected. What stood out was that these experiences were not tied to a single event or policy but emerged through patterns of tone, language, and interactions. For many, trust eroded not because of disagreement over facts but because the interaction itself felt one-sided or demoralizing.

One of the clearest examples came from parents' reflections on the ISPA exemption process. Several described the official language as emotionally loaded and accusatory. *"Problem with it is that they want me to sign that I understand that I could cause harm or death to my child, and that's not my opinion."* (Participant 1). For this parent, the affidavit's wording implied negligence rather than informed choice. The feeling of being shamed rather than respected as a capable decision-maker was familiar. Another participant described the education session component as equally alienating:

> *I had to go into public health and watch this video on a laptop in this tiny little room they put you in. I was on my phone the whole time. It looked like it was a children's cartoon… I think my four-year-old could probably understand that video* (Participant 7).

The process was often interpreted as punitive or performative rather than educational.

> *Oh yes, the quote-unquote education session. When I first heard about it, I thought, all right, give us both sides. But of course, it's all one-sided… nice*

colourful cartoons, little quotes and sound bites… I didn't even watch the whole thing, I just walked away and realized it's propaganda, it's not education (Participant 2).

These accounts show that alienation was not about disagreement with vaccine educational content itself, but about being treated as incapable of critical thought. When Public Health relied on pre-scripted materials, they communicated a lack of interest in dialogue. What parents described as condescension or "talking down" was often interpreted as a sign that institutions did not trust them to make informed decisions or participate in genuine dialogue. These interactions made some parents feel that respect from institutions depended on accepting the recommended course of action rather than being engaged as partners in the conversation.

For some, the tone of written communication carried the same moral judgment. Parents spoke of letters that implied threat rather than partnership. *"It is a fucking joke. I get this stupid letter for my daughter's school that says you're going to be suspended… like she's a criminal. It's not even a phone call, just a threat in your mailbox."* (Participant 3). *"I always just throw them (the notices) in the garbage… I'm not a criminal for asking questions."* (Participant 1). Institutional formality, such as letters, affidavits, and deadlines, was interpreted as coercive rather than administrative. Even if messages were factual, their bureaucratic tone signalled distrust in parents' capacity for responsible decision-making.

Experiences within clinical settings reflected similar challenges. One participant described a situation where raising a possible concern about a vaccine reaction or asking

whether their child's recent illness might be connected to a vaccination was met with condescension and ridicule.

> *I tried to bring that up with our pediatrician, just asking if it could have played a role, and she just dismissed me right away and she said that I shouldn't be relying on Dr. Google… I walked out of the office feeling angry and honestly humiliated* (Participant 2).

Another parent shared a friend's encounter with an unknown illness, noting that even gentle inquiry could lead to being branded as defiant and unreasonable: *"But no one could tell her why. She was in and out of Sick Kids for weeks. Still, the minute she asked if it could be vaccine related, she was treated like she was being difficult and anti-vax.*" (Participant 2*).* These experiences reinforced the perception that professionals were not open to dialogue. For parents, being dismissed by their healthcare providers or told what to think undermined both trust and personal autonomy.

For some, distrust was also expressed through assertions of personal intelligence and integrity. Participants rejected being labelled as "anti-vax" or uneducated, instead describing themselves as thoughtful and responsible parents. *"Once you say you're not sure about vaccines, they lump you in with conspiracy people. I'm not anti-anything, I just don't like being bullied."* (Participant 6). *"They felt like we were just dumb little lemmings that were just kind of following each other off the cliff and not critical thinkers."* (Participant 4). Others went further, using defiance to restore dignity in a system they felt denied it to them. *"I don't know, I'm not going to like comply with some Public Health… where everyone fucking thinks that they know better than me because*

they wear a lanyard." (Participant 3). Others described the system itself as emotionally sterile, where process replaced empathy.

> *Sometimes it felt like they (Public Health) didn't actually see my kid or our family. Just a checkbox. Like, 'Why isn't he vaccinated?' and not 'Why is this such a struggle for your family?' There's no room for nuance in those forms.* (Participant 6).

These sentiments were mirrored by Participant 4 who stated, *"With my family doctor it feels like all decisions have been made for me and not with me. I didn't feel like I was participating in my children's care at all."* (Participant 4). For some parents, lingering anxiety about institutional encounters made it difficult to trust public health again, even when they remained open to vaccination. One mother shared, *"Public health worries me a lot. When I check the school newsletters, whenever I know public health is going to be at school, I keep my kids home that day"* (Participant 1). Her words captured the emotional residue of earlier experiences in which engagement with the system felt more threatening than supportive.

These narratives highlight how procedural rigidity and moral undertones can transform public health measures into experiences of exclusion. Within these moments, the promise of informed consent was replaced by an expectation of compliance. Alienation, in this sense, became both emotional and relational, a breakdown of mutual recognition that shaped how parents interpreted every future encounter with Public Health institutions. *"It's like they already have their mind made up about you the minute you walk in. You're not there to talk, you're there to agree."* (Participant 4). In this theme, alienation extends beyond dissatisfaction with service delivery. It reveals how

communication practices that prioritize standardization and authority can unintentionally signal moral judgment. For these parents, feeling disrespected or unheard was not a side effect of the process; it was the process.

As feelings of alienation deepened, parents described developing a defensive posture toward institutions they perceived as condescending or coercive. What began as frustration with tone and process evolved into a broader distrust of institutional authority and an effort to reclaim legitimacy and intellectual credibility. Participants spoke about needing to protect themselves and their families from what they viewed as manipulative systems. For many, resistance was not simply refusal but a form of self-preservation. One parent explained that standing up to public health had become an act of personal conviction. *"It just reaffirmed that we can stand up, that we don't have to listen to government."* (Participant 1). This participant, like several others, described opposition not as disobedience but as moral clarity, insisting that choice and autonomy were non-negotiable. Another parent described the emotional energy behind this shift, recalling how confrontation with a nurse in a clinical setting solidified her mistrust. *"She even at one point said you're making a dangerous choice, there in the hallway where other people hear in the waiting room and I was just speechless, there was nothing I could say, I was furious."* (Participant 2) The feeling of being judged or patronized often translated into an ongoing skepticism of institutional motives. *"I view them as high pressure, right, they seem like an organization that is trying to coerce my decision making or undermining my decision making and someone very much to stay away from and keep my kids away from."* (Participant 7). Additionally, participants discussed public health and government

as interchangeable, with both perceived as using authority to control rather than collaborate.

> *Public health really feels like an arm of the government and I know that all of our hospitals and doctors and stuff, I know that they're all publicly funded as well, but it feels like when I reach out to my own provider that I am more in control* (Participant 1).

This sense of distance and loss of control was echoed across interviews. Participant 3 described public health as "a bit of a joke" and "a large PR machine that just is an extension of the government," reinforcing the idea that institutional messages were viewed as strategic rather than caring. Together, these narratives show how distrust functions as a defence mechanism against perceived moral judgment. Participants positioned themselves as rational, informed, and caring, while institutions were portrayed as unaccountable. This defensive identity served as a form of autonomy, allowing parents to reinterpret refusal or exemption as moral action rather than deviance. In this way, mistrust became a form of empowerment and an assertion of credibility in the face of perceived institutional overreach.

After reviewing the transcripts, participants' accounts reveal a cycle of relational breakdown termed Mutual Othering. Parents felt dismissed, lectured, or shamed, leading to emotional withdrawal and defensive identities. These defences reinforced perceived stereotypes about the participants, creating a pattern in which attempts to establish credibility were seen as disrespectful, and communication was perceived as moral judgment rather than dialogue.

Trust was lost not just through perceived misinformation, but also when institutional tone and process failed to show empathy or respect. Parents viewed their skepticism as protective reasoning when institutions appeared bureaucratic and out of touch. These conflicting narratives fostered the belief that mutual understanding was impossible, turning public health encounters into emotionally charged conflicts. Parents did not speak about vaccine exemption as a simple administrative step. Instead, they described the process as emotionally charged and relational, shaping how they understood their own moral standing and how they believed public health viewed them. Even parents who supported vaccination described feeling that institutional communication positioned them as a problem to be managed rather than as partners in dialogue. Participant 6, for example, emphasized that he was not opposed to vaccines and had ensured his other children were fully immunized. His concern centred on his son, who is diagnosed with autism spectrum disorder and was unable to tolerate injections emotionally. When he pursued a non-medical exemption, the process felt impersonal and procedural.

> *I've had my shots. My daughter had hers. But with my son, it's a whole other ball game … for the non-medical exemption, I would say bureaucratic. That's the word I'd use. Forms, meetings, more forms. We had to go through the school board, the health unit, the family doctor, and this other guy (public health unit employee) who barely looked at us* (Participant 6).

This pattern often left them feeling stripped of credibility, with their experiences framed as ignorance or defiance rather than care or caution.

At the same time, parents responded to these experiences by constructing their own narratives about institutions, portraying public health as coercive, dismissive, or overly politicized. These responses were not solely reactive; they were part of a broader process of self-identity. Parents sought to reclaim legitimacy by rejecting what they perceived as unfair labelling or condescension. In doing so, they positioned themselves as thoughtful and caring, while institutions became associated with control, bureaucracy, and moral superiority.

Mutual Othering demonstrates that vaccination-related institutional relationships are not neutral. Being labelled as noncompliant led parents to see themselves as outsiders, deepening distrust. Frustration evolved into a stance that both resists and perpetuates alienation. These strained interactions set the stage for the next pattern, where disagreements were not only about tone but about whose understanding of health should be taken seriously. Feeling judged or dismissed pushed some parents to rely more on what they saw with their own children or what they heard from people they trusted, making institutional messages feel less convincing.

Theme 2: Epistemic Conflict (How They Know)

This theme captures the tensions participants experienced when their personal understandings of health clashed with institutional authority. Parents often described feeling that their lived experiences and independent research were dismissed when they did not align with biomedical frameworks. The resulting conflict was not simply about differing opinions on vaccination but about whose knowledge was recognized as credible.

Several participants articulated that the dominance of biomedical knowledge created an uneven playing field in conversations with healthcare and public health professionals. They felt that their perspectives were tolerated as long as they aligned with the institution's values, and that their questions were often interpreted as ignorance rather than genuine engagement. As one parent explained, the imbalance made them feel as though biomedical knowledge was used to justify decisions that excluded them.

