

Understanding Yukoners' Attitudes Towards Vaccines

Final Report



Council of Yukon
First Nations



One Yukon Coalition, Council of Yukon First Nations,
and Yukon University

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To all who contributed, we offer our heartfelt thanks. This report reflects your commitment to advancing health and wellness for all Yukoners.

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Shāw níthän • Gunałchîsh • Másin cho • Thank you

Project Team

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Organizational Support

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Kwanlin Dün First Nation
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Project at a Glance



This report shares the findings from the Understanding Yukoners' Attitudes Towards Vaccines (ATV) Project. The ATV Project explored how Yukoners made decisions about COVID-19 and influenza vaccines. The project was co-led by Champagne and Aishihik, Kwanlin Dün, and Selkirk First Nations, the Council of Yukon First Nations, One Yukon Coalition, and Yukon University. The goal was to understand where people obtained vaccine information, who they trusted for information, and how history, relationships, and community shaped vaccine decisions.

The project followed the principles of data sovereignty, which means each First Nation owns the data from their Nation, controls how it is used, and decides how findings are shared. This ensured the project respected each Nation's authority and supported self-determination. The project was led by a Steering Committee that included representatives from all partner organizations and Nations, as well as health professionals and researchers.

In total, this project included nearly 1500 responses: 78 participants took part in one-on-one and group community conversations; 575 participants took part in a Yukon-wide survey; and 839 participants took part in a national survey. The findings bring together community-level, territorial, and national perspectives on how people made decisions about COVID-19 and flu vaccines, while also documenting broader reflections on pandemic responses. Together, the findings show that vaccine decision-making was shaped by individual experiences, access to services, trusted relationships, health communication, and broader historical, social, and cultural contexts. By documenting these perspectives across multiple levels, the project supports Yukon First Nations' voices in health planning, contributes to pandemic preparedness in the Yukon, and identifies lessons that extend beyond the emergency context into the design of culturally safe and responsive health systems.

Mabel's Story

This fictional story draws together themes from the project findings. It is intended to show how relationships shape trust, what culturally responsive Yukon First Nations-led health care can look like, and why pandemic preparedness must happen before an emergency begins.

The kettle began whistling before Mabel noticed it. Her phone had been lighting up all morning. Her daughter sent a government announcement about the vaccine-rollout plan. Her brother sent a video from a man Mabel had never heard of. On the radio, an official promised more information soon.

"Soon," Mabel said as she turned it off. "They've been saying 'soon' for a year."

Her sister Rose called before the tea had finished steeping.

"I am getting mine," Rose said. "You know how your lungs get."

Neither spoke for a moment. Mabel had once spent months in an [Indian Hospital](#)¹ in Edmonton. She rarely spoke about it but remembered the pieces: the smell of the hallway, the sound of shoes outside the room, and adults speaking about her as though she wasn't there. Mabel learned that not everything described as care felt caring, especially when it meant taking away every choice a person had.

"Talk to Lena," Rose said.

Lena worked at the Nation's health centre. Mabel had known her since the days when, as a child, Lena would fall asleep under the tables at community meetings. Over the years, Lena arranged rides to appointments, helped Elders with medical travel, brought groceries after Mabel's surgery, and sat quietly in Mabel's kitchen after her husband died. She knew about Mabel's asthma and understood Mabel needed time before making decisions.

¹for more information on Federal Indian Hospitals visit: <https://ihsettlement.ca/>

Lena called the next afternoon. She didn't begin with the vaccine. She asked whether Mabel's prescriptions had arrived and whether the driveway had been cleared. Then she asked what Mabel had been hearing.

"Too much," Mabel said. "I do not want someone reading me a government speech."

"Neither do I," Lena said. "What do you want to know?"

Mabel asked about side effects, changing guidance, and what would happen if she became sick after the shoot. Then she asked the question she had been carrying since the vaccine was announced.

"If I say no, will you still help me?"

"Yes," Lena said.

The answer came quickly enough that Mabel believed her.

They met the next day at the health centre, sitting several feet apart with their masks on. Mabel brought a list of questions. Lena answered what she could. When she didn't know, she wrote the question down. "I will find out," she said.

"And if you find out you were wrong?"

"Then I will tell you I was wrong."

"What if I wait?"

"Then you wait."

"What if I say no?"

"Then we keep taking care of you."

Over the next several days, the decision moved through Mabel's relationships. Rose worried about Mabel's lungs. Family members shared stories about people who became sick. At the store, Mabel heard two people arguing near the freezer aisle, one accusing the other of putting the community at risk and the other saying nobody had the right to tell him what to do.



That evening, Mabel thought about who had listened to her and who seemed more interested in her decision than in her. She thought about Lena saying, *We keep taking care of you.*

The Nation's updates included more than appointment times. They explained how to request groceries, where to get masks and testing supplies, and who could help with transportation or medication during isolation. When territorial guidance changed, the health team discussed what it meant for Elders, families, people living alone, and those without reliable internet. Then staff called the people they knew might otherwise be missed.

When Lena offered Mabel a place at the clinic, Mabel asked whether she could still change her mind.

"Yes."

"Will you be there?"

"I will."

"Is there food?"

"There is always food."

The clinic was held in a wall tent beside the health centre. Smoke rose from the stovepipe, spruce boughs covered the floor, and the sides were opened slightly for ventilation. Chairs were spaced around the wood stove and everyone wore masks. Soup, bannock, and sandwiches were packed for people to take home.

An Elder teased a health worker about trying to drink coffee through a mask. A man nervous about needles stood near the doorway talking with Lena. Nobody pulled him farther inside.

Mabel sat near the stove with her coat still fastened. Lena brought over a chair and sat several feet away. "You do not have to decide because you came through the door," she said.

Mabel looked around the tent. They asked what she needed, answered her questions, and gave her time. She knew who would answer the phone if something went wrong.

"I will do it," she said. "After tea."



Lena wrote the after-hours number across the top of Mabel's information sheet.

"I know where it is," Mabel said.

"I know you know."

"Then why are you writing it?"

"So you do not have to look for it."

When Mabel developed a headache that evening, she called the number. Lena answered.

The months that followed were harder than the vaccination itself. There were funerals without gatherings, postponed ceremonies, cancelled programs, and visits made through windows. The Nation delivered food and medication, but some needs couldn't be left on a doorstep. People needed someone to notice when they stopped answering the phone. Elders needed connection. Children needed time together and on the land.

Years later, Mabel sat in the community hall during a meeting about emergency preparedness. There was no outbreak. Elders, youth, health staff, leaders, community members, and territorial representatives sat together while people spoke about food, transportation, traditional medicines, mental wellness, local information, and who would make decisions when territorial guidance did not fit the community.

When it was Mabel's turn, she looked toward Lena. "It was not the spruce boughs that made me trust you," she said. "Though they helped. It was that I knew who was there. I knew who would answer. I could ask a question without someone deciding what kind of person I was. I knew you would still help me if I said no. When I said yes, I knew you would be there afterward."

For a moment, the room was quiet. Then Lena nodded. "That is what we need to remember," she said.

Outside, pieces of ice moved slowly down the river. Inside, people were preparing for an emergency that had not yet come.

The kettle began to whistle in the kitchen at the back of the hall.

This time, Mabel heard it.



Key Findings and Recommendations

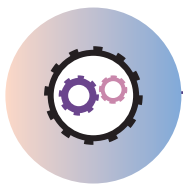
Mabel's story illustrates what the ATV Project found: relationships were the foundation of trust and Yukon First Nations leadership strengthened that trust by connecting health information and services with familiar people, practical support, and cultural safety. At the same time, systemic gaps undermined trust, limited community-led care, and contributed to social, cultural, and mental health harms. The summary below draws these findings together and presents recommendations for strengthening health care delivery and preparing for future public health emergencies.

01 | Relationships were the foundation of trust.

In Mabel's story, trust grew because of the relationship between Mabel and Lena. Lena listened to Mabel's concerns, respected her right to decide, and remained available before and after the vaccination. The clinic also brought health care, food, social connection, and practical support together in a familiar community setting.

These experiences reflect the ATV Project's broader findings. Accessible, proactive, and low-barrier services supported vaccine uptake. This was clearly demonstrated by Kwanlin Dün First Nation's Natsékhi Kù Health Centre.

