

Trust Dynamics and Equity in Public Health in Canada: Protocol for a Mixed-Methods Project in the post-pandemic era

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Abstract

Background: The COVID-19 pandemic significantly impacted public trust in public health, medical care, scientific, and governmental institutions; in turn, influencing health and health seeking behaviours and adherence to public health measures. Understanding the evolution of trust is necessary for informing future public health crisis management and strategies. Rebuilding public trust is a key goal of pandemic preparedness worldwide. This research protocol examines these trust dynamics, their determinants, and implications for health equity.

Objective: The study aims to investigate the evolution of public trust in scientists, public health and medical care institutions, governments, and social and personal networks during the COVID-19 pandemic. It seeks to identify key factors contributing to trust maintenance or erosion, particularly in marginalized and minority communities, and understand the impact of trust level on public health adherence.

Methods: A sequential, explanatory mixed-methods approach was implemented, consisting of an initial quantitative survey followed by qualitative interviews. The nationally representative survey included 5,609 Canadian residents as of March 2020. The questionnaire assessed trust in six key trust sources before and during the pandemic: provincial and federal governments, public health authority, medical care providers, health scientists, and social and personal networks. To complement, 41 qualitative interviews were conducted to understand participants' lived experiences, perceptions and how trust played into both. Data have been analyzed using statistical techniques for quantitative data and thematic analysis for the qualitative data and results integrated to derive comprehensive insights.

Results: This Canadian survey included participants from all 10 provinces and two territories; provinces and territories samples matched the proportions of each in the overall Canadian population. Age, sex/gender were well distributed in the sample. Additionally, 18.6% identified as an ethnic minority, 12.7% identified as Indigenous, including 7.2% First Nations, 4.8% Métis, and 0.4% Inuit. Fifty-five percent (55.2%) had received at least one dose and planned to stay up to date with booster recommendations, while 36.6% were vaccinated but did not intend to receive additional doses. A small percentage, 0.7%, had

not yet been vaccinated but were open to it, whereas 6.4% had not received a vaccine and did not plan to take a vaccine.

Conclusions: The COVID-19 pandemic has underscored the critical role of trust in shaping public health behavior and crisis response. This study aims to explore how consistent, transparent communication and equity-driven policies may contribute to maintaining public trust, particularly among marginalized communities. By examining trust dynamics and identifying potential disparities, the study seeks to generate insights that can inform future evidence-based public health strategies and improve preparedness for future health emergencies. Clinical Trial: Not Applicable

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Original Manuscript

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Abstract

Background

The COVID-19 pandemic significantly impacted public trust in public health, medical care, scientific, and governmental institutions; in turn, influencing health and health seeking behaviours and adherence to public health measures. Understanding the evolution of trust is necessary for informing future public health crisis management and strategies. Rebuilding public trust is a key

goal of pandemic preparedness worldwide. This research protocol examines these trust dynamics, their determinants, and implications for health equity.

Objective

The study aims to investigate the evolution of public trust in scientists, public health and medical care institutions, governments, and social and personal networks during the COVID-19 pandemic. It seeks to identify key factors contributing to trust maintenance or erosion, particularly in marginalized and minority communities, and understand the impact of trust level on public health adherence.

Methods

A sequential, explanatory mixed-methods approach was implemented, consisting of an initial quantitative survey followed by qualitative interviews. The nationally representative survey included 5,609 Canadian residents as of March 2020. The questionnaire assessed trust in six key trust sources before and during the pandemic: provincial and federal governments, public health authority, medical care providers, health scientists, and social and personal networks. To complement, 41 qualitative interviews were conducted to understand participants' lived experiences, perceptions and how trust played into both. Data have been analyzed using statistical techniques for quantitative data and thematic analysis for the qualitative data and results integrated to derive comprehensive insights.

Results

This Canadian survey included participants from all 10 provinces and two territories; provinces and territories samples matched the proportions of each in the overall Canadian population. Age, sex/gender were well distributed in the sample. Additionally, 18.6% identified as an ethnic minority, 12.7% identified as Indigenous, including 7.2% First Nations, 4.8% Métis, and 0.4% Inuit. Fifty-five percent (55.2%) had received at least one dose and planned to stay up to date with booster recommendations, while 36.6% were vaccinated but did not intend to receive additional doses. A small percentage, 0.7%, had not yet been vaccinated but were open to it, whereas 6.4% had not received a vaccine and did not plan to take a vaccine.

Conclusion

The COVID-19 pandemic has underscored the critical role of trust in shaping public health behavior and crisis response. This study aims to explore how consistent, transparent communication and equity-driven policies may contribute to maintaining public trust, particularly among marginalized communities. By examining trust dynamics and identifying potential disparities, the study seeks to generate insights that can inform future evidence-based public health strategies and improve preparedness for future health emergencies.