Several participants reflected on how this imbalance positioned biomedical knowledge as the only legitimate source of truth, leaving little room for dialogue or shared understanding. Parents often entered these discussions hoping to be heard, yet felt their questions were interpreted as defiance rather than engagement. Participant 6 stated, "He's my son, I spend every day with him. I think I know if he can tolerate a vaccine or not." Over time, these experiences deepened mistrust and strengthened parents' reliance on personal and community-based forms of knowledge.

Participants frequently described feeling dismissed or intellectually undermined when they tried to share their experiences or ask questions about vaccines. Their attempts to engage were often met with correction rather than conversation, reinforcing perceptions that biomedical authority was far superior to experiential knowledge. Participant 2 explained that when she raised concerns about her child's vaccine reaction, her pediatrician *"barely looked up from her clipboard"* and *"made me feel like I was a nuisance… like I was holding up her system".* Similarly, one participant described how her child's severe post-vaccine illness was minimized, recounting that the doctor "*said basically his body is reacting as though he has the diseases… it didn't make sense to me, but they just brushed it off"* (Participant 1). For others, such dismissal extended to

moments when they sought clarification or dialogue. Participant 4 stated "*I never see the physician. I always just see the nurse who comes in with the shots and pretty much has the needle in their leg before I can even ask any questions*" (Participant 4). These encounters left parents feeling that their reasoning was not only devalued, but problematic, as if uncertainty signified ignorance. The resulting imbalance deepened skepticism toward biomedical authority, shaping a broader. perception that healthcare professionals prioritized obedience over understanding.

In response to these experiences, many participants asserted their own authority by developing alternative ways of knowing that they felt better reflected their values and observations. This self-directed approach to knowledge was described not as defiance, but as a necessary act of protection in an environment where biomedical perspectives were viewed as absolute. Across interviews, participants positioned their autonomy and experiential understanding as legitimate counterweights to biomedical authority, redefining credibility to make lived experience equal to designated professional expertise. Several participants explained that when questions were discouraged or treated as a sign of ignorance, they felt compelled to strengthen their own authority to fulfill their responsibilities as caregivers. Participant 3 expressed this clearly, saying, *"I have no problem with parents vaccinating their kids, but it should be the parent's decision"* (Participant 3). Participant 7 shared a similar view, noting that she told her provider, *"I will be the one to make these decisions… I'm responsible for their health and well-being"* (Participant 7) Others described withdrawing from institutional settings when they felt excluded from the decision-making process. Participant 4 captured this experience when she said,

> *But again, with my family doctor it feels like all decisions have been made for me and not with me. I didn't feel like I was participating in my children's care at all and as soon as that happens, I say nope we're done here* (Participant 4).

For many, these moments signalled that relying solely on clinical guidance was not enough to ensure their child's safety. Parents responded by asserting their own interpretive authority through careful reflection, independent research, or consultation with trusted peers. Across interviews, parents positioned the protection of their children and the protection of their own ability to question and decide as inseparable. In their view, maintaining this autonomy was essential for navigating a health system where their lived experience did not always feel welcome.

As institutional trust weakened, participants began to cultivate their own expertise, blending scientific research with personal experience. They described these efforts as reclaiming control over information that felt hidden or simplified by official sources. Participant 2 explained,

> *We start on Google and we start looking up scholarly articles and academic reviewed papers and journals… I do still follow traditional academic journals such as Nature or the New England Journal of Medicine… but you don't know who is funding the research or where the information is coming from* (Participant 2).

Similarly, Participant 4 rejected stereotypes of uninformed parents, asserting,

> *I get my information from the exact same places as the public does… I just go one layer deeper… I click on the same links and read the same articles… I'm not some sort of conspiracy theorist whack job* (Participant 4).

Participant 1 expressed a similar concern about selective visibility, explaining that some peer-reviewed work on vaccine reactions *"are good studies, but they're not… I don't know… the information isn't getting out"* (Participant 1). Together, these accounts show how parents constructed their own knowledge pathways in response to perceived gaps in institutional transparency, relying on deeper searching and personal vigilance to interpret vaccine information on their own terms.

Even when participants sought to remain informed through traditional scientific channels, they felt excluded from legitimate discourse. As one parent stated, "*I just wanted a little bit of transparency, ask questions"* (Participant 3). Another participant described watching the required education video for a non-medical exemption under the Immunization of School Pupils Act, and realizing "*it's propaganda, it's not education,"* noting that "*there was no discussion of ingredients or mention of possible reactions"* (Participant 1). Across accounts, biomedical knowledge was perceived as rigid and self-protective, a system that "talks at" rather than "talks with" parents. This dissonance between institutional expertise and parental observation deepened mistrust, transforming what might have been a cooperative process into a defensive one.

Through these accounts, participants framed self-education as a moral response to feeling excluded from biomedical dialogue. Participant 7 captured this tension, stating,

> *They should have the ability to assess somebody's competence and see that I am more informed on vaccines and immunizations than most of them. I've done my research… I shouldn't have to sit there and watch that video that's for a 5-year-old* (Participant 7).

The pursuit of knowledge occasionally came at a social and emotional cost. Participant 4 reflected on how quickly her family became ostracized after voicing concerns about vaccination, explaining,

> *The neighbours in which my boys were really close… said that their children can't play with mine anymore until they received it. That mine were some sort of disease risk… even though they were the exact same children that were playing with them not one week earlier* (Participant 4).

Similarly, Participant 7 recalled losing long-standing friendships after refusing to share proof of immunization, stating, *"I wasn't going to show my papers to go over to your (a friend's) house. So that friendship dissolved pretty quickly, and that was a 10-year friendship that dissolved just over one disagreement"* (Participant 7).

These experiences deepened the sense of distance between participants and those that firmly aligned with biomedical knowledge, reinforcing the perception that questioning vaccines carried moral or social penalties. Participant 1 described how this tension altered her relationship with her child's school, saying,

> *I had a good reputation at my kids' school prior to this… I volunteered there a lot… Well, then something like this (vaccine exemption) happens, and now it's*

> *awkward… It kind of makes me not want to go back and show my face at the school* (Participant 1).

Across these accounts, emotional strain and defensive withdrawal functioned as both outcomes and reinforcements of epistemic conflict. Parents who sought recognition of their experiential knowledge instead found themselves further marginalized, leading many to retreat into spaces, both online and within community networks, where their perspectives were respected and shared.

The process of navigating vaccine exemptions under the ISPA further illustrated the epistemic divide participants described. Many felt that the exemption procedure reinforced a hierarchy in which legislative authority was treated as unquestionable, while parents' interpretations and lived experiences carried little weight. Participant 7 expressed strong dissatisfaction with the policy framework itself, stating, *"The ISPA is a garbage act that was made through a backroom deal through the Ministry of Health and the Ministry of Education and has no standing in Ontario, but it's just been enforced as business as usual*" (Participant 7). These experiences underscored how institutional processes positioned legal and administrative expertise as dominant and often left parents feeling that their own perspectives were incompatible with the assumptions embedded in the policy.

Across participants, epistemic conflict reflected more than disagreement over vaccines. It revealed an ongoing struggle for recognition within systems that privilege institutional knowledge over lived experience. When parents felt their perspectives were demonized, they sought alternative ways to make sense of health information through personal research and shared community dialogue. These efforts allowed participants to

construct their own frameworks to reclaim credibility. Yet these same efforts deepened their sense of distance from healthcare institutions, creating a feedback loop in which exclusion reinforced skepticism. For many, epistemic conflict was not simply about vaccination evidence or risk but about belonging, about who is permitted to speak, to question, and the right to be heard within the structures that define public health. This contest over credibility laid the groundwork for how vaccine refusal and exemption later became symbolic expressions of protection, conviction, and moral integrity.

Theme 3: Vaccine Refusal and Exemption as Symbolic Resistance (How They Act)

This theme examines how participants used vaccine exemption as both a symbolic act of resistance and a pragmatic strategy to navigate required immunization legislation. For many, refusal was rooted in moral conviction and a desire to protect their family's autonomy, yet the act of completing the exemption process also reflected practicality. Parents described walking a careful line between defying institutional authority and ensuring their children remained eligible for education.

While exemption served as a form of protest against perceived pressure, it was also a means of compliance that preserved access to education for their children. Though not explicitly stated by the participants, this decision-making process has been labelled as *performative compliance*, fulfilling bureaucratic expectations without internal agreement. Performative compliance was exemplified by Participant 7 when she stated, "I signed it (the affidavit) but crossed out all of the information that I knew was wrong on the form" or Participant 2, who stated that she "did not even watch the video" when attending the ISPA education session. Watching the required education videos, signing forms, or

discarding school suspension letters were seen as rituals to satisfy procedure rather than expressions of consent.

Through these experiences, exemption emerged as both resistance and accommodation, a negotiated middle ground that allowed parents to preserve their values while functioning within institutional constraints. Vaccine refusal and exemption thus became moral, relational, and strategic acts that embodied participants' efforts to maintain legitimacy in the face of authority.

Participants frequently described their vaccination decisions as informed, rooted in conscience and responsibility, rather than as acts of defiance. What was perceived as outright refusal was explained as a way to reclaim power over their children's health. Participant 4 explained, "*I'm not a whack job, and I'm not some full-blown conspiracy theorist. I just believe in informed consent and doing a risk-benefit analysis".* Similarly, Participant 3 described his skepticism as an ethical response to pressure, stating, *"It just feels like there's too much that we don't know, and it feels like no one wants you to ask questions… if it's that safe, why do they got to scare you into doing it?"* Across these accounts, resistance was not portrayed as rebellion but as an assertion of care and integrity. Parents viewed their stance as protecting their families from both physical and moral harm while preserving their ability to make decisions consistent with their values.

While participants often framed their exemption decisions as moral and spiritual acts, they also described navigating the bureaucratic process in calculated and pragmatic ways. Completing the required steps was seen as something that had to be done rather than an act of genuine consent. Participant 5 recalled, "*I remember the video we had to watch. That felt a little off. Like we were being corrected or talked down to... it felt more*

like a warning" (Participant 5). Participant 4 described a similar experience, stating, *"It's straightforward but it's so condescending… the animation looks like it was made for children. I didn't watch the video. I just told public health I did, but they're clearly trying to shame or pressure parents into watching it.".* Others found ways to minimize their engagement altogether, with Participant 1 explaining, "*I've gotten letters for suspensions for a long time, like over a decade with him. He's never being suspended…I always just throw them in the garbage*". Across these accounts, parents fulfilled institutional expectations but did so symbolically, treating the exemption process as a ritual of compliance rather than meaningful education. These actions reflected a form of resistance grounded in pragmatism. Parents recognized that cooperation was necessary to avoid penalties such as school suspension, but they refused to acknowledge the morality of the process itself.