The Health Centre was a highly utilized and trusted community hub for health and wellness, and strong relationships with the Health Centre were associated with trust in health care information. Its fall immunization clinic served as a vaccination site and gathering space that supported social connection, particularly for Elders. Across Champagne and Aishihik First Nation and Selkirk First Nation, designated coordinators and champions strengthened trust by connecting clear communication with practical support and helping community members navigate health services.



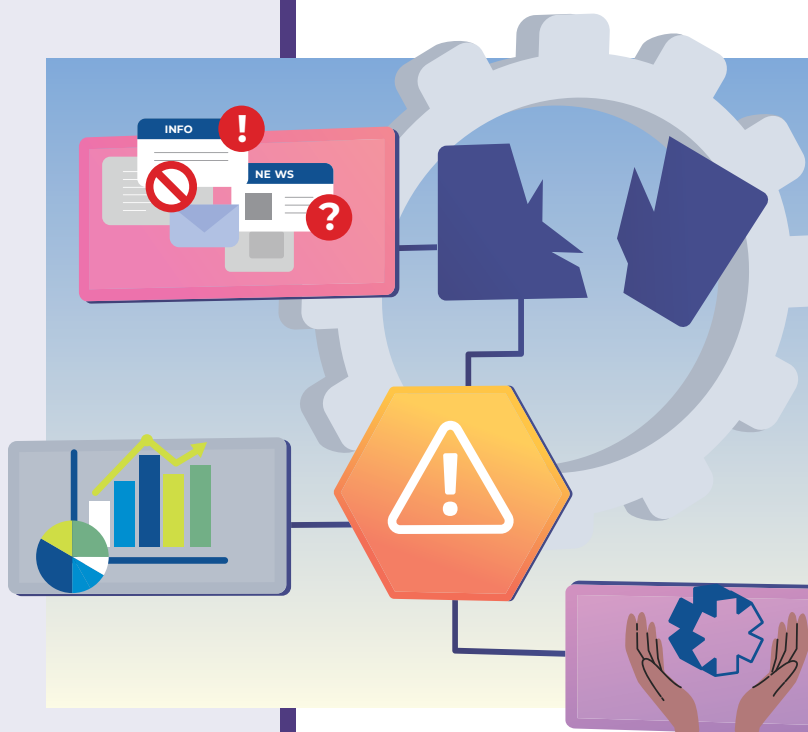
RECOMMENDATIONS

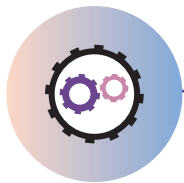
- Keep doing what worked well: culturally safe, community-based vaccine delivery that supports informed choice and allows community members to access care, ask questions, and receive social, physical, cultural, and financial supports in one place.
- Sustain and strengthen the Natsékhi Kù Health Centre as a central hub for care, information, and community-based supports.
- Review equity of outreach to ensure remote citizens, Elders, and vulnerable populations receive equal access to public health supports.
- Ensure consistency in service delivery during public health responses so community members know where to go and whom to trust.



02 | Systemic Gaps Undermined Trust and Community Well-being

In Mabel's story, changing guidance and competing information created uncertainty. The ATV Project found that misinformation flourished when accessible, community-specific health information was unavailable, while political polarization made respectful health communication difficult. Mabel's experience in an Indian Hospital also shaped how she understood health care, choice, and trust. Likewise, the findings from this study showed that systemic racism shaped community members' experiences with health care. The loss of community programming, opportunities to gather, and ceremony had significant social, cultural, and mental health impacts. At the system level, disconnects between health data access agreements and their implementation across governments created challenges for efficient immunization record keeping and continuity of care for Yukon First Nations-delivered health services. Trust was also weakened when vaccination requirements affected employment, travel, or access to services and were experienced as coercive or as limiting meaningful choice.





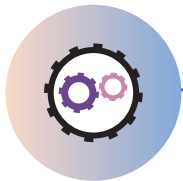
RECOMMENDATIONS

- Improve Panorama database access, functionality, and intergovernmental coordination to support timely information sharing and continuity of care for Yukon First Nations-delivered health care services.
- Develop and implement a Yukon First Nations-governed process for timely access to appropriately disaggregated health data, with privacy safeguards that protect individuals and small communities while supporting accurate, community-informed interpretation of health risks and outcomes.
- Plan explicitly for social and mental well-being during public health emergencies, including safe ways to maintain family connection, community activities, and land-based time.
- Use trauma-informed risk mitigation strategies that recognize the social, cultural, emotional, and historical impacts of isolation, restricted gathering, and disruptions to community life.
- Embed cultural safety and anti-racism training into all health roles, including communicators and decision-makers.



03 | Carrying the Lessons Forward

Mabel's story ends with the community gathering and Elders, youth, health staff, leaders, community members, and territorial representatives discussing how decisions will be made and how physical, social, cultural, and mental well-being will be protected during the next emergency. This reflects a central lesson from the ATV Project: Pandemic preparedness must be culturally grounded in Yukon First Nations traditional governance and values. During the COVID-19 pandemic, named and trusted people, supported by a clear communication hub, reduced confusion and helped community members access reliable information. These findings demonstrate the importance of establishing strong relationships, clear roles, and trusted communication processes before an emergency begins.



RECOMMENDATIONS

- Establish a standing governance and communication table between Yukon First Nations and the Government of Yukon that includes First Nations governments, community leaders, health care providers, and public health representatives; which meets regularly outside of emergencies; and clarifies roles, decision-making authority, communication processes, and accountability.
- Make relationship-building a health care priority by dedicating time, resources, and accountability to maintaining connections between individuals, communities, First Nations governments, and the public health system.
- Identify trusted local communicators and a clear communication hub or pathway appropriate to each community before future emergencies, supported by protocols for timely, coordinated, and community-specific information.
- Create safe, moderated spaces for respectful public conversations where community members can ask questions, share concerns, and receive accurate information. These spaces should support listening to different perspectives and ensuring misinformation is respectfully addressed and corrected in the moment.

2. Project and Methods in Brief

The Understanding Yukoners' Attitudes Towards Vaccines (ATV) Project aimed to understand how Yukoners, and Yukon First Nations (YFN) communities in particular, make decisions about COVID-19 and influenza vaccines. The ATV Project began taking form during the COVID-19 pandemic, when Yukon First Nations initiated the YFN COVID-19 Response Team and YFN COVID-19 Communications Working Group to coordinate essential health information and communications across Nations, allowing them to make rapid, emergency decisions to protect the health of their communities.¹ As COVID-19 vaccines became available, the YFN COVID-19 response team observed vaccination rates differed widely among Yukon communities despite widespread, community-led support for vaccine access. At the same time, the team learned there was little to no data or research into vaccine attitudes and decision-making that reflected the nuanced context of rural, remote, and Indigenous communities in the Yukon. So, the organizers of the YFN COVID-19 Response Team (which later became One Yukon Coalition) identified a research need and began putting together a team to address it.

One Yukon Coalition partnered with the Council of Yukon First Nations and reached out to all 14 Yukon First Nations to determine interest in partnering on the research. In the end, this laid the groundwork to partner with the three Nations involved in leading this project. With Yukon First Nations leadership support for a community-led investigation into vaccine decision-making, the team partnered with researchers who were doing COVID-19 related research at Yukon University. Finally, the team brought together additional experts on medicine, communication, and Indigenous health research to expand the team's expertise even further.

2.1 Community Context

The community-based conversations included three self-governing Yukon First Nations: Champagne and Aishihik First Nations, Kwanlin Dün First Nation, and Selkirk First Nation. These three Nations reflect the diversity of Yukon First Nations communities, including an urban First Nation, a First Nation with both rural and urban connections, and a more rural First Nation community. These three contexts are important for interpreting the project findings. The participating Nations shared important commonalities as self-governing Yukon First Nations, but they also differed in geography, population distribution, health service arrangements, relationships with health care providers, and local pandemic response structures. These differences show why community leadership, local context, and community-specific relationships with health systems are essential to informing pandemic preparedness and public health decision-making. Each Nation was provided a detailed Nation-specific report; therefore, this comprehensive report summarizes the findings that span across Nations.

