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The Impact of the Pandemic Experience on Future Vaccine-Related Intentions and Behaviours (2022)

Final Report

Prepared for the Public Health Agency of Canada

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Canada

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This public opinion research report presents the results of an online survey and focus groups conducted concurrently by Earnscliffe Strategy Group on behalf of the Public Health Agency of Canada. The fieldwork for the qualitative research was conducted in November 2022 and in December 2022 for the quantitative research.

Cette publication est aussi disponible en français sous le titre : L'impact de l'expérience de la pandémie de COVID-19 sur les intentions et les comportements futurs liés aux vaccins (2022).

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Executive summary

Earnscliffe Strategy Group (Earnscliffe) is pleased to present this report to the Public Health Agency of Canada (PHAC) summarizing the results of quantitative and qualitative research undertaken to understand the impact of the pandemic experience on future vaccine-related intentions and behaviours.

Vaccines are a core public health tool to protect the population's health. Public sentiment around COVID-19 vaccines has been even more dynamic and rapidly changing than with other vaccines, reflecting evolving epidemiology and anxieties about the newness of COVID-19 vaccines and emerging variants, reported risks of side-effects, misinformation circulating, vaccine and public health measure fatigue, and increased distrust of government and science.

Research prior to the pandemic established various key factors and determinants that impacted vaccine confidence and resulting vaccine behaviours. However, the pandemic experience has been novel to this generation and has necessitated the general population to engage with intense and ongoing adaptation. The consequences of this burden are still unknown and as society transitions towards recovery, it was critical that PHAC gain insight into how these events are processed and what this might mean for vaccine confidence (that is, routine and/or boosters for COVID-19) going forward.

To that end, the primary objective of this research was to provide PHAC with insights into Canadians' overall awareness, perceptions, and concerns about the impacts of the COVID-19 pandemic, including mental health impacts, government relief efforts and expectations, recovery, public health measures, and vaccines in order to develop targeted communications strategies and products. The contract value for this project was $171,545.30 including HST.

To meet the current objectives, Earnscliffe conducted a two-phased research program involving both quantitative and qualitative research that ran concurrently.

The quantitative phase involved an online survey of 2,088 Canadians aged 18 and older. The online survey was conducted using Leger's opt-in panel between December 1 and 6, 2022. The online survey was completed in either English or French and took an average of 16 minutes to complete.

Respondents for the online survey were selected from among those who have volunteered to participate in online surveys. The data was weighted to reflect the demographic composition of the Canadian population aged 18 and older. Because the online sample is based on those who initially self-selected for participation in the panel, no estimates of sampling error can be calculated, and the results cannot be described as statistically projectable to the target population. The treatment here of the non-probability sample is aligned with the Standards for the Conduct of Government of Canada Public Opinion Research - Online Surveys. Appendix A provides full details on the survey methodology and Appendix C provides the survey instrument used.

At the same time, qualitative research was undertaken, which included a series of sixteen (16) focus groups between November 21 and 24, 2022 with adults aged 18 and older, adults 18-39, Indigenous adults aged 18 and older who live off-reservation, and health care professionals. A maximum of ten (10) individuals were recruited for each group. In total, 144 people participated in the focus group discussions. One discussion group among each target audience was conducted with residents of Atlantic Canada (Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick), Quebec, Ontario, and the West/North (Manitoba, Saskatchewan, Alberta, British Columbia, Yukon, Northwest Territories, Nunavut). Those living in official language minority communities (OLMCs) were invited to participate in a group in their preferred language at a date and time that was convenient to them. The sessions were approximately 90 minutes in length.

It is important to note that qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is not designed to help a group reach a consensus or to make decisions, but rather to elicit the full range of ideas, attitudes, experiences, and opinions of a selected sample of participants on a defined topic. Because of the small numbers involved, the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn, and findings cannot reliably be generalized beyond their number. As such, results are directional only.

The key findings from the research are presented below.

Key quantitative findings

- Roughly half of respondents say they have personally been infected with COVID-19 (51%) and/or a member of their household has (52%).
- Current uptake of COVID-19 vaccinations is quite high in that the majority of respondents (93%) say they have received two doses (primary series) (22%) or one booster dose (that is 3 or more doses) (71%) of COVID-19 vaccines. The remainder (7%) say they have received a single dose (1%) or none (6%).
- Nearly two-thirds of respondents are likely (65%) to get additional doses in the future including half (49%) who are very likely to or definitely will.
    - Among those likely to get a future COVID-19 vaccine dose, the vast majority (80%) are likely to get a flu shot as well.
- Respondents 40 years and older are more likely to say that they have received all the recommended doses as compared to respondents 18 to 39 years (53% versus 41%). Similarly, they are more likely (58% versus 32%) to get additional doses in the future.
- The most common reasons respondents say they are not likely to get future COVID-19 vaccine doses are concerns over the long-term side effects of the vaccines (32%), the belief that the vaccine is not effective enough (29%), and the perception that they themselves are protected enough by the doses they already have (20%).

- Pandemic fatigue varies widely. However, more respondents say they are experiencing higher levels of pandemic fatigue (rating between 6 and 10; 48%) than those who rate their pandemic fatigue lower or non-existent (rating between 0 and 4; 36%). The remaining respondents (16%) would mark their pandemic fatigue at the mid-point between no fatigue and the worst possible fatigue.

- Fewer than half say their pandemic experience has impacted their future vaccination intentions for themselves or their child(ren), for either the COVID-19 vaccine doses (45% for themselves) or routine vaccines (36% for oneself and 37% for their child(ren)).

    - Among those who say it has, more say their experiences have made them more likely to get future vaccinations than less likely.

- While most do not say their pandemic experience has impacted their trust in any of the sources tested, among those for which it has the impact on trust varies among the sources.

    - More say they are more likely to trust healthcare workers (34% vs. 9%) and scientists (31% vs. 12%) than less likely to, whereas the reverse is true for social (4% vs. 25%) and traditional (11% vs. 22%) media.

- The majority of respondents support the proof-of-vaccination system (64%) and say they always adhere to the most recommended public health measures, including:

    - Staying at home when they are sick (70%), using individual public health measures around vulnerable people (62%), wearing a mask indoors when they're feeling sick (60%), and wearing a mask indoors when in public or around people from outside their household (56%).

    - If required to prevent widespread outbreak, most respondents would support reimplementing most of the public health measures except stay-at-home orders (47% support), closing schools or daycares (44% support), and closing businesses (31% support).

Key qualitative findings

- Virtually every participant had firsthand experience with COVID-19 infection and were very forthcoming in sharing their experience(s). The stories shared varied widely and tended to focus on descriptions of symptoms, their severity, and the length of time it took to recover from infection.

- The stated impacts on non-health care professionals' lives included: their work or income being negatively impacted; the struggle to deal with the logistics of quarantining themselves or others in their household; being unable to do things they needed or wanted to do; and, for parents, the challenges of trying to work from home while caring for children.

- While the impacts on the personal lives of health care professionals were very consistent, the additional impacts on their work, included: for family physicians, the move to virtual care, and concern for the quality of care; for nurses, the emotional toll associated with being one of the

primary points of care and information in a highly uncertain environment; and, for pharmacists, especially those owning their own businesses, a surge in the success of their businesses as pharmacies became a go-to location for just about everything pandemic-related.

- When prompted to discuss how they coped, responses ranged widely and seemingly in correlation with the severity of the illness. For some, their experience with the infection was insignificant, and the notion of "coping" felt overstated; while for others, their lives were far more disrupted and stressful including beyond infection.
    - Some Indigenous participants in the West/North and Quebec raised Indigenous-specific aspects to coping. These included traditional medicine, spiritual resilience, and interacting with elders or others in the community to provide or receive help.
- Some participants reflected on, or explained when prompted, that one of the reasons they felt their symptoms were milder than anticipated was because they had received (at least one dose of) the COVID-19 vaccine. However, there were also participants who felt the fact they were vaccinated did little or nothing for them.
- Provided with a definition of pandemic fatigue participants expressed varying degrees of fatigue though there was a sense that their rating would have been higher had they been asked at the beginning of the pandemic.
- For non-health care professionals, the imposition of public health recommendations and requirements and/or dealing with the social pressures of complying or being vaccinated were higher sources of fatigue. Parents also appeared to have higher degrees of pandemic fatigue given the challenges of juggling work from home, home schooling, and caring for children.
- On a personal level, health care professionals shared all of these same feelings and challenges and described their pandemic fatigue in much the same way. On a professional level, however, there was a certain amount of fatigue and concern about the long-term impact of the pandemic on the health care system.
- The overwhelming majority of non-health care professionals acknowledged that their pandemic experience would have an influence on their behaviours going forward. For some, they will be at least as committed to vaccines and/or other public health measures. Others will be less committed and cited the milder than anticipated symptoms, inconsistency in recommendations, and/or counter-intuitive changes that were seen as unhelpful.
- Health care professionals spoke of relaxing some of their own behaviours over the course of the pandemic, but in contrast to non-health care professionals, they had not relaxed on mask-wearing and felt that guidelines surrounding mask-wearing were relaxed too early.
- On the topic of vaccines, non-health care professionals' perspectives ranged from being absolutely committed to receiving the COVID-19 vaccines doses whenever they are recommended to being absolutely committed to never getting a dose. The rationale for not continuing to get doses included concern about unknown long-term side effects and/or a sense the vaccine was not as effective as they had expected. When the vaccine was

assumed to be effective and the risk of infection seen as having very dire consequences, some seemed to find it easier to set aside nagging thoughts they had about side effects.

- For nearly all, the pandemic had no effect on their intentions regarding routine vaccines. The distinction tended to be around the certainty of routine vaccines at blocking the possibility of contracting a certain illness, whereas the COVID-19 vaccine seemed to only lessen the severity of the symptoms.

- The discussion around how their trust in information sources had been affected by their pandemic experience, there were few who indicated that their trust in any source had increased and many who indicated having lost trust in one or more sources.

  - One sentiment that came up during this discussion was that some non-health care professionals stopped looking for or accessing information – sometimes because it had become overwhelming, or difficult to reconcile, or too heated an issue.

- Some non-health care professionals felt less trust in one level of government or another (or multiple) – this much was echoed by health care professionals who indicated their patients' trust in at least one level of government had waned. Health care professionals explained that information from the government was fast evolving (too fast), not always clear, and at times contradictory.

- Health care professionals also often blamed social media for the misinformation over the course of the pandemic. Mirroring this, at least one non-health care professional in each group noted that social media was one source in which they had less trust now.

- Asked what the remedy might be for restoring trust, participants suggested being honest and admit your mistakes about the trials and tribulations faced.

  - Participants want factual, balanced, unbiased, and politically neutral information that includes source attribution (especially scientific evidence); laying out the reasoning behind the recommended guidelines; the pros and cons of COVID-19 vaccines; different side effects of the vaccines; how many people experienced side effects; and the positive results/impact of vaccines on addressing the COVID-19 pandemic (though they appreciated this would be difficult to do).

Research firm: Earnscliffe Strategy Group (Earnscliffe)
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I hereby certify as a representative of Earnscliffe Strategy Group that the final deliverables fully comply with the Government of Canada political neutrality requirements outlined in the Communications Policy of the Government of Canada and Procedures for Planning and Contracting Public Opinion Research. Specifically, the deliverables do not include information on electoral voting intentions, political party preferences, standings with the electorate or ratings of the performance of a political party or its leaders.

Signed: Date: January 20, 2023

Stephanie Constable
Principal, Earnscliffe

Introduction

Earnscliffe Strategy Group (Earnscliffe) is pleased to present this report to the Public Health Agency of Canada (PHAC) summarizing the results of quantitative and qualitative research undertaken to understand the impact of the pandemic experience on future vaccine-related intentions and behaviours.

Vaccines are a core public health tool to protect the population's health. Public sentiment around COVID-19 vaccines has been even more dynamic and rapidly changing than with other vaccines, reflecting evolving epidemiology and anxieties about the newness of COVID-19 vaccines and emerging variants, reported risks of side-effects, misinformation circulating, vaccine and public health measure fatigue and increased distrust of government and science.

Research prior to the pandemic established various key factors and determinants that impacted vaccine confidence and resulting vaccine behaviours. However, the pandemic experience has been novel to this generation and has necessitated the general population to engage with intense and ongoing adaptation. The consequences of this burden are still unknown and as society transitions towards recovery, it was critical that PHAC gain insight into how these events are processed and what this might mean for vaccine confidence (that is, routine and/or boosters for COVID-19) going forward.

To that end, the primary objective of this research was to provide PHAC with insights into Canadians' overall awareness, perceptions, and concerns about the impacts of the COVID-19 pandemic, including mental health impacts, government relief efforts and expectations, recovery, public health measures, and vaccines in order to develop targeted communications strategies and products. The contract value for this project was $171,545.30 including HST.

The quantitative research will be used to:
- Support the renewal of the National Immunization Strategy;
- Plan for future vaccination campaigns and programming to bolster Canadians' trust in the science of using vaccination; and,
- Provide and inform current evidence synthesis in the Vaccine Confidence Division.

To complement the survey, qualitative research was conducted to:
- Elicit further insights from specific populations;
- Further explore emerging vaccine-related events; and,
- Identify and characterise vaccine-related motivations and behaviours.

To meet the current objectives, Earnscliffe conducted a two-phased research program involving both quantitative and qualitative research that ran concurrently.

The quantitative phase involved an online survey of 2,088 Canadians aged 18 and older. The online survey was conducted using Leger's opt-in panel between December 1 and 6, 2022. The online survey was completed in either English or French and took an average of 16 minutes to complete.

Respondents for the online survey were selected from among those who have volunteered to participate in online surveys. The data for the general population sample was weighted to reflect the demographic composition of the Canadian population aged 18 and older. Because the online sample is based on those who initially self-selected for participation in the panel, no estimates of sampling error can be calculated, and the results cannot be described as statistically projectable to the target population. The treatment here of the non-probability sample is aligned with the Standards for the Conduct of Government of Canada Public Opinion Research - Online Surveys.

The final data were weighted to replicate actual population distribution by region, age, and gender according to the most recent Census data available. Appendix A provides full details on the survey methodology and Appendix C provides the survey instrument used.

Within the tables included in the body of the report, letters below percentages indicate results that are significantly different than those found in the specific comparison columns indicated by the letter. Unless otherwise noted, differences highlighted are statistically significant at the 95% confidence level. The statistical test used to determine the significance of the results was the Z-test. Due to rounding, results may not add to 100%. Throughout the report, the acronym "DK/NR" represents responses of either "don't know" or "prefer not to respond."

At the same time, qualitative research was undertaken, which included a series of sixteen (16) focus groups between November 21 and 24, 2022, with adults aged 18 and older, adults 18-39, Indigenous adults aged 18 and older who live off-reservation, and health care professionals. A maximum of ten (10) individuals were recruited for each group. In total, 144 people participated in the focus group discussions. One discussion group among each target audience was conducted with residents of Atlantic Canada (Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick), Quebec, Ontario, and the West/North (Manitoba, Saskatchewan, Alberta, British Columbia, Yukon, Northwest Territories, Nunavut). Those living in official language minority communities (OLMCs) were invited to participate in a group in their preferred language at a date and time that was convenient to them. Please refer to the recruitment screeners in the Appendix D and E of this report for all relevant screening and qualifications criteria.

The sessions were approximately 90 minutes in length. Focus group participants were given an honorarium as a token of appreciation for their time ($100 for adults 18 and older, $200 for Indigenous adults, $350 for nurses and pharmacists, and $400 for general practitioners). Appendix B provides greater detail on how the groups were recruited, while Appendices F and G provide the discussion guides used for the focus groups and Appendices D and E provide the screeners used for recruiting the focus group participants.

It is important to note that qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is not designed to help a group reach a consensus or to make decisions, but rather to elicit the full range of ideas, attitudes, experiences, and opinions of a selected sample of participants on a defined topic. Because of the small numbers involved, the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn, and findings cannot reliably be generalized beyond their number. As such, results are directional only.

The detailed findings from this research are presented in subsequent sections of this report. Appended to this report are the research instruments and data tables (presented under a separate cover).

Detailed findings

The following report presents the analysis of the quantitative and qualitative research to understand the impact of the pandemic experience on future vaccine-related intentions and behaviours. While the two phases of research were led concurrently, the results of each phase of research are presented separately beginning with the quantitative results which provides an understanding of the public's pandemic experience, intentions, and behaviours. This is followed by the qualitative results which provide the nuance to understand what and how those views are informed.

The term "respondent" is typically used when quantitative (survey) results are discussed, and "participant" when qualitative (focus group) results are discussed.

Section A: Quantitative research

The following quantitative results are divided into three sections: COVID-19 experience and vaccination status; Perceptions of pandemic fatigue; and Future intentions and behaviours.

These results are based on the findings of the online survey with percentages reported for respondents overall, and by key audiences.

For the purposes of this report, the key audiences are respondents' Indigenous identity (that is, Indigenous and non-Indigenous) and age (that is, 18 to 39 years, and 40 years or older). Some questions include additional tables that display the results by respondents' COVID-19 vaccination status (that is, 0 or 1 dose, 2 doses, or 3 or more doses). In this context, 3 or more doses is also described as "receive one or more booster doses." Further, analyses were conducted to see what, if any, differences exist beyond the demographic characteristics identified above, including gender identity, region, and household income inter alia. Analysis revealed strong correlation between income and education, so only differences by income are detailed herein.

Column labels have been provided to identify statistically significant results within the included tables. Letters that are depicted under percentages indicate results that are significantly different than those found in the specific comparison columns indicated by the letter in the Column Labels. Unless otherwise noted, differences highlighted are statistically significant at the 95% confidence level. The statistical test used to determine the significance of the results was the Z-test. Due to rounding, results may not add to 100%. The response options "Don't know" and "prefer not to respond" are denoted by DK/NR. Results with a base of fewer than 30 responses have been removed due to the unreliability of the result.

Details about the survey design, methodology, sampling approach, and weighting of the results may be found in the quantitative methodology report in Appendix A. Appended data tables (under separate cover) provide results of findings across a much broader range of demographics and attitudes.

COVID-19 experience and vaccination status

To better understand the range of experiences with COVID-19 and vaccinations, respondents were asked a series of questions related to their behaviour, attitudes, and perceptions.

When asked, the majority of respondents (71%) say they have received at least one booster dose of a COVID-19 vaccine (that is 3 or more doses). One-fifth (21%) say they have received two doses and the remainder (7%) say they have received a single dose (1%) or none (6%).

Looking at the key audiences, respondents who are non-Indigenous and 40 years or older are more likely to have received all the available vaccine booster doses.

Exhibit A1. Q5: How many doses of a COVID-19 vaccine have you received?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
None, I am not vaccinated against COVID-19	6%	14%	6%	7%	6%
	-	-	-	-	-
1 dose	1%	1%	1%	2%	0%
	-	-	-	E	-
2 doses	21%	27%	21%	31%	16%
	-	-	-	E	-
3 doses	29%	31%	29%	37%	25%
	-	-	-	E	-
4 doses	29%	25%	30%	22%	33%
	-	-	-	--	D
5 doses	13%	2%	14%	2%	19%
	-	-	B		D
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- At 76%, respondents who do not have any kids at home are more likely than their counterparts (61%) to have received at least one COVID-19 vaccine booster dose.
- Respondents whose household income is $80,000 or more are more likely to have received at least one booster dose (77%), compared to respondents whose household income is lower (64% for households with income under $40,000 and 69% for households with income between $40,000 and under $80,000).
- Those who have not been infected with COVID-19 are more likely to have received at least one booster dose (at 76%), compared to 68% among respondents who say they have been infected or think they have.

When respondents who have received at least two doses were asked why they have not received additional COVID-19 vaccine doses beyond the ones they have received, the most common response was the impression that they have already received all the recommended doses for their age group (49%). The next most common responses were the perception that they are protected enough (10%) or that they recently were infected with COVID-19 and

therefore have to wait before getting additional doses (8%). All other reasons were cited by 5% or fewer respondents.

Fewer Indigenous responses said they received all the recommended doses (32% compared to 50% among non-Indigenous) or felt they were protected enough (3% compared to 10% among non-Indigenous), which led to more variance across the remaining reasons; including 13% who indicated that they recently contracted COVID-19 and needed to wait to get additional doses, 13% who expressed concern over the long-term effects of the vaccine and 11% who feel that the vaccine does not provide much protection since you can still contract COVID-19 if you have been vaccinated.

Looking at the results among the two age groups, there are also notable differences. Respondents 40 years and older are more likely to say that they have received all the recommended doses (53% versus 41%), and that they recently contracted COVID-19 (9% versus 7%). Conversely, respondents 18 to 39 years are more likely to say that they feel protected enough (14% versus 8%) or that the vaccine does not provide much protection since you can still contract COVID-19 if you have been vaccinated (5% versus 3%). All other differences are among responses with fewer than 5% of respondents.

Exhibit A2. Q6: What is the top reason you have not gotten additional doses of COVID-19 vaccine?
Base: Respondents who have received at least two doses in Q5 (n=1,925).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
I have already received all recommended COVID-19 vaccine doses for my age group	49%	32%	50%	41%	53%
	-	-	B	-	D
I think I am protected enough with the current number of vaccine doses	10%	3%	10%	14%	8%
	-	-	B	E	-
I recently had COVID-19 and need to wait the recommended time before getting additional doses	8%	13%	8%	7%	9%
	-	-	-	-	D
I'm concerned about the long-term effects of the vaccine	5%	13%	5%	5%	5%
	-	-	-	-	-
I feel that the vaccine does not provide much protection as you can still get COVID-19 even if vaccinated	4%	11%	4%	5%	3%
	-	-	-	E	-
Don't want it / Don't need it	4%	2%	4%	5%	3%
	-	-	-	-	-
I prefer to wait a while before getting vaccinated	4%	2%	4%	5%	3%
	-	-	-	-	-
I'm fed up with getting vaccinated	3%	6%	3%	4%	2%
	-	-	-	E	-
I'm concerned about the safety of additional doses	2%	2%	2%	3%	2%
	-	-	-	-	-
I had short term non-serious side effects with the dose/doses I already got and don't want additional doses because of	2%	3%	2%	3%	1%
	-	-	-	E	-
I had long term side effects with the dose/doses I already got and don't want additional doses because of this	2%	1%	2%	2%	2%
	-	-	-	-	-

I am not exposed to risks of COVID-19 in my daily life and therefore feel that I do not need to receive additional doses	1%	1%	1%	2%	1%
	-	-	-	E	-
I'm tired of being told what to do to protect my health	1%	3%	1%	2%	0%
	-	-	-	E	-
Other	5%	8%	5%	4%	6%
	-	-	-	-	D
Don't know/ refusal	0%	0%	0%	0%	0%
	-	-	-	-	-
Sample size (n)	1925	74*	1838	1126	799
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Respondents who do not have children at home are more likely to say that they have already received all the recommended doses (53% versus 39% among those who have children at home), or that they recently had COVID-19 (9% versus 8%). Respondents with children at home are more likely to say they feel protected enough (13% versus 9%) of that the vaccine does not provide enough protection (6% versus 3%).
- Compared to those born in Canada, respondents who were not born in Canada are more likely to feel that they are protected enough with the doses they have already received (14% versus 9%).

Respondents were asked to consider the list of factors provided to them in the current COVID-19 context and select up to three that would motivate them to get additional doses of a COVID-19 vaccine.

Motivating factors varied widely among respondents and no single motivator is shared among a majority of respondents. One-fifth say they would be motivated by knowing they could help protect vulnerable members of society (22%) or if variant-specific formulations were offered (20%). Rounding out the top five factors are: helping to get things back to normal (17%), advice from a primary health care provider (16%) and being able to more safely spend time with friends and family in-person (15%). Another one in five (19%) say none of the factors listed would motivate them to get additional doses.

Looking at the key audiences, non-Indigenous respondents are more likely to be motivated than Indigenous respondents by vaccine formulations that are specific to latest variants (20% versus 11%), helping to get things back to normal (17% versus 9%), being required to be able to travel internationally (15% versus 6%), and knowing that additional doses reduce the risk of hospitalization (15% versus 6%).

There are notable differences in the motivational factors by age as well. Most notably, respondents 40 years or older are more likely to be motivated by helping to protect vulnerable members of society (24% versus 18%), new vaccine formulations (23% versus 13%), and recommendations by a primary health care provider (18% versus 11%). Conversely, respondents who are 18 to 39 years are more likely to be motivated by requirements to travel, both internationally (17% versus 14%) and in Canada (13% versus 6%), as well as getting additional doses at convenient times and location (12% versus 9%).