For many participants, seeking an exemption was less about defiance and more about ensuring their children's continued access to school. Exemption represented a compromise that allowed families to live according to their beliefs without facing exclusion from public education. Participant 6 explained, *"It would have been nice to have a little bit more time (to immunize), but we had to keep him in school and keep up his routine."* Similarly, Participant 2 described the process as an exhausting but necessary workaround, stating, "*I was emotionally drained after it (the exemption) … but eventually I just got it done and I got done for both kids at once. I'm hoping to never hear back from the health unit again"*. Other parents discussed the emotional toll of being positioned as defiant while simply trying to protect their children from disruption. Participant 5 shared, "*There's a verse in Romans about living peaceably with all, and we really try to do that.*

We aren't trying to stir trouble like they may think. But it felt like we were being put in a box." Across these narratives, exemption was a strategic act of resistance that balanced moral conviction with practical concern. Parents complied outwardly to avoid institutional repercussions but maintained autonomy over their decisions. This approach allowed them to navigate coercive structures on their own terms, blending resistance with cooperation to preserve both principle and stability.

Vaccine refusal and exemption functioned as both moral resistance and practical negotiation. Parents viewed their decisions as acts of protection that extended beyond health to encompass conscience, family, and faith. Their engagement with exemption policies reflected the broader tension between personal agency and institutional control. The process itself was described as transactional rather than relational, reinforcing a sense that compliance was expected without understanding. As Participant 4 explained,

> *The process is very straightforward you have to have the form notarized. My brother's a lawyer so that was easy enough to have done, and you have to watch this little video they to send you, and then they ask if you have any questions* (Participant 4).

Parents did not reject the system entirely but sought to redefine the terms of their participation within it. Many described exemptions as a strategy to shield their children from social and educational penalties while preserving integrity in the face of coercion. Participant 6 emphasized this balance, noting, "*It was just a way to keep him in school"* (Participant 6).

Ultimately, the exemption embodied the ongoing negotiation between institutional power and individual agency. Parents sought not to dismantle the system but to find space within it to live according to their values. Their choices reflected both distrust and deep responsibility. Vaccine refusal and exemption were not simply oppositional acts but expressions of belonging to an alternative moral community that prioritized discernment, protection, and relational integrity over institutional obedience.

Theme 4: Reconstructing Trust through Relationships (How They Trust)

This theme explores how parents who withdrew trust from public health and government institutions did not abandon trust entirely but redirected it toward individuals and communities that embodied empathy, shared values, and moral understanding. Across interviews, participants described a process of rebuilding confidence through personal connection rather than institutional authority. In contrast to the bureaucratic tone of exemption processes and clinical encounters, trust was sustained through moments of listening and respect. Providers who treated them as equals, friends who offered understanding, and online communities that validated their concerns became the new anchors of credibility.

For these parents, trust was no longer grounded in the exclusively perceived objectivity of science or policy but in the authenticity of human interaction. It became relational and selective. Participants emphasized that trust could still exist within healthcare, but only when it was felt rather than prescribed. This shift signalled not the disappearance of trust but its reallocation from systems to relationships, where credibility was earned through empathy and shared experience. Individual healthcare providers who took time to listen or demonstrate care were remembered with gratitude and became

exceptions to broader patterns of distrust. Participant 5 recalled a moment of compassion that stayed with his family, explaining,

> *We've had great care when it came to emergencies or births. I remember one nurse who prayed with my wife when she was in labour. That meant the world to us. Those are the types of things that stick with you* (Participant 5).

For others, trust was reinforced when providers acknowledged their experiences without judgment. Participant 6 reflected, *"It's like they want kids to fit the system instead of the system fitting the kids. We found a really good occupational therapist though. She helped us prep him for medical visits…That helped."* Participant 2 expressed a similar sentiment, stating,

> *There's been rare moments… where I felt supported, but I think that had more to do with the individual connecting with me whether it was a nurse or a doctor in the ER or even just somebody from even just a custodian…. I think it was about connecting with me as a human* (Participant 2).

These moments of relational care contrasted sharply with prior encounters that felt procedural or dismissive. Parents emphasized that trust did not depend on credentials but on feeling respected and heard. Through these interactions, participants showed that trust could exist within healthcare when it was rooted in empathy and genuine connection rather than institutional hierarchy.

As trust in formal institutions declined, participants sought understanding and reassurance within peer networks and alternative communities. Online spaces, homeschooling groups, and church circles became central sources of information and

emotional support. These networks were described as places where parents could ask questions without judgment and share experiences that mainstream healthcare dismissed. Participant 2 explained,

> *I started talking to some friends in a mom group on Facebook in (City). One of the moms was a naturopath who shared their experience with a vaccine reaction and it was exactly the same thing… realizing that a lot of the information is still under researched* (Participant 2).

Participant 1 also described turning to online communities as a counterbalance to institutional immunization enforcement, stating, they're useful for connecting with other people. "*So through these (Facebook) groups…I'm able to, for example, find other teachers who are like me, who during COVID were being pressured and connect with them*". Participant 5 reflected on the value of this shared understanding, noting, "*We had the chance to talk to more people in the community. For us, it became more about stewardship too."* (Participant 5). Across these accounts, online and peer networks offered both affirmation and refuge. Parents perceived these spaces as trustworthy because they were relational and, more importantly, voluntary. Trust was earned through shared experience and empathy, not institutional posturing or expertise.

This reallocation of trust often landed in the hands of knowledge holders outside traditional healthcare, including alternative practitioners and independent information media. These sources were described as more transparent, open-minded, and aligned with personal values. This is outlined by Participant 2, who stated "*there's some medical professionals who blend science and holistic care, they're not just yelling don't vaccinate, like Jess Peatross or Suzanne Humphries".* She described these providers as more open

to all evidence and diving deeper into immunization history, side effects and alternative medicine. Participants also described following individuals who shared their skepticism toward institutional messaging. Participant 3 shared that he frequently listens to "*a guy who used to be a paramedic who has a podcast,"* and appreciated how this figure raised questions about vaccine safety and transparency. He expressed frustration that these perspectives are not welcomed in mainstream spaces, explaining, "*They get pretty scared pretty quickly when someone speaks out… being silenced by these large platforms"* (Participant 3). For him, censorship reinforced the credibility of alternative voices and undermined institutional claims of openness. "*She got banned (from a social media platform), obviously, but she came back under a new name. That's a pretty big hint that she's telling the truth."* (Participant 3).

Among participants, the decline in institutional trust didn't erase trust entirely but shifted it toward more personal and morally rooted relationships. Parents emphasized that credibility was no longer granted through professional authority or credentials but through perceived sincerity and respect. This was exemplified by Participant 3 who stated "It actually seems like the younger ones (physicians) with less experience are better because they actually listen" when discussing his experience with walk-in clinics. Interactions with individual providers who demonstrated compassion served as reminders that trust in healthcare could survive, but only when it was built relationally rather than bureaucratically. Peer and online communities filled the gaps left by institutional alienation, offering spaces where parents felt recognized, supported, and safe to express uncertainty. These networks served as repositories of shared experience, acting both as sources of information and emotional support.

For many, this reconstruction of trust was selective and intentional. Participants expressed confidence in individuals, communities, and practitioners whose values matched their own. They emphasized trusting people more than systems, and prioritizing policies over procedural relationships. Participant 5's recollection of the nurse who prayed with his wife reflected the power of empathy to reestablish confidence within a system otherwise experienced as distant and impersonal. Similarly, Participant 2's reliance on like-minded peers demonstrates how trust was maintained through moral and experiential resonance rather than institutional messaging. In this reallocation of trust, participants sought belonging where understanding felt possible. Therefore, trust became relational currency exchanged within networks of shared conviction. It was rebuilt not through persuasion or policy but through connection, affirmation, and mutual recognition.

Conclusion

Across all four themes, participants described a process of navigating institutional encounters that reshaped their understanding of trust, authority, and autonomy. The interviews showed that parents' views shifted over time and were strongly shaped by moments when they felt excluded, misunderstood, or morally judged. Participants moved through a process in which early encounters with institutional authority produced feelings of alienation, which then evolved into contestation, resistance, and, ultimately, the reconstruction of trust within alternative networks of meaning.

In the first theme, *Institutional Othering,* parents' interactions with public health and education systems created a sense of distance that positioned them as outsiders to the very structures designed to protect them. This loss of belonging and recognition set the stage for *Epistemic Conflict*, where participants confronted the hierarchy of knowledge

that privileged biomedical expertise over lived experience. As these tensions deepened, they were expressed through *Symbolic Resistance,* where vaccine refusal and exemption became moral and strategic acts of self-definition. Finally, in *Reconstructing Trust through Relationships,* parents redirected confidence toward people and communities that reflected empathy and shared values, demonstrating that trust was not destroyed but transformed.

Together, these findings illustrate a relational process in which distrust is both an outcome of institutional failure and a catalyst for new connections. Parents' decisions around vaccination were intertwined with efforts to protect autonomy, and seek understanding in vaccine/immunization processes. Their experiences reveal how trust, once fractured, can be reassembled through care, dialogue, and moral alignment.

Chapter 5: Discussion

This study examined how parents in Ontario who refused or delayed vaccination for their children made sense of their decisions and navigated interactions with institutions during the exemption process under the *Immunization of School Pupils Act* (ISPA). Using Thorne's (2016) *Interpretive Description* methodology, the aim of this research was to move beyond describing vaccine hesitancy as a matter of misinformation or personal belief. Instead, I sought to understand how experiences of institutional trust shaped parents' relationships with public health systems. The focus was not on exploring attitudes toward vaccines, but on examining the relational and contextual factors that influenced how parents perceived authority within Ontario's immunization framework.