¹ Council of Yukon First Nations, Alatini, M., Johnston, K., Perrin, A., Klein, R., Staples, K., & McTavish, K. (2023). Indigenous approaches to public health: Lessons learned from the Yukon First Nations responses to the COVID-19 pandemic. *Arctic Yearbook, Special Issue*. https://arcticyearbook.com/images/yearbook/2023-special/scholarly_papers/7_Indigenous_approaches_to_public_health.pdf

2.2 Data Sovereignty & Ethics

Respecting First Nations data sovereignty was central to the ATV Project. Each participating Nation retained ownership, control, and authority over access to their community's data. Details of this ownership were laid out in Community Partnership Agreements.

Community Partnership Agreements outlined the data management plan in accordance with the principles of OCAP® (Ownership, Control, Access, and Possession).² Each Nation was the rightful owner of its data, but all project partners shared intellectual property rights to the findings and output of the research. The Council of Yukon First Nations and Yukon University shared data stewardship responsibilities, with one safely storing the secure identifying list, but no conversation transcripts, and the other storing de-identified transcripts and analyzed data, but no identifying data. An identifying list is a secure document that matches participants' names to their unique participant code and is kept separate from transcripts to protect privacy. This dual structure ensured that neither steward could access both identifiers and data, protecting participant confidentiality while also supporting First Nations' decision-making. Data was held "in trust" for each Nation, meaning any future access or use required the Nation's explicit approval. Parameters for repatriation of the data were built into the agreement.

All members of the ATV Project research team completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans³ tutorial, ensuring a shared foundation in ethical research practice. In addition, all researchers were trained on the principles of data sovereignty, and many research team members completed The Fundamentals of OCAP®² training, which strengthened the project's alignment with First Nations research and data sovereignty. Ethical approval for the study was granted by the Yukon University Research Ethics Board, in addition to the Community Partnership Agreements with each Nation. All participants reviewed and signed a Letter of Informed Consent that provided detailed information on the project, including discussion of both individual and community-level data governance, to ensure participants expressed informed consent over their individual data rights and how their First Nation government could exercise collective authority over the data.

2.3 Methodology

We used a collaborative, community-driven, mixed-methods design.^{4, 5, 6} All parts of the research design involved Yukon First Nations partners directly shaping priorities and deciding what questions to ask, deciding how data would be collected, and guiding how results would be shared and brought back for discussion and action.⁷ Before submitting the original funding application, the research team initiated discussions with First Nations governments and the

² First Nations Information Governance Centre. (2025). *The fundamentals of OCAP®*. <https://fnigc.ca/ocap-training/>

³ Panel on Research Ethics. (2018). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*. https://ethics.gc.ca/eng/tcps2-eptc2_2018_chapter9-chapitre9.html

⁴ Stake, R. (2006). *Multiple case study analysis*. The Guildford Press

⁵ Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage.

⁶ Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage Publications.

⁷ Smith, L. T. (2012). *Decolonizing methodologies: research and Indigenous peoples* (2nd ed.). Zed Books.

Yukon First Nations Health and Social Development Commission. These conversations established early interest in the project, affirmed the relevance of vaccine attitudes research, and built trust for future data governance. Throughout the project, the team maintained regular updates with the Yukon First Nations Health and Social Development Commission, where health directors and representatives from each Yukon First Nation gathered to discuss health issues across the territory. A Steering Committee of Yukon First Nations partners, health care providers, and researchers collaborated to shape objectives, confirm research questions, and guide decision-making at each stage of the project. Community kickoff events and follow-up meetings created spaces for open dialogue and ongoing feedback with community members.

The mixed-methods design combined qualitative approaches (interviews, focus groups, and conversations) with quantitative approaches (surveys) to capture both individual lived experiences and broad patterns in the population.^{8,9} We combined two streams of data collection: national and territorial surveys and interviews and focus groups with three Yukon First Nations communities. Together, they provided breadth (through survey data) and depth (through conversations). See Table 1 for complete Project Objectives and Research Questions.

2.4 Methods

In 2021, the Yukon First Nations COVID-19 Response Working Group identified the need for Yukon First Nations-led research on vaccine decision-making. This was driven by differences in vaccine uptake across communities and a data gap, where the Government of Yukon held vaccination data that was not consistently shared with Nations. All 14 Yukon First Nations were invited to participate in the ATV Project through the Working Group and direct outreach. As the ATV project progressed, participating Nations changed and additional invitations were shared through the Yukon First Nations Health and Social Development Commission and other engagement opportunities. Champagne and Aishihik First Nations (CAFN), Selkirk First Nation (SFN), and Kwanlin Dün First Nation (KDFN) signed their partnerships agreements in 2023–2024, and community-based conversations took place across 2024 and early 2025. This timeline reflects the realities of community-led and partnered research, where participation develops over time and requires ongoing relationship-building and flexibility. The territorial and national surveys were administered in late 2024 and early 2025.

⁸ Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage Publications.

⁹ Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. <https://doi.org/10.1177/1558689806298224>

Table 1

ATV Project Objectives and Research Questions

Project Objectives	Research Questions
1. Contribute Yukon-specific data to national data collection efforts aimed at understanding vaccine access, uptake, and hesitancy.	1. How do Yukoners make their decisions regarding vaccines? a. Where do Yukoners get their vaccine-related information? b. Who do Yukoners trust for information about vaccines?
2. Improve understanding of attitudes and opinions related to vaccines, including COVID-19 and routine vaccines.	
3. Explore perspectives and experiences of First Nation communities with vaccines, including COVID-19 and routine vaccines.	2. What lessons can be drawn from the perspectives and experiences of Yukon First Nations communities regarding vaccines? a. How did Yukon First Nations communities perceive and experience vaccine-communication during the COVID-19 pandemic? b. How do Yukon First Nations communities perceive and experience COVID-19 and routine vaccines today?
4. Build understanding of factors that contribute to vaccine uptake and vaccine hesitancy.	
5. Identify community-based innovations for improving equitable access to vaccines and supporting informed decision-making.	
6. Hire and train community researchers, thereby supporting local employment, skill development, and research capacity through project training and mentorship opportunities.	3. How do Yukoners respond to different types of vaccine communication?

Community-Based Conversations

Community-based conversations were designed with each community; details of the community-specific methods are included in the community-level reports. Information was gathered through one-on-one or group-interview-style guided conversations lasting approximately 45–60 minutes. Conversations were held in locations chosen by participants, including community spaces, First Nation offices, Yukon University campuses, the Council of Yukon First Nations, the Natsékhi Kù Health Centre, over Zoom, or by phone.

In total, 78 people participated in community-based conversations across the three Nations: 21 CAFN participants, 13 SFN participants, and 44 KDFN participants. See Table 2 for a detailed description of community-based conversation participant demographics.

Table 2

Community-based conversation participant demographics

Variable	Community Conversations	
	<i>n</i>	%
Gender		
Male	25	32.1
Female	52	66.7
Chose not to respond	1	1.2
Age		
16–29 years*	7	9.0
30–54 years	36	46.2
55+ years	28	35.8
Chose not to respond	7	9.0
First Nation		
Citizen or beneficiary	67	85.9
Family member**	11	14.1
Community**		
Whitehorse	40	51.3
Champagne, Haines Junction, Pelly Crossing, and Takhini River Subdivision	23	29.5
Other	15	19.2

*Participants in CAFN and SFN were required to be 19 years of age

**These participants were not CAFN, KDFN, or SFN citizens or beneficiaries themselves, but were part of a CAFN, KDFN, or SFN family. For example, a parent or spouse of a citizen or beneficiary.

Territory-Wide Survey

The territory-wide survey was designed to understand vaccine attitudes, vaccine decision-making, and vaccine communication needs across Yukon, while allowing the results to be compared with those from the national survey. A Yukon-based market research company, Datapath Systems, recruited participants and administered the online survey between November 2024 and January 2025. In total, 575 usable responses from Yukon residents were included in the analysis.

The national survey used nearly identical questions as the territory-wide survey, allowing the research team to compare the experiences and perspectives of Yukon residents with those of people across Canada. Abacus Data administered the online survey to 1,000 Canadian residents

in September 2024. Quotas were used to make the sample broadly similar to the Canadian population in age, gender, region, and language. After responses that did not pass quality checks were excluded, 839 usable responses were included in the analysis. See Table 3 for complete survey participant demographics.