Exhibit A3. Q7: Amongst the following factors and thinking about the current COVID-19 context, what would motivate you to get additional doses of COVID-19 vaccine? Please select up to 3. Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Knowing that getting vaccinated could help protect the most vulnerable members of society	22%	16%	22%	18%	24%
	-	-	-	-	D
New COVID-19 vaccine formulations that are specific to latest variants	20%	11%	20%	13%	23%
	-	-	B	-	D
Helping to get things back to normal	17%	9%	17%	16%	17%
	-	-	B	-	-
Advice from my primary health care provider that it is recommended for me	16%	10%	16%	11%	18%
	-	-	-	-	D
Being able to more safely spend time with friends and family in-person	15%	17%	15%	15%	16%
	-	-	-	-	-
Required to be able to travel internationally	15%	6%	15%	17%	14%
	-	-	B	E	-
Knowing that the majority of new COVID-19 hospitalizations are among those who have not received additional doses	14%	6%	15%	12%	15%
	-	-	B	-	-
Knowing that the majority of new COVID-19 cases are among those who have not received additional doses	13%	19%	12%	13%	12%
	-	-	-	-	-
Getting additional doses at a convenient time and location	10%	16%	10%	12%	9%
	-	-	-	E	-
If getting additional doses would make it more likely for my area to avoid reinstating local public health restrictions	10%	9%	10%	12%	8%
	-	-	-	E	-
Understanding the benefits and importance of additional doses	9%	9%	9%	8%	10%
	-	-	-	-	-
Required to be able to travel within Canada	8%	9%	8%	13%	6%
	-	-	-	E	-
Receiving paid time off work to get an additional dose	5%	5%	5%	10%	3%
	-	-	-	E	-
Don't need motivation/ already up to date on my vaccination/ got all doses	1%	4%	1%	1%	2%
	-	-	-	-	-
Other	1%	2%	1%	1%	1%
	-	-	-	-	-
None of the above	19%	24%	19%	21%	19%
	-	-	-	-	-
Don't know/ refusal	0%	3%	0%	0%	0%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Analyses of these results by respondents' vaccination status reveals that the extent to which each of these factors motivate respondents is correlated with the number of vaccinations received. For nearly all of them, respondents with at least one booster dose are the most likely to say any of these reasons would be motivating, followed by those who have received two doses, and least by respondents with one dose or who are not vaccinated at all.

Exhibit A4. Q7: Amongst the following factors and thinking about the current COVID-19 context, what would motivate you to get additional doses of COVID-19 vaccine? Please select up to 3. Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Knowing that getting vaccinated could help protect the most vulnerable members of society	22%	1%	11%	27%
	-	-	B	B C
New COVID-19 vaccine formulations that are specific to latest variants	20%	2%	8%	25%
	-	-	B	B C
Helping to get things back to normal	17%	2%	9%	20%
	-	-	B	B C
Advice from my primary health care provider that it is recommended for me	16%	3%	7%	19%
	-	-	B	B C
Being able to more safely spend time with friends and family in-person	15%	2%	8%	19%
	-	-	B	B C
Required to be able to travel internationally	15%	4%	15%	16%
	-	-	B	B
Knowing that the majority of new COVID-19 hospitalizations are among those who have not received additional doses	14%	2%	9%	17%
	-	-	B	B C
Knowing that the majority of new COVID-19 cases are among those who have not received additional doses	13%	2%	12%	14%
	-	-	B	B
Getting additional doses at a convenient time and location	10%	1%	7%	12%
	-	-	B	B C
If getting additional doses would make it more likely for my area to avoid reinstating local public health restrictions	10%	2%	9%	10%
	-	-	B	B
Understanding the benefits and importance of additional doses	9%	0%	7%	11%
	-	-	B	B C
Required to be able to travel within Canada	8%	4%	11%	8%
	-	-	B	B
Receiving paid time off work to get an additional dose	5%	0%	6%	6%
	-	-	B	B
Don't need motivation/ already up to date on my vaccination/ got all doses	1%	0%	0%	2%
	-	-	-	B C
Other	1%	7%	1%	0%
	-	C D	-	-
None of the above	19%	79%	37%	8%
	-	C D	D	
Don't know/ refusal	0%	1%	0%	0%
	-	-	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Compared to respondents in other areas of the country, respondents in Quebec are less motivated by a recommendation by a primary health care provider (10%) but are more likely to be motivated by being able to spend time more safely with family and friends indoors (19%).

A plurality (47%) of children 12 to 17 years of age have received two COVID-19 vaccine doses, and more than a third (36%) have received at least one booster dose. Compared to parents who are between the ages of 18 and 39, parents 40 years or older are more likely to say that their child(ren) have received at least one booster dose (22% versus 39%).

Exhibit A5. Q10: Thinking about your child(ren) aged 12-17, how many doses of a COVID-19 vaccine have they received? Please select all that apply.
Base: Respondents who have a child that is between the ages of 12 and 17 (n=230).

Column %	Total	Age	
		18-39 years	40+ years
None	15%	13%	15%
	-	-	-
1 dose	4%	15%	2%
	-	C	-
2 doses	47%	51%	47%
	-	-	-
3 doses	26%	15%	28%
	-	-	B
4 doses	10%	7%	11%
	-	-	-
Sample size (n)	230	55*	175
Column label	A	B	C

*Bear in mind the small sample sizes for this question, results should be regarded with caution.

There are no other demographic differences.

The largest proportions of children 5 to 11 years of age have received two COVID-19 vaccine doses (42%) or none at all (33%). One-fifth (18%) have received a booster dose. Parents between the ages of 18 to 39 are more likely to say their child(ren) between the ages of 5 to 11 are unvaccinated (42%), whereas parents 40 years or older are more likely to say their child(ren) has received a booster dose (22%).

Exhibit A6. Q11: Thinking about your child(ren) aged 5-11, how many doses of a COVID-19 vaccine have they received? Please select all that apply.
Base: Respondents who have a child that is between the ages of 5 and 11 (n=282).

Column %	Total	Age	
		18-39 years	40+ years
None	33%	42%	27%
	-	C	-
1 dose	10%	13%	7%
	-	C	-
2 doses	42%	35%	47%
	-	-	B
3 doses	18%	11%	22%
	-	-	B
Sample size (n)	282	170	112
Column label	A	B	C

Other demographic differences:

- Respondents who identify as male are more likely than those who identify as female to say their child(ren) between the ages of 5 and 11 years have received a booster dose (24% versus 10%).
- Respondents in Ontario and in the West or North are more likely to say that their child(ren) between the ages of 5 and 11 have received a booster dose (19% and 24%, respectively), compared to those in Atlantic Canada (9%) and Quebec (6%).
- Respondents whose household income is under $80,000 are more likely to say their child(ren) in this age group are unvaccinated (48% for $40,000 to $79,999; 47% for under $40,000).

Three-quarters of respondents (74%) who are a parent of at least one child between the ages of 6 months and under 5 years say their child(ren) have received at least one dose of a COVID-19 vaccine. There are no notable differences among the key audiences.

Exhibit A7. Q12: Thinking about your child(ren) between the ages of 6 months and under 5, have they received at least one dose of a COVID-19 vaccine?
Base: Respondents who have a child that is between the ages of 6 months and 4 years (n=272).

Column %	Total	Age	
		18-39 years	40+ years
Yes	26%	23%	38%
	-	-	-
No	74%	77%	62%
	-	-	-
Sample size (n)	272	242	30*
Column label	A	B	C

*Bear in mind the small sample sizes for this question, results should be regarded with caution.

Other demographic differences:

- Respondents who identify as male are more likely than those who identify as female to say their child(ren) between the ages of 6 months and under 5 years have received at least one dose (34% versus 18%).
- Those who reside in an urban area (as defined by them) are more likely to say their child(ren) in this age range has received at least one dose (36%) compared to those who live in a suburban area of small city (20%).

Respondents were asked if they have or believe they have been infected with COVID-19 and/or if anyone in their household has. A slight majority of respondents say they have/believe they have themselves been infected by COVID-19 (51%) and have had someone in their household (excluding themselves) infected with COVID-19 (52%). More respondents that are Indigenous and those between the ages of 18 to 39 say they have/believe they have been infected (66% and 59%, respectively), compared to 50% of respondents who are non-Indigenous and 46% of respondents who are 40 years or older. Younger respondents are also more likely to say that someone in their household (excluding themselves) has been infected with COVID-19 (62%), compared to respondents who are older (47%).

Exhibit A8. Q13: Have you ever been infected with COVID-19?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes	44%	61%	43%	51%	40%
	-	C	-	E	-
I think so (not confirmed by a positive PCR or rapid test)	7%	5%	7%	8%	6%
	-	-	-	-	-
No	45%	30%	46%	35%	51%
	-	-	B	-	D
DK/NR	3%	4%	3%	5%	3%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Exhibit A9. Q14: Has anyone (“else” for respondents who said “no” or “DK/NR” in Q13) in your household ever been infected with COVID-19?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes	47%	54%	47%	56%	43%
	-	-	-	E	-
I think so (not confirmed by a positive PCR or rapid test)	5%	4%	5%	6%	4%
	-	-	-	E	-
No	42%	39%	42%	32%	47%
	-	-	-	-	D
Not applicable	4%	1%	4%	3%	4%
	-	-	B	-	-
DK/NR	2%	2%	2%	3%	2%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Those who have a household income of under $40,000 are the most likely to say they have not contracted COVID-19 (55%).
- Respondents who do not have children at home are more likely than those who don’t say they have not been infected with COVID-19 (50% versus 35%) nor has anyone in their household (47% versus 28%).

Respondents were shown a series of public health measures that were recommended or implemented at various points during the COVID-19 pandemic and were asked how often they followed each. A majority of respondents say they always stay at home when they are sick (70%), use individual public health measures around vulnerable people (62%), wear a mask indoors when they’re feeling sick (60%), and wear a mask indoors when in public/around people from outside their household (56%). Three in ten say they always improve ventilation (29%) or wear a mask when outdoors (28%).

Exhibit A10. Q15: During the pandemic, how often have you followed the public health measures listed below?
Base: All respondents (n=2,088).

Row %	Always	Often	Sometimes	Rarely	Never	DK
Staying home and away from others if you feel sick	70%	18%	7%	2%	2%	1%
Using individual public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19	62%	22%	8%	3%	3%	3%
Wearing a mask inside with others when you're feeling sick	60%	17%	8%	4%	8%	3%

Wearing a mask when indoors in a public space or in an indoor space with people from outside your immediate household	56%	24%	12%	5%	3%	1%
Improving ventilation (even if just temporarily, such as when people from outside your immediate household are in your home)	29%	23%	18%	8%	15%	6%
Wearing a mask when outside	28%	19%	18%	16%	18%	0%

Looking at those who follow the public health guidelines often or more among the key audiences reveals some differences. Those results, which are ranked descending, are provided in the tables that follow.

The vast majority of respondents say they have always or often stayed home and away from others if they feel sick. Respondents who are 40 years or older are more likely than those who at 18 to 39 years to say they always or often stay home and away from others if they feel sick (90% versus 84%).

Exhibit A11. Q15a: During the pandemic, how often have you followed the public health measures listed below? Staying home and away from others if you feel sick.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Always/Often	88%	87%	88%	84%	90%
	-	-	-	-	D
Always	70%	67%	70%	59%	76%
	-	-	-	-	D
Often	18%	20%	18%	25%	14%
	-	-	-	E	-
Sometimes	7%	9%	7%	11%	5%
	-	-	-	E	-
Rarely	2%	3%	2%	3%	1%
	-	-	-	E	-
Never	2%	1%	2%	1%	2%
	-	-	-	-	-
Don’t know	1%	0%	1%	1%	1%
	-	-	B	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Three quarters of respondents (75%) who have received one or more booster doses say they always stay home and away from others when they feel sick; 16% say they often do. All told, at 91%, respondents with at least one booster dose are significantly more likely to always or often stay home (91%), compared to those with two (82%) or fewer vaccines (77%).

Exhibit A12. Q15a: During the pandemic, how often have you followed the public health measures listed below? Staying home and away from others if you feel sick.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Always/Often	88%	77%	82%	91%
	-	-	-	B C
Always	70%	56%	60%	75%
	-	-	-	B C
Often	18%	21%	22%	16%
	-	-	D	-
Sometimes	7%	9%	11%	5%
	-	-	D	-
Rarely	2%	5%	4%	1%
	-	D	D	-
Never	2%	6%	2%	1%
	-	-	-	-
Don't know	1%	3%	0%	1%
	-	-	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who identify as females are more likely than those who identify as males to say they always or often stay home and away from others when they are sick (92% versus 84%)
- Respondents who say they live in a rural area are the least likely to say they always or often stay home and away from others when they are sick (81% versus 88% nationally).

Over eight in ten respondents (83%) say they always or often use public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19. Respondents who are 40 years or older are more likely to always or often follow that guideline (at 87%) than those who are 18 to 39 years (78%).

Exhibit A13. Q15b: During the pandemic, how often have you followed the public health measures listed below? Using individual public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Always/Often	83%	85%	83%	78%	87%
	-	-	-	-	D
Always	62%	67%	62%	48%	69%
	-	-	-	-	D
Often	22%	18%	22%	30%	17%
	-	-	-	E	-
Sometimes	8%	10%	8%	13%	5%
	-	-	-	E	-
Rarely	3%	3%	3%	4%	2%
	-	-	-	E	-
Never	3%	0%	3%	2%	3%
	-	-	B	-	-
Don't know	3%	1%	3%	3%	3%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

There is a correlation between vaccination status and the extent to which an individual followed the guideline to use individual public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19. Specifically, those who have received three or more doses are the most likely to always or often follow that guideline (at 90%), followed by those who have received two doses (73%). Slightly more than half of respondents (54%) who have received a single dose or none say they always or often follow this public health guideline.

Exhibit A14. Q15b: During the pandemic, how often have you followed the public health measures listed below? Using individual public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Always/Often	83%	54%	73%	90%
	-	-	B	B C
Always	62%	35%	49%	68%
	-	-	B	B C
Often	22%	19%	23%	22%
	-	-	-	-
Sometimes	8%	17%	15%	5%
	-	D	D	-
Rarely	3%	7%	5%	2%
	-	D	D	-
Never	3%	12%	4%	2%
	-	C D	D	-
Don't know	3%	10%	3%	2%
	-	C D	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who identify as females (86%) are more likely than those who identify as males (81%) to say they always or often use individual public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19.
- Respondents who do not have children at home are more likely to follow this public health guideline always or often (85%), compared to 81% among respondents who do have children at home.
- Those who reside in the West coast or in the North are the least likely to say they always or often follow the guideline (80%).
- Respondents who were not born in Canada are more likely to say they always or often use individual public health measures when interacting with vulnerable individuals (88%), than those who were born in Canada (82%).

When it comes to wearing a mask inside with others when feeling sick, three-quarters (77%) of respondents say they always or often do this. Respondents who are 40 years or older are more likely than younger respondents to always or often follow this guideline (79% versus 73%).

Exhibit A15. Q15: During the pandemic, how often have you followed the public health measures listed below? Wearing a mask inside with others when you're feeling sick.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Always/Often	77%	74%	77%	73%	79%
	-	-	-	-	D
Always	60%	53%	61%	51%	65%
	-	-	-	-	D
Often	17%	21%	17%	23%	14%
	-	-	-	E	-
Sometimes	8%	14%	8%	12%	6%
	-	-	-	E	-
Rarely	4%	4%	4%	6%	2%
	-	-	-	E	-
Never	8%	5%	8%	7%	9%
	-	-	-	-	-
Don't know	3%	3%	3%	2%	4%
	-	-	-	-	D
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Vaccination status also has an impact on whether an individual is likely to wear a mask indoors around others when they are feeling sick. Specifically, respondents who have received at least one booster dose are almost twice as likely to say they always or often follow this guideline compared to those who have received zero or one dose (83% versus 45%).

Exhibit A16. Q15: During the pandemic, how often have you followed the public health measures listed below? Wearing a mask inside with others when you're feeling sick.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Always/Often	77%	45%	68%	83%
	-	-	B	B C
Always	60%	32%	48%	67%
	-	-	B	B C
Often	17%	13%	20%	17%
	-	-	-	-
Sometimes	8%	11%	13%	7%
	-	-	D	-
Rarely	4%	11%	6%	2%
	-	D	D	-
Never	8%	24%	10%	6%
	-	C D	D	-
Don't know	3%	9%	3%	2%
	-	C D	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who are retired (70% versus 60% nationally) or unable to work (74% versus 60% nationally) are more likely to say they always wear a mask inside when feeling sick.
- Those who were not born in Canada (82%) or whose first language is neither English nor French (89%) are more likely to say they always or often wear a mask inside when feeling sick.
- Those living in urban areas (80%) are more likely to say they always or often wear a mask inside when feeling sick than those living in suburban areas or small cities (76%).

When it comes to following the guideline to wear a mask indoors in a public space or in a space with people outside immediate household members, eight in ten respondents (79%) say they do this always or often. Looking at the key audiences, both non-Indigenous (80%) and those who are 40 years of age or older (83%) are significantly more likely to always or often follow this guideline than their counterparts (69% among Indigenous respondents and 73% among respondents 18 to 39 years of age).

Exhibit A17. Q15: During the pandemic, how often have you followed the public health measures listed below? Wearing a mask when indoors in a public space or in an indoor space with people from outside your immediate household.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Always/Often	79%	69%	80%	73%	83%
	-	-	B	-	D
Always	56%	47%	56%	41%	63%
	-	-	-	-	D
Often	24%	22%	24%	31%	20%
	-	-	-	E	-
Sometimes	12%	21%	11%	17%	9%
	-	-	-	E	-
Rarely	5%	5%	5%	6%	4%
	-	-	-	E	-
Never	3%	4%	3%	4%	3%
	-	-	-	-	-
Don’t know	1%	1%	1%	1%	0%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Vaccination status is correlated with how often an individual is likely to wear a mask when indoors in a public space or in an indoor space with people from outside their immediate household. Specifically, respondents who have received at least one booster dose are the most likely to say they always or often follow this guideline while those who have received zero or one dose are the least likely to (85% versus 53%).

Exhibit A18. Q15: During the pandemic, how often have you followed the public health measures listed below? Wearing a mask when indoors in a public space or in an indoor space with people from outside your immediate household.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Always/Often	79%	53%	69%	85%
	-	-	B	B C
Always	56%	30%	43%	62%
	-	-	B	B C
Often	24%	23%	26%	23%
	-	-	-	-
Sometimes	12%	15%	18%	10%
	-	-	D	-
Rarely	5%	14%	8%	3%
	-	D	D	-
Never	3%	15%	4%	2%
	-	C D	D	-
Don’t know	1%	3%	1%	0%
	-	-	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those unable to work (87%) or retired (89%) are more likely to always or often wear a mask indoors in a public space or in a space with people outside immediate household members.
- Those who were not born in Canada (88%) or whose first language is neither English nor French (90%) are more likely to always or often follow this guidance.
- Those whose first language is French (83%) are also more likely to always or often follow this guidance

When it comes to improving ventilation (even if just temporarily, such as when people from outside your immediate household are in your home), half (52%) of respondents say they do this always or often. Looking at the key audiences, Indigenous respondents are more likely than non-Indigenous respondents to say they always follow this guideline (42% versus 28%). Respondents who are 40 years or older are more likely than younger respondents to say they always or often improve ventilation as well (54% versus 47%).

Exhibit A19. Q15: During the pandemic, how often have you followed the public health measures listed below? Improving ventilation (even if just temporarily, such as when people from outside your immediate household are in your home).
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Always/Often	52%	58%	51%	47%	54%
	-	-	-	-	D
Always	29%	42%	28%	23%	32%
	-	C	-	-	D
Often	23%	16%	23%	24%	22%
	-	-	-	-	-
Sometimes	18%	18%	18%	24%	15%
	-	-	-	E	-
Rarely	8%	8%	8%	10%	7%
	-	-	-	-	-
Never	15%	9%	16%	13%	17%
	-	-	-	-	D
Don't know	6%	7%	6%	7%	6%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Vaccination status is correlated with how often an individual improves their ventilation. Specifically, respondents who have received at least one booster dose are the most likely to say they always or often follow this guideline while those who have received zero or one dose are the least likely to (55% versus 36%).

Exhibit A20. Q15: During the pandemic, how often have you followed the public health measures listed below? Improving ventilation (even if just temporarily, such as when people from outside your immediate household are in your home).
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Always/Often	52%	36%	47%	55%
	-	-	B	B C
Always	29%	24%	25%	30%
	-	-	-	C
Often	23%	11%	22%	24%
	-	-	B	B
Sometimes	18%	19%	20%	18%
	-	-	-	-
Rarely	8%	8%	9%	8%
	-	-	-	-
Never	15%	32%	17%	13%
	-	C D	-	-
Don't know	6%	5%	6%	7%
	-	-	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Residents of Ontario (55%) are more likely to say they always or often have been improving ventilation.
- Those who were not born in Canada (67%) or whose first language is neither English nor French (79%) are more likely to always or often follow this guidance.
- Those living in an urban area (57%) are also more likely to always or often do this.
- Those who identified as White (47%) are less likely than everyone else to be doing so.

Nearly half (48%) of respondents say they always or often wear a mask when outside. Respondents who are 40 years or older are significantly more likely than those who are 18 to 39 years to say they always or often do so (50% versus 43%).

Exhibit A21. Q15: During the pandemic, how often have you followed the public health measures listed below? Wearing a mask when outside.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Always/Often	48%	42%	48%	43%	50%
	-	-	-	-	D
Always	28%	26%	28%	23%	31%
	-	-	-	-	D
Often	19%	16%	19%	20%	19%
	-	-	-	-	-
Sometimes	18%	24%	18%	20%	18%
	-	-	-	-	-
Rarely	16%	16%	16%	18%	14%
	-	-	-	E	-
Never	18%	15%	18%	19%	18%
	-	-	-	-	-
Don’t know	0%	2%	0%	1%	0%
	-	-		--	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Vaccination status is correlated with how often one wears a mask while outside. Specifically, respondents who have received at least one booster dose are the most likely to say they always or often follow this guideline while those who have received zero or one dose are the least likely to (51% versus 24%).

Exhibit A22. Q15: During the pandemic, how often have you followed the public health measures listed below? Wearing a mask when outside.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Always/Often	48%	24%	45%	51%
	-	-	B	B C
Always	28%	12%	26%	31%
	-	-	B	B
Often	19%	12%	18%	20%
	-	-	-	B
Sometimes	18%	12%	14%	20%
	-	-	-	B C
Rarely	16%	16%	15%	16%
	-	-	-	-
Never	18%	47%	25%	13%
	-	C D	D	-
Don’t know	0%	1%	1%	0%
	-	-	-	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who were not born in Canada (67%) or whose first language is neither English nor French (71%) are more likely to always or often follow this guidance.
- Those living in an urban area (52%) and those with household incomes of less than $40,000 (53%) are also more likely to always or often do this.
- Those who identified as White (42%) are less likely than everyone else to be doing so.

Respondents were asked to reflect on the pandemic and express to what extent they have supported or opposed the proof-of-vaccination system required for certain activities. Slightly more than half (52%) of respondents say they have strongly supported or supported the proof-of-vaccination status. One-quarter (26%) say they have somewhat supported or neither supported nor opposed the system, while a similar proportion (23%) say they have opposed it (in varying degrees).

Non-Indigenous (53%) and respondents 40 years or older (59%) are more likely to say they have strongly supported or support the proof-of-vaccination system. Conversely, one-in-five Indigenous respondents (21%) say they have strongly opposed it.

Exhibit A23. Q16: During the pandemic so far, to what extent have you supported or opposed the proof-of-vaccination system where Canadians have been required to provide proof of vaccination status for certain activities such as attending large public events or travel.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	52%	40%	53%	39%	59%
	-	-	B	-	D
Strongly support	35%	25%	35%	21%	42%
	-	-	B	-	D
Support	17%	14%	17%	18%	17%
	-	-	-	-	-
Somewhat support	12%	9%	12%	15%	10%
	-	-	-	E	-
Neither support nor oppose	14%	16%	13%	19%	11%
	-	-	-	E	-
Somewhat oppose	6%	7%	6%	9%	4%
	-	-	-	E	-
Oppose	5%	7%	4%	6%	4%
	-	-	-	E	-
Strongly oppose	12%	21%	12%	12%	12%
	-	C	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

When looking at the support or opposition of the proof-of-vaccination system, there is a strong correlation between that level of support (or opposition) and vaccination status. That is, a strong majority (65%) of respondents who have at least one booster dose say they strongly support or support that system, with only 13% who feel some level of opposition to it. Conversely, respondents who have fewer than two doses have the opposite position. In fact, seven in ten (70%) of respondents who have no doses or just one say they have strongly opposed the proof-of-vaccination system, with only 7% who have supported it to some degree. Among respondents who have two doses (and would likely have been permitted at any event or activity that required a proof-of-vaccination), support and opposition is fairly evenly divided: 23% say they have strongly supported or supported the system, while 28% have strongly opposed or opposed it.