The findings of this study showed that vaccine hesitancy under the ISPA was shaped more by the quality of relationships and institutional interactions than by a lack of knowledge about vaccines. Parents often described encounters with healthcare providers or public health staff that left them feeling dismissed, corrected, or morally judged. These experiences reinforced the sense that the exemption process was not about choice but about compliance. The theme of *Institutional Othering* captured this pattern, illustrating how the tone of communication and procedural rigidity contributed to feelings of mistrust and exclusion. The second theme, *Epistemic Conflict*, reflected the tension between personal experience and biomedical authority. Parents valued scientific information but felt that their lived experiences and moral reasoning were treated as secondary. The third theme, *Exemption as Resistance*, revealed that parents often complied pragmatically rather than ideologically. The final theme, *Relational Trust Reallocation*, illustrated how trust was not simply lost but redirected. Parents placed confidence in individuals and

communities who treated them with empathy and respect, including select healthcare providers, alternative practitioners, and peer networks. These relationships offered emotional safety and a sense of being understood. Taken together, the findings suggest that vaccine hesitancy within the context of the ISPA emerged through experiences of relational disconnection, and not exclusively through misinformation or defiance. Confidence in vaccination was influenced by how institutions engaged with parents and whether interactions preserved or diminished a sense of respect and acknowledgement.

The purpose of this discussion is to interpret these findings within broader social contexts and explore what they reveal about how trust, authority, and communication shape parents' experiences under the ISPA. This chapter situates the findings within the Behavioural and Social Drivers (BeSD) model and the growing literature on trust in public health. It also considers how institutional tone, moral communication, and procedural design influence vaccine confidence. Finally, consistent with the pragmatic aims of ID methodology, the discussion considers what these insights mean for nursing and public health practice, emphasizing opportunities to improve relationships and communication in ways that foster trust and understanding. While this study is based on a small, information-rich sample, the discussion that follows interprets patterns evident across participants' accounts rather than making claims about prevalence or generalizability.

Interpreting Findings Through the BeSD Model

The Behavioural and Social Drivers (BeSD) model (Figure 1) (WHO, 2021) offers a structured way to examine the factors that shape vaccine uptake by assessing beliefs, social influences, and environmental conditions. It has been used to inform

communication strategies and policy design by identifying measurable determinants of vaccine behaviour (Alagarsamy et al., 2022). However, the findings of this study suggest that the experiences of vaccine-hesitant parents cannot be fully understood through a behavioural perspective alone. The BeSD model identifies what influences a decision but does not account for how those influences are interpreted within relationships. In the context of the ISPA exemption process, parents were not only responding to information or logistical barriers. They were also attuned to institutional tone, fairness, and respect as signals of whether they belonged within the system. Earlier descriptions of the process as a "high-pressure position" (Participant 1) and of mandatory materials as a "children's cartoon education video" (Participant 7) resurface here as shorthand for experiences that felt coercive and dismissive. These moments shaped how parents interpreted public health not simply as an authority, but as a moral actor that either affirmed or undermined their legitimacy as decision-makers. These relational cues shaped trust more powerfully than any single belief or practical issue. When viewed through the experiences shared in this study, the BeSD framework becomes not just a behavioural tool but a way to understand how institutional communication and procedural design carry emotional and moral meaning that can influence participation in ways that are difficult to quantify.

Beliefs and Motivations

Within the BeSD framework, beliefs and motivations are often described as individual factors that shape vaccine behaviour. The findings from this study point to a more relational and moral process. Participants described reading studies, speaking with trusted practitioners, or other such as Participant 5 who drew on prayer and intuition when making decisions. Their beliefs were rooted in care, not defiance. Rather than

rejecting knowledge, parents questioned whose knowledge was recognized as legitimate. They viewed personal experience and observation as valid forms of understanding that should complement professional expertise.

For these parents, decision-making was not simply about evaluating scientific facts but about maintaining integrity and protecting their children's well-being. Belief transformed into an expression of moral obligation and relational trust, rather than remaining a fixed cognitive stance. This perspective challenges the BeSD model's tendency to treat beliefs as internal attitudes that are detached from their context. The findings suggest that beliefs about vaccines evolve through lived experience and interaction. Beliefs (Thinking and Feeling), therefore, depend as much on being heard and respected as on access to information.

Social Processes

The findings from this study show that these social dynamics operate in far more personal and restorative ways than the model suggests. Parents relied on social connections not simply for information, but for emotional validation after experiencing judgment or exclusion within institutional settings. Relationships with peers, faith communities, or alternative health practitioners offered a sense of belonging that public health encounters often failed to provide. These social networks allowed parents to rebuild trust in a space where they felt understood and respected.

For many participants, trust moved rather than disappeared. Confidence shifted away from formal systems and toward individuals who demonstrated empathy and humility. This redistribution of trust highlights the role of emotional safety in shaping

what information feels credible. Within the BeSD model, social processes are typically viewed as mechanisms of influence, yet the findings here suggest that they also serve as mechanisms of support in the face of institutional harm. Parents turned to these relationships not to resist science, but to repair the loss of respect and relational security that occurred in institutional interactions. Understanding these processes as relational, rather than behavioural, expands how vaccine hesitancy can be interpreted and addressed in practice.

Environmental and Structural Context

The BeSD framework describes environmental and structural factors as the practical conditions that enable or hinder vaccine uptake, such as accessibility, cost, or convenience. The findings from this study reveal that structural influences extend well beyond logistics. Parents experienced the ISPA exemption process as an emotionally charged environment. Procedures that were intended to promote informed decision-making often communicated surveillance and control. The mandatory education session, the standardized video, and the language of school suspension were seen as signals of distrust rather than opportunities for dialogue. These experiences illustrate how policies can unintentionally convey moral judgment, transforming a health requirement into a test of compliance.

Parents' emotional responses to these processes show that the structural environment is not neutral. It shapes how people feel within systems of care. While the BeSD model includes respect from healthcare workers as a factor that can influence uptake, this is primarily framed in terms of accessibility, such as whether someone avoids a vaccine because they dislike a particular provider (WHO, 2021). The findings of this

study point to a deeper relational dynamic. Through the ISPA, parents were responding not only to interpersonal interactions but also to the broader design of the exemption process, including the language of legal forms, the required education module, and the way authority was communicated. These elements shaped whether parents felt recognized as partners or positioned as problems. When participants described feeling threatened with exclusion, they were reacting to these structural cues rather than to the vaccine or public health professional. The BeSD framework captures access as a determinant but does not account for how access is experienced within policy and administrative procedures. Expanding the model to include relational practices such as procedural clarity, institutional humility, and emotional safety offers a more complete understanding of the conditions that support cooperation or fuel resistance.

Adapting the Behavioural and Social Drivers of Immunization Model

Taken together, these findings suggest that the three domains of the BeSD model are not distinct categories but parts of a shared relational process. Beliefs are influenced by how people are treated, social networks are formed through the search for respect, and structural contexts communicate moral meaning through their tone and design. Parents' decisions about vaccination did not arise from isolated factors but from how these domains intersected in their daily interactions with public health systems. When care felt conditional or dismissive, belief shifted from confidence to doubt, and social trust

followed that trajectory.

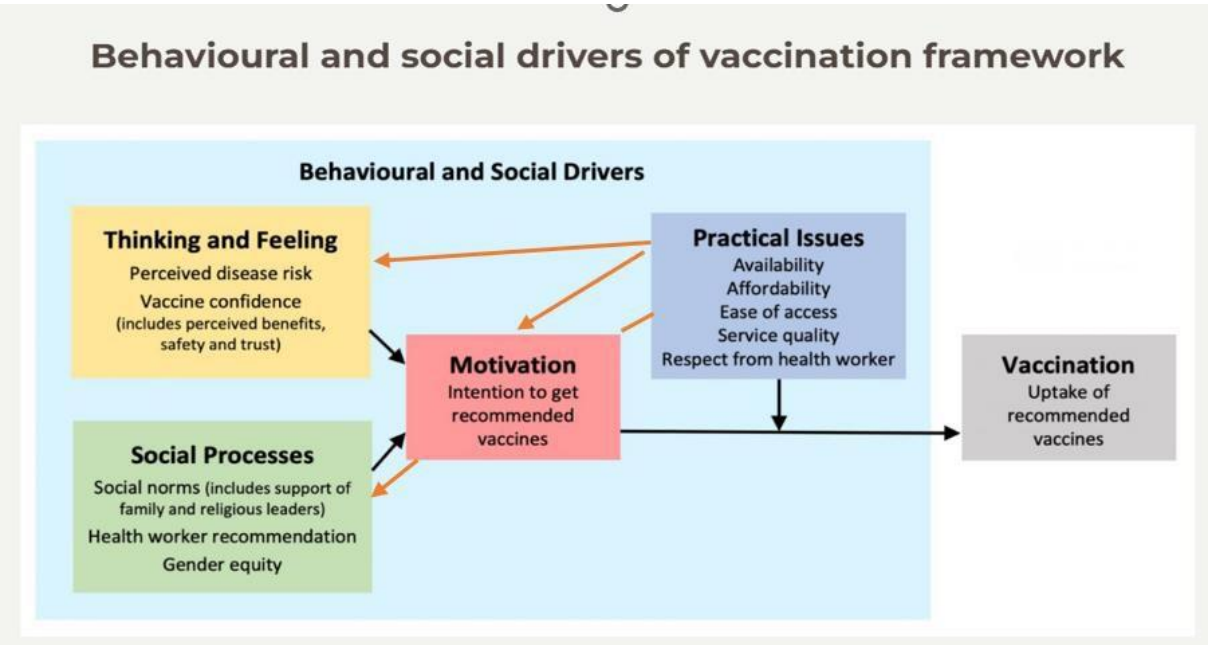


Figure 3: Adapted Behavioural and Social Drivers Model

This integration highlights the need to view the BeSD model not only as a behavioural framework but as a relational one. In its current format, the model appears linear in that practical issues act as a barrier after a patient's motivation has been determined. However, the results of this study show that motivation is dynamic, emotional, and responsive to context. Public health efforts that focus on correcting beliefs without addressing the quality of relationships risk reinforcing the very skepticism they seek to resolve. In this way, the BeSD model can be expanded to include how practical issues and institutional procedures influence motivation, just as social processes or the perceived importance of immunization can (figure 2). Understanding these interconnections opens space for more human approaches to public health communication, where respect and empathy become as essential as accuracy and access.