Table 3
Territorial and national survey participant demographics

	Territorial Survey		National Survey	
Gender	<i>n</i>	%	<i>n</i>	%
Male	238	41.4	420	50.1
Female	335	58.3	414	49.3
Other	2	0.3	5	0.6
Age				
18–35	29	5.0	232	27.7
36–55	220	38.3	292	34.8
56+	326	56.7	315	37.5
First Nation Self-Identification				
Yes	59	10.3	60	7.2
No	516	89.7	779	92.8
Community				
Whitehorse	397	69	-	-
Other Yukon community	178	31	-	-
Territories	-	-	2	0.2
British Columbia and Alberta	-	-	214	25.5
Saskatchewan and Manitoba	-	-	61	7.3
Ontario and Quebec	-	-	508	60.5
New Brunswick, PEI, Nova Scotia, Newfoundland, and Labrador	-	-	54	6.5

3. Findings

Across the three communities, vaccine decision-making was shaped through relationships. Participants considered medical information, but they did not encounter or interpret that information in isolation. They worked through it with family members, friends, Elders, health care providers, community leaders, and First Nations government staff. They also brought previous experiences with health systems and governments into these conversations. These relationships shaped what information felt trustworthy, how risks were understood, and whether health services felt safe and accessible.

3.1 Reflections on Response to the COVID-19 Pandemic

The COVID-19 pandemic affected nearly every aspect of community life. Participants reflected on vaccine mandates, travel restrictions, community closures, reduced access to services, and limits on social and cultural gatherings. They also described the actions Yukon First Nations governments took to protect citizens, communicate health information, provide practical supports, and make vaccination accessible. Participants generally recognized that First Nations governments were responding under difficult and rapidly changing circumstances. Many believed their Nation did the best it could to protect the community, especially Elders and others at greater risk. At the same time, participants identified important lessons related to meaningful choice, communication, community connection, equitable access to services, and Yukon First Nations authority in emergency decision-making.

Vaccine Mandates, Restrictions, and Choice

Participants made vaccination decisions within a complex set of territorial, federal, workplace, travel, and private-sector requirements. Although Canada did not introduce a universal vaccine mandate, remaining unvaccinated could affect a person's employment, ability to travel, access to services, or participation in everyday activities. Participants often experienced these consequences as a form of mandate, regardless of which government or organization had introduced the policy. Some participants described vaccination requirements as coercive, using words such as "forced," "threatening," and "manipulated." Employment requirements were particularly consequential because refusing vaccination could affect income, housing, and the ability to support a family:

It was your job; that or be fired. [...] It's something that a lot of people would have probably refused and didn't want but they had to do it to keep food on the table.

Travel restrictions also shaped vaccination decisions. Some participants received the vaccine primarily so they could travel for medical treatment or accompany relatives receiving care outside the territory. Others described vaccination as necessary to regain freedom of movement or participate in ordinary social activities. A smaller number said vaccination requirements affected their access to addictions treatment and other essential supports.

A number of participants interpreted mandates and restrictions through colonialism and systemic racism. They connected the absence of meaningful choice, the authoritative tone of

public health requirements, and the threat of punishment for non-compliance with experiences of residential schooling, Indian Hospitals, forced medical procedures, child removal, and other colonial interventions. Restrictions on movement could also affect access to the land, which participants understood as essential to culture, health, and well-being.

Nation-Led Responses

Participants overwhelmingly spoke positively about the efforts of Yukon First Nations governments to protect their communities. They recognized that leaders were working with limited information during a rapidly changing emergency. Participants particularly appreciated responses that communicated care for all citizens, regardless of their vaccination status.

Participants Appreciated. Participants appreciated supports that addressed their holistic well-being. These included food hampers, grocery subsidies and deliveries, hot meals, transportation, personal protective equipment, testing supplies, financial assistance, paid sick leave, wellness checks, and help collecting groceries or mail. Paid leave allowed people to stay home without losing income. Food and grocery supports reduced the need to enter public spaces. Transportation and delivery services ensured Elders, people isolating, and those without vehicles could continue accessing necessities. Wellness checks helped some participants feel they had not been forgotten. These practical supports helped people follow public health guidance while reducing stress during an already destabilizing period.

Participants appreciated communication that was clear, consistent, concise, locally relevant, and shared through several channels. Effective approaches included posters, flyers, mail, phone calls, text messages, websites, social media, workplace distribution, and locally created artwork. Participants also valued communication delivered by First Nations leadership, local health providers, and designated coordinators whom they knew and trusted. At the same time, some participants felt that information was distributed without enough explanation. They wanted to understand why recommendations were changing, how vaccines worked, what risks were being considered, and why particular restrictions were necessary.

Participants also emphasized that online communication could not reach everyone. Reliance on Facebook, websites, or online booking excluded people without reliable internet, digital devices, or confidence using online systems. Phone calls, printed information, door-to-door distribution, and direct conversations remained important. Future emergency communication should therefore include clear transition plans, continued points of contact, and follow-up with Elders, isolated citizens, and people requiring additional support.

Participants described the COVID-19 vaccine rollout as accessible, fast, and well-organized. Vaccines were offered in familiar community buildings, nursing stations, and health centres. Walk-in options, simple booking processes, transportation, refreshments, and clinics designed specifically for Elders reduced barriers. Where designated COVID-19 coordinators were used, participants valued having an identifiable person who could explain current guidance, answer questions, organize appointments, distribute materials, and connect citizens with services.

Room for Improvement. Participants described social isolation as one of the most significant and lasting harms of the pandemic. Restrictions disrupted ordinary contact with family and friends, community programming, school, recreation, celebrations, potlatches, and time on the land. Participants also described painful disruptions to ceremony and, in particular, end-of-life care and grieving. Families could not always be with loved ones, provide care, or practice ceremonies in ways they normally would. These experiences created harms that continued after formal restrictions ended. These losses affected mental, emotional, spiritual, physical, and community health. One participant shared the following:

What do you do with nothing going on? How do you measure their health? Your mental health? Do you have individuals go see Elders and see how they're doing? That's where families come in because we always check on one another. [...] Some families are more together and others are not. And some are more fragmented.

This reflection emphasizes that community and family relationships were central to well-being, while recognizing that informal family support did not reach everyone equally. Emergency responses cannot assume all people have safe housing, close family connections, or someone regularly checking on them.

Some participants wanted greater transparency about how pandemic decisions were made, whose expertise informed them, and how community members could participate. They raised concerns when decisions appeared to come primarily from political leadership or external governments without visible involvement from health experts, Elders, families, or established community governance structures. Participants described family systems, Elders, community leadership, and other traditional governance processes as potential pathways for emergency communication and decision-making. Participants wanted these systems recognized as governing institutions rather than treated as informal sources of advice.

These reflections point toward emergency governance that brings together scientific and medical evidence, Yukon First Nations governance, community knowledge, and lived experience. Community involvement should begin before an emergency occurs, ensuring Nations establish roles, decision-making processes, communication pathways, and accountability structures in advance of emergency conditions.

3.2 COVID-19 Vaccine Decision-Making

Most participants across all three components of the study reported receiving at least two doses of COVID vaccine: 80.8% ($n = 63$) of community-based conversation participants, 88% ($n = 507$) of Yukon survey respondents, and 82% ($n = 685$) of national survey respondents. (See Table 4 for self-reported vaccination status among all participants.) Participants' decisions were shaped by concerns with personal health, responsibility to family and community, confidence in vaccination, advice from health care providers, employment and travel requirements, perceived vaccine effectiveness, side effects, and trust in governments and health systems.

Table 4
Self-reported COVID-19 vaccination status

Variable	Community-based conversations		Territorial survey		National survey	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
None	4	5.1	38	6.6	74	8.8
One	4	5.1	24	4.2	34	4.1
Two	34	43.6	142	24.7	252	30.0
More than two	29	37.2	365	63.5	433	51.6
No response	7	9.0	6	1.0	46	5.5

Personal Health. Protecting personal health was a common reason for participants receiving the first two COVID-19 vaccines. Many viewed the vaccine as a practical measure that could reduce risk of serious illness, long-term health effects, or complications related to existing health conditions. Survey findings reinforce the importance of personal protection among people who continued vaccinating. Among Yukon respondents who received more than two doses, 89.8% ($n = 380$) identified protecting themselves as a reason for vaccination.

Family and Community Responsibilities. Participants commonly described vaccination as a decision grounded in responsibility to family and community. Participants wanted to protect children, Elders, parents, grandparents, people with compromised immune systems, and those who could not receive the vaccine themselves. Caregivers also recognized that protecting their own health helped them continue caring for others. Among Yukon survey respondents who received more than two doses, 83.7% ($n = 354$) identified protecting people around them as a reason for vaccination.