Keywords: COVID-19 Pandemic; Trust Dynamics; Canada; Mixed Methods; Health Equity; Public Health.

Introduction

Background

March 11, 2020, marks the five-year anniversary of the official declaration of the COVID-19 pandemic by the World Health Organization (WHO), a milestone that reflects the immense challenges faced and the ongoing impacts of this global health emergency. The COVID-19 pandemic, one of the most devastating public health crises in modern history, emerged at a time when the world, including Canada, was largely unprepared. Canada's first confirmed case was reported in Ontario on January 25, 2020, and within weeks, the country recorded its first death from the virus on March 09, 2020. On March 11, 2020, the WHO declared the outbreak as a pandemic [1]. In

response, Quebec declared a state of public health emergency on March 13, followed by all other provinces and territories by March 27, as the virus spread rapidly across the country [2]. By December 2020, the vaccines were developed and brought to people, and the rollout began across many countries, including in Canada, making a critical and definitive turning point in the fight against the virus.

Government response and Canada in global context

In the early stages of the pandemic, Canada prioritized restricting international travel, based on the belief that limiting travel from the virus's point of origin—Wuhan, China—could help reduce its introduction into the country [3]. Early measures included travel advisories, closure of the Canada-U.S. border, and a mandatory 14-days self-isolation for those entering the country [4]. As COVID-19 transitioned from being a concern primarily for travelers to widespread community transmission, additional public health measures were implemented, including social distancing, hand hygiene, mask-mandates, and the closure of schools and daycares [5]. Many workers transitioned to remote work, public gatherings were prohibited, restaurant capacities were limited, and public spaces like gyms and recreational facilities were closed. While the federal government provided oversight relating to national measures, the pandemic countermeasures closest to people were introduced and enforced by provincial and territorial governments, depending on local conditions [2].

Globally, Canada's response in the first two years of the pandemic outperformed many other G10 countries [6]. Canada had the second-lowest infection rate and mortality rate among the G10, just behind Japan [7]. According to the Oxford Stringency Index, which measures the intensity of governmental responses based on indicators such as travel bans, school closures, and workplace lockdowns, Canada ranked as the second-most stringent country among the G10 during the first two years of the pandemic, just behind Italy [4]. Unlike many other nations, Canada's response was characterized by its prolonged and sustained measures, lasting more than two years.

Overall impact of the COVID-19 pandemic in Canada

The impact of the COVID-19 pandemic on Canadians was profound, affecting nearly every aspect of daily life. Beyond physical health, mental health became a major concern. Canadians experienced heightened anxiety, depression, and stress due to isolation, uncertainty, and economic struggles [8,9]. Alongside psychological distress, alcohol and substance abuse spiked [8,10], while studies also reported rising rates of self-harm and suicidal ideation compared to pre-pandemic levels [11–13]. Vulnerable populations—such as children and youth, low-income groups, racial and ethnic minorities, and immigrants—were disproportionately affected, facing even greater mental health challenges [14–18]. The economic impact was also severe, with rising unemployment, government debt, and inflation [7]. Domestic violence and relationship conflicts also increased, particularly among those who experienced job loss or reduction [19]. These economic hardships deepened the existing social inequities, with marginalized communities bearing the brunt of the effects [20,21].

Change in Trust during the pandemic

Although Canada's COVID-19 outcomes in terms of infection rates and death rates were relatively moderate compared to many countries, especially the U.S, it still faced criticism for its pandemic management when compared to exemplars like Australia, New Zealand and South Korea [22].

A key point of contention was the vaccine mandate, which required proof of vaccination for discretionary activities like dining in restaurants, entering gyms, and cross-border travels. This policy sparked widespread protests, including the "freedom convoy" in early 2022 [23].

Canada initially saw low vaccine uptake, due to supply issues, but once vaccines were acquired in plentiful numbers, Canada's vaccination rates climbed rapidly [7,24]. The vaccine uptake, however, plateaued at a high level, due to growing vaccine hesitancy and refusal, particularly for booster doses in 2021 and 2022 [25,26]. A major contributing factor was declining trust in governments and in public health agencies, which negatively influenced the public acceptability of Covid-19 vaccines [27,28].

The rapid development of COVID-19 vaccines, completed in just 11 months, raised skepticism, as vaccine development typically takes years. In the face of rapidly developed, and changing, scientific data, trust in government and public health agencies become crucial for vaccine uptake [29]. One study showed that public trust in healthcare providers, public health agencies, and pharmaceutical companies significantly shaped their perception of vaccine effectiveness and safety, and, ultimately, their willingness to get vaccinated [27]. A systematic review and metanalysis conducted in Canada revealed that in 2021, one in five people did not want to get vaccinated and that vaccine hesitancy and unwillingness was especially higher among women, rural residents, non-white individuals, and those with lower educational levels [25].