Exhibit A24. Q16: During the pandemic so far, to what extent have you supported or opposed the proof-of-vaccination system where Canadians have been required to provide proof of vaccination status for certain activities such as attending large public events or travel.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	52%	4%	23%	65%
	-	-	B	B C
Strongly support	35%	0%	10%	46%
	-	-	B	B C
Support	17%	4%	13%	20%
	-	-	B	B C
Somewhat support	12%	3%	13%	12%
	-	-	B	B
Neither support nor oppose	14%	12%	24%	11%
	-	-	B D	-
Somewhat oppose	6%	4%	11%	5%
	-	-	B D	-
Oppose	5%	8%	6%	4%
	-	-	D	-
Strongly oppose	12%	70%	22%	4%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those with household incomes of $80,000 or more (69%), those with university degrees (71%), those with no child at home (67%) and those who are retired (80%) are all more likely to indicate having been in support of the proof-of-vaccination requirement.
- Those who are self-employed (34%), those living in rural areas (30%), those with household incomes of less than $40,000 (27%), and those with a child at home (28%) are all more like to say they have been opposed to the requirement.

A list of potential public health measures was shown to respondents, and they were asked to consider the extent of support or opposition they would have for each if they were implemented to prevent a widespread outbreak.

If required to prevent a widespread outbreak, a majority of respondents would support (that is, strongly support or support) reimplementing a mask mandate (67%), a proof-of-vaccination system (58%), gathering limits (56%), travel restrictions (52%) and avoiding indoor gatherings with people outside one's household (51%). Fewer than half of respondents say they would support stay-at-home orders (47%), closing school or daycares (44%), or businesses (31%). Notably, opposition to closing business (26%) is stronger than support of it (31%).

The tables that follow details the results by key audiences and are ordered by the largest proportion of those who strongly support the measure to the least.

Exhibit A25. Q27: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them?
Base: All respondents (n=2,088).

Row %	NET: Strongly support/ Support	Strongly support	Support	Neither support nor oppose	Oppose	Strongly oppose
A requirement to wear a mask in indoor public settings	67%	36%	30%	16%	7%	10%
Requirements to provide proof of COVID-19 vaccination status for certain activities (for example, travel or attending large public events)	58%	32%	27%	17%	9%	16%
Gathering limits	56%	26%	31%	19%	12%	13%
Travel restrictions/border closures	52%	25%	27%	19%	14%	16%
Avoiding indoor gatherings with people outside of your household	51%	23%	28%	20%	14%	15%
Stay-at-home orders	47%	19%	27%	18%	16%	19%
School or daycare closures	44%	20%	24%	26%	14%	15%
Closing of businesses	31%	12%	19%	24%	24%	22%

When it comes to implementing a requirement to wear a mask in indoor public settings, two-thirds (67%) of respondents say they would support it, with 16% who say they would have a neutral position. Seventeen percent (17%) would oppose implementing that measure to prevent widespread outbreak. Respondents 40 years or older are more likely than those 18 to 39 years old to support implementing the measure (73% versus 54%).

Exhibit A26. Q27g: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? A requirement to wear a mask in indoor public settings.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	67%	61%	67%	54%	73%
	-	-	-	-	D
Strongly support	36%	37%	36%	24%	43%
	-	-	-	-	D
Support	30%	24%	31%	31%	30%
	-	-	-	-	-
Neither support nor oppose	16%	17%	16%	23%	12%
	-	-	-	E	-
Oppose	7%	7%	7%	11%	5%
	-	-	-	E	-
Strongly oppose	10%	15%	10%	12%	9%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Support of a requirement to wear a mask in indoor public settings is correlated with vaccination status. Respondents with at least one booster dose are over three times more likely to support implementing this measure to prevent widespread outbreak than those who have fewer than two doses (78% versus 24%). Among those who have two doses, support (45%) outweighs opposition (33%), but not to the same degree as those who have at least one booster dose.

Exhibit A27. Q27g: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? A requirement to wear a mask in indoor public settings.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	67%	24%	45%	78%
	-	-	B	B C
Strongly support	36%	11%	15%	45%
	-	-	-	B C
Support	30%	13%	29%	32%
	-	-	B	B
Neither support nor oppose	16%	24%	22%	13%
	-	D	D	-
Oppose	7%	12%	14%	5%
	-	D	D	-
Strongly oppose	10%	40%	19%	4%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those with no children at home (69%), those with a university degree (72%), those not born in Canada (76%) and those who are retired (84%) are all more likely to support a return to requiring masks to be worn in indoor public settings if necessary, in the future.
- Those who identify as male (20%), those with children at home (22%), those born in Canada (19%), those who identify as White (19%) and those living in rural areas (24%) are all more likely to say they would oppose that requirement.

When it comes to implementing a proof of COVID-19 vaccination status for certain activities to prevent widespread outbreak, a slight majority (58%) say they would support the measure. The remaining respondents hold a more neutral position (17%) or would oppose it (25%). Respondents 40 years or older are more likely (at 64%) to say they would support the measure, compared to respondents who are 18 to 39 years of age (47%).

Exhibit A28. Q27h: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Requirements to provide proof of COVID-19 vaccination status for certain activities (for example, travel or attending large public events).
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	58%	46%	59%	47%	64%
	-	-	-	-	D
Strongly support	32%	22%	32%	19%	38%
	-	-	-	-	D
Support	27%	24%	27%	27%	26%
	-	-	-	-	-
Neither support nor oppose	17%	18%	17%	23%	13%
	-	-	-	E	-
Oppose	9%	12%	9%	13%	8%
	-	-	-	E	-
Strongly oppose	16%	24%	15%	17%	15%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

When looking at the support or opposition of implementing a proof-of-vaccination system, there is a strong correlation between that level of support (or opposition) and vaccination status. That is, a strong majority (72%) of respondents who have at least one booster dose say they would strongly support or support that system, with only 14% who would feel some level of opposition to it. Conversely, respondents who have fewer than two doses have the opposite position. In fact, over three-quarters (77%) of respondents who have no doses or just one say they would strongly oppose the proof-of-vaccination system, with only 5% who would support it (none strongly). Among respondents who have two doses, support, and opposition more divided: 28% say they would support the system, while 44% would oppose it.

Exhibit A29. Q27h: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Requirements to provide proof of COVID-19 vaccination status for certain activities (for example, travel or attending large public events).
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	58%	5%	28%	72%
	-	-	B	B C
Strongly support	32%	0%	6%	42%
	-	-	B	B C
Support	27%	5%	21%	30%
	-	-	B	B C
Neither support nor oppose	17%	7%	29%	14%
	-	-	B D	B
Oppose	9%	10%	16%	8%
	-	-	D	-
Strongly oppose	16%	77%	28%	6%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those aged 65 years and older (75%), those with no children at home (61%), those with a university degree (65%), those not born in Canada (65%), those who are retired (75%) and those living in urban (62%) or suburban areas/small cities (57%) are all more likely to support a return to requiring proof-of-vaccination, if necessary.
- Those who are self-employed (42%), those living in rural areas (35%), those who identify as White (27%), those born in Canada (27%), those whose first language is French (31%), and those with a child at home (32%) are all more like to say they would oppose a return to this requirement.

When it comes to implementing gathering limits to prevent widespread outbreak, over half (56%) of respondents say they would support the measure, while one-quarter (25%) would oppose it. One in five respondents (19%) say they would neither support or oppose its implementation. Respondents who are 40 years or older are more likely to say they would support the measure (63%), compared to 43% of respondents who are 18 to 39 years of age.

Exhibit A30. Q27a: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Gathering limits.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	56%	54%	57%	43%	63%
	-	-	-	-	D
Strongly support	26%	26%	26%	14%	32%
	-	-	-	-	D
Support	31%	28%	31%	30%	31%
	-	-	-	-	-
Neither support nor oppose	19%	17%	19%	24%	16%
	-	-	-	E	-
Oppose	12%	8%	12%	16%	10%
	-	-	-	E	-
Strongly oppose	13%	21%	12%	16%	11%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

When looking at the support or opposition of implementing gathering limits, there is a strong correlation between that level of support (or opposition) and vaccination status. That is, two-thirds (67%) of respondents who have at least one booster dose say they would support that measure, with 17% who would feel some level of opposition to it. Conversely, respondents who have fewer than two doses have the opposite position. Specifically, six in ten (62%) of respondents who have no doses or just one say they oppose gathering limits, with 17% who would support it. Among respondents who have two doses, support and opposition more divided: 36% say they would support the limits, while 41% would oppose them.

Exhibit A31. Q27a: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Gathering limits.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	56%	17%	36%	67%
	-	-	B	B C
Strongly support	26%	9%	9%	32%
	-	-	-	B C
Support	31%	8%	27%	34%
	-	-	B	B C
Neither support nor oppose	19%	22%	24%	17%
	-	-	D	-
Oppose	12%	17%	18%	10%
	-	D	D	-
Strongly oppose	13%	45%	23%	7%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those with no children at home (59%), those who are unemployed (61%), unable to work (66%) or retired (72%), those not born in Canada (67%) those living in urban areas (59%) are all more likely to say they would support a return to gathering limits, if necessary.
- Those with children at home (31%) – and particularly, those with a child under 6 months (45%) – those living in Quebec (30%), those whose first language is French (30%), those who were born in Canada (27%) and those who identify as White (27%) are all more like to oppose a return to gathering limits.

When it comes to implementing travel restrictions or border closures to prevent widespread outbreak, half (52%) of respondents say they would support the measure, while three in ten (30%) would oppose it. One in five respondents (19%) say they would neither support nor oppose its implementation. Respondents who are 40 years or older are more likely to say they would support the measure (58%), compared to 40% of respondents who are 18 to 39 years of age.

Exhibit A32. Q27d: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Travel restrictions/border closures.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	52%	50%	52%	40%	58%
	-	-	-	-	D
Strongly support	25%	32%	25%	15%	31%
	-	-	-	-	D
Support	27%	18%	27%	25%	27%
	-	-	-	-	-
Neither support nor oppose	19%	19%	19%	25%	16%
	-	-	-	E	-
Oppose	14%	18%	13%	18%	11%
	-	-	-	E	-
Strongly oppose	16%	12%	16%	17%	15%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

When looking at the support or opposition of implementing travel restrictions, there is a correlation between that level of support (or opposition) and vaccination status. That is, six in ten respondents (61%) who have at least one booster dose say they would support that measure, with 22% who would feel some level of opposition to it. Conversely, respondents who have fewer than two doses hold the opposite position. Specifically, nearly two-thirds (64%) of respondents who have no doses or just one say they oppose travel restrictions, with 13% who would support it. Among respondents who have two doses, support and opposition are more divided: 36% say they would support the restrictions, while 41% would oppose them.

Exhibit A33. Q27d: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Travel restrictions/border closures.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	52%	13%	36%	61%
	-	-	B	B C
Strongly support	25%	7%	10%	32%
	-	-	-	B C
Support	27%	6%	26%	29%
	-	-	B	B
Neither support nor oppose	19%	23%	23%	17%
	-	-	D	-
Oppose	14%	15%	18%	12%
	-	-	D	-
Strongly oppose	16%	49%	23%	10%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who did not complete a high school education (73%), and those who are unemployed (63%), unable to work (67%) or retired (63%) are all more likely to say they would support a return to travel restrictions, if necessary.
- Those with children at home (33%), those with household incomes of $80,000 or more (32%), those who are employed fulltime (32%), those who are self-employed (44%) and those who identify as White (31%) are all more like to oppose a return to travel restrictions.

When it comes to avoiding indoor gatherings with people outside of one's household to prevent widespread outbreak, half (51%) of respondents say they would support the measure, while three in ten (29%) would oppose it. One in five respondents (20%) say they would neither support nor oppose that measure. Respondents who are 40 years or older are more likely to say they would support the measure (59%), compared to 35% of respondents who are 18 to 39 years of age.

Exhibit A34. Q27e: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Avoiding indoor gatherings with people outside of your household.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	51%	49%	51%	35%	59%
	-	-	-	-	D
Strongly support	23%	25%	23%	12%	29%
	-	-	-	-	D
Support	28%	25%	28%	23%	30%
	-	-	-	-	D
Neither support nor oppose	20%	21%	20%	27%	17%
	-	-	-	E	-
Oppose	14%	13%	14%	20%	11%
	-	-	-	E	-
Strongly oppose	15%	17%	14%	18%	13%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Support of a requirement to avoid indoor gatherings with people outside of one's own household is correlated with vaccination status. Respondents with at least one booster dose are nearly five times more likely to support implementing this measure to prevent widespread outbreak than those who have fewer than two doses (61% versus 13%). Among those who have two doses, opposition (46%) outweighs support (29%), but not to the same degree as those who have received one or no doses.

Exhibit A35. Q27e: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Avoiding indoor gatherings with people outside of your household.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	51%	13%	29%	61%
	-	-	B	B C
Strongly support	23%	6%	8%	29%
	-	-	-	B C
Support	28%	7%	22%	32%
	-	-	B	B C
Neither support nor oppose	20%	24%	25%	19%
	-	-	D	-
Oppose	14%	13%	19%	13%
	-	-	D	-
Strongly oppose	15%	50%	27%	7%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those with a university education (56%), those who are unable to work (61%) or retired (68%), those not born in Canada (60%), those whose first language is English (54%) or some language other than English of French (61%), and those living in an urban area (55%) are all more likely to say they would support a return to avoiding indoor gatherings with people outside of their home, if necessary.
- Those with children at home (36%), those living in Quebec (39%), those whose first language is French (40%), those born in Canada (31%), and those who identify as White (31%) are all more like to oppose a return to avoiding indoor gatherings with people outside of their home.

With fewer than half of respondents expressing support for closing school or daycares in order to prevent widespread outbreak, the variation between support and opposition is smaller (44% versus 29%). One-quarter (26%) say they would neither support nor oppose implementing the measure. Half (51%) of those who are 40 years of age or older say they would support the measure, which is significantly higher than respondents who are 18 to 39 years of age (33%).

Exhibit A36. Q27f: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? School or daycare closures.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	44%	53%	44%	33%	51%
	-	-	-	-	D
Strongly support	20%	36%	19%	12%	24%
	-	C	-	-	D
Support	24%	17%	25%	21%	26%
	-	-	-	-	D
Neither support nor oppose	26%	22%	26%	29%	24%
	-	-	-	E	-
Oppose	14%	14%	14%	19%	12%
	-	-	-	E	-
Strongly oppose	15%	11%	16%	19%	13%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Support of school or daycare closures to avoid widespread outbreak is correlated with vaccination status. Respondents with at least one booster dose are nearly five times more likely to support implementing this measure to prevent widespread outbreak than those who have fewer than two doses (52% versus 11%). Among those who have two doses, opposition (43%) outweighs support (31%), but not to the same degree as those who have received one or no doses.

Exhibit A37. Q27f: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? School or daycare closures.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	44%	11%	31%	52%
	-	-	B	B C
Strongly support	20%	6%	8%	25%
	-	-	-	B C
Support	24%	6%	23%	27%
	-	-	B	B
Neither support nor oppose	26%	28%	26%	26%
	-	-	-	-
Oppose	14%	11%	19%	13%
	-	-	B D	-
Strongly oppose	15%	49%	24%	9%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who are unemployed (54%), unable to work (56%) or retired (55%), those not born in Canada (50%), those living in an urban area (48%) are all more likely to say they would support a return to school or daycare closures, if necessary.
- Those with children at home (39%) – and particularly, those with children under 6 months (48%) – those who are self-employed (41%), those living in Quebec (39%), those whose first language is French (40%), those born in Canada (32%), and those who identify as White (32%) are all more like to oppose a return to school or daycare closures.

When it comes to implementing stay-at-home orders to prevent widespread outbreak, support and opposition are nearly balanced. Specifically, fewer than half (47%) of respondents say they would support the measure, while over one-third (35%) would oppose it. The remaining respondents (18%) say they would neither support nor oppose that measure. Respondents who are 40 years or older are more likely to say they would support the measure (54%), compared to 34% of respondents who are 18 to 39 years of age.

Exhibit A38. Q27b: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Stay-at-home orders.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	47%	47%	47%	34%	54%
	-	-	-	-	D
Strongly support	19%	23%	19%	11%	24%
	-	-	-	-	D
Support	27%	24%	27%	23%	30%
	-	-	-	-	D
Neither support nor oppose	18%	24%	18%	24%	14%
	-	-	-	E	-
Oppose	16%	17%	16%	20%	14%
	-	-	-	E	-
Strongly oppose	19%	13%	20%	22%	18%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

When looking at the support or opposition of implementing a stay-at-home order, there is a correlation between that level of support (or opposition) and vaccination status. That is, over half of respondents (56%) who have at least one booster dose say they would support that measure, with 28% who would feel some level of opposition to it. Conversely, respondents who have fewer than two doses hold the opposite position. Specifically, seven in ten respondents (72%) of respondents who have no doses or just one say they would oppose a stay-at-home order, with 12% who would support it. Among those who have two doses, opposition (50%) outweighs support (27%), but not to the same degree as those who have received one or no doses.

Exhibit A39. Q27b: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Stay-at-home orders.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	47%	12%	27%	56%
	-	-	B	B C
Strongly support	19%	6%	6%	25%
	-	-	-	B C
Support	27%	6%	21%	31%
	-	-	B	B C
Neither support nor oppose	18%	16%	24%	16%
	-	-	D	-
Oppose	16%	17%	20%	15%
	-	-	D	-
Strongly oppose	19%	55%	30%	13%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those aged 65 years or older (61%), those who are unemployed (52%), unable to work (61%) or retired (59%), those with no children at home (49%) or those whose children at home are aged 12-17 (48%), those not born in Canada (53%), those whose first language is English (50%) are all more likely to say they would support a return to stay-at-home orders, if necessary.
- Those with children at home (41%) – and particularly, those with children under 6 months (55%) – those living in Quebec (46%), those whose first language is French (48%), those born in Canada (38%), and those who identify as White (39%) are all more like to oppose a return to stay-at-home orders.

Support of implementing the closing of businesses to prevent widespread outbreak is the lowest, as 31% of respondents. In fact, opposition (46%) to this measure outweighs the support by fifteen percentage points. The remaining one-quarter respondents (24%) say they would neither support nor oppose the measure.

Overall support for the measure among Indigenous (32%) and non-Indigenous (31%) respondents is the same, however, Indigenous respondents' support has greater intensity, with 24% indicating that they would strongly support the measure, compared to 11% of non-Indigenous respondents. Compared to those who are 18 to 39 years of age (20%), respondents who are 40 years are more likely to support this measure (37%).

Exhibit A40. Q27c: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Closing of businesses.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Strongly support/Support	31%	32%	31%	20%	37%
	-	-	-	-	D
Strongly support	12%	24%	11%	7%	15%
	-	C	-	-	D
Support	19%	8%	19%	13%	22%
	-	-	B	-	D
Neither support nor oppose	24%	28%	24%	25%	23%
	-	-	-	-	-
Oppose	24%	19%	24%	29%	21%
	-	-	-	E	-
Strongly oppose	22%	21%	21%	26%	19%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Support of the closing of businesses to avoid widespread outbreak is correlated with vaccination status. Respondents with at least one booster dose are the most likely to support this measure (at 38%), despite opposition (at 38%) being as significant among this group overall. Conversely, only a handful of respondents who have fewer than two doses would support closing business (5%), while the vast majority (81%) would oppose it. Among those who have two doses,

opposition (60%) outweighs support (17%), but not to the same degree as those who have received one or no doses.

Exhibit A41. Q27c: In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? Closing of businesses.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Strongly support/Support	31%	5%	17%	38%
	-	-	B	B C
Strongly support	12%	2%	4%	15%
	-	-	-	B C
Support	19%	2%	13%	22%
	-	-	B	B C
Neither support nor oppose	24%	15%	24%	25%
	-	-	B	B
Oppose	24%	22%	28%	23%
	-	-	-	-
Strongly oppose	22%	59%	32%	15%
	-	C D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those aged 65 years or older (46%), those living in Atlantic Canada (42%), those who are retired (43%), and those who have not completed a high school education (49%) are all more likely to say they would support a return to the closing of businesses, if necessary.
- Those with children at home (50%) – and particularly, those with children under 6 months (61%) – those living in Quebec (51%), those whose first language is French (51%), and those born in Canada (47%) are all more like to oppose a return to the closing of businesses.

Perceptions of pandemic fatigue

Respondents were asked a question related to pandemic fatigue, which was defined to them as:

> Pandemic fatigue can be defined as the stress you may be feeling as a result of spending extra time and energy dealing with what has been your pandemic experience (e.g., illness, job, family, or other lifestyle changes).

Respondents were asked to use the definition provided to rate their individual level of pandemic fatigue, from zero being no fatigue at all, to ten being the worst possible pandemic fatigue. Respondents are fairly evenly divided along this pandemic fatigue scale, with one-fifth (20%) providing a rating between eight and ten (described as “very fatigued” herein, but left unlabeled for respondents), and three in ten respondents (28%) providing a rating between six and seven (described herein as “somewhat fatigued”). On the opposite end of the scale, one quarter (24%) would rate their level of pandemic fatigue between zero and two (described as “not fatigued at all”) and 12% give a rating of three or four (“not very fatigued”).

Looking at the key audiences, respondents between the ages of 18 and 39 are more likely to suggest they are fatigued, with 24% who are very fatigued and 35% who are somewhat fatigued. In contrast, 18% and 25% of respondents who are 40 years or older would say they are very or somewhat fatigued, respectively.

Exhibit A42. Q17: Using the definition above, on a scale of 0 to 10, how would you rate your individual level of pandemic fatigue overall, with 0 being no fatigue experience at all and 10 being the worst possible fatigue experience?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Very fatigued (8-10)	20%	21%	19%	24%	18%
	-	-	-	E	-
Somewhat fatigued (6-7)	28%	27%	28%	35%	25%
	-	-	-	E	-
5	16%	9%	16%	16%	16%
	-	-	-	-	-
Not very fatigued (3-4)	12%	15%	12%	11%	13%
	-	-	-	-	-
Not fatigued at all (0-2)	24%	27%	24%	14%	29%
	-	-	-	-	D
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

There is not a strong correlation between pandemic fatigue and vaccination status, though there are some differences. Specifically, respondents who do not have a booster dose are significantly more likely to be described as very fatigued (31% for zero or one dose, and 25% for two doses). This is in contrast to respondents who have at least one booster dose, of which 17% can be described as very fatigued. At the other end of the pandemic fatigue scale, the statistical difference lies between those with at least one booster dose and those who have received two doses; 27% of respondents with three or more doses can be described as not fatigued at all, compared to 16% of respondents who have two doses.

Exhibit A43. Q17: Using the definition above, on a scale of 0 to 10, how would you rate your individual level of pandemic fatigue overall, with 0 being no fatigue experience at all and 10 being the worst possible fatigue experience?
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Very fatigued (8-10)	20%	31%	25%	17%
	-	D	D	-
Somewhat fatigued (6-7)	28%	19%	34%	27%
	-	-	B D	B
5	16%	20%	15%	16%
	-	-	-	-
Not very fatigued (3-4)	12%	8%	11%	13%
	-	-	-	B
Not fatigued at all (0-2)	24%	22%	16%	27%
	-	-	-	C

Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who identify as female (22%), those with children at home (25%) – and particularly, those with children between 6 months and 5 years of age (30%) – are more likely to provide ratings of 8 to 10, indicating being "very fatigued."
- Those aged 65 years and older (39%), those with no children at home (27%), those are self-employed (34%) or retired (37%), those who identify as White (26%) and those living in rural areas (32%) are all most likely to provide the lowest ratings (0 to 2) on pandemic fatigue.

Future intention and behaviours

Survey respondents were asked a series of questions about their intentions regarding receiving additional COVID-19 vaccine doses offered in the future, in addition to the impact the pandemic has had on their impression of routine vaccinations and trust with various sources.