Employment, Mandates, and Restrictions. Employment requirements, travel restrictions, and proof-of-vaccination policies also shaped participants' decisions. Some participants felt they had little meaningful choice because refusing vaccination could affect their income, housing, ability to travel, access to services, or capacity to support family members requiring medical care outside the Yukon. Some complied only to the extent required and chose not to receive further doses once mandates and restrictions were lifted. In the territorial survey, 57.8% ($n = 244$) of participants who received more than two vaccines and 62.1% ($n = 93$) of participants who only received two vaccines indicated they did so because of COVID-19 mandates.

Table 5

Reasons for getting the first two vaccines or more than two

	Yukon				National			
	More than 2 vaccines (423 respondents)		2 vaccines (150 respondents)		More than 2 vaccines (445 respondents)		2 vaccines (259 respondents)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
To protect myself	380	89.8	18	11.9	359	80.6	113	43.7
To protect the people around me	354	83.7	40	26.4	323	72.6	103	39.7
I wanted to get community life back to normal	247	58.5	21	13.8	191	43.0	72	27.9
Health care providers advised me to get vaccinated	237	56.0	14	9.6	157	35.4	44	17.1
COVID-19 mandates (e.g., to be able to work or travel)	244	57.8	93	62.1	153	34.3	133	51.4
To preserve personal relationships	78	18.3	3	2.3	64	14.4	29	11.3
Friends and/or family advised me to get vaccinated	95	22.4	14	9.6	60	13.6	46	17.6
Other	29	7.0	10	6.5	6	1.3	5	1.7

Notes: The margin of error on these responses are +/- 4.8% 19 times out of 20 for the booster subsample and +/- 8% 19 times out of 20 for the no booster subsample.

Overall, participants' decisions were influenced by trust, relationships, and information. Receiving the vaccine could reflect confidence in vaccination, concern about illness, trust in medical advice, responsibility to family and community, or the practical consequences of remaining unvaccinated. (See Table 5 for detailed survey data on reasons people provided for getting vaccinated.) Importantly, uptake of the COVID-19 vaccine did not always indicate broad or ongoing confidence in vaccination, but neither did a refusal to get the COVID-19 vaccine always indicate a broad or ongoing anti-vaccine sentiment.

Regarding reasons participants chose not to get vaccinated, Yukon respondents who received fewer than two doses cited safety concerns as their primary reason. Among those who received the first two doses, perceived lack of necessity and effectiveness played a larger role. (See Table 6 for detailed survey data on reasons people chose not to take the vaccine.)

Perceived Lack of Necessity. Many participants felt that COVID-19 vaccines were unnecessary, especially after completing the initial vaccine series (two doses). Some believed their previous doses provided sufficient protection, while others assessed their personal risk from COVID-19 as low based on their age, good health, or previous experience with the illness. Participants who had contracted COVID-19 without becoming seriously ill sometimes compared it to the flu or expressed confidence in their body's ability to recover without additional vaccination. Others questioned the vaccine's effectiveness because vaccinated people could still

contract COVID-19. These experiences contributed to the view that the potential benefits of further doses did not outweigh the need or inconvenience of continuing to vaccinate. In the territorial survey, results similarly showed high response rates for reasons connected to perceived lack of necessity. For example, 71% ($n = 28$) of participants chose not to get the first two COVID-19 vaccines because they did not think the vaccine worked well, and 68% ($n = 27$) felt COVID-19 was not a serious concern for them.

Concerns About Side Effects. The COVID-19 vaccine has been proven to have similar risk as other vaccines; large scale clinical trials and real-world studies consistently show that most side effects are mild and short-term (e.g., soreness at the injection site, fatigue, or fever) and serious adverse events are rare.^{10, 11} The risk of severe outcomes, including hospitalization and death, is significantly higher from COVID-19 infection itself than from vaccination, reinforcing the overall safety and benefit of COVID-19 vaccines.¹² Despite this, concerns about side effects shaped participants' decisions. Some participants had felt unwell after earlier doses and did not want to repeat the experience. Others were influenced by reactions experienced by family members, friends, or people in their communities. Even where participants acknowledged the connection was uncertain, the possibility that vaccination had contributed to harm was enough to discourage further doses. In the territorial survey, a concern about side-effects was the most selected option for reasons participants chose not to get the first two vaccines (82.5%, $n = 32$). A similar proportion, (81.9%, $n = 32$), believed the COVID-19 vaccine was dangerous.

Newness, Safety, and Research. COVID-19 vaccines were developed and authorized for use within a shorter timeline than most previous vaccines, but their underlying technology was not entirely new. Research on mRNA vaccines had been underway for decades before the pandemic, including applications for other viruses such as SARS.^{13, 14, 15} The accelerated COVID-19 timeline was made possible by unprecedented global funding, overlapping phases of clinical trials, and large-scale manufacturing that began before trial results were finalized.^{16, 17}

¹⁰ Baden, L. R., El Sahly, H. M., Essink, B., Kotloff, K., Frey, S., Novak, R., Diemert, D., Spector, S. A., Roupael, N., Creech, C. B., McGettigan, J., Khetan, S., Segall, N., Solis, J., Brosz, A., Fierro, C., Schwartz, H., Neuzil, K., Corey, L., Gilbert, P., Janes, H., Follmann, D., Marovich, M., Mascola, J., Polakowski, L., Ledgwerwood, J., Graham, B. S., Bennett, H., Pajom, R., Knightly, C., Leav, B., Deng, W., Zhou, H., Han, S., Ivarsson, M., Miller, J., & Zaks, T. (2021). Efficacy and safety of the mRNA-1273 SARS-CoV-2 vaccine. *New England Journal of Medicine*, 384(5), 403–416. <https://doi.org/10.1056/NEJMoa2035389>

¹¹ Polack, F. P., Thomas, S. J., Kitchin, N., Absalon, J., Gurtman, A., Lockhart, S., Perez, J. L., Pérez Marc, G., Moreira, E. D., Zerbini, C., Bailey, R., Swanson, K. A., Roychoudhury, S., Koury, K., Li, P., Kalina, W. V., Cooper, D., Frenck, R. W., Hammitt, L. L., Türeci, Ö., Nell, H., Schaefer, A., Ünal, S., Tresnan, D. B., Mather, S., Dormitzer, P. R., Şahin, U., Jansen, K. U., & Gruber, W. C. (2020). Safety and efficacy of the BNT162b2 mRNA Covid-19 vaccine. *New England Journal of Medicine*, 383(27), 2603–2615. <https://doi.org/10.1056/NEJMoa2034577>

¹² Haas, E. J., Angulo, F. J., McLaughlin, J. M., Anis, E., Singer, S. R., Khan, F., Brooks, N., Smaja, M., Mircus, G., Pan, K., Southern, J., Swerdlow, D. L., Jodar, L., Levy, Y., & Alroy-Preis, S. (2021). Impact and effectiveness of mRNA BNT162b2 vaccine against SARS-CoV-2 infections and COVID-19 cases, hospitalisations, and deaths following a nationwide vaccination campaign in Israel: An observational study using national surveillance data. *The Lancet*, 397(10287), 1819–1829. [https://doi.org/10.1016/S0140-6736\(21\)00947-8](https://doi.org/10.1016/S0140-6736(21)00947-8)

¹³ Pardi, N., Hogan, M. J., Porter, F. W., & Weissman, D. (2018). mRNA vaccines—a new era in vaccinology. *Nature Reviews Drug Discovery*, 17(4), 261–279. <https://doi.org/10.1038/nrd.2017.243>

¹⁴ Verbeke, R., Lentacker, I., De Smedt, S. C., & Dewitte, H. (2019). Three decades of messenger RNA vaccine development. *Nano Today*, 28, 100766. <https://doi.org/10.1016/j.nantod.2019.100766>

¹⁵ Beyrer, C. (2021). *The long history of mRNA vaccines*. Johns Hopkins University. <https://publichealth.jhu.edu/2021/the-long-history-of-mrna-vaccines>

¹⁶ Kalinke, U., Barouch, D.H., Rizzi, R., Lagkadinou, E., Türeci, Ö., Pather, S., & Neels, P. (2022). Clinical development and approval of COVID-19 vaccines. *Expert Review of Vaccines*, 21(5), 606–619. <https://doi.org/10.1080/14760584.2022.2042257>

¹⁷ United States Government Accountability Office (2021). *Operation Warp Speed: Accelerated COVID-19 vaccine development status and efforts to address manufacturing challenges*. <https://www.gao.gov/products/gao-21-319>

COVID-19 vaccines were tested in tens of thousands of participants before rollout; afterwards, real-world studies involving millions of people confirmed their safety and strong protection against severe illness, hospitalization, and death.^{18, 19, 20} Post-market safety monitoring continues to track and investigate rare adverse events, making the COVID-19 vaccine one of the most closely studied vaccines in history.