Another key factor that contributed to the erosion of trust was the rapid policy reversals and inconsistent messaging [30]. For instance, the Public Health Agency of Canada (PHAC) initially advised against mask-wearing for asymptomatic individuals, only to later mandate masks in public spaces. A survey in Ontario revealed that more than half of the participants had encountered COVID-19 misinformation and had challenges identifying or appraising COVID-19 information [31]. While provincial leaders, especially in British Columbia and Quebec, were praised for their effective communication, the federal government, as were a few other provincial governments, struggled to provide unified, transparent messaging. The reliance on vague objectives like "flattening the curve", was widely criticized for lacking clarity and concrete targets, making it harder for the public to rally behind a shared goal. In contrast, countries like New Zealand and Australia, with clearer, and more ambitious targets such as "virus elimination", were more successful in maintaining public support [22].

The 2021 Edelman Trust Barometer revealed that public trust in the Canadian government dropped by 11% between May 2020 and January 2021, alongside a decline in trust in traditional media, social media and search engines [32]. Additionally, the pandemic and the related restriction imposed impacted vulnerable communities disproportionately, exacerbating the existing inequalities, which added another layer of complexity to public trust [21].

As of 2025, Canada has largely entered a post-pandemic phase, though COVID-19 continues to circulate. The pandemic not only exposed vulnerabilities in Canada's response but also raised concerns about the government's ability to manage future emergencies effectively. The pandemic's long-term effects, including the erosion of public trust, remain a significant and immediate challenge. Understanding this shift in trust, and rebuilding trustworthiness and trust, are crucial for Canada's preparedness for future crises.

Trust Dynamic and Equity in Public Health Project

Trust can be conceptualized as a combination of behavioral practices and norms, perceptions and preferences, as well as the functional and institutional properties of interactions between individuals and organizations. This conceptual framing informs the types of interventions that may be designed to rebuild or strengthen trust and trustworthiness. The Trust Dynamics and Equity in Public Health Project, a program of interlinked studies, investigates the evolution of public trust in scientists, public health, medical care, and governmental institutions during the COVID-19 pandemic. It sought

to understand the extent to which Canadians trusted their own social and personal networks (traditional media, social media, and friends, family and faith leaders) as sources of information during the pandemic. This research aims to understand how trust was maintained or was eroded, particularly among marginalized and minority communities, and how this trust influenced adherence to public health measures and healthcare-seeking behaviors. Key Objectives include:

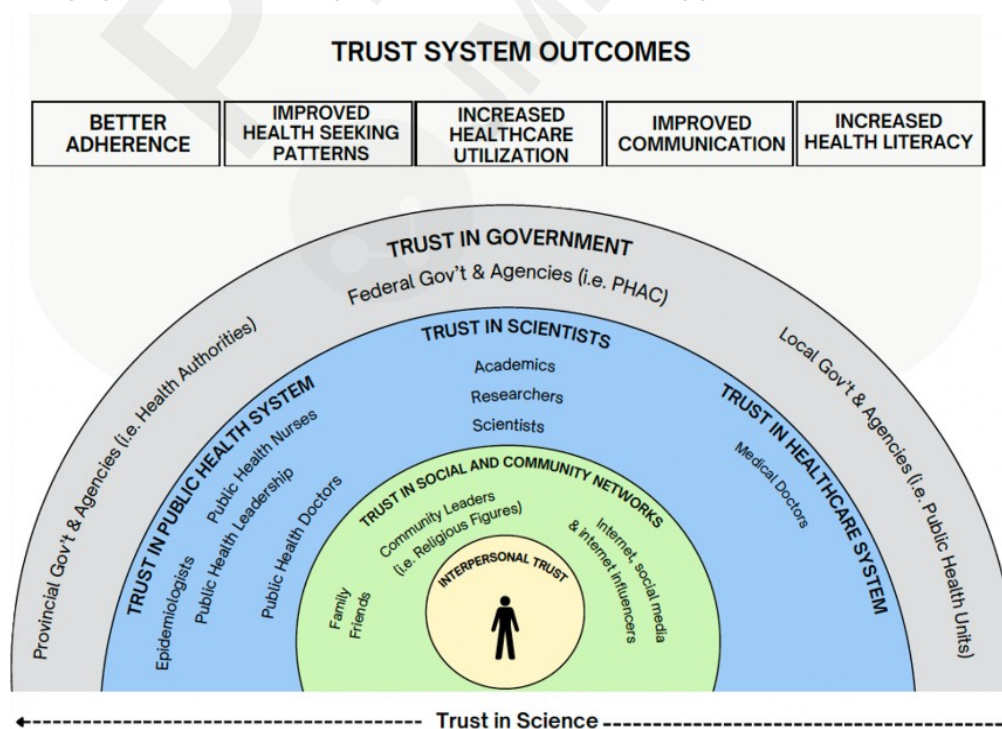
1. Investigating the evolution of public trust in scientists, public health authorities, medical care providers, and governments during the pandemic.
2. Identify factors influencing trust, specifically the erosion of trust or maintenance of trust among Canadians at large and in equity-seeking communities.
3. Identify factors that are associated with change in trust (trust increased, decreased, stayed the same) in May 2024 compared to before the pandemic (before March 2020).
4. Understand how Canadians describe trust and trust change during the pandemic, how it impacted vaccine receipt, and how to rebuild trust moving forward.