When asked how likely they are to get additional doses of a COVID-19 vaccine in the future, half (49%) say they are very likely to or definitely will. In the middle of the scale, 16% of respondents say they are somewhat likely and 10% are somewhat unlikely to. The remaining respondents (19%) are very unlikely to or say they definitely will not.

Exhibit A44. Q18: As additional COVID-19 vaccine doses are offered to you in the future, how likely are you to get one?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Definitely will/Very likely	49%	38%	49%	32%	58%
	-	-	-	-	D
Definitely will	34%	18%	35%	18%	43%
	-	-	B	-	D
Very likely	15%	20%	15%	14%	15%
	-	-	-	-	-
Somewhat likely	16%	13%	16%	22%	13%
	-	-	-	E	-
Somewhat unlikely	10%	13%	9%	16%	6%
	-	-	-	E	-
Very unlikely	7%	9%	7%	11%	5%
	-	-	-	E	
Definitely not	12%	22%	11%	12%	12%
	-	-	-	-	-
DK/NR	6%	5%	6%	7%	6%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Likelihood of getting additional doses of COVID-19 in the future is correlated with current vaccination status, where those who already have at least one booster dose are the most likely

to (65% are very likely to or definitely will), while those who have one dose or are unvaccinated are the least likely to (2% are very likely to or definitely will). Furthermore, three-quarters (74%) of respondents who have zero or one dose say they definitely will not get a COVID-19 vaccine dose in the future and one-quarter of those with two doses say the same. Only 2% of respondents who have at least one booster dose say they will definitely not get another in the future.

Exhibit A45. Q18: As additional COVID-19 vaccine doses are offered to you in the future, how likely are you to get one?
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
NET: Definitely will/Very likely	49%	2%	12%	65%
	-	-	B	B C
Definitely will	34%	1%	5%	46%
	-	-	B	B C
Very likely	15%	2%	7%	18%
	-	-	B	B C
Somewhat likely	16%	2%	18%	17%
	-	-	B	B
Somewhat unlikely	10%	6%	18%	8%
	-	-	B D	-
Very unlikely	7%	8%	20%	3%
	-	-	B D	-
Definitely not	12%	74%	23%	2%
	-	C D	D	-
DK/NR	6%	7%	9%	5%
	-	-	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those aged 65 years or older (72%), those with no children at home (53%), those unable to work (56%) or retired (74%), those who identify as White (52%) are all more likely to say they will get additional doses as they are offered.
- Those with children at home (24%), those who identify as Black (32%), and those who live in rural areas (29%) all indicate being unlikely more often than others to get additional doses as they are offered.

Respondents who said they were unlikely to get a future dose or who were uncertain were asked to provide the main reason(s) for their position. Reasons vary, though the top mentions center on how safe or unsafe the vaccines are and protection. Specifically, 32% of respondents say they are concerned about the long-term side effects and 17% are concerned about the safety of additional doses. Three in ten (29%) believe that the vaccine does not provide much protection since you can still contract COVID-19 and one-fifth (20%) say they feel protected enough by the doses they have already received.

Other respondents appear fatigued, with 16% who indicate that they are fed up with getting vaccinated, 14% who say they are tired of being told what to do to protect their health, and 11% who say they already received additional doses and do not want more. All other reasons are cited by 10% or fewer of respondents.

Compared to their counterpart, respondents who are 40 years or older are more likely to be uncertain or unlikely to get future doses due to the concern over long-term effects (36%) or because they have read or seen information about the vaccine safety that has scared them (13%). In turn, respondents 18 to 39 years of age are more likely to feel that they are protected enough with the current number of vaccine doses (25%).

Exhibit A46. Q21: What is/are the main reason(s) you are unlikely or uncertain about getting an additional COVID-19 vaccine dose?
Base: Respondents who are unlikely or uncertain about getting a future COVID-19 vaccine dose in the future from Q20 (n=844).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
I'm concerned about the long-term side effects of the vaccine	32%	30%	32%	27%	36%
	-	-	-	-	D
I feel that the vaccine does not provide much protection as you can still get COVID-19	29%	23%	29%	27%	30%
	-	-	-	-	-
I think I am protected enough with the current number of vaccine doses	20%	24%	20%	25%	16%
	-	-	-	E	-
I'm concerned about the safety of the additional doses	17%	20%	17%	14%	20%
	-	-	-	-	-
I'm fed up with getting vaccinated	16%	13%	17%	18%	15%
	-	-	-	-	-
I'm tired of being told what to do to protect my health	14%	19%	14%	15%	14%
	-	-	-	-	-
I already got additional doses and don't want to get more	11%	16%	10%	12%	10%
	-	-	-	-	-
I prefer to wait a while before getting vaccinated	10%	10%	10%	10%	10%
	-	-	-	-	-
I have read or seen information online about vaccine safety which worries me	10%	17%	10%	7%	13%
	-	-	-	-	D
I had short term non-serious side effects with COVID-19 vaccine additional doses	8%	6%	8%	10%	7%
	-	-	-	-	-
I'm not exposed to the risks of COVID-19 in my daily life and therefore I feel that I do not need to	5%	4%	6%	6%	5%
	-	-	-	-	-
Other	3%	0%	3%	3%	3%
	-	-	-	-	-
DK/NR	1%	3%	1%	1%	1%
	-	-	-	-	-
Sample size (n)	844	42*	794	567	277
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Among those who describe themselves as unlikely to get additional doses of the vaccine as they are offered, those who identify as male (33%) and those living in rural areas (43%) are more likely to say that it is because the vaccine doesn't offer much protection.
- Those identifying as men (24%), those living in Quebec (24%), and students (30%) skew higher than others on feeling they are already adequately protected.
- Those who identify as female (36%) and those living in rural areas (44%) are more likely than others to cite worry of long-term side effects as a reason for not getting additional doses.
- Those who identify as female (12%) are also more likely than others to say they prefer to wait a while.
- Those with household incomes of $80,000 or more (15%), those living in urban areas (14%), and people who do not identify as Black or White (18%) have a higher tendency to say they already received additional doses and do not want to receive more.

When asked if their pandemic experience has affected their intentions towards COVID-19 vaccines going forward, fewer than half of respondents 45% say their pandemic experience has impacted their intentions toward COVID-19 vaccines going forward, with one-third (33%) who say they are more likely to get recommended doses and 12% who say they are less likely to do so. Non-Indigenous respondents are more likely than Indigenous respondents to say their experience has made them more likely to get the recommended COVID-19 vaccines (34% versus 22%), as are respondents who are 40 years or older (37% compared to 28% of respondents 18 to 39).

Exhibit A47. Q22: Have your experiences during the pandemic affected your intentions towards COVID-19 vaccines going forward?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to get the recommended COVID-19 vaccines	33%	22%	34%	28%	37%
	-	-	B	-	D
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to get a recommended COVID-19 vaccine	36%	37%	36%	36%	36%
	-	-	-	-	-
Yes, I am less likely to get the recommended COVID-19 vaccines	12%	15%	12%	15%	10%
	-	-	-	E	-
No, the pandemic has not affected my decision making; I never planned to get a COVID-19 vaccine even prior to the vaccines being developed	9%	22%	8%	8%	9%
	-	C	-	-	-
DK	10%	5%	10%	13%	8%
	-			E	
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

One's vaccination status has an impact on whether the pandemic has impacted intentions toward COVID-19 vaccines going forward and to what extent. To begin, there is a significant difference between those who have zero or one dose and those with at least one booster in on each of the answers provided. Respondents who have three or more doses are also more likely than those who have two doses to be more likely to get the recommended vaccines (42% versus 14%). Whereas respondents who have zero or one dose are more likely than those with two doses to say that they never planned to get a COVID-19 vaccine and the pandemic did not change that.

Exhibit A48. Q22: Have your experiences during the pandemic affected your intentions towards COVID-19 vaccines going forward?
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to get the recommended COVID-19 vaccines	33%	1%	14%	42%
	-	-	B	B C
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to get a recommended COVID-19 vaccine	36%	6%	32%	40%
	-	-	B	B C
Yes, I am less likely to get the recommended COVID-19 vaccines	12%	20%	24%	7%
	-	D	D	-
No, the pandemic has not affected my decision making; I never planned to get a COVID-19 vaccine even prior to the vaccines being developed	9%	60%	12%	3%
	-	C D	D	-
DK	10%	12%	17%	7%
	-	-	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those aged 65 years or older (43%), those with university level education (38%), those who are retired (41%), and people who do not identify as Black or White (42%) are all more likely to say the pandemic experience has made them more likely to get vaccines going forward.
- Those who identify as male (14%) and those who identify as Black (33%) say the pandemic experience has made them less likely to get vaccines going forward.
- Those living in Ontario (10%) or West/North (10%), those who are self-employed (18%) and those who living in rural areas (17%) are all more likely than others to say the pandemic experience has them no less likely to get vaccines going forward because they were never going to get vaccinated anyway.

Respondents who indicated that their pandemic experience has made them less likely to get future COVID-19 vaccines were asked what their reasons are. The most common response, at four in ten respondents (40%) is the belief that vaccines need to have long term studies. Between three in ten and one-third of respondents say they do not trust Pharma or the Government (33%), that vaccines do not work very well (33%), believe that vaccines in general do not have much benefit in stopping the spread of viruses (32%), and say they have concerns about the safety of vaccines in general.

One-fifth of respondents say that COVID-19 vaccines have negatively impacted their view of on vaccines in general (21%), that we have strong immune systems without vaccines (18%), and that vaccines do not have as much benefit in preventing severe outcomes (18%).

Respondents who are 40 years of age or older are more likely than those who are 18 to 39 years to say that they are unlikely to get future doses due to their pandemic experience because they do not trust Pharma or Government (41% versus 23%), they do not think vaccines work very well (39% versus 25%), they do not believe that vaccines have as much benefit in stopping the spread of viruses (39% versus 23%), and they have concerns about the safety of vaccines in general (36% versus 22%).

Exhibit A49. Q23: If you are less likely to get the recommended COVID-19 vaccines, what are some reasons?
Base: Respondents who are less likely to get additional COVID-19 vaccine doses in the future in Q22 (n=287).

Column %	Total	Age	
		18-39 years	40+ years
Vaccinations need to have long term testing/studies	40%	38%	41%
	-	-	-
I do not trust Pharma or the Government	33%	23%	41%
	-	-	B
The pandemic has shown that vaccines do not work very well	33%	25%	39%
	-	-	B
I now believe that vaccines in general does not have as much benefit in stopping the spread of viruses	32%	23%	39%
	-	-	B
I have more concerns about the safety of vaccines in general	29%	22%	36%
	-	-	B
COVID-19 vaccines have negatively impacted my view on vaccines in general	21%	19%	22%
	-	-	-
The pandemic has shown that we have strong immune systems without vaccines	18%	16%	19%
	-	-	-
I now believe that vaccines do not have as much benefit in preventing severe outcomes	18%	19%	16%
	-	-	-
Other	4%	5%	3%
	-	-	-
DK	7%	9%	6%
	-	-	-
Sample size (n)	287	190	97*
Column label	A	B	C

*Bear in mind the small sample sizes. Results should be regarded with caution.

Relative to those who have two or more doses, those who have one or less doses of a COVID-19 vaccine are much more likely to say that there needs to be more long term testing (57%), that they do not trust Pharma or the Government (56%), and that the pandemic has shown that vaccines do not work very well (45%) when explaining why they are less likely to get additional doses in the future.

Exhibit A50. Q23: If you are less likely to get the recommended COVID-19 vaccines, what are some reasons?
Base: Respondents who are less likely to get additional COVID-19 vaccine doses in the future in Q22 (n=287).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Vaccinations need to have long term testing/studies	40%	57%	43%	32%
	-	-	-	-
I do not trust Pharma or the Government	33%	56%	33%	25%
	-	-	-	-
I now believe that vaccines in general does not have as much benefit in stopping the spread of viruses	32%	39%	37%	24%
	-	-	D	-
The pandemic has shown that vaccines do not work very well	33%	45%	32%	29%
	-	-	-	-
I have more concerns about the safety of vaccines in general	29%	38%	36%	21%
	-	-	D	-
COVID-19 vaccines have negatively impacted my view on vaccines in general	21%	37%	17%	20%
	-	-	-	-
The pandemic has shown that we have strong immune systems without vaccines	18%	38%	17%	12%
	-	-	-	-
I now believe that vaccines do not have as much benefit in preventing severe outcomes	18%	32%	18%	13%
	-	-	-	-
Other	4%	2%	3%	5%
	-	-	-	-
DK	7%	2%	3%	13%
	-	-	-	C
Sample size (n)	287	38*	127	122
Column label	A	B	C	D

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Because the number of respondents asked this question was relatively low, most demographic differences are not statistically significant.
- However, those who identify as male are more likely to say they do not trust pharma or government (38%) and that the pandemic has shown that vaccines do not work well (41%).
- Those with household incomes of less than $40,000 are more likely to say the pandemic has shown that we have strong immune systems without vaccines (31%).
- Compared to those whose first language is French, those whose first language is English respondents are more likely to say they have more concerns about the safety of vaccines in general (32%), that pandemic has shown that we have strong immune systems without vaccines (20%), and that they now believe that vaccines do not have as much benefit in preventing severe outcomes (20%).

Respondents who indicated that their pandemic experience had made them at least somewhat likely to get an additional COVID-19 vaccine dose were asked if, now that the COVID-19 vaccine is recommended at the same time as the flu shot, how likely they were to get it. Overall

four in five (80%) of respondents said that they were at least somewhat likely to do so, with over half (57%) saying that they were very likely to do so.
Two thirds (64%) of those aged 40 years or older said they were very likely to get the COVID-19 vaccine now that it was recommended at the same time as the flu shot, this compared with two in five (41%) of those aged 18 to 39 who said the same.

Exhibit A51. Q24: Now that the COVID vaccine is recommended at the same time as a flu shot, how likely are you to get it?
Base: Respondents who are at least somewhat likely to get additional COVID-19 vaccine doses in Q18 (n=1,244).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
NET: Very likely/Somewhat likely	80%	83%	80%	75%	82%
	-	-	-	-	D
Very likely	57%	59%	57%	41%	64%
	-	-	-	-	D
Somewhat likely	22%	24%	22%	34%	18%
	-	-	-	E	-
Not very likely	7%	6%	7%	13%	4%
	-	-	-	E	-
Not at all likely	2%	1%	2%	2%	2%
	-	-	-	-	-
I do not intend to get a flu shot	9%	5%	9%	8%	10%
	-	-	-	-	-
DK	3%	5%	3%	3%	3%
	-	-	-	-	-
Sample size (n)	1244	44*	1194	659	585
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Those aged over 65 years (86%), residents of Atlantic Canada (90%), those who are retired (86%) and those whose first language is English (82%) are all more likely to say they will get the regular, seasonal flu shot.
- Residents of Quebec (13%) and those whose first language is French (12%) skew a little higher on saying they are unlikely to get the regular, seasonal flu shot.

When asked how the pandemic affected their intentions towards routine vaccinations, 28% of respondents say they are now more likely to get recommended vaccines; 43% say that the pandemic has not affected their decision making and that they are just as likely to get routine vaccinations as before; 8% say they are less likely to get the recommended vaccinations; and 14% say they were never intending to get any of those types of vaccinations even prior to the pandemic.

When compared with non-Indigenous respondents, three in ten (28%) of whom say they are more likely to get recommended vaccines as a result of their pandemic experience, Indigenous respondents are less likely to say the same at 16%. Indigenous respondents are also the most likely to say that they are less likely to get recommended vaccines at 19%.

If older respondents are the most likely to say they are more likely to get recommended vaccines at three in ten (29%), younger respondents are the most likely to be uncertain about their future vaccine intentions at one in ten (10%).

Exhibit A52. Q25: Have your experiences during the pandemic affected your intentions towards routine vaccines (e.g., shingles, flu, polio) going forward?
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to get recommended vaccines	28%	16%	28%	25%	29%
	-	-	B	-	D
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to get a r	43%	37%	43%	42%	43%
	-	-	-	-	-
Yes, I am less likely to get recommended vaccines	8%	19%	8%	11%	7%
	-	C	-	E	-
No, the pandemic has not affected my decision making; I was not planning to get any of those types of vaccine even prior	14%	19%	13%	12%	14%
	-	-	-	-	-
DK	8%	8%	7%	10%	6%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Those living in Atlantic Canada (39%), those with university education (32%), and those who people who do not identify as Black or White (37%) are all more likely than others to say the pandemic experience has made them more likely to get recommended routine vaccines going forward.
- Those with children at home are a little more inclined than others to say the pandemic experience has made them less likely to get routine vaccines.

Respondents who have at least one child between the ages of 12 and 17 years were asked whether they would get their child(ren) vaccinated as additional doses of the COVID-19 vaccine become available. Three in five (60%) of respondents said they were at least somewhat likely to get their child(ren) additional doses, with 22% saying they definitely will, 17% saying they are very likely to do so, and 22% saying they are somewhat likely to do so. Only three in twenty (15%) said they definitely would not get their children additional COVID-19 vaccines.

Exhibit A53. Q19: As additional COVID-19 vaccine doses are offered to your child(ren) in the future, how likely are you to get one for your child(ren) aged 12-17?
Base: Respondents who have a child that is between the ages of 12 and 17 years (n=230).

Column %	Total	Age	
		18-39 years	40+ years
NET: Definitely will/Very likely	38%	36%	39%
	-	-	-
Definitely will	22%	16%	22%
	-	-	-
Very likely	17%	20%	16%
	-	-	-
Somewhat likely	22%	18%	22%
	-	-	-
Somewhat unlikely	9%	11%	9%
	-	-	-
Very unlikely	7%	11%	6%
	-	-	-
Definitely not	15%	16%	15%
	-	-	-
DK/NR	9%	8%	9%
	-	-	-
Sample size (n)	230	55*	175
Column label	A	B	C

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Because the number of respondents asked this question was relatively low, most demographic differences are not statistically significant.
- However, residents living in the West/North are more inclined than others to say they are less likely to get their children aged 12-17 vaccinated against COVID-19 as additional doses are offered.

The same question – whether parents would get their child(ren) additional doses of the COVID-19 vaccine – was asked of respondents between the ages of 5 and 11. Compared with those with older children, 60% of whom say they were at least somewhat likely to get their children additional doses, just over half (52%) of those with younger children said the same. Respondents with younger children were less likely to say that they definitely would (17%) get their child(ren) vaccinated with additional doses, and more likely to say they definitely would not (18%), than those with older child(ren) (at 22% and 15% respectively).

Exhibit A54. Q20: As additional COVID-19 vaccine doses are offered to your child(ren) in the future, how likely are you to get one for your child(ren) aged 5-11?
Base: Respondents who have a child that is between the ages of 5 and 11 years (n=282).

Column %	Total	Age	
		18-39 years	40+ years
NET: Definitely will/Very likely	34%	26%	40%
	-	-	B
Definitely will	17%	11%	21%
	-	-	B
Very likely	18%	15%	19%
	-	-	-
Somewhat likely	17%	19%	16%
	-	-	-
Somewhat unlikely	12%	12%	12%
	-	-	-
Very unlikely	9%	10%	7%
	-	-	-
Definitely not	18%	22%	16%
	-	-	-
DK/NR	9%	11%	8%
	-	-	-
Sample size (n)	282	170	112
Column label	A	B	C

Other demographic differences:

- Because the number of respondents asked this question was relatively low, most demographic differences are not statistically significant.
- However, those who identify as male are more inclined to say they will likely get their children aged 5-11 vaccinated against COVID-19 as additional doses are offered (44%).
- Conversely, those who identify as female are more inclined to say they are unlikely get their children aged 5-11 vaccinated against COVID-19 as additional doses are offered (35%).

Those with children under the age of 18 years were asked how they felt about giving their children routine vaccines going forward in light of their experiences over the pandemic. Over a quarter (28%) of parents surveyed said that they are now more likely to have their child(ren) get the recommended vaccines while almost half (46%) say they are just as likely to do so as they were prior to the pandemic. One in ten (9%) said that they are less likely to have their child get the recommended vaccines, or that they were never intending to have their child get the vaccines, respectively.

Exhibit A55. Q26: Have your experiences during the pandemic affected your intentions towards routine vaccines for your children (e.g., measles, mumps, rubella or flu vaccines) going forward? Base: Respondents who have a child that is under 18 years (n=679).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to have my child get recommended vaccines	28%	33%	28%	25%	30%
	-	-	-	-	-
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to have my	46%	26%	48%	49%	44%
	-	-	B	-	-
Yes, I am less likely to have my child get recommended vaccines	9%	13%	9%	10%	8%
	-	-	-	-	-
No, the pandemic has not affected my decision making; I was not planning to have my child get any of those types of vaccine even prior to the pandemic	9%	18%	9%	8%	10%
	-	-	-	-	-
DK	8%	11%	7%	8%	8%
	-	-	-	-	-
Sample size (n)	679	44*	629	412	267
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Other demographic differences:

- Because the number of respondents asked this question was relatively low, most demographic differences are not statistically significant.
- However, those born outside of Canada are more likely to say the pandemic experience has made them more likely to have their children receive the routine vaccines (35%).
- Those who identify as male are more inclined than others to say the pandemic experience has made them less likely to have their children receive the routine vaccines (12%).

Respondents were asked about how the experiences they lived over the course of the pandemic affected their trust in a range of sources that provided information related to vaccines and public health advice.

The sources that were most likely to be perceived by respondents as more trustworthy due to their pandemic experience are healthcare workers (34%) and scientists (31%). Respondents were also the most likely to say that their level of trust in these two sources had not been affected, and that it was just as high as it was at the beginning of the pandemic at 44% and 42% respectively – a number only eclipsed by those who said that their trust in friends and family remained as high as it was previously (46%).

On the other end of the spectrum, respondents were most likely to say that their trust in newspapers, radio, podcasts, and other forms of journalism (22%), as well as social media (25%), declined relative to their levels of trust prior to the pandemic.

When it comes to websites or briefings administered by the federal of provincial/territorial governments, just over a third (35% and 34% respectively) said their level of trust was just as high as it was at the beginning of the pandemic.

Exhibit A56. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice?
Base: All respondents (n=2,088).

Row %	Yes, I am more likely to trust this source	No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	Yes, I am less likely to trust this source	No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	DK
Scientists	31%	42%	12%	6%	10%
Healthcare workers (e.g., doctors, nurses)	34%	44%	9%	6%	8%
International health authorities (e.g., World Health Organization [WHO])	24%	34%	19%	10%	12%
Canadian federal government briefings and/or websites	22%	35%	17%	14%	12%
Provincial/Territorial government briefings and/or websites	21%	34%	19%	13%	13%
Newspapers, radio, podcasts and other journalism	11%	36%	22%	16%	16%
Friends and family	14%	46%	14%	10%	16%
Social media (e.g., Facebook, Twitter)	4%	16%	25%	44%	11%

When it comes to trust in scientists, almost a third (31%) of respondents say they are more likely to trust them as a source of information related to vaccines and public health advice. This compared with one in ten (12%) who say their trust in scientists have declined. At a quarter (24%), Indigenous respondents are more likely to say that they are less likely to trust scientists as a source of information than non-Indigenous respondents (11% who say the same).

Exhibit A57. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Scientists. Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	31%	27%	31%	28%	32%
	-	-	-	-	-
Yes, I am less likely to trust this source	12%	24%	11%	12%	12%
	-	C	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	42%	32%	42%	43%	41%
	-	-	-	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	6%	7%	6%	6%	6%
	-	-	-	-	-
I am unsure/don't know	10%	10%	10%	11%	9%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

The number of doses of a COVID-19 vaccine a respondent received is correlated to their level of trusts in scientists as a source of information on vaccine and public health information. One third (33%) of those with one dose or less are say they are less likely to trust scientists, compared with 21% of those with two doses, and only 7% of those who have three or more doses.

The fewer the doses a respondent has, the more likely they are to say that they did not trust scientists as a source of information even prior to the pandemic with 19% who have one dose or less saying so, and 12% of those with two doses saying the same.

Those with two doses are less are also the most likely to be uncertain about their levels of trust in scientists, with 15% of those with two doses saying so and 19% of those with one dose or less saying the same.

Exhibit A58. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Scientists. Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	31%	9%	19%	36%
	-	-	B	B C
Yes, I am less likely to trust this source	12%	33%	21%	7%
	-	C D	D	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	42%	20%	33%	47%
	-	-	B	B C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	6%	19%	12%	3%
	-	C D	D	-
I am unsure/don't know	10%	19%	15%	7%
	-	D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who have not completed high school (51%) and residents of Quebec (37%) are more likely than others to say they are now more likely to trust scientists.
- Those who identify as male (14%) and those whose first language is English (13%) are more inclined than others to say they now trust scientists less.