Relational Trust and Public Health Communication

Trust emerged in this study as an ongoing relationship rather than a fixed attitude toward vaccines or institutions. Parents did not talk about trust as simple confidence in biomedical facts, but as a question of whether health systems behaved in ways that felt competent, honest, and aligned with their interests. This aligns with Platt et al.'s (2018) work on "system trust," which shows that public confidence in health information sharing depends on perceptions of fidelity, integrity, and trustworthiness across the broader health system, not just individual encounters. Many people lack trust in at least one of these dimensions, even when technical systems are in place to protect data and support care. In this context, the dismissive or rushed interactions described by parents in this study can be understood as moments where the "fabric of trust" is weakened rather than strengthened. Their accounts also echo Hornsey et al.'s (2020) finding that vaccine hesitancy is strongly linked to distrust of conventional medicine, while trust in alternative medicine is only a weak predictor of hesitancy, suggesting that institutional mistrust is often the more proximal issue. At the same time, Correia (2024) argues that trust in public health strengthens when responses are clearly directed at meeting community needs. This includes how institutions communicate during periods of uncertainty, how transparent they are about decision-making, and how consistently they involve communities in shaping health guidance. Taken together, these studies help clarify why the parents in this project judged institutions less on their formal authority and more on whether communication felt fair, respectful, and oriented to their well-being.

Many parents described interactions with public health that felt less like conversations and more like moral evaluations. The emphasis on compliance within the

ISPA framework positioned them as subjects of correction rather than participants in dialogue. This sense of being judged carried emotional weight, often transforming uncertainty into a sense of resistance. Several parents spoke about feeling "talked down to" or treated as uninformed, even when they had researched vaccines extensively. These encounters reinforced the perception that the system valued obedience over understanding. Communication that sought to persuade instead of engage made parents feel that their moral character was under scrutiny. Rather than fostering trust, these exchanges encouraged what some participants described as "going through the motions" essentially fulfilling exemption requirements to avoid conflict while privately maintaining skepticism.

This pattern exemplifies an uneven power dynamic. In these exchanges, power takes precedence over information. The parent's role changes from decision-maker to listener who is expected to concede. Over time, this moral imbalance undermines trust not only in the message but also in the messenger. Consequently, compliance occurs without real conviction, with procedural steps completed but true understanding lacking.

Fractured Institutional Trust and the Turn Toward Alternative Information Spaces

The findings of this study show that weakened institutional trust can shape where parents turn for reassurance and understanding. Participants did not describe rejecting science or embracing fringe beliefs. Rather, they withdrew from institutional guidance when interactions felt dismissive, moralizing, or misaligned with their lived experiences. This pattern reflects broader work showing that experiences of exclusion or marginalization can increase openness to alternative sources of meaning. Schnell (2024) notes that when people feel disconnected from systems or communities, they often seek

out explanations that restore a sense of recognition and clarity. For the parents in this study, alternative spaces became meaningful because they offered validation and a sense of being taken seriously.

Social isolation can further intensify this shift. The Canadian Medical Association (2023) observes that people who feel unsupported are more likely to gravitate toward online networks that provide connection and affirmation, even when those networks circulate inaccurate information. Several parents in this study described online groups or informal peer communities as the only places where their experiences were acknowledged without judgment. These environments met emotional needs that institutional settings did not, which made them feel more trustworthy than traditional authorities.

Recent reviews emphasize that mistrust in government and health systems is one of the strongest drivers of health-related misinformation, often more influential than the content itself (Kisa & Kisa, 2025). Belief formation is shaped by how people interpret institutional intentions and whether they feel respected in their interactions. The findings of this study mirror that pattern. Parents did not reject evidence outright. They rejected systems that, in their view, did not recognize their experiences or allow them to participate meaningfully in decision-making.

Addressing misinformation therefore requires more than correcting factual errors. Boumans (2025) argues that trustworthy information environments depend on transparency, responsiveness, and relational accountability. When trust was weakened, parents in this study viewed corrections as insincere or irrelevant. When trust was strengthened through empathy and relational consistency, they became more open to

discussion. This suggests that the rise of alternative information sources is rooted not in gullibility or ideology, but in relational gaps within institutional systems. People gravitate toward sources that make them feel recognized, respected, and safe.

Modern Context of Vaccine Hesitancy

Vaccine hesitancy today cannot be separated from the wider uncertainty shaping public life. The global health landscape is rapidly evolving, and the conditions that make vaccination both essential and contested are becoming increasingly complex. Across Ontario and Alberta, measles outbreaks have re-emerged after years of near elimination, highlighting the fragility of public confidence. Reports from Public Health Ontario (2025) describe hundreds of cases across both provinces, many in under-immunized communities. These outbreaks are not only the result of misinformation or neglect but also a reflection of deeper relational and institutional fatigue. When trust weakens, even long-standing systems begin to struggle.

The likelihood of new infectious threats is also increasing. Climate change is altering ecosystems and expanding the range of viruses that were once confined to specific regions (Carlson et al., 2022). Global health agencies now warn that rising temperatures and environmental disruption are creating ideal conditions for new pathogens to appear (Liao et al., 2024; WHO, 2024). This reality makes it clear that vaccine programs will continue to expand in both scope and complexity, necessitating rapid development, adaptable delivery, and a robust foundation of public cooperation. The social foundations of that cooperation are the same qualities that this study explored within everyday interactions between parents and institutions.

Recent events in North America show how fragile those foundations can be. In the United States, the removal of all seventeen members of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices raised widespread concern about the politicization of vaccine oversight (National Foundation for Infectious Diseases, 2025). When long-trusted advisory systems appear unstable, it reinforces doubts about institutional consistency and integrity. In Canada, shifting COVID-19 vaccine policies, particularly in Alberta, have added to the confusion about eligibility and necessity, leaving families uncertain about whom to trust and when to act (Alberta Medical Association, 2025).

Together, these developments demonstrate that vaccine hesitancy is not a fringe movement, but rather a reflection of the moral and political tensions that shape modern societies. Polio cases are once again being detected in several countries, and measles continues to spread in areas that were once considered fully protected. These trends reveal that scientific progress alone is not enough to secure participation. The challenges ahead are as much relational as they are technical. As health systems prepare for new vaccines, whether in response to emerging viruses or the return of older ones, the lessons from this study are increasingly relevant. Rebuilding confidence will depend on whether institutions can practice care, humility, and fairness in a world where authority is constantly questioned.

Healthism and the Moralization of Vaccination

The experiences described in this study also reflect a broader cultural pattern often referred to as healthism. First identified by Robert Crawford (1980), healthism describes the tendency to view health as a matter of personal discipline, responsibility,

and moral virtue. Within this framework, good citizens are those who manage their bodies responsibly and make choices that align with medical advice, while illness or refusal is interpreted as a moral lapse. In current context, health is not only an individual pursuit but a marker of character. Parents who vaccinate are often seen as fulfilling their civic duty, while those who refuse are positioned as negligent or selfish. These judgments extend beyond risk perception to touch the moral and emotional dimensions of identity, belonging, and care.

In this context, the act of vaccination becomes more than a medical decision; it becomes a public performance of morality. Public health messaging, however unintentionally, can reinforce this divide. Appeals to "protect your community" or "do your part" situate vaccination within a language of moral citizenship. For many parents in this study, those expectations were experienced as coercive or patronizing rather than empowering. When parents felt reduced to compliance targets, their decision to seek exemption became a way to reclaim moral agency. They viewed themselves not as careless or misinformed but as deeply invested in their children's wellbeing, guided by values of autonomy, natural living, and informed consent.

Healthism helps explain why vaccine hesitancy can thrive even among highly health-conscious parents. Their refusal is often an extension of the same cultural logic that public health relies upon: the ideal of self-regulation and informed decision-making. As Kirbiš (2023) notes, modern and individual-centric health culture encourages taking personal responsibility for every aspect of wellness, creating anxiety and self-surveillance rather than genuine empowerment. Several participants embodied this tension. They distrusted institutions but still sought moral legitimacy through their own research,

alternative practitioners, and wellness communities. Their actions reveal how resistance to institutional authority can coexist with deep commitment to health and responsibility.

Moving beyond the moralizing tendencies of healthism requires reframing vaccination as a collective and relational act rather than an individual test of virtue. Zota et al. (2023) argue that health communication grounded in shared responsibility and empathy can challenge the isolating effects of neoliberal self-management. This perspective aligns with the relational framework that emerged from this study. Parents responded more positively when they felt that care and respect were mutual rather than conditional. If public health approaches vaccination as a partnership built on trust, rather than a compliance exercise, it becomes possible to sustain confidence without reinforcing the moral hierarchies that divide "responsible" from "irresponsible" citizens.

ISPA Exemption and the Perceived Moral Panic Around Vaccine Hesitancy

Parents' accounts of navigating the ISPA exemption process reveal that communication with public health authorities was not perceived as neutral or purely procedural. Instead, it was experienced as a moral encounter. The educational sessions, official documents, and institutional tone were interpreted not just as informative, but as mechanisms for defining what it meant to be a "good" parent or responsible citizen. Rather than fostering open dialogue, these interactions often conveyed implicit moral judgments, suggesting that trust, compliance, and cooperation were not simply expected but morally required.

This dynamic reflects Cohen's (1972) theory of moral panic, which explains how social anxieties are projected onto certain groups that are seen as deviant or threatening.

In the case of vaccine hesitancy, parents who expressed uncertainty or questions about vaccines often felt they were being cast into such a role. As explored by Capurro et al. (2022), individuals who questioned public health guidelines during the COVID-19 pandemic were frequently stigmatized in the Canadian media, labeled as “covidiots” and portrayed as threats to the public good. Similarly, participants in this study reported feeling judged rather than engaged, as if their concerns were not legitimate but instead reflective of a moral deficiency.

The exemption process became more than a legal obligation. For many, it felt like a test of character. Communication focused on compliance signalled that moral legitimacy belonged to the institution, not the individual. This framing positioned hesitancy not as a perspective to be understood, but as a flaw to be corrected. Many parents described experiencing a form of moral surveillance, where their values and identities were measured against institutional norms.

For those who valued autonomy, care, or critical inquiry as central to their role as parents, this approach felt deeply disempowering. Cooperation came to mean submission rather than partnership. In response, some complied with procedural requirements while disengaging emotionally. This quiet withdrawal can be understood as a subtle form of resistance, revealing how moral language and institutional power interact to shape behaviour, not just beliefs.