The study is guided by a concept map (Figure 1) developed through a literature review. This concept map serves as the framework for understanding trust dynamics and their impact on health behaviors. The concept map highlights the multi-layered nature of trust in government, scientists, the healthcare system, public health, social and community networks, and interpersonal trust. It illustrates how different sources of trust interact and influence health behaviours and crisis responses. Trust in these systems is essential for public compliance, effective communication, and improved healthcare outcomes. The survey questionnaire was designed and structured based on the concepts in the map.

Methods

Study setting and design

This study enrolled participants from across Canada, all ten provinces and two of the three territories (a sample from Nunavut was not drawn), capturing a diverse and representative sample of the adult population. The sequential mixed-methods approach was chosen for this research to



provide both breadth and depth in understanding trust dynamics in public health. The survey of Canadian adults allowed for the collection of large amounts of data, identifying trends and patterns in trust perceptions across diverse demographic groups and places. However, trust is a complex and context-dependent phenomenon that cannot be fully captured through survey responses alone. By incorporating qualitative interviews in the second phase, the study gained deeper insights into the motivations, experiences, and concerns underlying the observed quantitative trends. This methodological combination ensured a comprehensive analysis, strengthening the validity and applicability of the findings for public health policies and interventions.

Figure 1: Concept framework of Trust Dynamic and Equity in Public Health Project

The recruitment phases have been completed, with a population representative sample of 5,609 Canadian adult residents surveyed to assess trust perceptions and attitudes and behaviours related to COVID-19 vaccines. The sample size was selected to ensure adequate representation across key sociodemographic groups, supporting robust descriptive and subgroup analyses. Additionally, 41 in-depth qualitative interviews have been conducted to explore underlying motivations and concerns.

Population survey

The quantitative phase of this study involved an online survey designed and developed by the University of Saskatchewan team in collaboration with Léger, the largest Canadian-owned research and analytics company. The questionnaire comprised approximately 70 questions, including screening and demographic questions (MULTIMEDIA APPENDIX 1). Three attention check questions were inserted into the survey, approximately every 4-5 screens. Specifically, these directed questions asked participants to give specific answers (e.g., “This is a control question. Mark “Agree” and “move on”). The survey was translated and programmed in both English and French by Léger, ensuring accessibility for respondents in their preferred language. Respondents were primarily recruited through Léger LEO panel, Canada’s largest consumer panel with nearly 400,000 active members. For respondents in the Northwest Territories and Yukon, recruitment was conducted through Leger DGTL’s Hard-to-Reach (HTR) solution, which leverages digital marketing strategies to engage niche populations. A stratified random sampling method was used to ensure representative coverage. The survey targeted Canadian residents aged 18 and older who had resided in Canada for most or all of the COVID-19 pandemic. Additional quotas were implemented to ensure adequate representation of Indigenous Canadians, young adults (18-34 years old), and residents of the Northwest Territories and Yukon.

The online survey was conducted between May 1st and May 29th, 2024. Respondents received personalized invitation emails containing a unique URL, allowing them to complete the survey at their convenience using a computer, smartphone, or tablet. The average survey completion time was 13 minutes and 23 seconds. Prior to full deployment, a pre-test was conducted on May 1st, 2024, with 44 respondents to assess completion time, question clarity, and logical structure. No major revisions were required following the pre-test, and the data collected were included in the final dataset. To prevent duplicate entries, LEO assigned unique IDs to each respondent, ensuring that once a survey was completed or terminated, re-entry was not possible. The final sample consisted of 5,609 fully completed responses from an initial pool of 7,858 invitees. Of these, 710 respondents identified as Indigenous Canadians (First Nations: 403, Métis: 270, Inuit: 25, Prefer to self-identify: 11, and Don’t know/Refused: 1). A two-step approach was implemented to achieve a representative sample: 1. Recruitment and sampling were monitored and adjusted in real time

based on the latest Canadian Census data (2021) to ensure demographic balance, and 2. At the conclusion of data collection, weighting adjustments were applied to align the final dataset with population benchmarks for age, sex, and region.