A third (34%) of respondents say that their trust in healthcare workers as a source of public health information increased over the pandemic, a plurality (44%) responded that, while their trust had not increased, it remained just as high as it was pre-pandemic. Those most uncertain were respondents aged 18 to 39, one in ten (10%) of whom reported being unsure.

Exhibit A59. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Healthcare workers (e.g., doctors, nurses).
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	34%	35%	34%	32%	35%
	-	-	-	-	-
Yes, I am less likely to trust this source	9%	18%	9%	10%	9%
	-	-	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	44%	31%	44%	43%	44%
	-	-	B	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	6%	8%	5%	5%	6%
	-	-	-	-	-
I am unsure/don't know	8%	9%	8%	10%	6%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

The number of doses of a COVID-19 vaccine that a respondent received again is correlated with levels of trust in healthcare workers as a source of information about vaccines and public health advice. One third (31%) of those who had one dose or less say they are less likely to trust healthcare workers, compared with 14% of those with two doses and only 6% of those with three or more doses who say the same.

Echoing the findings with the levels of trust in scientists, those with one dose or less of a COVID-19 vaccine were the most likely at one in five (19%) to say that they never trusted healthcare workers even prior to the pandemic.

Exhibit A60. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Healthcare workers (e.g., doctors, nurses).
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	34%	12%	27%	38%
	-	-	B	B C
Yes, I am less likely to trust this source	9%	31%	14%	6%
	-	C D	D	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	44%	26%	38%	47%
	-	-	B	B C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	6%	19%	9%	3%
	-	C D	D	-
I am unsure/don't know	8%	14%	12%	6%
	-	D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who have not completed high school (54%) are more likely than others to say they are now more likely to trust healthcare workers.
- Those who identify as male (11%), those with children at home (12%) and those whose first language is English (10%) are more inclined than others to say they now trust healthcare workers less.

A quarter (24%) of respondents reported that they were more likely to trust international health authorities such as the World Health Organization as a purveyor of public health advice and vaccine information as a result of their pandemic experiences, whereas one in five (19%) say that they are less likely to trust this source. A plurality (34%) say their level of trust is just as high as it was pre-pandemic, while 10% say they never trusted this source and another 12% say they are uncertain.

Exhibit A61. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? International health authorities (e.g., World Health Organization [WHO]).
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	24%	31%	24%	23%	25%
	-	-	-	-	-
Yes, I am less likely to trust this source	19%	20%	19%	20%	18%
	-	-	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	34%	17%	35%	36%	34%
	-	-	B	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	10%	20%	10%	8%	12%
	-	-	-	-	D
I am unsure/don't know	12%	12%	12%	12%	12%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Those with two or less doses of a COVID-19 vaccine are the most likely to report losing trust in international health authorities as a source of information: 28% of those with two doses saying so, and 34% of those with one dose or less saying the same.

If a plurality (39%) of those with three or more doses say that their levels of trust in international health authorities remain unaffected by the pandemic, almost a third (31%) of those with one dose or less say that they never vested any trust in such organizations.

Exhibit A62. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? International health authorities (e.g., World Health Organization [WHO]).
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	24%	6%	14%	29%
	-	-	B	B C
Yes, I am less likely to trust this source	19%	34%	28%	15%
	-	D	D	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	34%	14%	26%	39%
	-	-	B	B C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	10%	31%	16%	7%
	-	C D	D	-
I am unsure/don't know	12%	15%	16%	10%
	-	-	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Residents of Quebec (32%), those who have not completed high school (44%), and those whose first language is French (32%) are more likely than others to say they are now more likely to trust the WHO.
- Those who identify as male (23%), and those whose first language is English (20%) are more inclined than others to say they now trust the WHO less.

While a plurality (35%) of respondents reported that their trust in the websites and briefings of the Canadian federal government remained the same as its pre-pandemic levels, roughly similar proportions noted that they were more likely to trust this source (22%) as they were less likely to trust it (17%). Respondents between the ages of 18 and 39 were the most likely to report being uncertain at 17%.

Exhibit A63. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Canadian federal government briefings and/or websites.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	22%	27%	22%	20%	24%
	-	-	-	-	-
Yes, I am less likely to trust this source	17%	17%	17%	18%	16%
	-	-	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	35%	23%	36%	34%	36%
	-	-	B	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	14%	20%	13%	12%	15%
	-	-	-	-	-
I am unsure/don't know	12%	13%	12%	17%	10%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Those who have received two or fewer doses of a COVID-19 vaccine were less likely than those who received three or more doses to express trust in Canadian federal government briefings and websites. Over one third (36%) of those with one or less doses, and a quarter (25%) of those with two doses or less, say that they are less likely to trust this source.

In comparison, just over a quarter (27%) of those with three or more doses say that they are more likely to trust this source, while a plurality (41%) say that their levels of trust remain just as high as they were prior to the pandemic.

Exhibit A64. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Canadian federal government briefings and/or websites.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	22%	8%	13%	27%
	-	-	-	B C
Yes, I am less likely to trust this source	17%	36%	25%	13%
	-	C D	D	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	35%	10%	25%	41%
	-	-	B	B C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	14%	34%	20%	10%
	-	C D	D	-
I am unsure/don't know	12%	12%	18%	10%
	-	-	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Residents of Atlantic Canada (32%), Quebec (25%) and Ontario (23%) are all more likely than residents of West/North (17%) to say they are now more likely to trust Canadian federal government briefings/website.
- As well, those who identify as Black (34%) or people who do not identify as Black or White (28%) are more likely than those who identify as White (20%) to say they are now more likely to trust Canadian federal government briefings/website.
- Those who are self-employed (26%) or unemployed (23%) are more inclined than others to say they now trust Canadian federal government briefings/website less.

When it comes to trust in provincial and territorial government websites and briefings, the overall breakdown is similar to that of the federal government: 21% say they are more likely to trust this source, 19% say they are less likely to do so, 34% say their trust remains unaffected, 13% say they never trusted this source, and 13% say they are unsure.

Echoing what was seen above with the federal government, those aged 18 to 39 are the most likely to report not being certain at 17%.

Exhibit A65. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Provincial/Territorial government briefings and/or websites.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	21%	24%	21%	18%	23%
	-	-	-	-	D
Yes, I am less likely to trust this source	19%	21%	19%	22%	17%
	-	-	-	E	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	34%	23%	35%	33%	35%
	-	-	B	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	13%	20%	13%	10%	14%
	-	-	-	-	D
I am unsure/don't know	13%	12%	13%	17%	10%
	-	-	-	E	
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Respondents with one or fewer doses are even more likely to report losing trust in provincial or territorial governments as source of public health information over the course of the pandemic (41%) than they are to say the same of the federal government (36%). In contrast, the proportion of respondents who say they did not trust the federal government prior to the pandemic (34%) is higher than those who say the same of provincial or territorial governments (22%).

Again, echoing patterns seen above with the federal government, a plurality of those with three or more doses (38%) say that their levels of trust in provincial and territorial governments as sources of public health information remains just as high as it was prior to the pandemic.

Exhibit A66. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Provincial/Territorial government briefings and/or websites.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	21%	3%	14%	25%
	-	-	B	B C
Yes, I am less likely to trust this source	19%	41%	23%	16%
	-	C D	D	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	34%	18%	25%	38%
	-	-	-	B C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	13%	22%	18%	10%
	-	D	D	-
I am unsure/don't know	13%	16%	20%	10%
	-	-	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Residents of Atlantic Canada (31%), Quebec (27%) and Ontario (21%) are all more likely than residents of West/North (15%) to say they are now more likely to trust provincial/territorial government briefings/websites.
- Those who have not completed high school (45%), those living in urban areas (21%) or in suburbs/small cities (23%) and those whose first language is French (26%) are more likely than others to say they are now more likely to trust provincial/territorial government briefings/websites.
- Those who identify as male (21%), and those whose first language is English (21%) and residents of Ontario (22%) and West/North (22%) are more inclined than others to say they now trust provincial/territorial government briefings/websites less.

Overall respondents were more likely to say they had lost (22%) trust in various journalistic mediums as sources of public health information than say they had gained trust (11%) in these sources. A plurality of just over a third (36%) reported that their trust remained just as high as it was prior to the pandemic.

Exhibit A67. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Newspapers, radio, podcasts and other journalism.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	11%	13%	11%	10%	11%
	-	-	-	-	-
Yes, I am less likely to trust this source	22%	31%	21%	24%	20%
	-	-	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	36%	22%	37%	34%	37%
	-	-	B	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	16%	19%	16%	15%	16%
	-	-	-	-	-
I am unsure/don't know	16%	14%	16%	17%	15%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Those with one dose or less of a COVID-19 vaccine are more likely to report losing trust in various journalistic mediums as sources of public health advice (41%) with virtually none (3%) saying that their levels of trust had increased. Almost a third (30%) of this same group of respondents reported never placing any trust in journalistic sources in this regard, while a quarter (24%) of those with two doses say the same.

Paralleling patterns seen above, those with three or more doses are the most likely to indicate that their levels of trust in newspapers, radio, podcasts, and other journalism remains unchanged at 41%.

Exhibit A68. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Newspapers, radio, podcasts and other journalism.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	11%	3%	7%	12%
	-	-	B	B C
Yes, I am less likely to trust this source	22%	41%	25%	19%
	-	C D	D	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	36%	16%	25%	41%
	-	-	B	B C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	16%	30%	24%	12%
	-	D	D	-
I am unsure/don't know	16%	11%	19%	15%
	-	-	B	-
Sample size (n)	2088	163	543	1382

Column label	A	B	C	D

Other demographic differences:

- Residents of Atlantic Canada (21%), those who identify as Black (20%), people who do not identify as Black or White (15%), and those living in urban areas (12%) or in suburbs/small cities (11%) are all more likely than others to say they are now more likely to trust newspapers, radio, podcasts, and other journalism.
- Those whose first language is English (23%) are more inclined than others to say they now trust newspapers, radio, podcasts, and other journalism less.

At almost half (46%), respondents were the most likely to say that the pandemic had not affected their level of trust in their friends and family compared to other potential sources of information about vaccines and public health advice. While 14% of respondents nationwide say that they are less likely to trust friends and family as a result of their pandemic experiences, this number jumps to 18% among respondents aged 18 to 39 – this in comparison with 12% of those aged 40 or more.

Exhibit A69. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Friends and family.
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	14%	21%	13%	13%	14%
	-	-	-	-	-
Yes, I am less likely to trust this source	14%	19%	14%	18%	12%
	-	-	-	E	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	46%	35%	47%	43%	48%
	-	-	-	-	D
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	10%	10%	10%	10%	10%
	-	-	-	-	-
I am unsure/don't know	16%	15%	16%	16%	16%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

While 16% of respondents reported being unsure how their experiences over the pandemic had affected their levels of trust in friends and families as sources of public health advice, this number climbs to 21% among those with one or fewer doses and 20% of those with two doses.

Exhibit A70. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Friends and family.
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	14%	11%	13%	14%
	-	-	-	-
Yes, I am less likely to trust this source	14%	11%	15%	14%
	-	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	46%	42%	39%	49%
	-	-	-	C
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	10%	14%	13%	8%
	-	-	D	-
I am unsure/don’t know	16%	21%	20%	15%
	-		D	
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those whose first language is English (15%) or something other than French or English (22%) are all more likely than those whose first language is French (9%) to say they are now more likely to trust friends and family on this topic.
- Those who have not completed high school (34%) are also more likely than others to say they are now more likely to trust friends and family on this topic.

Among all the potential sources of information tested, overall levels of trust in social media was the lowest with over two in five (44%) saying they did not trust social media for information even prior to the pandemic.

There are differences by age, however, with half (49%) of those aged 40 or more saying they never trusted social media, compared with a third (34%) of those aged 18 to 39 who say the same. That being said, those aged 18 to 39 were more likely to report that their trust in social media had declined relative to their older counterparts (at 28% and 24% respectively).

Additionally, three in twenty (16%) non-Indigenous respondents say that their trust in social media remained unchanged whereas only 7% of Indigenous respondents say the same.

Exhibit A71. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Social media (e.g., Facebook, Twitter).
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Yes, I am more likely to trust this source	4%	15%	4%	5%	3%
	-	C	-	E	-
Yes, I am less likely to trust this source	25%	31%	25%	28%	24%
	-	-	-	E	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	16%	7%	16%	20%	13%
	-	-	B	E	
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	44%	37%	44%	34%	49%
	-	-	-	-	D
I am unsure/don't know	11%	11%	11%	12%	11%
	-	-	-	-	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

Unlike other potential sources of information which proved to be more polarizing a plurality of respondents – regardless of the number of COVID-19 doses they reported receiving – said they did not trust social media as a source of public health advice even pre-pandemic. This was true of two in five (39%) of those with two doses or less, as well as almost half (46%) of those with three doses or more.

Exhibit A72. Q28: Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? Social media (e.g., Facebook, Twitter).
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Yes, I am more likely to trust this source	4%	6%	4%	4%
	-	-	-	-
Yes, I am less likely to trust this source	25%	24%	24%	25%
	-	-	-	-
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	16%	13%	18%	15%
	-	-	-	-
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	44%	39%	39%	46%
	-	-	-	C
I am unsure/don't know	11%	18%	14%	10%
	-	D	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Residents of Ontario (7%), those who live in urban areas (6%) and those with children at home (6%) to say they are now more likely to trust social media on this topic.
- Those whose first language is English (26%) or something other than English or French (37%), those who identify as White (24%) or people who do not identify as Black or White (29%) and those with children at home (29%) are more inclined than others to say they now trust social media less on this topic.

When asked which measures might be useful in the future to help guide personal decision making about vaccines and other public health measures, over half (51%) of respondents opted for clear communications from the government and public health officials. This was followed by information on the spread of COVID-19 in the respondent's community (45%); information on the effectiveness of individual public health measures (43%); information about potential risks to themselves (42%); and information on the spread of a cold, flu, or other respiratory illness going around in their community (40%). Just under a third (29%) of respondents opted to rely on their own common sense.

Respondents over the age of 40 were more likely than those between the age of 18 and 39 to select any of the options presented.

Exhibit A73. Q29: Based on your experiences during the pandemic, which of the following do you think would be useful in the future to help your decision making about vaccines and other public health measures (e.g., wearing a mask).
Base: All respondents (n=2,088).

Column %	Total	Indigenous identity		Age	
		Indigenous	Non-Indigenous	18-39 years	40+ years
Clear communications from the government/public health officials on when and which individual public health measures should be used	51%	41%	52%	43%	55%
	-	-	-	-	D
Information on the spread of COVID-19 in my community	45%	36%	45%	37%	49%
	-				D
Information on the effectiveness of individual public health measures	43%	44%	43%	40%	44%
	-	-	-	-	-
Information about potential risks to myself personally (i.e., infection, severe illness)	42%	29%	43%	37%	45%
	-	-	B	-	D
Information on the spread of a cold, flu or other respiratory illness going around in my community	40%	31%	40%	34%	43%
	-	-	-	-	D
I will use my own common sense	29%	45%	28%	26%	31%
	-	C	-	-	-
Do not trust government/health officials	11%	15%	11%	10%	12%
	-	-	-	-	-
None / Nothing / No information	3%	0%	3%	4%	2%
	-	-	B	E	-
DK	6%	2%	6%	8%	4%
	-	-	-	E	-
Sample size (n)	2088	86*	1988	1226	862
Column label	A	B	C	D	E

*Bear in mind the small sample sizes. Results should be regarded with caution.

For every measure tested, the more doses that a respond had received, the more likely they were to select it as a useful future option to help guide decision making about vaccines and other public health measures. Over half (56%) of those with one or fewer doses say they will rely on their own common sense, compared with a third (34%) of those who received two doses, as well as a quarter (25%) who have three or more doses who say the same.

Exhibit A74. Q29: Based on your experiences during the pandemic, which of the following do you think would be useful in the future to help your decision making about vaccines and other public health measures (e.g., wearing a mask)
Base: All respondents (n=2,088).

Column %	Total	Vaccine status		
		0-1 dose(s)	2 doses	3+ doses
Clear communications from the government/public health officials on when and which individual public health measures should be used	51%	13%	30%	61%
	-	-	B	B C
Information on the spread of COVID-19 in my community	45%	17%	26%	53%
	-	-	B	B C
Information on the effectiveness of individual public health measures	43%	18%	31%	49%
	-	-	B	B C
Information about potential risks to myself personally (i.e., infection, severe illness)	42%	19%	25%	50%
	-	-	-	B C
Information on the spread of a cold, flu or other respiratory illness going around in my community	40%	13%	24%	47%
	-	-	B	B C
I will use my own common sense	29%	56%	34%	25%
	-	C D	D	-
Do not trust government/health officials	11%	42%	17%	6%
	-	C D	D	-
None/ Nothing / No information	3%	10%	7%	1%
	-	D	D	-
DK	6%	5%	8%	5%
	-	-	D	-
Sample size (n)	2088	163	543	1382
Column label	A	B	C	D

Other demographic differences:

- Those who are retired and those aged 65 years or older, those with no children at home and those whose first language is English were all more likely than others to any of the types of information or clarity of communications would be useful to their decision-making in the future.
- Those unable to work (43%) and those with household incomes of less than $40,000 (37%) were more likely than others to say they will be using their own common sense.

Section B: Qualitative research

The following qualitative results are divided into four sections: COVID-19 experience; Perceptions of pandemic fatigue; Future intentions and behaviours; and Communications needs and preferences.

The target audiences for the online focus groups were: adults aged 18 to 39 years; adults aged 18 and older; Indigenous adult Canadians who live off-reservation; and health care professionals (including general practitioners, nurses and pharmacists).

Qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is not designed to help a group reach a consensus or to make decisions, but rather to elicit the full range of ideas, attitudes, experiences, and opinions of a selected sample of participants on a defined topic.

Because of the small numbers involved, the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn, and findings cannot reliably be generalized beyond their number. As such, results are directional only. Except where specifically identified, the qualitative findings represent the combined results across the various audiences and for both English and French participants.

For the purposes of this report, members of the general population are referred to as non-health care professionals while those working in health care are referred to as health care professionals. Quotations used throughout this section were selected to bring the analysis to life and provide unique verbatim commentary from participants across the various audiences.

Details about the focus group design, methodology, and analysis may be found in the qualitative methodology report in Appendix B.

COVID-19 experience

Personal experiences with COVID-19 infection among participants were almost universal, with virtually every participant having either been infected themselves or having someone in their household who was infected. Only a few participants reported having neither experienced COVID-19 firsthand, nor having experienced it in the context of someone else in their household being infected. Among the minority who had not been personally infected, some suggested that they might have been infected and had simply not known. Others felt that it was only a matter of time before they too were infected. As one participant noted, “Je n'ai pas encore eu de COVID, mais je trouve ça bizarre.” (I haven’t had COVID yet, but I find that bizarre.) – Indigenous, Quebec

Overall, participants were very open about their experiences of infection with some additionally noting that they welcomed the fact that someone was listening to their stories. The act of sharing their experience with a group was even identified by some participants as an important step, especially against the backdrop of a perceived divide between those who have received COVID-19 vaccines and those who have not.

> “C'était bon de partager. Parfois, je me sens seul. C'était bon pour moi de partager ce qui s'est passé pendant la pandémie.” (It was good to share.

> Sometimes I feel lonely. It was good for me to share what happened during the pandemic.) – Indigenous, Quebec

When it came to individual experiences of infection, participants shared a great diversity of stories, but tended to focus on the description of their symptoms, the severity of the symptoms, and the length of time it took to recover from COVID-19. Many participants reported having mild symptoms that only represented a minor inconvenience – which often led them to characterize themselves as fortunate relative to those who had more severe symptoms and outcomes. If a majority of participants reported relatively manageable symptoms, most groups that were not focused on health care professionals had at least one person who described a far more serious and challenging experience with COVID-19. The severity of the experience was typically linked to the symptoms experienced, the residual health impacts, and/or the anxiety surrounding uncertain health outcomes.

> "It was extremely bad for me. It was almost to the point of going to the hospital. My husband then got it a week later, he got a cough and a sniffle, and it seemed like I was going to get better, but then it came back. And now I have long COVID." – Adult (18+), Atlantic Canada

> "[After describing symptoms of brain swelling and high blood pressure] Now I am on pills for the rest of my life." – Adult (18-39), West

> "I had the Delta. It was the sickest I have ever been in my life." – Indigenous, Atlantic Canada

> "They suspect I have long COVID. I have damage to my kidneys and lungs. It's really impacted my physical and mental health. It's been a long couple years." – Indigenous, Ontario

> "Pendant trois jours, c'était le chaos total - c'était la misère tout simplement d'exister." (During three days it was complete chaos – it was misery simply existing.) – Adult (18-39), Quebec

Those who had personal experience with infection often, but not always, described an array of other ways in which their lives were impacted. Some of the commonly cited impacts included having their income negatively impacted, with some noting that they had to change jobs or professions; struggling to deal with the logistic of quarantining, in particular when it came to managing working from home in busy or small households; as well as having to curtail many social and recreational activities and the consequences this had on the mental health of participants.

Those with children highlighted the unique challenges that this engendered. Some of the issues mentioned by participants with children included trying to find meaningful activities for them to do at home, trying to ensure that they were keeping up with their schoolwork, and taking care of them when they were sick. Parents noted that this was particularly difficult against the backdrop of uncertain employment situations in light of COVID-19 restrictions and/or having to shift to working from home.

> "Huit de mes dix enfants l'ont eu. Ma femme a dû aller aux urgences alors qu'elle était enceinte. C'était un désastre." (Eight out of my ten children got it. My wife

> needed to go to the ER while she was pregnant. It was a disaster.) – Adult (18+), Quebec

> "The only part that I found COVID was a real issue with, was kids in school." – Adult (18+), Atlantic Canada

> "Our biggest issue was managing kids who were supposed to be in school." – Health Care Professional, Atlantic Canada

> "Le plus difficile a été de concilier la naissance d'un enfant, le travail à distance et la quarantaine." (The most difficult was balancing having a child, remote work, and the quarantine.) – Adults (18-39), Quebec

While the impacts on the personal lives of health care professionals tended to be consistent with the experiences listed by other participants, the ways in which COVID-19 factored into their professional lives varied significantly both from non-health care professionals as well as those who worked in different areas of the health care system. If there was a unifying thread tying together all the diverse experiences of health care professionals, it was the challenges, stressors, and emotional toll introduced by the COVID-19 pandemic.

> "I remember getting off the phone and thinking, 'I'm out'." – Health Care Professional, Atlantic Canada

> "Feel like we in health care are running on empty. We've been on a war footing in health care, running on adrenaline for the first couple of years without ever closing or reducing access for care. Now we have a backlog of cancer and other complex diagnoses." – Health Care Professional, West

> "You need to do what needs to be done. But it's the physical fatigue." – Health Care Professional, Atlantic Canada

This was reflected in the move to virtual care – a move which elicited concern from a number of health care professionals who, while acknowledging the benefits, also noted that this affected the quality of care they were able to provide. To this point, one respondent shared that a family member had passed away a few days before the focus group due to a misdiagnosis stemming from virtual care and a delayed physical assessment.

> "Maple has resulted in some disasters in our chemo patients." – Health Care Professional, Atlantic Canada

> "Virtual care has a great place, but if that's the only place you can access medicine, I'm really concerned." – Health Care Professional, Atlantic Canada

Many health care professionals also cited the emotional toll that the pandemic had taken on them personally and professionally, with many also expressing that they were burnt out. Feelings of anxiety, stress, and of being overwhelmed were all noted by various participants. This was especially true of those such as nurses who ended up being the primary point of care for many – a position described as particularly difficult in the highly uncertain context of shifting pandemic restrictions and of contradictory information.

> "There were days I would cry after work because it was emotionally draining. You never knew who you were going to talk to. About 50% of the time it was good, but there was a lot of bad as well." – Health Care Professional, Atlantic Canada

> "[In response to the above comment] You're not alone. I cried too. I think most of my team did most nights." – Health Care Professional, Atlantic Canada

As for their part, pharmacists, and especially those who owned their own businesses, saw themselves as part of the solution. In particular, they witnessed a surge in the success of their businesses as pharmacies became a go-to location for just about everything pandemic-related (e.g., groceries/essentials, personal protective equipment, polymerase chain reaction tests, rapid test kits, COVID-19 vaccinations).