Participants often raised questions about how quickly the vaccines were developed and distributed. Some felt there had not been enough time to understand potential long-term effects or believed the vaccines had not been sufficiently tested. Others wanted clearer and more accessible information about vaccine ingredients, how mRNA vaccines worked, and how safety was assessed. For these participants, the accelerated timeline increased uncertainty and encouraged a cautious or “wait-and-see” approach. As one participant shared, “There was just so much communication about everything that you didn’t know what was real and true at all.” Feeling unable to determine which information was accurate further reinforced hesitation.

Distrust in Government, Health Systems, and Vaccination Efforts. Distrust in governments, health systems, and vaccination efforts was another important factor. Some participants questioned the intentions behind the vaccine rollout or felt mandates and employment requirements made vaccination coercive. For these participants, pressure to vaccinate weakened trust and contributed to uncertainty about whether vaccination efforts were intended to protect them.

A few participants referenced feeling like a “government guinea pig,” reflecting a broader concern about being subjected to experimentation or harm. These concerns must be understood within the context of colonialism and the longstanding systemic racism against Indigenous people built into government, health, and research systems. In Canada, Indigenous people have experienced a long history of unethical and non-consensual medical treatment and research. For example, Indigenous patients in federally run Indian Hospitals were subjected to segregated care, and survivors have reported experiences of coercion, harmful treatment, and non-consensual medical experimentation.^{21, 22, 23} Indigenous children in residential schools were subject to

¹⁸ Polack, F. P., Thomas, S. J., Kitchin, N., Absalon, J., Gurtman, A., Lockhart, S., Perez, J. L., Pérez Marc, G., Moreira, E. D., Zerbini, C., Bailey, R., Swanson, K. A., Roychoudhury, S., Koury, K., Li, P., Kalina, W. V., Cooper, D., Frenck, R. W., Hammitt, L. L., Türeci, Ö., Nell, H., Schaefer, A., Ünal, S., Tresnan, D. B., Mather, S., Dormitzer, P. R., Şahin, U., Jansen, K. U., & Gruber, W. C. (2020). Safety and efficacy of the BNT162b2 mRNA Covid-19 vaccine. *New England Journal of Medicine*, 383(27), 2603–2615. <https://doi.org/10.1056/NEJMoa2034577>

¹⁹ Baden, L. R., El Sahly, H. M., Essink, B., Kotloff, K., Frey, S., Novak, R., Diemert, D., Spector, S. A., Rouphael, N., Creech, C. B., McGettigan, J., Khetan, S., Segall, N., Solis, J., Brosz, A., Fierro, C., Schwartz, H., Neuzil, K., Corey, L., Gilbert, P., Janes, H., Follmann, D., Marovich, M., Mascola, J., Polakowski, L., Ledgwerwood, J., Graham, B. S., Bennett, H., Pajom, R., Knightly, C., Leav, B., Deng, W., Zhou, H., Han, S., Ivarsson, M., Miller, J., & Zaks, T. (2021). Efficacy and safety of the mRNA-1273 SARS-CoV-2 vaccine. *New England Journal of Medicine*, 384(5), 403–416. <https://doi.org/10.1056/NEJMoa2035389>

²⁰ Tartof, S. Y. et al. (2021). Effectiveness of mRNA BNT162b2 COVID-19 vaccine up to 6 months in a large integrated health system in the USA: a retrospective cohort study. *The Lancet*, 398(10309), 1407–1416. [https://doi.org/10.1016/S0140-6736\(21\)02183-8](https://doi.org/10.1016/S0140-6736(21)02183-8)

²¹ Lux, M. K. (2016). *Separate beds: A history of Indian Hospitals in Canada, 1920s–1980s*. University of Toronto Press.

²² Truth and Reconciliation Commission of Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. <https://nctr.ca/records/reports>

²³ Mosby, I. (2013). Administering colonial science: Nutrition research and human biomedical experimentation in Aboriginal communities and residential schools, 1942–1952. *Histoire sociale / Social History*, 46(91), 145–172.

harmful and deeply unethical nutrition experiments.^{24, 25, 26} The collection and use of Indigenous biological data without consent, such as the misuse of blood samples for unrelated research, has further reinforced concerns about transparency and control over health research.²⁷ This very real colonial history of medical malpractice and experimentation in Indigenous communities contributes to lasting mistrust of governments, medical institutions, and research. One Elder recounted their experience of forced vaccination at Residential School:

You don't have no choice. You were forced into it. [...] My brother went to Grade 3 [at Mission School]. [...] We were forced into having needles in the back of my back, here. I still got a scar. I think for TB. Big scratch. I didn't know what was going on. They don't tell us anything. What they do to us or anything? [...] Nobody explained to us. [...] And to this day, the government doesn't even. They try to push us to be like them. [...] They say with the news, if you don't get a shot they're going to get policemen. [...] I think back, my brother ran away from Mission School. [...] And then I went to school and, just, no one explained. They would take the parents to jail if our kids don't go to school.

In this reflection, the participant is describing how vaccine mandates reminded them of the coercion and punishment associated with residential schooling. The emphasis is placed on being forced to comply, the use of authority and police to enforce rules, and the absence of explanation or dialogue. The participant's account shows how COVID-19 vaccination requirements were understood through lived experiences of colonial coercion, in which health interventions were imposed without consent, explanation, or meaningful choice.

3.3 Information, Trust, and Relationship

How information was communicated played a significant role in shaping participants' vaccine decision-making. Participants reflected on the amount of information they received, the sources they turned to, and the voices they trusted. Some felt sufficient information was available, while others wanted clearer explanations about vaccine ingredients, safety, changing recommendations, or the purpose of additional doses. Others described receiving an overwhelming amount of inaccurate, misleading, and politically charged information, which made it difficult to separate fact from fiction. Across these experiences, trust in information was grounded most strongly in relationships.

²⁴ Mosby, 2013.

²⁵ Truth and Reconciliation Commission of Canada, 2015.

²⁶ Indian Residential School History and Dialogue Centre. (2014, September 23). *The legacy of nutritional experiments in residential schools*. University of British Columbia. <https://ikbhc.ubc.ca/indigenous/the-legacy-of-nutritional-experiments-in-residential-schools/>

²⁷ Ha-Shilth-Sa (2013, July 22.) Genetic researcher uses Nuu-chah-nulth blood for unapproved studies in Genetic Anthropology. *Ha-Shilth-Sa*. <https://hashilthsa.com/news/2013-07-22/genetic-researcher-uses-nuu-chah-nulth-blood-unapproved-studies-genetic>

Table 6
Reasons for not getting vaccine or booster

	Yukon				National			
	Less than 2 vaccines (39 respondents)		Only 2 vaccines (101 respondents)		Less than 2 vaccines (115 respondents)		Only 2 vaccines (223 respondents)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
I, or someone I know, experienced serious side effects from previous doses/vaccines	32	82.5	31	31.3	25	21.4	39	17.4
I think the COVID-19 vaccine is dangerous	32	81.9	26	26.0	48	41.6	40	18.0
I do not think the vaccine works that well	28	70.9	52	52.4	42	36.8	46	20.6
COVID-19 is not a serious concern for me	27	68.0	68	68.0	42	36.8	65	29.2
I use something other than the vaccine (e.g., traditional medicines or non-COVID specific drugs)	13	34.6	4	4.4	7	6.1	9	4.2
I already had COVID-19, so I don't believe that I need any/any more	12	29.8	21	20.6	16	14.1	54	24.2
I think most vaccines are dangerous	9	24.3	4	4.0	22	18.9	16	7.4
Someone advised me not to get the vaccine	5	13.2	1	0.9	19	16.6	12	5.6
I don't like needles/shots	3	7.8	17	17.4	13	11.1	41	18.5
I don't have time to get vaccinated	1	1.2	6	6.2	8	6.8	13	5.9
I have difficulty accessing the vaccine	0	0.0	2	2.1	3	2.3	7	3.2
Other	3	8.1	14	14.0	6	5.0	14	6.1

Notes: The margin of error on these responses are +/- 16% 19 times out of 20 for the no primary series subsample and +/- 9.8% 19 times out of 20 for the no booster subsample.