The questionnaire was designed to assess six primary sources of trust, with participants reflecting on their trust levels before and during the COVID-19 pandemic, alongside comprehensive demographic data, as described in Figure 2. Respondents provided insights into their trust in provincial/territorial government, federal government, public health authorities, medical care providers, health scientists, and social and personal networks. These trust dimensions were explored in relation to transparency, communication strategies, decision-making processes, and sources of information. Additionally, demographic questions covered aspects such as age, sex, gender, ethnicity, born in/outside of Canada, education, occupation, parental status, household income, and adherence to spiritual beliefs and practices to provide a detailed understanding of trust variations across different population groups.

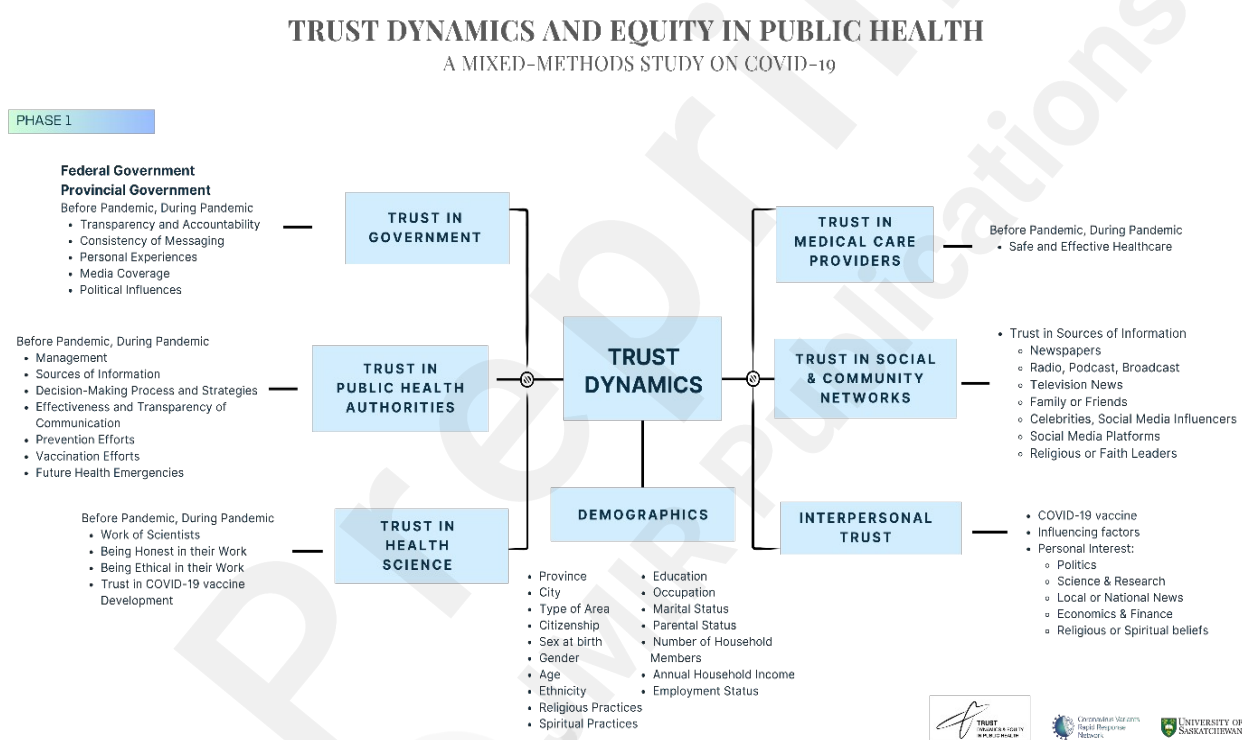


Figure 2: Questionnaire content: Public trust before and during the COVID-19 pandemic

Statistical methods

The survey data were analyzed using descriptive and inferential statistical techniques in R and STATA. Descriptive statistics summarized demographic characteristics such as age, gender, ethnicity, education, occupation, household income, adherence to spiritual beliefs and practices, and other socioeconomic factors; geographic factors such as province/territory of residency, rural/urban residence; vaccine related attitudes and behaviours such as trust in the vaccine, willingness to receive the vaccine; and sources of trust such as provincial/territorial government, public health authority, health scientists, and medical care providers. Bivariate analyses using cross-tabulations with chi-square tests examined relationships between trust and trust changes of six primary sources of trust and demographic and socioeconomic, geographic, and vaccine related variables.