> "The pharmacy was the only place people could easily and safely go to. Being part of the solution was kind of cool." – Health Care Professional, West

When prompted to discuss how participants coped over the course of the COVID-19 pandemic, responses varied widely and appeared to be related to the severity of the symptoms that a participant had experienced. Discussions included some participants who felt that coping was an overstatement given how minimal their symptoms were, to others who experienced COVID-19 as far more disruptive to their lives both during and after the infection period. Throughout, many respondents expressed a stoicism reflected in comments about how one simply had to get through it or soldier on. To this, some participants added that the support their received from the Government of Canada, as well as friends and family, had proved important.

Indigenous participants, particularly those in Western Canada and Quebec, raised a number of Indigenous specific aspects to coping with, and navigating through, the pandemic. These included relying on traditional medicine, spiritual resilience, seeking council with elders, and drawing on support from their community to provide and/or receive help. A few also expressed how Indigenous experiences of COVID-19 appeared to differ from what was happening in the rest of Canada.

> "Je suis Métis et j'ai une famille blanche et une famille autochtone. Ma famille autochtone a dit que nous verrons si le grand esprit nous guérit - la nature est notre pharmacie. Ma famille blanche était beaucoup plus inquiète. J'étais pris entre les deux camps, les regardant se jeter des pierres. J'étais moi-même neutre. (I'm Métis and have a White family and an Indigenous family. My Indigenous family said we'll see if the great spirit heals us—nature is our pharmacy. My White family was much more worried. I was caught between the two sides, watching them throw rocks at each other. I was neutral myself.) – Indigenous, Quebec

> "It seems like First Nations are more restricted than the rest of society." – Indigenous, West

It is also worth noting that participants made links between their experiences with being infected with COVID-19 and being vaccinated. For some, this led to better outcomes in the sense that they experienced milder symptoms than they anticipated. Other participants, however, felt that their vaccination had done little to nothing to protect them or alleviate their symptoms.

> "The vaccine protected me in some ways, so I was glad I took the vaccines." – Adult (18+), Ontario

For non-health care professionals, discussions on how their lives have been affected by the threat of risk of infection was sometimes the first point in the discussion where polarized views of the threat began to be elicited. While all participants felt that there had been some sort of impact – notably when it came to questions of employment, social life, finances, or mental health – opinions diverged as to whether this was the result of the policies put in place or the fear of infection itself.

When it came to the perceived risk posed by COVID-19 over the coming winter, the opinions shared by non-health care professionals during discussions were quite diverse. Despite this, it appeared that most participants felt that the worst was past and that the risks going forward were not as severe as they once were. This is not to say that participants did not think they would be infected, but instead that they perceived the risks associated with being infected as far lower than they might once have. This was particularly true of younger participants, with those aged 18-39 more likely to describe the risks of the coming winter as insignificant.

> "Am I scared to get it again? Absolutely not... I'm just living the way I used to live." – Adult (18+), Atlantic Canada

> "Je ne suis pas effrayé par le COVID lui-même, car je sais ce que c'est." (I'm not scared by COVID itself because I know what it is.) – Adult (18-39), Quebec

> "At this point I think COVID is obsolete." Adult (18-39), Atlantic Canada

> "Je considère que c'est pratiquement terminé, conclu - maintenant, cela deviendra simplement une maladie infectieuse que nous attrapons comme n'importe quelle autre." (I see it as practically over, concluded – now it will just become an infectious disease that we catch just like any other.) Adult (18-39), Quebec

Exceptions to this were generally those who had experienced far more severe symptoms in the short- or long-term; many of whom felt that significant risks were still present for themselves, for their children, and/or for their loved ones. Many who felt the risk was as great or greater, noted the complications influenza and other respiratory illnesses (e.g., respiratory syncytial virus) pose heading into the winter months.

> "I am immunocompromised, so my family has decided that come December 1, we are going to start masking again. My daughter is 9, so she's not thrilled. But you see that sickness is already spreading." – Adult (18+), Ontario

> "I have survived COVID before, and I would likely survive it again. But I don't think that's true of my friend battling cancer, so I don't go visit her." – Indigenous, Atlantic Canada

> "Seems like the main focus now is the flu or RSV." – Adult (18-39), West

While health care professionals did not feel the risk posed solely by COVID-19 was as high as it once was among vaccinated populations (with the exception of the elderly and the

immunocompromised), there was a sense of concern and urgency surrounding the "triple-demic" overloading emergency rooms in the wake of public health measures being scaled back.

> "The risk right now is COVID itself, but also other respiratory viruses that are also currently circulating." – Health Care Professional, West

> "Burden to a system that was already well over capacity [in reference to the coming flu season]." – Health Care Professional, Atlantic Canada

Health care professionals also highlighted the residual implications of the pandemic on the health care system writ large. Issues raised included: the inordinate number of professionals who have left the profession (e.g., nurses, pharmacy assistants/staff); family doctors now managing higher risk patients because of the lack of specialists; wait times for elective surgery; and the reliance of the general public on virtual care platforms (e.g., Maple app) and their predilection for recommending hospital emergency visits, to name a few.

> "I still think we're never going to get caught up from the backlog of patients. I can't fix this problem." – Health Care Professional, West

> "The trickle-down effect: [family doctors] are managing more because the capacity is getting less and less." – Health Care Professional, Atlantic Canada

> "People have news updates but little insight into the depth of burnout and attrition amongst health care professionals and how long-term the effects of this will be. They don't recognize that there hasn't been any structural change to improve the system." – Health Care Professional, West

> "The public doesn't really get a sense about the amount of pressure put on pharmacies." – Health Care Professional, West

Perceptions of pandemic fatigue

When prompted with a definition of pandemic fatigue and given an opportunity to self-assess their own level of pandemic fatigue on a 10-point scale, participants offered a range of different responses. Over the course of the groups, every point on the scale was selected at some point.

Exhibit B1. On a scale of 1-10, how you would rate your individual level of pandemic fatigue overall? (Response options: 1 = No fatigue experience at all, 10 = Worst possible fatigue) Base: All valid responses (n=140).

	Total	General Population	Health Care Professionals
Very fatigued (8-10)	48	36	12
Somewhat fatigued (6-7)	39	27	12
5	17	14	3
Not very fatigued (3-4)	25	19	6
Not fatigued at all (1-2)	11	9	2
Number of participants	140	105	35

As the discussion evolved, many participants explained that their rating would have been higher had they been asked at the beginning of the pandemic but that their fatigue had decreased, often as a result of loosening public health measures and increased vaccine uptake.

Despite this, there was nonetheless still a sense of lingering fatigue among non-health care professionals. Of note, the level of fatigue expressed did not appear to necessarily depend on a participants' experiences with infection, although this was certainly a contributing factor amongst those who had more severe or challenging experiences of being infected with COVID-19. Some participants traced the root of their fatigue back to having to comply with public health measures or, in some instances, the social pressure they felt to comply with these recommendations and requirements.

> "Burnt out. Done with it. Constantly hearing it. We're still needing to do everything at work. It's being pushed and pushed and pushed… when is enough, enough?" – Adult (18-39), Ontario

> "Nous avions l'impression d'étouffer, et ce n'était pas parce que nous avions le COVID. C'est parce que nous ne pouvions pas sortir de chez nous et que notre santé physique se dégradait." (We had the impression that we were suffocating, and it wasn't because we had COVID. It's because we couldn't leave our homes and our physical health was degrading.) - Adults (18-39), Quebec

> "I am completely over all the guidelines. It's so greatly affected me. People have changed now." – Adult (18+), Ontario

As mentioned previously, parents underlined the difficulties of juggling working from home, having to take an active role in the schooling of their children, and navigating the anxiety and stress of having to care for sick children while also feeling sick themselves.

Health care professionals, for their part, expressed many of the same feelings of fatigue associated with the challenge of managing their personal lives in highly uncertain times. When it came to their professional lives, however, there was a deep sense of fatigue and burnout among health care professionals. As alluded to above, many health care professionals spoke to the emotional toll induced by the pandemic.

> "Since the pandemic started, I've never worked this hard in my entire life." – Health Care Professional, West

While many continued to adopt a stoic attitude and noted the importance of their work, other health care professionals offered that they felt completely overwhelmed by the scope of the problems – that the system was breaking down around them and that there was nothing they could do. As one family physician put it: "We're sinking."

The fatigue felt by health care professionals was, to a certain extent, understood by the public. Many non-health care professionals suggested that they felt that the impacts on health care workers have been significant even if they themselves did not fully understand it. That being said, in many groups there was at least one participant who felt the impacts have been exaggerated.

> "Je trouve ça triste pour les personnels de santé avec leur charge de travail qui fluctue autant, sauf qu'après c'est des choix de société. On est un pays du G7 mais on a un système de santé qui est digne d'un pays en voie de développement." (I find it sad for the health care workers with their workloads that fluctuate so much, except that after that it's society's choices. We're a G7 country but we have a health system that is worthy of a developing country.) – Adult (18-39), Quebec

> "Unless you're in it, or have a family member in it, I don't think we can fully comprehend how exhausted the health care workers are. I think the whole system is in burnout." – Indigenous, Ontario

> "I think we know but we are tired of hearing how it's affected them because it hasn't just affected them." – Adult (18-39), Ontario

> "I didn't really understand until I took my son to SickKids. How tired the nurses and doctors are – you can see it on their faces. I don't think the public understands what's going on with them." – Indigenous, Ontario

> "I couldn't imagine the impact and how it has affected them and their family, I know it has to be rough." Adult (18-39), Atlantic Canada

> "That's what they signed up for isn't it? If you can't handle it, don't do it. I don't have any empathy for them." – Indigenous, West

There was similarly a mixed set of reactions among health care professionals. Some spoke of patients and clients who went out of their way to demonstrate gratitude and appreciation for their work and commitment – with a few noting that they believed that experiences over the COVID-19 pandemic had served to humanize health care professionals.

> "For the first time [my patients] asked me how I am and they're sympathetic to how hard it's been for us." – Health Care Professional, West

By contrast, health care professionals also spoke of negative interactions with patients or clients who had been disrespectful. There was, in particular, a sense of frustration that many health care professionals became punching bags for those upset over uncertain or misunderstood public health measures. When asked what they would appreciate most from the general public, health care professionals asked for patience, respect, to keep up to date on news and public health measures, sanitize your hands regularly, and most of all, to continue to wear a mask in public (despite the relaxation of this measure).

> "[My patients] always say what a good job the nurses are doing, what the doctors are doing, until they have to go to an 'emerg' department and have to wait for hours, and it completely shifts … but one same patient can have two totally different views on the same situation within five minutes. It makes you wonder if they're really understanding it." – Health Care Professional, Atlantic Canada

> "I'm the one providing the vaccine, I'm not the one forcing you to get it. I just shut them down because I don't want to have that argument. They were a bit confrontational and that's not my issue." – Health Care Professional, West

> "There is a disconnect between the two: people need to get vaccines, but they don't understand the whole picture. There's a lot of pressure on us to explain at the point of care, which contributes to the burnout." – Health Care Professional, West

> "The uncertainty stokes fear, and you can only imagine what that does in a population that doesn't have our training." – Health Care Professional, Atlantic Canada

Future intentions and behaviours

The vast majority of non-health care professionals acknowledged that elements of their experience during the pandemic would continue to have an influence on their behaviours and social patterns going forward. The way participants defined their "experience" in this context was often broadly defined and did not always relate solely to their experience related to infection. For some participants, their commitment to vaccines and/or public health measures remained consistent or was even strengthened as a result of their experiences over the COVID-19 pandemic. For others, the pandemic was described as a time of mixed messaging from public health officials and political decision-makers set against the larger backdrop of the misinformation, confusion, and mistrust that they saw as defining public discourse on the topic.

The discussions that these prompts engendered suggested that, regardless of the starting point of non-health care professionals, most understood their changes in perception as a matter of kind and not of direction. Those who began from a position of skepticism often felt that their initial reaction was validated by events over the course of the pandemic. These participants often raised questions surrounding the effectiveness or necessity of vaccinations and/or public health measures. There were a few among this group, however, who indicated that their infection experience – or the experience of a loved one – specifically drove them to change course and re-evaluate their initial skepticism.

Similarly, those who began the pandemic either fairly or fully committed to public health measures often described their perceptions of public health measures shifting. Unlike many skeptics who saw their initial perceptions reinforced and strengthened, many who began the pandemic as committed to public health measures expressed that their initial conviction was tested and sometimes waivered. In these cases, people sometimes attributed it to inconsistency in recommendations or counter-intuitive changes that were seen as unhelpful in one way or another.

> "Je pense qu'avant ma foi dans le gouvernement était un peu aveugle, mais maintenant je remets les choses en question et je ne pense pas que ce soit une mauvaise chose." (I think before my faith in the government was a little blind, but now I question things and I don't think that's a bad thing.) – Adult (18-39), Quebec

Asked what would help restore their confidence, the non-health care professionals who said their intentions toward measures and vaccines was negatively affected by their pandemic experience often struggled to come up with something plausible. Among the suggestions were frank admissions of the perceived mistakes made by governments and public health officials, an

acknowledgement that this was "uncharted territory," and being "honest" about the effectiveness of the vaccine.

> "I have an inability to trust someone who can't say they got something wrong." – Indigenous, Atlantic Canada

> "Pour me faire changer d'avis, il faudrait vraiment que le gouvernement ait des chiffres réels et de la transparence." (To change my mind, the government would really have to have some real numbers, and transparency.) – Adult (18+), Quebec

Some participants also noted that they felt they had been led to believe that COVID-19 vaccines would prevent infection and expressed feeling disappointed and/or deceived when they later came to be infected. For some, this led to questioning whether it is actually a vaccine by definition.

> "There were untruths about the vaccines. They said you could take one and not get it." – Adult (18+), Ontario

> "There is so much research out there now that masks actually don't help. The vaccine has also been proven to not actually be a vaccine or help stop transmission. I feel like we were lied to." – Adult (18-39), Ontario

A few also indicated that their experiences during the pandemic, as well as the increased understanding of COVID-19, helped them feel the risk was lower than they initially feared. There were also a few whose experience with the vaccine dose was negative enough to make them reluctant to getting further doses. For some this was the symptoms experienced immediately after being vaccinated, with a few expressing that they felt this was worse than catching COVID-19 itself. A few also described long-term health complications associated with their vaccination.

> "Getting a booster every year doesn't make a whole lot of sense to me. I won't be getting a booster. For both my shots, I got sick for three days, each." – Adult (18+), Ontario

When asked to describe their consistency in following public health measures over the course of the pandemic, most non-health care professionals tended to describe behaviours that were more disciplined at the outset than they were as time wore on. Participants described following required measures (e.g., proof-of-vaccination) far more consistently than optional or suggested ones. In terms of specific measures, the topic of mask wearing was raised in every group. Many participants said that they were more consistent in their use of masks in the initial period of the pandemic. Many also described having effectively developed their own guidelines such as consistently wearing them around their elderly relatives but being much less consistent in other circumstances. Some also noted that they were still unclear as to whether wearing a mask was meant to protect themselves, others, or both.

> "I never felt like it affected me too much. I just masked when I had to and never really thought about it too much." – Adult (18-39), West

> "I hated the masks. But I wore them, and I never got sick. I will now wear one if I have to. I don't love it, but I believe they do work." – Adult (18+), Ontario

Health care professionals also spoke of changing their own behaviours over the course of the pandemic. Many spoke to the extensive safety, cleaning, and decontamination procedures they adopted both in the workplace and at home. Several participants described, for example, how they would fully disrobe in the garage, sanitize their clothes, and then shower immediately so as to protect others in their household. While most had since developed and adopted less extensive safety precautions, those in the medical field were far more ardent in their continued support for wearing masks and felt that guidelines surrounding mask-wearing were relaxed too early. This was also noted in the context of the "triple-demic" and the potential that masks provided in terms of stemming the spread of other viruses currently in circulation.

> "The idea of re-masking, I would support that mainly in the context of hospital volume flow." – Health Care Professional, Atlantic Canada

> "For me it feels like we're back to our normal routine, and we've given up on our normal routine—we've gone too far in our relaxing" – Health Care Professional, West

The continued importance placed on mask wearing and other public health measures by health care professionals stands in contrast with the declining priority attached to these measures in the minds of the rest of the population. It is difficult to recall more than a single participant saying their sense of the importance of these measures had increased and in those cases, it was because of how bad COVID-19 ended up being for that participant.

While the question of a potential reinstatement of public health measure was included in the discussion guide, this topic was organically raised early on in groups of non-health professionals. Those who offered reactions to this possibility tended to express negative views, often expressing anger, anxiety, or fear at what may be coming. As the focus groups were held in the lead up to the holiday season, many participants spoke of the excitement of being able to gather with loved ones and of the potential disappointment of being prevented from doing so by public health measures. Although there were some participants who indicated that they would not be opposed to new public health measures, or that they would comply with whatever health officials felt required to protect society at large, on the whole there was reluctance among most to be that positive towards a possible reinstatement of health measures.

> "I'm done. I am not going into this rabbit hole again." – Adult (18-39), Ontario

> "You got to do what you got to do. Ultimately, it's for our safety." – Adult (18+), Ontario

When it came to COVID-19 vaccines, the perspectives of non-health care professionals ranged from being completely committed to receiving further doses as soon as they became available, to being absolutely determined to never get a/another dose – whether that means stopping at the number of doses they have currently received or never getting even a first dose. Among the participants who fell between both extremes, some offered that they would be willing to get it annually in the same way they get their flu shot. There was little enthusiasm for getting a new dose at intervals less than a year, with many questioning the underlying reasons that would require such frequent doses. The diversity of views was evident among parents as much as it was among those with no children.

> "It's kind of like the flu vaccine for me. I'll just keep getting it every year. I'll just keep getting it as required." – Adult (18+), Atlantic Canada

And while nearly all of the non-health care professionals had received at least one dose of a COVID-19 vaccine and most had the primary series (2 doses), the motivating factor was often that one had to be vaccinated (e.g., to maintain their employment, to be able to go out to restaurants or to a movie, to travel, etc.). Among those who indicated that they continued to want additional doses of the vaccine, a number of reasons were expressed. These ranged from personal health considerations through to saying it was the right thing to do for society.

In contrast, those who felt obligated to get vaccinated for professional or social reasons expressed lingering dissatisfaction, in particular surrounding the notion that their choice in the matter had been removed. Others explained that they stopped at two doses in order to satisfy the requirements implemented in their area but had very little interest in getting a further dose.

> "I hadn't made my choice about whether or not I wanted to get vaccinated, but my work made a policy. Because I wasn't given a choice, I was forced into it, I'm kind of reluctant and hesitant to continue on." – Adult (18-39), Atlantic Canada

Among the few participants who were unvaccinated, there were a number of reasons given. For many unvaccinated participants, concerns were raised about the health implications of the vaccine and a sense of uncertainty about the speed at which it was developed. Other unvaccinated participants framed it as a matter of control. For them the imposition of public health measures such as requiring proof-of-vaccination was seeing as an overstep on the part of governments. Yet others explained that the solutions offered by vaccines did not align with their ways of being and that they had instead sought options grounded in different knowledge systems or worldviews.

> "I think it's wrong that the government pushed it on people. That's a major overreach of government I think to force people to get vaccines to keep their jobs and travel. It's made me skeptical of the government and I don't really trust a lot of the information coming from them." – Adult (18+), Atlantic Canada

> "Je respecte toutes leurs croyances, l'important est de suivre ce que nous croyons. En tant qu'autochtones, nous avons nos propres systèmes médicinaux. Nous ne l'avons pas inventé. C'est notre héritage. Mais nous avons perdu ces pratiques. Les gens vont simplement à la pharmacie pour obtenir des pilules." (I respect no matter their beliefs, what's important is to follow what we believe. Being Indigenous, we have our own medicinal systems. We didn't just invent this. This is our heritage. But we've lost these practices. People just go to a pharmacy to get pills.) – Indigenous, Quebec

In addition to the points made earlier about negative vaccine experiences and evolving perceptions of it, there were a number of rationales offered for not continuing to get doses. One concern raised was the perceived lack of knowledge surrounding the long-term side effects of vaccination, with a few participants citing complications experienced by loved ones. As alluded to earlier, there was also a sense among participants that the vaccine was not as effective as many felt they had been led to believe. Some explained, for example, that they felt that the vaccine was presented to them as a solution to the pandemic and that it had failed to live up to those expectations. These participants appeared to have a greater ability to factor unknown

consequences into their intentions. In contrast, those who expressed a stronger conviction in the effectiveness of the vaccines seemed to find it easier to set aside any potential nagging thoughts they have about side effects.

> "I felt lied to. I was made to believe that I would get two vaccines and I would get my life back. But I didn't. And I won't be getting any others." – Adult (18-39), Ontario

> "I think a large portion of the population felt that the vaccine would provide immunity. We would get that often on the phone lines; people very angry they contracted COVID." – Health Care Professional, Atlantic Canada

Despite a broad array of opinions on the COVID-19 vaccine, it is worth noting that for nearly all participants, the pandemic had no effect on their intentions regarding routine vaccines. That is to say that a vast majority of participants expressed that they would continue to get what they perceived as routine vaccinations, or get their children vaccinated, regardless of whether or not they had received the COVID-19 vaccine or intended to get further doses. The distinction tended to be around the certainty of routine vaccines at blocking the possibility of contracting a certain illness, whereas the COVID-19 vaccine seemed to only lessen the severity of the symptoms.

> "[Bien que n'étant pas vaccinée] je respecte le calendrier de vaccination de mes enfants - ce n'est pas négociable pour moi." ([Despite being unvaccinated] I respect the vaccination schedule for my children – it's non-negotiable for me.) – Adult (18-39), Quebec

> "I might actually go get a flu shot now that I've had COVID a couple times. I never would have done that before." – Indigenous, West

> "With flu shots, there's always a larger population who are on the fence. With older vaccines, I have not noticed a change. It was MRNA that people were worried about." – Health Care Professional, Atlantic Canada

When it came to the question of trust in information sources and to what extent that had been impacted by the experience of the pandemic, there were few who indicated that their trust in any source had increased. Echoing concerns noted above, many instead indicated that they had lost trust in one or more sources of information. Reasons for this ranged from confusing and contradictory information available online to an overall erosion of trust in governments and public health officials over the handling of public health measures. To the former point, several participants explained that they had simply stopped looking for information online due to feeling of it being overly polarized, of being too overwhelming to grapple with, and/or simply too difficult to process or reconcile.

As already touched upon briefly above, a reoccurring theme in conversations was trust in various levels of government, in particular among non-health care professionals. This much was echoed by those in health care professions who spoke to how they had witnessed their patients' trust in at least one level of government wane over the course of the pandemic.

Although health care professionals were often quick to acknowledge the difficulty of the situation, they also explained that information from the government evolved too quickly, was not

always clear or accessible, and at times appeared contradictory. In fact, one of the biggest complaints from health care professionals was that they were learning new information, that impacted their work, in real time with everyone else which made it difficult for them to be prepared to be able to care for their patients. They felt this was counter-intuitive given their active role in providing health care during the pandemic and thought it could have been better handled had they been consulted.

> “I’m sure everybody’s doing the best that they can, but at times the information is very contradictory.” – Health Care Professional, Atlantic Canada

Despite these challenges, health care professionals did feel that their patients continued to be trusting of them. When asked, the majority of non-health care professionals did indicate relying on their doctor/family physician or local pharmacist for information about COVID-19, health measures, or vaccines. Some health care professionals even noted that the pandemic had strengthened their connection with their patients, notably in that many patients felt extremely grateful for the care they were receiving and become much more mindful of the ways in which the pandemic was impacting those in health care.

> “I would want to get my advice straight from my doctor, and not from talking heads that are appeasing politicians.” – Adult (18-39), West

> “My family doctor would definitely be a trusted source.” – Adult (18+), Atlantic Canada

Some health care professionals further noted that, while some patients placed immense trust in them to make their health decisions, there was still pushback on the question of vaccines. Others noted that they were able to overcome these barriers to trust in vaccinations when they had one-on-one contact with patients and clients.

> “A typical patient today trusted me about his heart failure and cancer care, but also stated clearly that he believes that COVID is a hoax and doesn't trust the scientists.” – Health Care Professional, West

> “Once you’re one-on-one, that trust is easy to rebuild. When you’re on the internet, you’re in a silo.” – Health Care Professional, Atlantic Canada

Another element frequently raised in conversations about trust was the issue of misinformation. In particular, social media was blamed for being a vector by which misinformation spread with at least one participant in each group of non-health care professionals noting that they had less trust in what they saw on social media now as opposed to before the pandemic. A few health care professionals expressed dismay that some unvaccinated health care professionals with no epidemiological training had used their medical background to gain legitimacy on social media to spread misinformation.