While it is vital to recognize the importance of promoting public health through robust routine immunization coverage, these experiences illustrate how moral panic around vaccine hesitancy, embedded in both policy and tone, can undermine meaningful

communication. Rather than building trust, it may reinforce division and reduce the possibility of open, respectful dialogue.

Performative Compliance and the Burden of Moral Framing

Across interviews, parents described navigating an environment where vaccine hesitancy is framed as a social risk. Pressure did not exclusively come from the perceived risks of vaccination, but from the fear of being publicly labelled as irresponsible or morally suspect. This reflects broader findings in the literature. Mendonça et al. (2023) show that vaccine-hesitant parents often experience stigma in clinical and school settings, where their concerns are interpreted as a threat to collective welfare rather than as legitimate health questions. This moral framing intensifies the sense that disagreement is socially dangerous. When vaccination becomes a marker of good citizenship, parents can feel compelled to maintain an appearance of cooperation even when uncertainty remains. The interviews in this study echo that dynamic. Parents complied with exemption requirements to avoid judgment, conflict, or the possibility of being positioned as a problem within the school system. Their cooperation functioned as a strategic choice rather than an expression of trust. Similar patterns are described by Wiley et al. (2021), who note that many non-vaccinating parents are not opposed to dialogue but are highly aware of the social consequences of hesitation. In their work, parents reported modifying their behaviour in public settings to avoid being cast as careless. This suggests that compliance can serve not only a practical purpose but also a protective one by preserving social belonging.

Research on vaccine refusal further confirms this view. Harmsen et al. (2012) observed that parents who oppose vaccination norms often feel misunderstood in

healthcare settings and expect negative reactions when sharing their opinions. Consequently, they tend to hide their disagreement to maintain relationships with schools, healthcare providers, or the community. In this study, parents described following steps to fulfill institutional expectations while secretly holding their own concerns. This allowed them to safeguard their children's education and avoid stigma without abandoning their beliefs.

These findings highlight performative compliance as a quiet form of self-protection. It is neither apathy nor defiance. It is a strategy that enables parents to fulfill their legal obligations, avoid moral labelling, and maintain autonomy in a system that leaves little room for respectful disagreement. Recognizing this behaviour helps shift the narrative from one of resistance to one of relational adaptation, shaped by the need to navigate strong social pressures and preserve a sense of dignity within institutional environments.

Position within Current Literature

The findings of this study contribute to a growing body of research that challenges narrow behavioural explanations of vaccine hesitancy and highlights its relational and moral dimensions. Existing models such as the 3Cs, 5Cs, and BeSD frameworks have been useful for identifying key determinants of vaccine uptake, including confidence, complacency, and convenience (MacDonald, 2015; Betsch et al., 2018; WHO, 2021). However, these models often overlook how such factors are experienced within everyday relationships. These omissions risk framing hesitancy as a deficit to be corrected rather than as a social process situated in trust, care, and legitimacy (Thomson et al., 2016). The current study extends this discussion by illustrating that beliefs, environments, and social

networks are interdependent forms of relational meaning. Parents' experiences demonstrate that confidence in vaccination depends not only on access and information but on the moral tone and emotional safety embedded in their interactions with public health systems.

This study aligns with recent scholarship that conceptualizes vaccine confidence as a social and ethical relationship rather than a simple attitude toward science. Larson et al. (2022) describe trust as an outcome of consistent and empathetic communication, while Sobo (2016) highlights that parental decisions about vaccination are often rooted in care and responsibility. The present study builds on this work by showing that trust is not necessarily lost but redistributed toward individuals and networks perceived as morally aligned and emotionally validating. This reallocation of trust reveals hesitancy not as rejection but as a protective adaptation in response to institutional distance. Giddens (1990) situates trust as a mechanism for managing uncertainty in complex systems, and these findings extend that perspective by demonstrating how parents reassert certainty through relationships when bureaucratic interactions feel impersonal or judgmental.

The moral and structural dimensions of vaccine hesitancy identified here also resonate with research linking confidence to perceptions of judgment and fairness within public health communication. Peretti-Watel et al. (2020) argue that hesitancy is shaped by how authority and legitimacy are interpreted in social contexts, while Hornsey et al. (2018) show that persuasive strategies fail when they disregard people's moral identities. This study advances these insights by examining how bureaucratic tone and administrative design themselves act as forms of moral communication. Within the ISPA framework, exemption procedures were often experienced as mechanisms of evaluation

and compliance, reinforcing the sense that moral worth was being assessed. This produced what I have labelled as performative compliance, where parents engaged with requirements strategically rather than relationally. These dynamics underscore how coercion and autonomy coexist within public health systems and how institutional tone can shape moral meaning as much as policy itself.

Ultimately, the study contributes to the literature by highlighting the importance of relational practice in health communication. Leask et al. (2012) propose that effective engagement with hesitant parents depends on conversational approaches grounded in listening and partnership rather than persuasion. This study supports and extends that position by demonstrating that such relational strategies are not only effective at the interpersonal level but essential within policy-driven contexts. Under Ontario's ISPA framework, nurses operate at the intersection of institutional authority and human experience, transforming procedural interactions into opportunities for connection. Integrating reflective communication and relational ethics into nursing education and public health policy can enhance both professional credibility and public trust, making care systems feel trustworthy and competent.

Contributions to the Literature

This study offers a new perspective by shifting focus from viewing vaccine exemption seeking as just individual beliefs or behavioral factors to understanding vaccine decision-making as a relational process influenced by daily institutional interactions. Although frameworks like BeSD recognize social and structural factors, they often function as diagnostic tools that classify determinants rather than exploring how parents experience and interpret their interactions with public health systems. This

research advances the existing literature by illustrating how elements such as moral tone, emotional safety, and perceived legitimacy in routine activities like exemption documentation, education sessions, and enforcement actively influence trust and resistance.

These results indicate that increasing vaccine confidence cannot depend solely on increasing access or providing correct information. Instead, public health efforts may need to focus more on how policies are implemented during individual interactions. Practical takeaways include using non-judgmental language in exemption documents, being transparent about enforcement goals and limitations, and training public health personnel to prioritize relational communication alongside informational accuracy. By emphasizing that trust is developed through institutional behavior rather than assumed through authority, this study offers practical guidance for public health systems aiming to sustain vaccination efforts while minimizing relational harm.

Implications for Public Health Practice

The findings of this study position communication as a relational practice that constructs trust and moral meaning rather than as a tool for persuasion. Within the ISPA framework, nurses and public health professionals occupy a unique position where tone can determine whether an interaction strengthens or strains confidence. Parents described feeling most understood in healthcare experiences when communication allowed them to share reasoning without fear of judgment. These findings echo broader discussions in vaccine confidence research that caution against treating communication as one-directional instruction. MacDonald (2015) notes that interventions built solely on education risk overlooking the social and emotional processes that shape confidence.

Similarly, Peretti-Watel et al. (2020) emphasize that trust in vaccination depends not only on facts but on perceptions of respect and fairness within institutional relationships.

Reframing communication as relational practice shifts attention from what professionals say to how dialogue unfolds. Empathy and moral attentiveness are not secondary skills but the foundation of credible public health practice. Each phone call, clinic encounter, or exemption discussion becomes an opportunity to model institutional care. When nurses engage families through active listening and relational transparency, communication becomes a means of restoring trust rather than enforcing compliance.

Bureaucratic Tone and Emotional Consequence

Parents frequently described the bureaucratic features of the ISPA process, such as the letters, education videos, and standardized forms, as emotionally charged experiences. The tone of official communication was often interpreted as corrective or disciplinary, carrying an unspoken assumption that hesitation equated to irresponsibility. Even when interactions with staff were polite, the procedural structure itself created a sense of distance. Scripted explanations, brief time slots, and the lack of personal dialogue made the experience feel mechanical. Parents often said they felt processed rather than heard. In their view, these encounters communicated suspicion rather than support.

These emotional reactions reveal that bureaucracy is not simply a tool for organization but a form of moral communication. Its tone, structure, and pace signal who is trusted and who must prove their legitimacy. Participants' frustration was not directed at individual staff but at a system that seemed to value control over understanding. When communication is standardized to ensure consistency, it can also strip away the empathy

that builds credibility. The emotional consequence of this detachment is cumulative; parents learn to interpret institutional communication as a moral judgment rather than a gesture of care. This dynamic erodes trust long before any scientific disagreement takes place, shaping how future messages are received and how the institution itself is understood.

The findings suggest that restoring trust in vaccination cannot rely on refined messaging alone. It requires a reimagining of how institutions communicate moral intent. For many parents, the issue was not a disagreement with science but a loss of moral connection to the system that delivers it. Dialogue that begins with correction or education signals hierarchy, while dialogue grounded in humility signals care. Rebuilding trust, therefore, depends on institutions recognizing that authority carries emotional and ethical responsibilities. When communication acknowledges uncertainty, allows questions without penalty, and treats parents as moral equals, it shifts from persuasion to partnership.

This shift would involve viewing the exemption process not as a compliance checkpoint, but as an opportunity for relationship-building. By slowing the pace of communication and creating space for genuine conversation, public health could transform moments of resistance into moments of learning. Such encounters require professionals to balance expertise with presence; a skill rooted in empathy and reflection rather than technical training alone. Reimagining institutional dialogue in this way positions care and curiosity as tools for legitimacy. It invites a form of public health that leads not through surveillance but through moral trustworthiness.

Implications for Individual Practice

For nurses and public health professionals working directly with families, the findings point to the importance of transforming everyday encounters into opportunities for trust-building. Parents' descriptions of exemption appointments and school-based vaccine clinics reveal that tone and attentiveness often mattered more than content. Interactions that felt transactional or rushed reinforced skepticism, while those that conveyed patience and respect fostered openness. This aligns with research emphasizing that vaccine confidence grows through positive, consistent contact with healthcare providers who acknowledge the legitimacy of parental concerns (Larson et al., 2018). Creating this atmosphere does not require lengthy discussions but an intentional effort to make communication reciprocal rather than directive.