Multinomial logistic regression then identified factors associated with trust (i.e. trust, distrust, preferred not to answer, or Neutral), trust change categories (trust increased, decreased, no change, or preferred not to answer) adjusting for demographic and economic factors, geographic and vaccine related factors. Analysis was conducted using a survey-weighted sample to represent the population benchmarks for age, sex, and region, and statistical significance was set at a five percent level.



In-depth interviews

The quantitative survey that we first conducted provided a broad set of information for understanding how Canadians experienced trust in public health actors, governments, and their communities. However, we recognized that this quantitative analysis, while providing an overview, required a deeper reading to gain insights into individual experiences of trust during the pandemic. Furthermore, some participants chose the “preferred not to answer” response alternate for certain questions on the quantitative survey, particularly questions dealing with spiritual beliefs, gender, and ethnicity ($n=285$, $n=74$, $n=99$, respectively). This suggested, in part, that deeper investigation was needed to understand the complex dynamics at play within the variables of the quantitative questionnaire. We developed a qualitative interview both expanding on, and responding to, information gleaned from the quantitative results. The main questions we framed the qualitative protocol on were: (1) What did participants remember most strongly about the COVID-19 pandemic? (2) How did participants define what trust means to them? (3) Did participants trust public health interventions by scientists and policymakers during the pandemic? (4) Did participants’ trust in government information, health authorities, and community leaders and family change over the course of the pandemic? (5) What actions would participants suggest policymakers and public health actors take in future pandemics to increase public trust?

Before beginning the interview process, all members of the interview team spent significant time discussing and reflecting on the potential volatility of our subject matter. Aware that discussing the pandemic, trust, and vaccination could potentially elicit or compound trauma for participants, we were mindful of both interviewer and participant safety throughout the interview process. All team members completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans certification. The team also undertook a day-long training session on trauma-informed interview practices and were diligent in recognizing their own positionality and bias, as well as preparing themselves to respond to participants’ potential trauma [33]. Some concerns were raised regarding interviewee safety, particularly if interviewees chose to keep their cameras on during Zoom interviews. However, after consulting with the whole interview team, consensus was reached that, in a project dealing with trust, it was deemed that as researchers it was our responsibility to set a base of trust by sharing our names and faces with interviewees. Recognizing that some interlocutors had likely lost trust in science and researchers during the pandemic, the team felt it was critical to begin rebuilding or further cementing that trust through our actions. Before the interview, participants were given a list of questions to consider that were thematically related to, but not direct copies of, the interview questions (MULTIMEDIA APPENDIX 2). Interviews lasted between 20-60 minutes and were conducted either over the phone or via Zoom, according to the participant’s preference. Participants received a CAD \$25 gift card as an honorarium for their time.

Analysis began from the time the first interview was conducted and continued to evolve as the qualitative study progressed. We employed a reflexive-rhetorical approach to guide our inquiry, through which both researcher and participant subjectivity and reflexivity guided the data/meaning creation process [34,35]. Experience of trust during the pandemic served as a gateway to meaning making about trust in public health actors, governments, and communities in a 'post-pandemic' world [35–37]. Throughout this process, a small team of interviewers acted both as facilitators and as analysts of participants' lived experiences. This reflexive-rhetorical inquiry during the interview process led to the creation of codes and themes that will be used during the structured analysis phase. The two interviewers who conducted the majority of the interviews (FB, KB) are also the team that is analyzing, coding, and extracting meaning from the data. The consistency of interviewers from interviewing through to result extraction was intentional and will lead to a deeper understanding of the data from both an experiential and rhetorical standpoint.

Incorporating qualitative data with quantitative analysis will allow us to gain a deeper understanding of how and why individuals' trust in various public actors and institutions might have been affected by the COVID-19 pandemic. While quantitative data enables us to describe prevalence of trust and its distributions across groups (person and place) and to identify factors associated with trust, the qualitative data enables deeper analysis into the individual experiences that are possibly associated with the trends observed in the quantitative results. It allows interviewees to give context to their experiences and decisions during the pandemic. Combining these two approaches allow us to gain both broad and individual insights into the narratives of trust that played out during the pandemic in Canada and to contextualize how the consequences of these narratives are impacting post-pandemic life.

Ethics Approval

This study, approved by the University of Saskatchewan Research Ethics Board (BEH-4565), follows the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans. Any protocol changes require REB approval through amendments. Participation was voluntary.