> “Social media was a double-edged sword giving us the negative and positive stuff.” – Adult (18+), Atlantic Canada

> “So hard to say the right things where there are so many influencers out there telling them the opposite. We did the best we could in clinics. We just gave them

> the facts and most of them listened to us.” – Health Care Professional, Atlantic Canada

When it came to whether or not trust could be restored and, if so, what steps would be required, the same advice mentioned above was offered: be honest and admit your mistakes about the trials and tribulations faced. For the government of Canada specifically, being honest and transparent meant presenting the pros and cons about vaccines, admitting that this was novel/new, and laying out the reasoning behind the recommended guidelines. For some, however, there was nothing at this stage which they felt would change their minds as, to their mind, any trust they had in governments or public health officials had been too far eroded.

> “I find it very difficult to trust what is said [by governments].” – Adult (18-39), Atlantic Canada

Communications needs and preferences

Over the course of the discussions, most non-health care professionals shared that they had looked up information about COVID-19 vaccines at some point over the course of the pandemic, even if they were not always able to share the exact ways in which they had conducted their search or the source they had eventually chosen.

When prompted to describe what they sought in an information source, participants gravitated towards something they saw as factual, balanced, unbiased, and politically neutral. Of note, a few participants who expressed that their trust in the government and public health officials had eroded over the course of the pandemic nonetheless admitted that they were likely to consult government or Health Canada websites as part of their search for information. In contrast, the few times in which the possibility of seeking information from the drug manufacturers themselves was raised, it was virtually always discussed in a negative light.

The tone used in communications was also raised a number of times by participants. In particular, relying on fear was felt to be an inappropriate way to approach public health questions in times of heightened anxiety. A few mentioned that whimsical or more lighthearted campaigns were at odds with the severity of the situation.

> “Not leading people in fear but leading people in truth.” – Adult (18-39), Ontario

> “Les campagnes gouvernementales ne sont pas venues me chercher, elles sont venues m'agresser - utiliser la peur n'était pas une bonne idée.” (The government campaigns didn’t come find me, they came and assaulted me – using fear was not a great idea.) – Adult (18+), Quebec

> “Nous devons arrêter les campagnes de peur.” (We need to stop fear campaigns.) – Adult (18+), Quebec

In terms of information needs, a few participants said they were interested in learning more about the sources of information, especially accessible and approachable scientific evidence; the pros and cons of COVID-19 vaccines; the different side effects of the vaccines, both long- and short-term; the prevalence of said side effects; and the positive results/impact of vaccines on addressing the COVID-19 pandemic (though they appreciated this would be difficult to do).

Conclusions

The purpose of this research is to understand Canadians' overall awareness, perceptions, and concerns about the impacts of the COVID-19 pandemic, including mental health impacts, government relief efforts and expectations, recovery, public health measures, and vaccines in order for PHAC to develop targeted communications strategies and products.

Both waves of the study – quantitative and qualitative – contribute insights into each of these and included specific target audiences in order to bring clarity to the need for nuance when communicating with one audience or another.

The research has demonstrated that the vast majority of Canadians have contributed to the national effort to reduce the impact of the COVID-19 pandemic in one way or another, with more than nine in ten completing the original recommendation of receiving two-doses of vaccine.

What the study also shows, is that there are a wide variety of feelings about experiences incurred over the course of the pandemic, and with vaccination in particular, including the motivations for becoming vaccinated, the likelihood to get doses beyond what was required for proof-of-vaccination, as well as the sense of efficacy of the vaccine and how the experience of the pandemic has affected their mindset going forward.

There are behaviours and attitudes expressed in this survey demonstrate a variety of patterns, with some Canadians being consistently responsive to, and supportive of, public health guidelines, with some Canadians consistently contrasting with that group and a plurality of Canadians falling somewhere in between these two fairly polarized groups.

The findings suggest that people who have been consistently responsive to guidelines are likely to continue to be that way and correspondingly, those who are at the opposite end of the spectrum on guideline adherence appear unlikely to become any more responsive to future guidelines.

In some cases, different segments of the population can share one challenging perspective (e.g., less inclination to continue to receive vaccine doses as they are offered), but do so for different reasons. As a result, those whose opinions appear more challenging than others when it comes to following public health guidelines and measures are not a particularly homogenous audience.

For example, those who are 18-39 years of age have been more likely than others to stop at two doses and compared to those older than them. For younger respondents, getting additional doses is less driven by the notion of contributing to the social good and more influenced by things like convenience or removing barriers travel (assuming they existed).

Parents, particularly those with children under the age of 5, consistently hold more challenging views than people with no children at home. The results are perhaps most striking when it comes to measures like closing daycares and schools or avoiding indoor gatherings with people who live outside of your household.

Trust in sources of information has taken a hit, particularly among residents of Ontario and the West/North. The focus groups helped shed light on the sense that some people are frustrated

with what they feel has been inconsistent messages and their frustration is compounded by the impact the mandates and rules have had on their day-to-day life. When given the opportunity to discuss examples, there was no shortage, although some would be more relevant in specific jurisdictions where they were an issue.

That said, these same individuals were able to offer some constructive criticism on how to restore their trust in information sources, and one of the more common suggestions had to do with admitting mistakes. It is unclear whether doing so would necessarily change the opinions of many, enabling more effective communications in the future about changes to requirements or recommendations that may need to be introduced, but that advice was offered frequently.

While the relatively small sample size meant that results between respondents who are Indigenous and non-Indigenous are not often significantly different, there are some noteworthy findings where the differences are statistically significant. Specifically, Indigenous respondents are more likely to have been infected with COVID-19 themselves and to not have been vaccinated (that is, have 0 doses of a COVID-19 vaccine). Furthermore, compared to non-Indigenous respondents, Indigenous respondents are more likely to say that their trust has worsened for scientists but improved for social media (though the majority still do not hold this position). Lastly, when asked what will be useful in the future to help their decision making about vaccines and other public health measures, nearly half of Indigenous respondents say they will use their common sense, which is significantly more than non-Indigenous respondents.

The experiences shared by Indigenous participants in the qualitive research component were also notable in that they tended to reflect more severe experiences with COVID-19 infection, as well as the social and economic impacts which occurred as a result of public health measures. A number of Indigenous participants also noted that they sought ways of adapting to, and navigating through, the pandemic that aligned with their ways of being and knowledge systems such as using natural remedies or relying on community support. This was at times done so as to supplement other public health measures including vaccination, whereas for other participants these were seen as a replacement.

These examples above shine light on some of the more challenging elements of public opinion in Canada when it comes to views towards past and potential public health measures and trust in information. It is worth noting that there are some whose opinions are significantly more receptive to just about any measures asked in just about any context. That is, Canadians over the age of 65 and those who are retired (highly overlapping categories) repeatedly indicate following guidelines more and generally being less opposed to future measures.

At the same time, while the pandemic experience has been challenging for many and catalyzed some new divisions over new issues related to public health measures and vaccines, the experience does not appear to have significantly altered future behaviour intentions relating to routine vaccines. In fact, if anything, the pandemic experience may have planted the seeds of a net increase in the total population receiving routine vaccinations – whether for themselves or their children.

Appendix A: Quantitative methodology report

Survey methodology

Earnscliffe Strategy Group's overall approach for this study was to conduct an online survey of a minimum of 2,000 Canadians aged 18 and older using an online panel sample. All respondents will be Canadian adults aged 18 and older who are making vaccine-related decisions for themselves and/or their children. A detailed discussion of the approach used to complete this research is presented below.

Questionnaire design

The questionnaire for this study was designed by Earnscliffe, in collaboration with PHAC, and provided for fielding to Leger. The survey was offered to respondents in both English and French and completed based on their preferences. All questions were mandatory.

Sample design and selection

The sampling plan for the study was designed by Earnscliffe in collaboration with PHAC, and the sample was drawn by Leger based on Earnscliffe's instructions. The surveys were completed using Leger's opt-in online research panel. Digital fingerprinting was used to help ensure that no respondent took the online survey more than once.

A total of 2,088 cases were collected as the sample of the general population. The profile of respondents will be that of the general population with an oversample of those aged 18-39 years. The following table outlines the target proportions as well as the resulting completions.

Sampling plan and survey completions

Demographic	**Target distribution**	**Final sample**
Gender	%	sample size
Male	48%	1,020
Female	52%	1,061
Age	%	sample size
18-39	60%	1,226
40-54	25%	537
55+	15%	325
Region	%	sample size
AC	6%	163
QC	21%	490
ON	40%	764
MB/SK	7%	163
AB	12%	233
BC	13%	267

The final data were weighted to replicate actual population distribution by region, age and gender according to the most recent Census data available.

Data Collection

The online survey was conducted in English and French from December 1 to 6, 2022 and took an average of 16 minutes to complete. The survey was undertaken by Leger using their proprietary online panel.

Weighting

In addition to setting quotas, the data was weighted based on age, gender, and region as reported by Statistics Canada.

Unweighted and weighted sample distribution

Demographic	Unweighted	Weighted
Gender	%	%
Male	49%	48%
Female	51%	51%
Age	%	%
18-39	59%	35%
40-54	26%	32%
55+	16%	33%
Region	%	%
AC	8%	7%
QC	23%	23%
ON	37%	39%
MB/SK	8%	6%
AB	11%	11%
BC	13%	13%
Territories	0%	1%

Quality Controls

Leger's panel is actively monitored for quality through a number of approaches (digital fingerprinting, in-survey quality measures, incentive redemption requirements, etc.) to ensure that responses are only collected from legitimate Canadian panel members.

Results

Final dispositions

A total of 2,424 individuals entered the online survey, of which 2,088 qualified as valid and completed the survey. The response rate for this survey was 16%.

Total entered survey: 2424
Completed: 2088
Not qualified/screen out: 13
Over quota: 155
Suspend/drop-off: 168

Unresolved (U): 10671
Email invitation bounce-backs: 10
Email invitations unanswered: 10661

In-scope non-responding (IS): 168
Qualified respondent break-off: 168

In-scope responding (R): 2088
Completed surveys disqualified – quota filled: 0
Completed surveys disqualified – other reasons: 0
Completed surveys – valid: 2088

Response rate = R/(U+IS+R): 16%

Nonresponse

Respondents for the online survey were selected from among those who have volunteered to participate in online surveys by joining an online opt-in panel. The notion of nonresponse is more complex than for random probability studies that begin with a sample universe that can, at least theoretically, include the entire population being studied. In such cases, nonresponse can occur at a number of points before being invited to participate in this particular survey, let alone in deciding to answer any particular question within the survey.

Margin of error

Respondents for the online survey were selected from among those who have volunteered or registered to participate in online surveys. Because the sample is based on those who initially self-selected for participation in the panel, no estimates of sampling error can be calculated. The results of such surveys cannot be described as statistically projectable to the target population. The treatment here of the non-probability sample is aligned with the Standards for the Conduct of Government of Canada Public Opinion Research - Online Surveys.

Appendix B: Qualitative methodology report

Methodology

The qualitative phase which involved a series of sixteen (16) focus groups between November 21 and 24, 2022 with adults aged 18 and older, adults 18-39, Indigenous adults aged 18 and older who live off-reservation, and health care professionals. One discussion group among each target audience was conducted with residents of Atlantic Canada (Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick), Quebec, Ontario, and the West/North (Manitoba, Saskatchewan, Alberta, British Columbia, Yukon, Northwest Territories, Nunavut). Those living in official language minority communities (OLMCs) were invited to participate in a group in their preferred language at a date and time that was convenient to them. The groups with participants in Quebec were conducted in French; all others were conducted in English.

Schedule and composition of the focus groups

Group #	Audience	Region/Language	Time	Number of participants
Monday, November 21, 2022				
1	Adults 18+	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT	9
2	Health care professionals	Atlantic Canada (EN)	6:00 pm ET / 7:00 pm AT / 7:30 pm NT	10
3	Adults 18+	Ontario (EN)	6:00 pm ET	10
4	Health care professionals	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT	10
5	Adults 18+	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT	9
Tuesday, November 22, 2022				
6	Adults 18-39	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT	10
7	Adults 18-39	Quebec (FR)	6:00 pm ET	7
8	Adults 18-39	Ontario (EN)	6:00 pm ET	9
9	Adults 18+	Quebec (FR)	8:00 pm ET	9
10	Adults 18-39	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT	9
Wednesday, November 23, 2022				

11	Indigenous off-reserve	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT	10
12	Indigenous off-reserve	Ontario (EN)	6:00 pm ET	9
13	Health care professionals	Quebec (FR)	6:00 pm ET	9
14	Indigenous off-reserve	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT	7
15	Health care professionals	Ontario (EN)	8:00 pm ET	8
Thursday, November 24, 2022				
16	Indigenous off-reserve	Quebec (FR)	5:30 pm ET	9

Recruitment

Participants were recruited using a five-minute screening questionnaire (included in Appendices D and E).

The screener contained a series of standard screening questions to ensure participants qualified based on their age, ethnic or cultural identity (that is, Indigenous and non-Indigenous) and occupation (pharmacists, nurses and general practitioners), ensuring a good mix of other demographics such as gender, household income, location, etc.

Our fieldwork subcontractor, Quality Response, relied on panels and databases of Canadians. This is the approach employed most often. Quality Response reaches out to members of their database first via email and follows-up with telephone calls to pre-qualify respondents.

Quality Response's database includes approximately 35,000 Canadians with profiling on a range of attributes including standard personal demographics, household composition, medical background, technology usage, financial services, health and wellness, business profiles, and other relevant criteria. Their database is constantly being updated and replenished and operates out of their own, onsite telephone room in Toronto, Ontario. Potential group participants are recruited to their database via mixed-mode: following a proprietary telephone survey, online, referral, social media and print advertising. Initial contact is often made via email or online pre-screening for speed and economies, followed up by personal telephone recruitment and pre-group attendance confirmation.

Quality Response understands the nuances of qualitative recruiting and the importance of locating qualified, interested respondents. Their recruiting is undertaken in strict accordance with the Standards for the Conduct of Government of Canada Public Opinion Research – Qualitative Research.

Reminder calls were made prior to the groups to confirm participants' intention to attend and to encourage higher rates of participation. As well, all participants received a cash honorarium at the end of the group discussion $100 for adults 18 and older, $200 for Indigenous adults, $350 for nurses and pharmacists, and $400 for general practitioners).

A total of ten participants were recruited for each group. All participants agreed to the presence of observers and recording of the session during the screening process and at the beginning of the session (for those who attended).

Moderation

We relied on two qualified moderators. Given the timeline for the project, using two moderators allowed us to conduct all of the focus groups over the course of one week (4 nights).

Both moderators attended the kick-off night of focus groups. This ensured that both were aware of the flow of the focus groups and were involved in any conversation about potential changes to the discussion guide or flow of conversation for each subsequent night.

In our experience, there is value in using multiple moderators (within reason) as it ensures that no single moderator develops early conclusions. Each moderator takes notes and summarizes their groups after each night. The moderators each provide a debrief on their groups including the functionality of the discussion guide; any issues relating to recruiting, turnout, or technology; and key findings including noting instances where they were unique and where they were similar to previous sessions. Together, they discuss the findings both on an ongoing basis in order to allow for probing of areas that require further investigation in subsequent groups, and before the final results are reported.

A note about interpreting qualitative research results

It is important to note, when reading the qualitative findings, that qualitative research is a form of scientific, social, policy, and public opinion research. Focus group research is designed to elicit the full range of ideas, attitudes, experiences, and opinions of a selected sample of participants on a defined topic. Because of the small numbers involved, the participants cannot be expected to be thoroughly representative in a statistical sense of the larger population from which they are drawn, and findings cannot reliably be generalized beyond their number.

Glossary of terms

The following is a glossary of terms used throughout the report to impart the qualitative findings. These phrases are used when groups of participants share a specific point of view. Unless otherwise stated, it should not be taken to mean that the rest of participants disagreed with the point; rather others either did not comment or did not have a strong opinion on the question.

Glossary of qualitative terms

Generalization	Interpretation
Few	Few is used when less than 10% of participants have responded with similar answers.
Several	Several is used when fewer than 20% of the participants responded with similar answers.

Some	Some is used when more than 20% but significantly fewer than 50% of participants with similar answers.
Many	Many is used when nearly 50% of participants responded with similar answers.
Majority/Plurality	Majority or plurality are used when more than 50% but fewer than 75% of the participants responded with similar answers.
Most	Most is used when more than 75% of the participants responded with similar answers.
Vast majority	Vast majority is used when nearly all participants responded with similar answers, but several had differing views.
Unanimous/Almost all	Unanimous or almost all are used when all participants gave similar answers or when the vast majority of participants gave similar answers and the remaining few declined to comment on the issue in question.

Appendix C: Survey questionnaire

Landing page

Thank you for agreeing to take part in this survey on health issues. We anticipate that the survey will take approximately 18 minutes to complete.

[NEXT]

Intro page

Background information
This research is being conducted by Earnscliffe Strategies, a Canadian public opinion research firm on behalf of Health Canada.

The purpose of this online survey is to collect opinions and feedback from Canadians that will be used by Health Canada to help inform government actions and decisions.

How does the online survey work?

a) You are being asked to offer your opinions and experiences related to vaccines through an online survey.
b) We anticipate that the survey will take 18 minutes to complete.
c) Your participation in the survey is completely voluntary.
d) Your decision on whether or not to participate will not affect any dealings you may have with the Government of Canada.

What about your personal information?

a) The personal information you provide to Health Canada is governed in accordance with the *Privacy Act* and is being collected under the authority of section 4 of the *Department of Health Act* in accordance with the *Treasury Board Directive on Privacy Practices*. We only collect the information we need to conduct the research project.
b) **Purpose of collection**: We require your personal information such as demographic information, views and opinions to better understand the topic of the research. However, your responses are always combined with the responses of others for analysis and reporting.
c) **For more information:** This personal information collection is described in the standard personal information bank Public Communications – PSU 914, in Info Source, available online at infosource.gc.ca.
d) **Your rights under the *Privacy Act*:** You have the right to access, and request a correction and/or notation to your personal information. You also have a right to complain to the Privacy Commissioner of Canada if you feel your personal information has been handled improperly. For more information about these rights, or about how we handle your personal information, please contact Health Canada's Privacy Coordinator at 613-948-1219 or privacy-vie.privee@hc-sc.gc.ca.
e) For any questions for which you are provided with the opportunity to type your own answers, please do not type in any identifiable personal information.

What happens after the online survey?
The final report written by Earnscliffe Strategies will be available to the public from Library and Archives Canada (http://www.bac-lac.gc.ca/).

If you have any questions about the survey, you may contact Earnscliffe Strategies at info@earnscliffe.camailto:research@phoenixspi.ca.

Your help is greatly appreciated, and we look forward to receiving your feedback.

[CONTINUE]

Section 1: Screening

1. What gender do you identify with?

Male	1
Female	2
Other gender identity	3
Prefer not to answer [TERMINATE]	9

2. In what year were you born?

[INSERT YEAR]	
Prefer not to answer	9

3. [IF PREFER NOT TO ANSWER BIRTH YEAR] Would you be willing to indicate in which of the following age categories you belong?

18-24	1
25-39	2
40-54	4
55-64	5
65 or older	6
Prefer not to answer [TERMINATE]	9

4. Which of the following provinces or territories do you live in?

Newfoundland and Labrador	1
Nova Scotia	2
Prince Edward Island	3
New Brunswick	4
Quebec	5
Ontario	6
Manitoba	7
Saskatchewan	8
Alberta	9
British Columbia	10
Yukon	11
Nunavut	12
Northwest Territories	13
Prefer not to answer [TERMINATE]	99

Section 2: COVID-19 experience and vaccination status

5. How many doses of a COVID-19 vaccine have you received?

1 dose	1
2 doses	2
3 doses	3
4 doses	4
5 doses	5
None, I am not vaccinated against COVID-19	6

6. [ASK IF AT LEAST 2 DOSES] What is the top reason you have not gotten additional doses of COVID-19 vaccine? [RANDOMIZE, ANCHOR TOP ANSWER AND LAST FOUR]

I have already received all recommended COVID-19 vaccine doses for my age group	1
I think I am protected enough with the current number of vaccine doses	2
I feel that the vaccine does not provide much protection as you can still get COVID-19 even if vaccinated	3
I'm concerned about the long-term effects of the vaccine	4
I'm fed up with getting vaccinated	5
I'm tired of being told what to do to protect my health	6
I prefer to wait a while before getting vaccinated	7
I'm concerned about the safety of additional doses	8
I had short term non-serious side effects with the dose/doses I already got and don't want additional doses because of this	9
I had long term side effects with the dose/doses I already got and don't want additional doses because of this	10
I am not exposed to risks of COVID-19 in my daily life and therefore feel that I do not need to receive additional doses	11
I recently had COVID-19 and need to wait the recommended time before getting additional doses	12
Don't want it / Don't need it	
Other (SPECIFY)	14

7. Amongst the following factors and thinking about the current COVID-19 context, what would motivate you to get additional doses of COVID-19 vaccine? Please select up to 3. [RANDOMIZE, ANCHOR LAST FOUR. ACCEPT UP TO THREE RESPONSES WHICH CAN INCLUDE "OTHER (SPECIFY)"]

Advice from my primary health care provider that it is recommended for me	1
Required to be able to travel within Canada	2
Required to be able to travel internationally	3
Helping to get things back to normal	4
Being able to more safely spend time with friends and family in-person	5
Knowing that the majority of new COVID-19 cases are among those who have not received additional doses	6
Knowing that the majority of new COVID-19 hospitalizations are among those who have not received additional doses	7
Knowing that getting vaccinated could help protect the most vulnerable members of society	8

If getting additional doses would make it more likely for my area to avoid reinstating local public health restrictions (e.g., mandatory mask wearing, gathering limits)	9
Getting additional doses at a convenient time and location	10
Receiving paid time off work to get an additional dose	11
Understanding the benefits and importance of additional doses	13
New COVID-19 vaccine formulations that are specific to latest variants	14
None of the above	
Other (SPECIFY)	15

8. Are you the parent or guardian of a child or children under 18 years of age living in your household?

Yes	1
No	2
Prefer not to answer	9

9. [ASK IF YES] How old is/are the child/children? Select all that apply.

Under 6 months of age	1
Between 6 months and 4 years of age	2
5 to 11 years of age	3
12 to 17 years of age	4
Prefer not to answer	9

10. [IF CHILD(REN) AGED 12-17] Thinking about your child(ren) aged 12-17, how many doses of a COVID-19 vaccine have they received? Please select all that apply.

1 dose	1
2 doses	2
3 doses	3
4 doses	4
None	0

11. [IF CHILD(REN) AGED 5-11] Thinking about your child(ren) aged 5-11, how many doses of a COVID-19 vaccine have they received? Please select all that apply.

1 dose	1
2 doses	2
3 doses	3
None	0

12. [IF CHILD(REN) AGED 6 MONTHS TO 4 YEARS OLD] Thinking about your child(ren) between the ages of 6 months and under 5, have they received at least one dose of a COVID-19 vaccine?

Yes	1
No	2

13. Have you ever been infected with COVID-19?

Yes	1

No	2
I think so (not confirmed by a positive PCR or rapid test)	3
Don't know	8
Prefer not to answer	9

14. Has anyone [ADD "else" IF NO, DK/NR IN PREVIOUS] in your household ever been infected with COVID-19?

Yes	1
No	2
I think so (not confirmed by a positive PCR or rapid test)	3
Don't know	8
Prefer not to answer	9
Not applicable	99

15. During the pandemic, how often have you followed the public health measures listed below? [RANDOMIZE]

a) Staying home and away from others if you feel sick
b) Using individual public health measures when interacting with someone who is at risk of more severe disease or outcomes from COVID-19
c) Wearing a mask inside with others when you're feeling sick
d) Wearing a mask when indoors in a public space or in an indoor space with people from outside your immediate household
e) Improving ventilation (even if just temporarily, such as when people from outside your immediate household are in your home)
f) Wearing a mask when outside

Always	1
Often	2
Sometimes	3
Rarely	4
Never	5
Don't know	8

16. During the pandemic so far, to what extent have you supported or opposed the proof-of-vaccination system where Canadians have been required to provide proof of vaccination status for certain activies such as attending large public events or travel:

Strongly oppose	1
Oppose	2
Somewhat oppose	3
Neither support nor oppose	4
Somewhat support	5
Support	6
Strongly support	7

Section 3: Perception of pandemic fatigue

17. Pandemic fatigue can be defined as the stress you may be feeling as a result of spending extra time and energy dealing with what has been your pandemic experience (e.g., illness, job, family, or other lifestyle changes).