Health Care Providers. Health care providers were among the most trusted sources of vaccine information, particularly where participants had established relationships with familiar doctors and nurses. Participants valued providers who knew their personal and family health histories, answered questions directly, and supported them in making their decisions. The Natsékhi Kù Health Centre was an especially strong example. Almost all KDFN participants described the Health Centre and its doctors and nurses as trusted sources of health information. Participants viewed the Health Centre as accessible, familiar, and accountable to the community. Many said they would return there for information during a future health emergency.

The survey findings also identified health care providers as a widely used and highly trusted source of information. Among Yukon respondents, 69.3% ($n = 394$) reported using health care providers to learn about COVID-19 vaccines. Respondents rated the knowledge and expertise of health care providers at 7.4 out of 10 (where 10 means “extremely knowledgeable”) and rated their belief that health care providers had the interests of people like them in mind at 7.6 (where 10 means “completely agree” they have the best interests of the respondent in mind). These ratings were similar in the national sample.

Participants emphasized that professional credentials alone did not create trust. Continuity, familiarity, and respectful communication gave health information its credibility:

I trust people, not systems. [...] So, Dr. [Name] has recently retired and the doctor replacing [them], I’m sure [they’re] a great doctor, but [they’re] not my doctor, not the person that I know and that I trust and that I’ve worked with on my health and my family’s health for years and years and years. So, in a way, the way that I make decisions has changed because I don’t have that same resource as I did.

This reflection shows that trust could not simply be transferred to a new provider or assumed because someone worked within the same health system. The loss of a longstanding provider also meant the loss of an important source of trusted advice. Across the communities, participants described similar trust in local health centres, nursing stations, and providers who took time to build relationships and engage with people beyond formal appointments.

Where distrust in health care providers emerged, it was often connected to negative experiences, directive or patronizing communication, provider turnover, a lack of community engagement, and historical and ongoing systemic racism. Participants described losing trust when providers appeared to be pushing vaccination, dismissed questions, or communicated as though there was only one acceptable decision. Some also described providers as disconnected from the community or fearful of community members. These findings demonstrate that culturally safe care requires sustained relationship-building, respect for personal autonomy, and meaningful engagement with the community.

Family, Friends, and Elders. Family, friends, and Elders also shaped how participants encountered and interpreted vaccine information. Participants commonly trusted people close to them for accounts of lived experience, including how they felt after vaccination or how they navigated appointments. Family conversations provided relational support and a space for collective decision-making. Elders were valued for stories, guidance, land-based knowledge, and historical perspectives that helped participants understand health within a broader context. Participants did not always view family, friends, or Elders as sources of scientific vaccine information unless the person had relevant medical knowledge or experience. Instead, participants often brought together information from several sources and made decisions within their relationships.

The survey findings support this distinction between trusting someone’s knowledge and trusting their intentions. Almost half of Yukon respondents used friends and family to learn

about COVID-19 vaccines (48.3%, $n = 275$). However, respondents gave family and friends relatively modest ratings for knowledge and expertise, at 4.2 and 4.0 out of 10 (where 10 means “extremely knowledgeable”). At the same time, family and friends were among the sources most trusted to have participants’ interests in mind, receiving ratings of 7.3 and 6.9 (where 10 means “completely agree” they have the best interests of the respondent in mind). These findings reinforce that family and friends were trusted relationally, even when participants did not view them as sources of scientific expertise.

Scientific Research. Scientific research was generally viewed as credible, although participants engaged with it in different ways. Some relied on doctors and nurses to interpret the evidence, while others reviewed research and emerging data themselves. Trust in science did not mean unquestioning acceptance. Participants raised important questions about who produced information, who provided oversight, whose interests were being served, and how research was governed and communicated. These concerns show that the credibility of health information depended partly on transparency, accountability, and Yukon First Nations involvement in deciding how information was developed and shared.

Scientists received the highest knowledge and expertise rating among Yukon survey respondents, at 7.8 out of 10 (where 10 means “extremely knowledgeable”), compared with 7.2 nationally. Yukon respondents also rated scientists relatively highly on whether they had the interests of people like them in mind, at 7.2 (where 10 means “completely agree” they have the best interests of the respondent in mind). The findings suggest respondents generally viewed scientists as both knowledgeable and credible, while the qualitative findings show this trust depended on transparency, accountability, and how scientific information was governed and communicated.

Government Information. Participants had mixed trust in government information. Many consulted Yukon and federal government websites, listened to Chief Medical Officer of Health briefings, or relied on information shared by their First Nation government. Participants were more likely to trust government information when they understood who developed it, knew the people communicating it, or saw that Yukon First Nations were meaningfully involved in decision-making. Territorial and Canadian government sources were the most widely used sources of vaccine information in the Yukon survey. Almost 90% ($n = 511$) of respondents used information from the territorial government, while 86.8% ($n = 494$) used information from the Canadian government. Yukon respondents rated the knowledge and expertise of the Canadian government at 6.3 out of 10 and the territorial government at 5.0 (where 10 means “extremely knowledgeable”). Ratings were slightly lower when respondents were asked whether these governments had the interests of people like them in mind, with 5.7 for the Canadian government and 5.6 for the territorial government (where 10 means “completely agree” they have the best interests of the respondent in mind).

These findings reflect the distinction raised by participants in the community-based conversations. Government information was widely accessed, but using government information did not necessarily mean participants fully trusted the institutions or people producing it.

Social Media. Social media was widely described as an unreliable source of vaccine information. Participants raised concerns about misinformation, fear-based content, scams, and the difficulty of verifying online claims. At the same time, social media, news, and community conversations continued shaping the questions and concerns participants encountered. Information could feel credible when it was shared by a trusted person or presented in a formal-looking document, even when its original source was unclear. In the absence of clear, timely, and community-specific information, informal stories and rumours sometimes filled the gap.

Although participants described social media as unreliable, 44.3% ($n = 252$) of Yukon survey respondents reported using it to learn about COVID-19 vaccines, compared with 24.6% ($n = 195$) of national respondents. However, Yukon respondents gave social media the lowest trust ratings of any source. They rated its knowledge and expertise at 2.2 out of 10 (where 10 means “extremely knowledgeable”) and gave the same rating when asked whether social media sources had the interests of people like them in mind (where 10 means “completely agree” they have the best interest of the respondent in mind). This distinction shows that participants could encounter or use information from social media without considering it credible or trustworthy.

Yukon respondents appeared to be more active seekers of information about COVID-19 vaccines than national respondents across nearly all sources examined. However, both samples showed a similar general pattern: respondents relied most heavily on governments and health care providers and placed greater confidence in professional and scientific expertise than in media-based or informal sources.

Effective health communication depends on trusted relationships, continuity of care, respectful dialogue, and local accountability. The strong trust placed in the Natsékhi Kù Health Centre, as well as the COVID Champion and COVID Coordinators, demonstrates the value of familiar, community-based health services. The survey findings similarly show that trust in information sources, especially confidence in their knowledge and belief that they have participants’ interests in mind, was strongly connected to willingness to vaccinate. The findings also show that trust in family, friends, and other non-official sources did not necessarily compete with trust in health care providers, scientists, or governments. Instead, participants often drew on different forms of knowledge and trust within their relationships. Future emergency communication should build on trusted Yukon First Nations health providers and community networks, support direct opportunities for questions and discussion, and ensure Yukon First Nations leadership in developing and sharing community health information.

Table 7
Participants most used sources for vaccine information

	Yukon 569 respondents		National 793 respondents	
	<i>n</i>	%	<i>n</i>	%
Provincial/territorial governments	511	89.9	357	45.1
Canadian government	494	86.8	519	65.4
News	394	68.8	328	41.3
Health care providers	394	69.3	382	48.2
Search engines	288	50.6	227	28.6
Friends and family	275	48.3	269	34.0
Social media	252	44.3	195	24.6
First Nations governments	120	21.0	18	2.2
Other	41	7.2	23	3.0
None	0	0.0	21	2.7

Notes: The margin of error on these responses are +/- 4% 19 times out of 20 in the Yukon sample and +/- 3.4% 19 times out of 20 in the national sample.