At the individual level, this approach involves small but meaningful shifts in language and posture. Inviting parents to share what has informed their decisions communicates respect for autonomy and can open pathways for dialogue. Pellegrini et al. (2020) frames vaccine hesitancy as a relational phenomenon, arguing that the decision is heavily influenced by the quality of the trust built between the parent and the healthcare provider. When questions are framed as collaboration rather than correction, parents interpret the exchange as supportive rather than disciplinary. This study suggests that such relational strategies may be especially important in policy-driven environments like Ontario's ISPA, where the interaction is structured by law. Nurses who recognize the emotional and moral dimensions of these encounters can serve as mediators between institutional authority and community experience, translating procedural requirements into moments of relational care.

Implications for Organizational and Policy Design

The findings also underscore the need for organizational and policy-level changes that support relational approaches to vaccine communication. The ISPA exemption process illustrates how institutional design can unintentionally perpetuate mistrust when procedures prioritize oversight over dialogue. Parents often interpreted letters, scripts, and standardized education modules as signals of suspicion rather than support. This suggests that public health systems must assess not only what information they provide but also how their processes communicate moral tone. Policies that integrate flexibility and mutual respect are more likely to sustain trust over time.

To operationalize the relational approach highlighted by these findings, a critical policy change within the ISPA exemption process should be the replacement of standardized education modules and scripts (such as videos or fixed presentations) with an unstructured, one-on-one conversation led by a trained public health nurse. This shift acknowledges that while information provision is necessary, the current design prioritizes compliance oversight and unintentionally signals suspicion. The goal of this conversational model is not to ensure standardized content delivery but to focus on reciprocity and trust-building. By allowing the nurse to listen actively and tailor the discussion to the parent's specific concerns, the interaction moves from a didactic "test of character" to a supportive engagement. Even if the immediate outcome is non-standardized information, this relational approach is more likely to foster openness and sustained trust, ultimately serving the broader public health goal of increasing long-term immunization rates by reducing the alienation and subtle resistance perpetuated by the current institutional design. However, it should be noted that these one-on-one education

sessions would be more resource-intensive, which would require additional funding to public health initiatives in a post-pandemic economy of budget cuts.

Limitations and Future Directions

This research was interpretive and exploratory in nature, aiming to generate insight rather than generalizable conclusions. The sample included seven Ontario parents who obtained vaccine exemptions under the Immunization of School Pupils Act. This design allowed for a detailed exploration of individual experiences but limited the ability to capture the full range of perspectives that exist within the broader population. The findings, therefore, reflect a contextual, rather than universal, understanding of vaccine hesitancy as it is lived and interpreted through encounters with institutional systems. While the study's depth offers valuable nuance, it is important to acknowledge that the results cannot be generalized to all parents or to other jurisdictions.

Methodological Considerations

The small sample size represents both a limitation and a deliberate methodological choice. Qualitative inquiry, particularly within Interpretive Description, prioritizes meaning over measurement (Thorne, 2016). The inclusion of seven participants allowed for deep engagement with each narrative, yet it is unlikely that data saturation could ever be achieved on a topic as multifaceted as vaccine hesitancy. The complexity of belief, identity, and moral meaning in vaccine decision-making is such that additional interviews, even in large numbers, would likely continue to surface new perspectives. The study sample was also limited to English-speaking participants within Ontario, which may have shaped the cultural and communicative dynamics observed.

Recruitment relied on voluntary participation, meaning that those who agreed to be interviewed were likely individuals who were comfortable articulating their experiences or motivated to share them. This may have produced a sample more reflective, critical, or engaged than the general population. The researcher's professional background as a public health nurse also shaped interpretation. Insider knowledge provided context for understanding institutional processes, yet it carried the potential for bias. To address this, reflexivity was maintained through journaling, analytic memoing, and supervisory consultation, ensuring that participant voices remained central to the analytic process.

Analytical and Interpretive Boundaries

The findings represent one possible construction of meaning shaped by both participant accounts and the researcher's interpretive lens. Analysis followed Thorne's (2016) Interpretive Description methodology, which seeks to generate practice-relevant insights rather than theory for its own sake. Although rigour was supported through iterative coding, peer debriefing, and documentation of analytic decisions, the results must be understood as contextually situated. Interpretation is inherently partial and relational; it reflects an engagement between researcher and participant.

Future Research Directions

The study's findings suggest several directions for future research. First, additional studies could investigate the views of public health nurses and administrators who enforce vaccine laws, focusing on how they manage the conflict between policy enforcement and relational ethics. This could shed light on the institutional aspect of the trust relationship mentioned here. Second, expanding the research to include parents from

different linguistic, cultural, and geographic backgrounds would enhance understanding of how social factors influence trust and compliance. Comparing different provinces or jurisdictions could reveal how local policy frameworks shape moral interpretation.

Future research could also examine interventions that incorporate relational communication principles into bureaucratic processes, assessing how adjustments in tone and timing influence perceptions of legitimacy and trust in dialogue. Mixed-methods or participatory approaches might be especially effective in aligning community viewpoints with institutional objectives. Ultimately, this area of research should aim not only to understand hesitancy but also to enhance the relational quality of public health, ensuring that care systems are experienced as both credible and compassionate.

Taken together, these limitations and future directions highlight that the meaning of vaccine hesitancy goes beyond attitudes toward immunization. It is influenced by the relational and institutional contexts in which decisions are made. The insights gained from this study emphasize that public health practice, especially within legislated frameworks like the ISPA, is as much about building relationships as it is about providing information.

Summary

Across this study, it becomes clear that institutional design and communication practices play a central role in shaping how parents navigate vaccine requirements and how they interpret public health authority. Their experiences demonstrate that trust is built through recognition and respect, and that its absence can lead to defensive decision-making, epistemic conflict, and performative compliance. Situating these findings within

the BeSD model highlights the need to integrate relational and ethical considerations into public health policy. As the thesis moves to its concluding chapter, attention turns to how these insights can inform a more responsive, trust-building approach to vaccine engagement in Ontario and beyond.

Conclusion

This study examined how vaccine-hesitant parents in Ontario interpret their experiences with healthcare institutions, construct their own forms of knowledge, and navigate the exemption process under the Immunization of School Pupils Act (ISPA). Using Interpretive Description, the analysis captured the ethical and relational dimensions of vaccine decision-making, offering insight into how trust is formed, broken, and redistributed within a mandatory immunization system. Rather than treating hesitancy as a problem of misinformation or access, the findings illuminate the ways parents make sense of institutional encounters and protect their autonomy in contexts where they often feel judged or misunderstood.

Four themes shaped the interpretation of these experiences. Parents described feeling alienated by interactions that conveyed condescension or moral judgment. They also engaged in epistemic contestation, challenging what counted as legitimate knowledge and asserting the value of lived experience. Many used the exemption process as a form of quiet resistance through what this study terms performative compliance. Finally, trust emerged as relational and selective, grounded in empathy and respect rather than professional authority alone. Together, these themes reveal that vaccine decision-making is deeply shaped by the moral quality of communication and by broader social forces that influence how parents position themselves in relation to public institutions.

These findings contribute to current literature by expanding how the Behavioural and Social Drivers model can be understood in practice. While the model highlights beliefs, social influences, and structural drivers, this study shows that relational dynamics and institutional tone play an equally meaningful role in shaping vaccine behaviour.

Parents discussed policies, clinical interactions, and exemption procedures through the lens of respect and moral alignment. These relational cues influenced not only hesitancy but also willingness to comply with institutional expectations. Understanding these dynamics allows for a more complete picture of why parents may withdraw trust from healthcare guidance despite having access to scientific information.

The findings emphasize important implications for public health nursing. Relying solely on correction or reassurance in communication may overlook how much parents respond to tone and transparency. Building trust isn't just about providing information; it requires creating an environment where questions are safe and parents are seen as partners, not problems. Nurses have a special role in fostering this environment by acknowledging uncertainties and prioritizing the parents' perspective through a caring approach. While these practices do not guarantee vaccine acceptance, they can help reduce defensiveness and encourage open dialogue, especially where institutional trust has been damaged.

This study also highlights broader issues for policy development. Mandatory frameworks such as ISPA serve not only as public health measures but also as platforms for moral communication. Policies that emphasize open channels for dialogue could help decrease the perceived institutional distance identified here. Enhancing these relational aspects is crucial, particularly in a context where mistrust of health systems and biomedical knowledge has increased both globally and within Canada (Steinburg, 2024).

Future studies might explore the experiences of parents from diverse cultural backgrounds, or examine how healthcare providers perceive their own role in trust-building within mandatory immunization systems. There is also a need for research that

traces how institutional tone, structural design, and relational norms influence families over time. A deeper understanding of these factors may improve not only vaccine communication but also the broader relationship between public health and the communities it serves.

The findings of this study highlight the importance of approaching vaccine hesitancy as a relational and moral process rather than a purely behavioural one. These interviews highlighted that parental decisions were shaped by their desire to protect their children, maintain autonomy, and interpret institutional expectations in ways that aligned with their values. When the healthcare system communicated in ways that felt dismissive or coercive, trust eroded. By recognizing these dynamics, public health practitioners can better support parents as they navigate complex decisions within systems that often feel impersonal or overwhelming. This study affirms that building trust is not an outcome of persuasion, but a result of care that is consistent, relational, and ethically grounded.

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Appendix A: Participant Recruitment Flyer

Appendix B: Examining the Influence of Institutional Trust and Personal Healthcare Experiences on Vaccine Hesitancy: Interview Guide

Primary Investigator: Nathan Koopman, RN, BScN

	Greeting and Introduction 1. Introduce yourself and explain the purpose of the interview. 2. Briefly describe the study and its goals. 3. Explain the format of the interview and its approximate duration. 4. Assure confidentiality and obtain verbal consent to proceed.	
Domain within the BeSD Framework	**Question**	**Prompts**
No Domain Background	1. Personal Background- Can you tell me a little about yourself?	(age, occupation, family structure) Whatever the individual is comfortable sharing
Thinking and Feeling	2. Vaccination- Please tell me your perspectives and experiences with vaccines.	- When did you decide not to vaccinate? - Have you received any vaccines? - Have your children received any vaccines? Which ones?
Social Processes	3. What was your experience like with the ISPA exemption process?	- What did you think of the process? - Did it affect your perception of public health? Of vaccines? How so?
Social Processes and Practical Issues	4. Can you describe your experiences within the healthcare system in general?	- Can you name a time that you felt particularly well-supported? - Can you name a time when you felt like your needs were not met? - Have you faced challenges or barriers in accessing healthcare?