Results

Survey participants

As described in figure 3, the survey included participants from across Canada, with 32.4% from Ontario and 25.6% from Quebec, followed by 13.5% from British Columbia and 11% from Alberta. The Prairie provinces accounted for 2.9% from Saskatchewan and 4.3% from Manitoba, while the Atlantic provinces had 2.2% from New Brunswick, 2.8% from Nova Scotia, 0.3% from Prince Edward Island, and 1.5% from Newfoundland. Additionally, 1.8% of participants were from the Northwest Territories and 1.8% from Yukon. With respect to sex assigned at birth, 45.5% of participants identified as male and 54.2% as female. In terms of self-reported gender identity, 45.6% identified as men, 53.6% identified as women, 0.52% identified as non-binary, and 0.32% opted not to disclose their gender. Age distribution varied, with 8.1% aged 18-24, 19.3% aged 25-34, 16.8% aged 35-44, 17% aged 45-54, 18.7% aged 55-64, and 20.1% aged 65 or older. Additionally, 18.6% identified as belonging to an ethnic minority, and 12.7% (710 participants) identified as Indigenous, including 7.2% First Nations (403 participants), 4.8% Métis (270 participants), and 0.4% Inuit (25 participants). Educational attainment varied, with 0.7% having completed primary school or less, 19.5% finishing high school, 9.2% attending trade school, and 69.5% earning a college or university degree.

The percent trust in provincial/territorial government, federal government, public health, medical care providers, and health scientists was calculated for the whole sample (n=5607 Canadian adults). These questions specifically were asked about each group: How much did you trust the government (federal, provincial) to take care of the population during the COVID-19 pandemic? How much did you trust Public Health Authorities in their management of the COVID-19 pandemic? Did you trust the work of scientists? Responses were categorized into Trust, Distrust, Neutral, and Prefer not to answer.

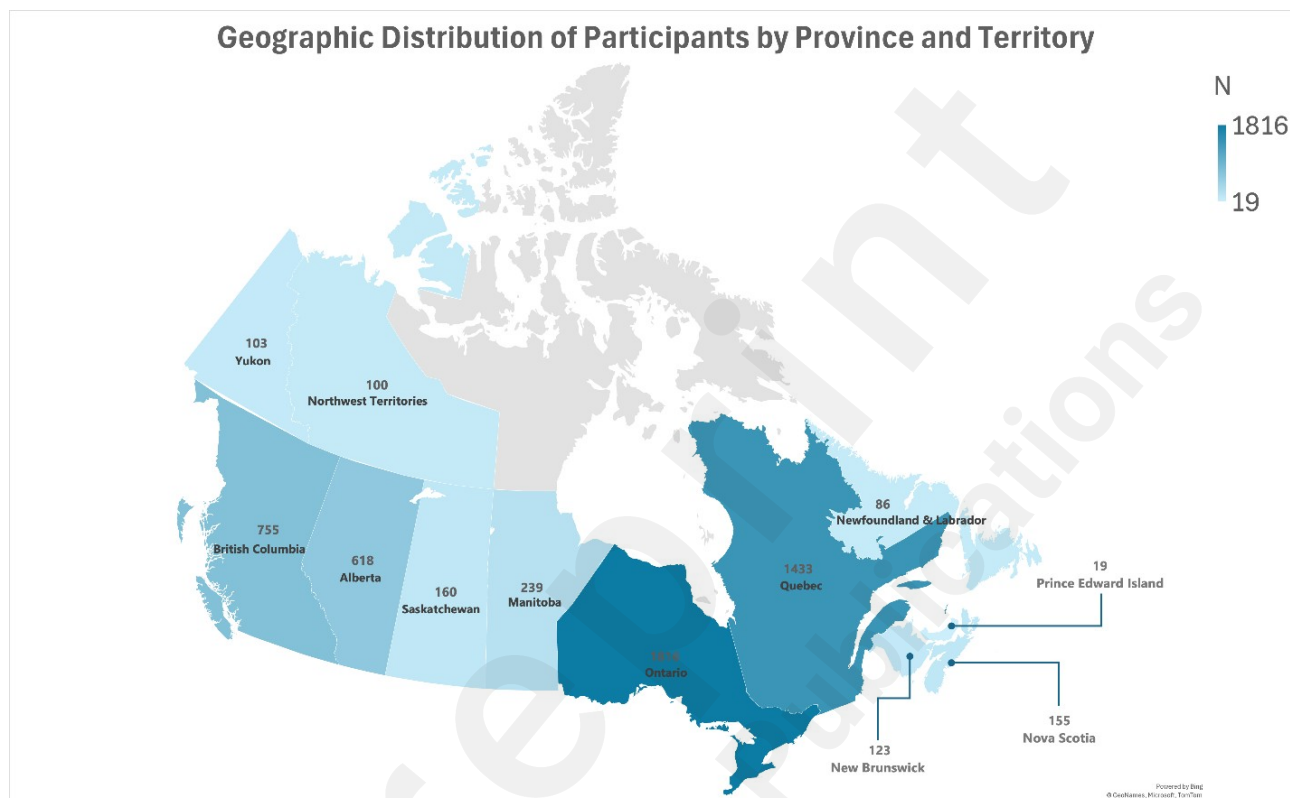


Figure 3: Geographic Distribution of Study Participants by Province and Territory, Canada; Trust Dynamic and Equity in Public Health Project