Table 8

Perceptions of the knowledge and expertise of information sources about COVID-19 vaccines

	Yukon	National
Health care providers	7.4	7.3
Scientists	7.8	7.2
Canadian government	6.3	6.6
Pharmaceutical companies	6.3	6.4
Provincial/territorial governments	5.0	6.4
Mainstream news	4.8	6.0
Family	4.2	5.7
Friends	4	5.5
Social media	2.2	4.3
First Nations leaders	3.6	4.2

Notes: figures represent average responses on 0 to 10 scale where 0 means “not at all knowledgeable” and 10 means “extremely knowledgeable.” The margin of error on these responses is +/- 0.20 19 times out of 20 in the Yukon sample and +/- 0.17 19 times out of 20 in the national sample.

Table 9

Perceptions that information sources about COVID-19 vaccines “have the interests of people like me in mind when they provide advice about vaccination.”

	Yukon	National
Health care providers	7.6	7.4
Family	7.3	7.5
Scientists	7.2	7.0
Friends	6.9	7.2
Canadian government	5.7	6.2
Provincial/territorial governments	5.6	6.3
First Nations leaders	5.2	5.0
Pharmaceutical companies	4.2	6.1
Mainstream news	4.0	5.8
Social media	2.2	4.4

Notes: figures represent average responses on 0 to 10 scale where 0 means “completely disagree” and 10 means “completely agree.” The margin of error on these responses is +/- 0.20 19 times out of 20 in the Yukon sample and +/- 0.17 19 times out of 20 in the national sample.

3.4 Participants' Future Intent to Vaccinate

Participants were asked whether they would get vaccinated again in the future. Although the question referred to any vaccine, most participants focused on whether they would receive another COVID-19 vaccine. Responses were mixed; some intended to vaccinate again, while many were unsure or did not currently plan to receive another COVID-19 dose.

The survey findings showed a similar division. Among Yukon respondents, 47.4% reported they were likely or extremely likely to receive a future COVID-19 vaccine, while 39.9% reported they were unlikely or extremely unlikely. A further 12.8% were neutral or did not know. National respondents reported slightly lower future vaccination intentions: 42.6% were likely or extremely likely to receive another dose, 38.4% were unlikely or extremely unlikely, and 19.1% were neutral or did not know. (See Table 10 for detailed survey data on intent for future COVID-19 vaccination.)

Participants who intended to vaccinate again generally viewed vaccines as a practical way to protect themselves, their families, and their communities. Those who were unsure or did not intend to receive another COVID-19 vaccine described further doses as unnecessary, expressed concerns about side effects, or felt COVID-19 no longer posed the same immediate risk. Their decisions were often conditional and could change in response to a serious outbreak, new information, medical advice, or travel requirements.

Future vaccination intentions also differed substantially by age. In the Yukon survey, 74% of respondents aged 65 and older reported they were likely to receive a future COVID-19 vaccine, compared with 34% of respondents aged 18 to 35. The national survey showed a similar pattern, with 67% of respondents aged 65 and older likely to vaccinate in the future, compared with 31% of respondents aged 35 and younger. Among survey respondents, older adults were more likely than younger adults to report an intention to receive a future COVID-19 vaccine.

Table 10
Likelihood of receiving future doses of COVID-19 vaccine

	Yukon (572 respondents)		National (799 respondents)	
	<i>n</i>	%	<i>n</i>	%
Extremely Likely	171	29.9	217	27.2
Likely	100	17.5	123	15.4
Neutral/Don't know	73	12.8	152	19.1
Unlikely	60	10.6	102	12.8
Extremely Unlikely	168	29.3	205	25.6

Notes: The margin of error on these responses are +/- 4% 19 times out of 20 in the Yukon sample and +/- 3.5% 19 times out of 20 in the national sample.

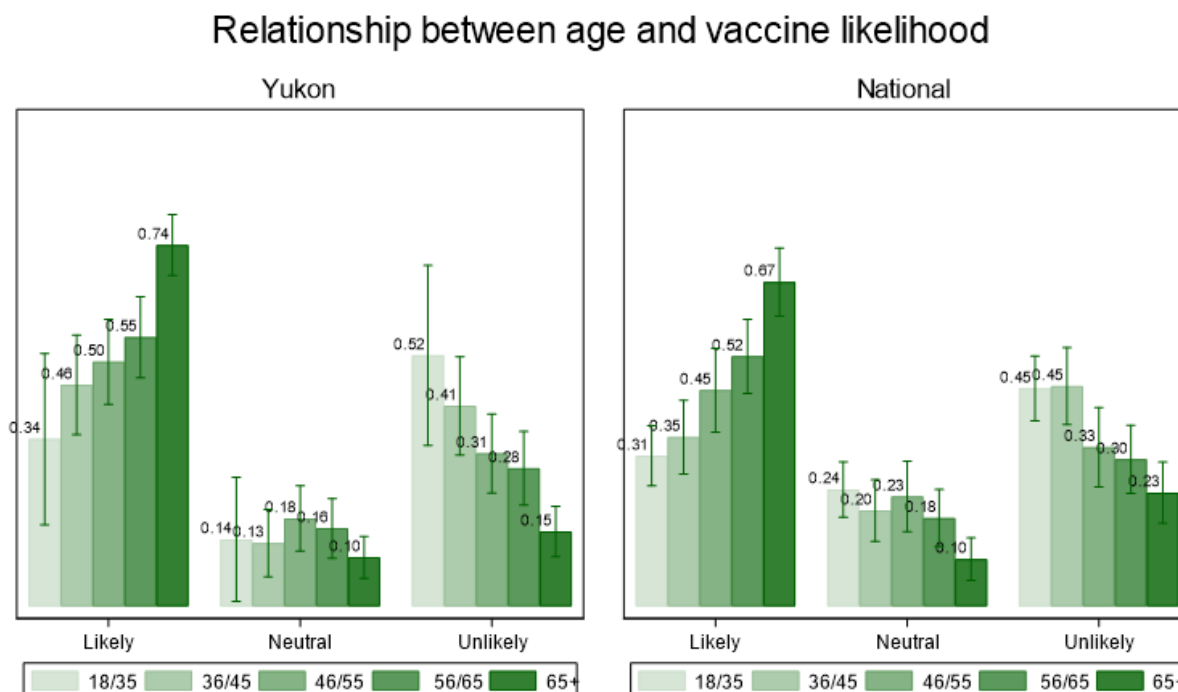


Figure 1: Likelihood of taking a COVID-19 vaccine in the future by age in the Yukon (left) and national samples (right). 95% confidence intervals.

There were no meaningful differences by gender in either the Yukon or national samples. All genders reported similar intentions to receive a COVID-19 vaccine in the future.

For many participants, future vaccination depended strongly on trust, meaningful choice, and how information was communicated. One participant shared the following:

Maybe if I do, it's because it would be well informed. I'm going to have that freedom of choice. If it ever comes to being forced again, I'll never do that again.

3.5 Influenza (Flu) Vaccine Decision-Making

Community-based conversation participants generally described influenza vaccination as a routine and relatively uncontroversial health decision. Their decisions about the flu vaccine did not appear closely connected to their views about COVID-19 vaccination. Participants who regularly received the flu vaccine generally intended to continue, while those who rarely or never received it expected to continue in the same way.

Those who received the flu vaccine commonly wanted to protect themselves from illness, reduce the severity of symptoms, or protect children, Elders, and family members at greater risk. Convenience and reminders were also influential. Participants were more likely to get vaccinated when the flu shot was readily available through a local health centre, workplace, travel clinic, or high-risk clinic or when a family member or health provider reminded them.

Participants who did not regularly receive the flu vaccine commonly viewed it as unnecessary because they felt healthy and confident their body could recover from influenza. Others associated previous vaccination with feeling sick, worried about side effects, preferred traditional or land-based medicines, or generally avoided putting pharmaceutical medicines into their bodies. Overall, participants often received the flu vaccine when it was convenient and recommended but were unlikely to actively seek it out without a clear personal or family reason.

Because the community-based conversations clearly indicated that influenza vaccination was not a priority area of discussion, the territorial and national surveys did not include questions about flu vaccination.

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