		- How much trust do you have in healthcare institutions?
Thinking and feeling	5. What were your experiences like during the COVID-19 pandemic?	- How did you feel about the public health measures? - Did you end up receiving a COVID-19 vaccine? - **Do you feel like the pandemic affected your views on vaccination?**
Social Processes	6. Where do you receive most of your vaccine information?	- Healthcare provider? Online? Social media? Family? Friends?
Thinking and Feeling	7. What are your experiences interacting with other government institutions?	- Provide examples of the school system, policing, justice system, and provincial and federal levels of government.
Potentially, any Domains	8. Is there any other information you think I missed or should know?	- Any recommendations for vaccine messaging?
	Thank the participant for their time and insights. Point to contact information on their copy of the consent form for any further questions or concerns they might have. Conclude the interview by thanking the participant again and reiterating the confidentiality of their responses.	

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PETERBOROUGH, ONTARIO, CANADA

Appendix C: Participant Information and Consent Form

Title of Study:

Exploring the Influences of Personal Healthcare Experiences and Institutional Trust on Vaccine Hesitancy

Principal Investigator:

Nathan Koopman, RN, BScN
Trent/Fleming School of Nursing, Trent University
705-313-3995
nathankoopman@trentu.ca

Research Supervisor:
Ellen Buck-McFadyen, RN, PhD
Trent/Fleming School of Nursing, Trent University
ellenbuckmcfadyen@trentu.ca
705-748-1011 ext. 7029

Your unique knowledge and experiences as a parent or guardian who has undergone the non-medical exemption process under the Immunization of School Pupils Act (ISPA), 1990, are invaluable. By participating in this research study, you can help us gain deeper insights into how healthcare experiences and trust in public institutions can influence vaccine hesitancy.

Before deciding to participate, it's important to understand the study's details, including the potential risks and benefits. By contributing to this research, you can help inform healthcare policy and improve healthcare worker interactions around vaccine education. Your participation is entirely voluntary, and your decision will be respected. **WHAT IS THE PURPOSE OF THIS STUDY?**

The study aims to understand the experiences and perspectives of individuals who have completed the *ISPA* non-medical exemption process. The objectives are to:

1. Understand how experiences within the healthcare system can impact the intention to vaccinate.
2. Explore how trust in public institutions influences opinions about vaccines.
3. Inform healthcare policy and healthcare worker interactions around vaccine education.

This research meets the thesis requirements for the MScN program at Trent University. Furthermore, the findings will be submitted to accredited journals for publication. The results may also be presented to local Public Health Units to enhance the knowledge of

frontline staff involved in vaccine education and may be shared at relevant conferences.

WHAT WILL MY RESPONSIBILITIES BE IF I TAKE PART IN THE STUDY?

If you choose to participate, we will arrange a convenient time for you to share your experiences with the researcher. This can be done over the phone, through video conferencing (Zoom, Microsoft Teams, etc.), or in person at a location of your choice. The interview will last approximately 20 to 60 minutes.

You will be asked questions about your experiences around vaccinations. Questions will focus on the ISPA exemption process, experiences during the COVID-19 pandemic, where you get vaccine information, and personal experiences with the healthcare system and other government institutions. With your permission, the interview will be audio recorded. This way the details of the conversation can be typed out in a transcript for analysis by the researcher. If you prefer not to have your interview recorded, the researcher can take notes during the interview instead.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

It is possible that some of the questions you will be asked during the interview could make you feel uncomfortable or upset. Vaccination can be a sensitive subject for some to discuss, and you may have encountered stigma or judgment about vaccine hesitancy. It can also be challenging to talk about healthcare experiences or experiences during the COVID-19 pandemic. However, we believe it is important to hear about these challenges to improve healthcare policy and services in the future. You do not have to answer any questions that you don't want to, and you may stop participating at any time during the study. Participation in the study and your answers to interview questions will not impact the services or care you receive in the community. If you find the questions have caused you emotional distress, a list of community resources will be provided to assist you in finding support.

It is also possible that your participation in the study will become known if community members see you before or after your interview. You may choose a location for the interview that helps maintain your privacy, and neither your identity nor personal or professional information will be disclosed when study findings are shared.

By agreeing to participate in this research, you are not waiving any legal right in the event that you are harmed during the research.

WHAT ARE THE POSSIBLE BENEFITS FOR ME AND/OR FOR SOCIETY?

Better understanding the experiences of parents and guardians who have undergone the process of non-medical exemption can help us improve our approach to vaccine discussion and potentially avoid future negative vaccine-related interactions. However, these outcomes are unlikely to benefit you directly in the short term. You will receive a

$25.00 honorarium for your time and valuable insights. This will be provided in cash or by e-transfer, depending on your preference.

WILL MY INFORMATION BE KEPT PRIVATE?

Your data will not be shared with anyone unless required by law. (If the safety of a child, yourself, or another person is at risk, we are required to report this to the authorities. This does not include the vaccination status of children.) If you agree to have your interview audio recorded, the recording will be erased after a typed transcript is made. You have the right to review your recording and transcript upon request. Your name will be replaced with an identification number on the transcript. The typed transcript will be stored on a secure network at Trent University. A hard copy transcript and list linking your code with your name and contact information will be kept in a locked filing cabinet in a locked office. Only the researcher and supervisor will have access to this information. When the study is complete, the transcripts will be destroyed (no later than 5 years from the beginning of the study). If the study results are published, your name will not be used. No information that discloses your identity will be released or published.

CAN PARTICIPATION IN THE STUDY END EARLY?

If you volunteer to be in this study, you may withdraw anytime. This includes stopping the interview if you change your mind about participation or contacting the researcher after the interview to remove your data. Your data may be removed from the study until such time as findings are shared publicly in a presentation or publication (about 3 to 4 months after your interview). You may also refuse to answer any questions you don't want to answer during the interview. If you choose to stop participating, you will still be given the incentive described above. Your choice of whether to participate will not influence your future relations with Trent University or the investigators [Nathan Koopman, Ellen Buck-McFadyen] involved in the research.

To withdraw from the study, please contact Nathan Koopman at (705) 313-3995 or nathankoopman@trentu.ca

HOW CAN I FIND OUT ABOUT THE RESEARCH FINDINGS?

If you would like to receive a summary of the research findings and a copy of any published articles that result from this study, you may share an email address on the consent form where these documents can be sent.

IF I HAVE ANY QUESTIONS OR PROBLEMS, WHO CAN I CALL?

If you have any questions about the research now or later, please contact:

Researcher:
Nathan Koopman, RN, BScN, MScN (student)
Trent/Fleming School of Nursing, Trent University
1600 West Bank Drive Peterborough, ON K9J 7B8
nathankoopman@trentu.ca
705-313-3995

Research Supervisor:
Ellen Buck-McFadyen, RN, PhD
Trent/Fleming School of Nursing, Trent University
ellenbuckmcfadyen@trentu.ca
705-748-1011 ext. 7029

This study has been reviewed by the Trent University Research Ethics Board, the study number is 29145. If you have questions or concerns that you don't wish to share with the researchers, please contact:

Anna Kisiala
Coordinator, Research Conduct and Reporting
c/o Office of the Vice President, Research and Innovation
Trent University
1600 West Bank Dr
Peterborough, ON K9L 0G2
705-748-1011 ext. 7866 annakisiala@trentu.ca

CONSENT STATEMENT

Participant:

Part A: I have read or had read to me, the information and consent form thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand that I will receive a signed copy of this form. I know I can change my mind and withdraw consent to participate anytime. I am not giving up any legal rights by signing this consent form. I agree to participate in this study.

Name	**Signature**	**Date**

OR

☐ **Verbal Consent Obtained** _____
Researcher Signature **Date**

Part B: I agree to have my interview audio recorded for transcription purposes.

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PETERBOROUGH, ONTARIO, CANADA

Name	Signature	Date

OR

☐ **Verbal Consent Obtained** _____

Researcher Signature **Date**

Part C: I would like to receive a copy of the study findings via email.

_____

Email Address (optional)

Person obtaining consent:

I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.

Name and Role	Signature	Date

Participant Code: _____

Appendix D: Trent University Ethics Board Approval Letter

July 26, 2024

File #: 29145
Title: Exploring the Influences of Personal Healthcare Experiences and Institutional Trust on Vaccine Hesitancy
Dear Mr. Koopman,

The Research Ethics Board (REB) has given approval to your proposal entitled "Exploring the Influences of Personal Healthcare Experiences and Institutional Trust on Vaccine Hesitancy".

When a project is approved by the REB, it is an Institutional approval. It is not to be used in place of any other ethics process.

To maintain its compliance with this approval, the REB must receive via ROMEO:

An Annual Update for each calendar year research is active;

A Study Renewal should the research extend beyond its approved end date of March 31, 2025;

A Study Closure Form at the end of active research.

This project has the following reporting milestones set:

Annual progress report-2024/12/31
Renewal Due-2025/03/31

To complete these milestones, click the Events tab in your ROMEO protocol to locate and submit the relevant form.

If an amendment to the protocol is required, you must submit an Amendment Form, available in the Events tab in your ROMEO protocol, for approval by the REB prior to implementation.

Any questions regarding the submission of reports or Event forms in ROMEO can be directed to Anna Kisiala, Coordinator, Research Conduct and Reporting, at annakisiala@trentu.ca

On behalf of the Trent Research Ethics Board, I wish you success with your research.

Best Wishes,

Dr. Blair Niblett
REB Chair
Phone: 705-748-1011 ext. 7052
Email: blairniblett@trentu.ca

c.c.: Anna Kisiala
Coordinator, Research Conduct and Reporting

Participant Code: _____

Appendix E: Demographics Form:

Exploring the Influences of Personal Healthcare Experiences and Institutional Trust on Vaccine Hesitancy

Gender _____

Age Category: 18-30 ____ 31-50 ____ 51-70 ____ 71+____

Do you have access to a Primary Care Physician (Family Doctor) or Nurse Practitioner?
_____

What is your highest level of education?

Some high school/no diploma _____ Grade 12 or GED _____

Some college or university _____ College or university degree _____

What category best describes your total family income (before taxes)?

Less than $20,000 _____

$20,000-$29,999 _____

$30,000-$49,999 _____

$50,000-$74,999 _____

$75,000-$99,999 _____

$100,000-$149,999 _____

$150,000 and over _____