Regarding COVID-19 vaccination, 55.2% had received at least one dose and planned to stay up to date with booster recommendations, while 36.6% were vaccinated but did not intend to receive additional doses. A small percentage, 0.7%, had not yet been vaccinated but were open to it, whereas 6.4% had not received a vaccine and did not plan to take one.

Interview participants

We conducted interviews with a subset of individuals (n=41) who indicated interest in being recontacted after completing the initial quantitative survey – however, their original survey answers were not connected to their responses in the qualitative portion, preserving respondent anonymity. Initially, 101 individuals were identified by our survey partner, Leger, who had indicated they wanted to be followed up with and included either an email or phone number where they could be contacted. All 101 participants were sent a follow-up email with a link to a survey asking them for basic demographic data, as well as their availability for an interview. We received 61 responses to this survey, all of whom were contacted to schedule an interview. Of those contacted, 41 responded

and completed their interview. These participants ranged in age between 18-24 (n=1), 25-32 (n=7), 35-44 (n=6), 45-54 (n=7), 55-64 (n=12), and 65+ (n=8), and came from ten different provinces and territories (Ontario, Alberta, British Columbia, Newfoundland and Labrador, Manitoba, Saskatchewan, Quebec, Nova Scotia, and Yukon).

Discussion

Five years on since the emergence of the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) and the COVID-19 pandemic that it wrought, the world has changed irrevocably. We have experienced mass disruptions to our way of life, lost people to the pandemic who would have otherwise lived longer and have gained respect for what micro-organisms could do to disrupt human lives, as well as human ingenuity to counter these threats (by way of novel inventions such as specific vaccines and tests). In the process, however, according to many accounts, we have seen an erosion of a fundamental value, public trust, during the pandemic. The project described in this protocol comprehensively addresses this issue. The study's methodological framework demonstrates the importance of capturing both statistical data and in-depth experiential insights to fully understand complex social phenomena, public trust.

Moving forward, this study will integrate quantitative and qualitative data to facilitate a more rigorous and comprehensive analysis of trust dynamics. A systematic analysis of these data sources will enable a deeper investigation into the underlying determinants of public trust and their implications for health behaviors. Moreover, the dissemination of findings through peer-reviewed academic publications, policy briefs, and targeted community engagement initiatives will be prioritized to ensure that the insights generated inform evidence-based decision-making and contribute to the refinement of public health strategies aimed at strengthening pandemic preparedness and response.

We will compile project findings into various academic outputs, including journal articles, research posters, technical reports, conference presentations, and infographics, which will also be stored in the Saskatchewan COVID-19 Archive.

In conclusion, the observed decline in public trust before and during the COVID-19 pandemic presents a significant challenge for policymakers, public health authorities, and scientific institutions. Rebuilding and maintaining trust necessitate a commitment to transparent communication, accountability, and the mitigation of structural inequities that perpetuate distrust. This research provides critical insights that can inform the development of resilient, equity-driven public health frameworks, ensuring that future public health crises are met with greater public confidence and compliance.

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Data Availability

Data collected in this work are archived for preservation and freely accessible at

www.RememberRebuild.ca.

Authors' Contributions

NM and CN conceived the trust project and obtained funding, assisted by TB and NA. NM and KM drafted the research protocol. NM, FB, KM, SR and SS drafted the protocol manuscript. NM, CN, KM, FB, RR, ZZ, TB, KB, SS, DA, SR, NA, KH, CB, MJ, TC, KLL and ED critically reviewed the manuscript for methodological and academic content and contributed content expertise and community knowledge. KM and SS managed the project under the supervision of NM and CN.

Conflicts of Interest

None declared.

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Supplementary Files

Multimedia Appendixes

Survey Questionnaire.

URL: <http://asset.jmir.pub/assets/326ad9a061bfbe698670f256f414412d.pdf>

Interview Topic Guide.

URL: <http://asset.jmir.pub/assets/2bcb5f3aee1f4499809545b4018ab89d.pdf>