    Using the definition above, on a scale of 0 to 10, how would you rate your individual level of pandemic fatigue overall, with 0 being no fatigue experience at all and 10 being the worst possible fatigue experience.

No fatigue experience	0
The worst possible fatigue experience	10

Section 4: Future intentions/behaviours

18. As additional COVID-19 vaccine doses are offered to you in the future, how likely are you to get one?

Definitely not	1
Very unlikely	2
Somewhat unlikely	3
Somewhat likely	4
Very likely	5
Definitely will	6
Don't know/Prefer not to say	9

19. [IF CHILD(REN) AGED 12-17] As additional COVID-19 vaccine doses are offered to your child(ren) in the future, how likely are you to get one for your child(ren) aged 12-17?

Definitely not	1
Very unlikely	2
Somewhat unlikely	3
Somewhat likely	4
Very likely	5
Definitely will	6
Don't know/Prefer not to say	9

20. [IF THEY HAVE CHILD(REN) "5-11" IN CHILD AGE] As additional COVID-19 vaccine doses are offered to your child(ren) in the future, how likely are you to get one for your child(ren) aged 5-11?

Definitely not	1
Very unlikely	2
Somewhat unlikely	3
Somewhat likely	4
Very likely	5
Definitely will	6
Don't know/Prefer not to say	9

21. [IF DEFINITELY NOT, VERY UNLIKELY, SOMEWHAT UNLIKELY, OR DK/NR ABOUT PERSONALLY GETTING ANOTHER DOSE Q18] What is/are the main reason(s) you are unlikely or uncertain about getting an additional COVID-19 vaccine dose? [RANDOMIZE, ANCHOR LAST THREE. ACCEPT UP TO THREE RESPONSES]

I think I am protected enough with the current number of vaccine doses 1
I feel that the vaccine does not provide much protection as you can still get COVID-19 2
I'm concerned about the long-term side effects of the vaccine 3
I'm fed up with getting vaccinated 4
I'm tired of being told what to do to protect my health 5
I prefer to wait a while before getting vaccinated 6
I'm concerned about the safety of the additional doses 7
I had short term non-serious side effects with COVID-19 vaccine additional doses 8
I already got additional doses and don't want to get more 9
I'm not exposed to the risks of COVID-19 in my daily life and therefore I feel that I do not need to 10
I have read or seen information online about vaccine safety which worries me 11
Other (Specify) 12

22. Have your experiences during the pandemic affected your intentions towards COVID-19 vaccines going forward?

Yes, I am more likely to get the recommended COVID-19 vaccines 1
Yes, I am less likely to get the recommended COVID-19 vaccines 2
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to get a recommended COVID-19 vaccine 3
No, the pandemic has not affected my decision making; I never planned to get a COVID-19 vaccine even prior to the vaccines being developed 4
I am unsure/don't know 8

23. [IF LESS LIKELY] If you are less likely to get the recommended COVID-19 vaccines, what are some reasons? Select all that apply. [RANDOMIZE]

I have more concerns about the safety of vaccines in general 1
I now believe that vaccines do not have as much benefit in preventing severe outcomes 2
COVID-19 vaccines have negatively impacted my view on vaccines in general 3
I now believe that vaccines in general does not have as much benefit in stopping the spread of viruses 4
The pandemic has shown that vaccines do not work very well 5
The pandemic has shown that we have strong immune systems without vaccines 6
I do not trust Pharma or the Government 7
Vaccinations need to have long term testing/studies 8
Other [SPECIFY] 9
Don't know 99

24. [IF Q18=4-6] Now that the COVID vaccine is recommended at the same time as a flu shot, how likely are you to get it?

Very likely 1
Somewhat likely 2
Not very likely 3
Not at all likely 4
I do not intend to get a flu shot 5
Don't know 9

25. Have your experiences during the pandemic affected your intentions towards routine vaccines (e.g., shingles, flu, polio) going forward?

Yes, I am more likely to get recommended vaccines	1
Yes, I am less likely to get recommended vaccines	2
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to get a recommended vaccine	3
No, the pandemic has not affected my decision making; I was not planning to get any of those types of vaccine even prior to the pandemic	4
I am unsure/don't know	8

26. [IF CHILD(REN)] Have your experiences during the pandemic affected your intentions towards routine vaccines for your chilren (e.g., measles, mumps, rubella or flu vaccines) going forward?

Yes, I am more likely to have my child get recommended vaccines	1
Yes, I am less likely to have my child get recommended vaccines	2
No, the pandemic has not affected my decision making; I am just as likely as at the beginning of the pandemic to have my child get a recommended vaccine	3
No, the pandemic has not affected my decision making; I was not planning to have my child get any of those types of vaccine even prior to the pandemic	4
I am unsure/don't know	8

27. In the future, if the following public health measures had to be implemented or reintroduced to prevent a widespread outbreak, to what extent would you support or oppose them? [RANDOMIZE]

a) Gathering limits
b) Stay-at-home orders
c) Closing of businesses
d) Travel restrictions/border closures
e) Avoiding indoor gatherings with people outside of your household
f) School or daycare closures
g) A requirement to wear a mask in indoor public settings
h) Requirements to provide proof of COVID-19 vaccination status for certain activities (e.g., travel or attending large public events)

Strongly oppose	1
Oppose	2
Neither support nor oppose	3
Support	4
Strongly support	5

28. Have your experiences during the pandemic affected your trust in each of the following sources for information related to vaccines and public health advice? [RANDOMIZE]

a) Scientists
b) Healthcare workers (e.g., doctors, nurses)
c) International health authorities (e.g., World Health Organization [WHO])
d) Canadian federal government briefings and/or websites
e) Provinical/Territorial government briefings and/or websites

f) Newspapers, radio, podcasts and other journalism
g) Friends and family
h) Social media (e.g., Facebook, Twitter)

Yes, I am more likely to trust this source	1
Yes, I am less likely to trust this source	2
No, the pandemic has not affected my level of trust, it is just as high as at the beginning of the pandemic	3
No, the pandemic has not affected my level of trust, I did not trust this source prior to the pandemic	4
I am unsure/don't know	8

29. Based on your experiences during the pandemic, which of the following do you think would be useful in the future to help your decision making about vaccines and other public health measures (e.g., wearing a mask ~~etc~~)? Select all that apply. [RANDOMIZE; ANCHOR LAST FOUR]

Information on the effectiveness of individual public health measures	1
Information about potential risks to myself personally (i.e., infection, severe illness~~, etc~~)	2
Information on the spread of a cold, flu or other respiratory illness going around in my community	3
Clear communications from the government/public health officials on when and which individual public health measures should be used	4
Information on the spread of COVID-19 in my community	5
Do not trust government/health officials	6
I will use my own common sense	7
None/ Nothing / No information	8
Don't know	9

Section 5: Demographics

The last few questions are strictly for statistical purposes. All of your answers are completely confidential.

30. What is the language you speak most often at home?

English	1
French	2
Other	3
Prefer not to answer	9

31. Are you an Indigenous person, that is, First Nations (North American Indian), Métis or Inuk (Inuit)?

Yes	1
No	2
Prefer not to answer	9

32. [IF NOT IDENTIFYING AS INDIGENOUS] Are you…? [SELECT UP TO THREE]

White	1

South Asian (e.g., East Indian, Pakistani, Sri Lankan)	2
Chinese	3
Black	4
Filipino	5
Latin American	6
Arab	7
Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian)	8
West Asian (e.g., Iranian, Afghan)	9
Korean	10
Japanese	11
Other [SPECIFY]	12
Prefer not to answer	99

33. [IF NOT IDENTIFYING AS INDIGENOUS] Were you born in Canada or in another country?

Canada	1
Another country	2
Prefer not to answer	9

34. What is the highest level of schooling that you have completed?

Some high school or less	1
High school diploma or equivalent	2
Registered apprenticeship or other trades certificate or diploma	3
College, CEGEP or other non-university certificate or diploma	4
University certificate or diploma below bachelor’s level	5
Bachelor’s degree	6
Post graduate degree above bachelor’s level	7
Prefer not to answer	9

35. What is your current employment status?

Student	1
Self-employed	2
Employed (full-time)	3
Employed (part-time)	4
Unemployed (looking for work)	5
Unemployed (not currently looking for work)	6
Unable to work	7
Retired	8
Prefer not to answer	9

36. Which of the following categories best describes your total household income for the last year? That is, the total income of all persons in your household combined, before taxes?

Under $20,000	1
$20,000 to just under $40,000	2
$40,000 to just under $60,000	3
$60,000 to just under $80,000	4
$80,000 to just under $100,000	5
$100,000 to just under $150,000	6

$150,000 and above	7
Don't know/Prefer not to answer	9

37. Which of the following best describes the place where you live now?

A large city	1
A suburb near a large city	2
A small city or town	3
A rural area	4
Prefer not to answer	9

38. What are the first three digits of your postal code?

[INSERT FIRST THREE DIGITS OF POSTAL CODE. FORMAT A1A]	
Prefer not to answer	9

[PRE-TEST ONLY ADD QUESTIONS A THRU J]

A. Did you find any aspect of this survey difficult to understand? Y/N
B. [IF A=YES] If so, please describe what you found difficult to understand.
C. Did you find the way of the any of the questions in this survey were asked made it impossible for you to provide your answer? Y/N
D. [IF C=YES] If so, please describe the problem with how the question was asked.
E. Did you experience any difficulties with the language? Y/N
F. [IF E=YES] If so, please describe what difficulties you had with the language.
G. Did you find any terms confusing? Y/N
H. [IF G=YES] If so, please describe what terms you found confusing.
I. Did you encounter any other issues during the course of this survey that you would like us to be aware of? Y/N
J. [IF I=YES] If so, what are they?

This concludes the survey. Thank you for your participation!

Appendix D: Recruitment screener (general population)

Focus Group Summary

- Recruit 10 participants per group
- Groups are 90 minutes in length
- 12 groups in total:
  - Four groups with adults 18-39
  - Four groups with adults 18+
  - Four groups with Indigenous peoples living off reserve
- Ensure good mix of other demos (province within regions, age, gender, income, education, urban/suburban/rural etc.)

Group #	Audience	Region/Language	Time
Monday, November 21, 2022			
1 (SC)	Adults 18+	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
2 (SC)	Health care professionals	Atlantic Canada (EN	6:00 pm ET / 7:00 pm AT / 7:30 pm NT
3 (DA)	Adults 18+	Ontario (EN)	6:00 pm ET
4 (SC)	Health care professionals	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
5 (DA)	Adults 18+	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Tuesday, November 22, 2022			
6 (SC)	Adults 18-39	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
7 (SC)	Adults 18-39	Quebec (FR)	6:00 pm ET
8 (DA)	Adults 18-39	Ontario (EN)	6:00 pm ET
9 (SC)	Adults 18+	Quebec (FR)	8:00 pm ET
10 (DA)	Adults 18-39	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Wednesday, November 23, 2022			
11 (DA)	Indigenous off-reserve	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
12 (DA)	Indigenous off-reserve	Ontario (EN)	6:00 pm ET
13 (SC)	Health care professionals	Quebec (FR)	6:00 pm ET
14 (DA)	Indigenous off-reserve	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT

15 (SC)	Health care professionals	Ontario (EN)	8:00 pm ET
Thursday, November 24, 2022			
16 (SC)	Indigenous off-reserve	Quebec (FR)	5:30 pm ET

Respondent's name:	Interviewer:
Respondent's phone number: (work)	Date:
Respondent's phone number: (cell)	Validated:
Respondent's email:	Quality Central:
Sample source: panel random client referral	On list:
	On quotas:

Hello/Bonjour, this is _______________ calling on behalf of Earnscliffe, a national public opinion research firm. Would you prefer that I continue in English or French? Préférez-vous continuer en français ou en anglais ?

NOTE: If at this point the respondent prefers to respond in French, then the interviewer must be able to either proceed with the interview in French or read the following statement: « Je vous remercie. Quelqu'un vous rappellera bientôt pour mener le sondage/ le questionnaire/ la preselection en français. »

We are organizing a series of discussion groups on issues of importance on behalf of the Government of Canada, specifically Health Canada. We are looking for people who would be willing to participate in a 90-minute online discussion group. Up to 10 participants will be taking part and for their time, participants will receive an honorarium. May I continue?

Yes CONTINUE
No THANK AND TERMINATE

Participation is voluntary. We are interested in hearing your opinions; no attempt will be made to sell you anything or change your point of view. The format is a 'round table' discussion led by a research professional. All opinions expressed will remain anonymous and views will be grouped together to ensure no particular individual can be identified. The information you provide will be administered according to the requirements of the *Privacy Act*, the *Access to Information Act*, and any other pertinent legislation.

I would like to ask you a few questions to see if you or someone in your household qualify to participate. This will take about three minutes. May I continue?

Yes CONTINUE
No THANK AND TERMINATE

Monitoring text:

READ TO ALL: "This call may be monitored or audio taped for quality control and evaluation purposes.
ADDITIONAL CLARIFICATION IF NEEDED:
To ensure that I (the interviewer) am reading the questions correctly and collecting your answers accurately;
To assess my (the interviewer) work for performance evaluation;
To ensure that the questionnaire is accurate/correct (i.e. evaluation of CATI programming and methodology – we're asking the right questions to meet our clients' research requirements – kind of like pre-testing)
If the call is audio taped, it is only for the purposes of playback to the interviewer for a performance evaluation immediately after the interview is conducted or it can be used by the Project Manager/client to evaluate the questionnaire if they are unavailable at the time of the interview – all audio tapes are destroyed after the evaluation.

1. Do you or does anyone in your immediate family or household work in any of the following areas?

	Yes	No
A marketing research firm	1	2
A magazine or newspaper, online or print	1	2
A radio or television station	1	2
A public relations company	1	2
An advertising agency or graphic design firm	1	2
An online media company or as a blog writer	1	2
In health care	1	2
The government, whether federal, provincial or municipal	1	2

IF "YES" TO ANY OF THE ABOVE, THANK AND TERMINATE

2. Which of the following age categories do you fall in to? Are you…? [ENSURE GOOD MIX]

Under 18 years	1	THANK AND TERMINATE
18-24 years	2	
25-29 years	3	
30-34 years	4	
35-39 years	5	
40-49 years	6	
50-59 years	7	
60-64 years	8	
65+ years	9	

3. In which province or territory do you live?

ATLANTIC CANADA	
Newfoundland and Labrador	1
Nova Scotia	2
New Brunswick	3
Prince Edward Island	4
QUEBEC	5
ONTARIO	6
WEST/NORTH	
Manitoba	7
Saskatchewan	8
Alberta	9
British-Columbia	10
Nunavut	11
Northwest Territories	12
Yukon	13

4. How would you describe the area in which you live? [ENSURE GOOD MIX]

Large urban population centre, that is, it has a population 100,000 or greater	1
Medium urban population centre, that is, it has a population of 30,000 to 99,999	2
Small urban population centre, that is, it has a population of 1,000 to 29,999	3
Rural area, that is, it has a population of less than 1,000	4
Remote area, that is, it has a population of less than 1,000 and you are isolated from other communities	5
Don’t know/Prefer not to say	9

5. What gender do you identify with? [ENSURE GOOD MIX]

Male	1	
Female	2	
Non-binary person	3	
Two spirit	4	
Another gender identify	5	
Prefer not to answer	9	

6. Do you identify as an Indigenous person, that is, First Nations (Status or non-Status) (North American Indian), Métis, or Inuk (Inuit)?

Yes	1	
No	2	PROCEED TO Q9

7. Are you First Nations, Métis, or Inuk (Inuit)?

First Nations (North American Indian)	1	PROCEED TO Q8
Métis	2	ELIGIBLE FOR GROUPS 11, 12, 14, 16
Inuk (Inuit)	3	ELIGIBLE FOR GROUPS 11, 12, 14, 16
None of the above	9	THANK AND TERMINATE

8. [ONLY FIRST NATIONS] Do you live…

On-reserve	1	
Off-reserve	2	ELIGIBLE FOR GROUPS 11, 12, 14, 16
Other	3	
DK/NR	9	

9. [IF NOT INDIGENOUS] To make sure that we speak to a diversity of people, could you please tell me what is your ethnic background? DO NOT READ [ENSURE GOOD MIX*]*

Caucasian	1
Chinese	2
South Asian (i.e., East Indian, Pakistani, etc.)	3
Black	4
Filipino	5
Latin American	6
Southeast Asian (i.e. Vietnamese, etc.)	7
Arab	8
West Asian (i.e. Iranian, Afghan, etc.)	9
Korean	10
Japanese	11
Other (please specify)	12
DK/NR	13

10. What is your current employment status? *ENSURE GOOD MIX*

Working full-time	1
Working part-time	2

Self-employed	3	
Retired	4	
Unemployed	5	
Student	6	
Other	7	
Prefer not to answer	9	THANK AND TERMINATE

11. Which of the following categories best describes your total household income; that is, the total income of all persons in your household combined, before taxes? [READ LIST] [ENSURE GOOD MIX]

Under $20,000	1	
$20,000 to under $40,000	2	
$40,000 to under $60,000	3	
$60,000 to under $80,000	4	
$80,000 to under $100,000	5	
$100,000 to under $150,000	6	
$150,000 or more	7	
DK/NR	9	THANK AND TERMINATE

12. What is the highest level of schooling that you have completed? [ENSURE GOOD MIX]

Some high school or less	1
High school diploma or equivalent	2
Registered apprenticeship or other trades certificate or diploma	3
College, CEGEP or other non-university certificate or diploma	4
University certificate or diploma below bachelor’s level	5
Bachelor’s degree	6
Post graduate degree above bachelor’s level	7
DK/NR	9

13. Have you participated in a discussion or focus group before? A discussion group brings together a few people in order to know their opinion about a given subject.

Yes	1	MAX 4 PER GROUP
No	2	SKIP TO Q16
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

14. When was the last time you attended a discussion or focus group?

If within the last 6 months	1	THANK AND TERMINATE
If not within the last 6 months	2	CONTINUE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

15. How many of these sessions have you attended in the last five years?

If 4 or less	1	CONTINUE
If 5 or more	2	THANK AND TERMINATE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

This research will require participating in a video call online.

16. Do you have access to a computer, smartphone or tablet with high-speed internet which will allow you to participate in an online discussion group?

Yes	CONTINUE
No	THANK AND TERMINATE

17. Does your computer/smartphone/tablet have a camera that will allow you to be visible to the moderator and other participants as part of an online discussion group?

Yes	CONTINUE
No	THANK AND TERMINATE

18. Do you have a personal email address that is currently active and available to you?

Yes	CONTINUE, PLEASE RECORD EMAIL
No	THANK AND TERMINATE

INVITATION

19. Participants in discussion groups are asked to voice their opinions and thoughts. How comfortable are you in voicing your opinions in front of others? Are you…? (READ LIST)

Very comfortable	1	MINIMUM 4 PER GROUP
Fairly comfortable	2	CONTINUE
Comfortable	3	CONTINUE
Not very comfortable	4	THANK AND TERMINATE
Not at all comfortable	5	THANK AND TERMINATE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

20. Sometimes participants are asked to read text, review images, or type out answers during the discussion. Is there any reason why you could not participate?

Yes	1	ASK Q21
No	2	SKIP TO Q23
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

21. Is there anything we could do to ensure that you can participate?

Yes	1	ASK Q22
No	2	THANK AND TERMINATE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

22. What specifically? [OPEN END] ***INTERVIEWER TO NOTE FOR POTENTIAL ONE-ON-ONE INTERVIEW***

23. Based on your responses, it looks like you have the profile we are looking for. I would like to invite you to participate in a small group discussion, called an online focus group, we are conducting at [TIME], on [DATE]. As you may know, focus groups are used to gather information on a particular subject matter. The discussion will consist of up to 10 people and will be very informal.

    It will last up to 90 minutes and you will receive an incentive of… [MEMBERS OF THE GENERAL PUBLIC] $100; [INDIGENOUS PERSONS] $200

    …as a thank you for your time. Would you be willing to attend?

Yes	1	RECRUIT
No	2	THANK AND TERMINATE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

PRIVACY QUESTIONS

Now I have a few questions that relate to privacy, your personal information and the research process. We will need your consent on a few issues that enable us to conduct our research. As I run through these questions, please feel free to ask me any questions you would like clarified.

P1) First, we will be providing a list of respondents' first names and profiles (screener responses) to the moderator so that they can sign you into the group. Do we have your permission to do this? I assure you it will be kept strictly confidential.

Yes	1	GO TO P2
No	2	GO TO P1A

We need to provide the first names and background of the people attending the focus group because only the individuals invited are allowed in the session and this information is necessary for verification purposes. Please be assured that this information will be kept strictly confidential. GO TO P1A

P1a) Now that I've explained this, do I have your permission to provide your first name and profile?

Yes	1	GO TO P2
No	2	THANK & TERMINATE

P2) A recording of the group session will be produced for research purposes. The recordings will be used by the research professional to assist in preparing a report on the research findings and may be used by the Government of Canada to inform their work in this subject area.

Do you agree to be recorded for research and reporting purposes only?

Yes	1	THANK & GO TO P3
No	2	READ RESPONDENT INFO BELOW & GO TO P2A

It is necessary for the research process for us to record the session as the researchers need this material to complete the report.

P2a) Now that I've explained this, do I have your permission for recording?

Yes	1	THANK & GO TO P3
No	2	THANK & TERMINATE

P3) Employees from the Government of Canada may also be online to observe the groups.

Do you agree to be observed by Government of Canada employees?

Yes	1	THANK & GO TO INVITATION
No	2	GO TO P3A

P3a) It is standard qualitative procedure to invite clients, in this case, Government of Canada employees, to observe the groups online. They will be there simply to hear your opinions firsthand although they may take their own notes and confer with the moderator on occasion to discuss whether there are any additional questions to ask the group.

Do you agree to be observed by Government of Canada employees and employees of the creative agency?

Yes	1	THANK & GO TO INVITATION
No	2	THANK & TERMINATE

INVITATION

Wonderful, you qualify to participate in one of our discussion sessions. As I mentioned earlier, the group discussion will take place on [DATE] at [TIME] for up to 90 minutes.

Group #	Audience	Region/Language	Time
Monday, November 21, 2022			
1 (SC)	Adults 18+	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
2 (SC)	Health care professionals	Atlantic Canada (EN	6:00 pm ET / 7:00 pm AT / 7:30 pm NT
3 (DA)	Adults 18+	Ontario (EN)	6:00 pm ET
4 (SC)	Health care professionals	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
5 (DA)	Adults 18+	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Tuesday, November 22, 2022			
6 (SC)	Adults 18-39	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
7 (SC)	Adults 18-39	Quebec (FR)	6:00 pm ET
8 (DA)	Adults 18-39	Ontario (EN)	6:00 pm ET
9 (SC)	Adults 18+	Quebec (FR)	8:00 pm ET
10 (DA)	Adults 18-39	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT

Wednesday, November 23, 2022			
11 (DA)	Indigenous off-reserve	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
12 (DA)	Indigenous off-reserve	Ontario (EN)	6:00 pm ET
13 (SC)	Health care professionals	Quebec (FR)	6:00 pm ET
14 (DA)	Indigenous off-reserve	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
15 (SC)	Health care professionals	Ontario (EN)	8:00 pm ET
Thursday, November 24, 2022			
16 (SC)	Indigenous off-reserve	Quebec (FR)	5:30 pm ET

Can I confirm your email address so that we can send you the link to the online discussion group?

We ask that you login a few minutes early to be sure you are able to connect and to test your sound (speaker and microphone). If you require glasses for reading, please make sure you have them handy as well.

As we are only inviting a small number of people, your participation is very important to us. If for some reason you are unable to attend, please call us so that we may get someone to replace you. You can reach us at [INSERT PHONE NUMBER] at our office. Please ask for [NAME]. Someone will call you in the days leading up to the discussion to remind you.

So that we can call you to remind you about the discussion group or contact you should there be any changes, can you please confirm your name and contact information for me?

First name
Last Name
email
Daytime phone number
Evening phone number

If the respondent refuses to give his/her first or last name, email or phone number please assure them that this information will be kept strictly confidential in accordance with the privacy law and that it is used strictly to contact them to confirm their attendance and to inform them of any changes to the discussion group. If they still refuse THANK & TERMINATE.

Appendix E: Recruitment screener (health care professionals)

Focus Group Summary

- Recruit 10 participants per group
- Groups are 90 minutes in length
- Four groups with health care professionals: 3 family physicians/GPs, 4 nurses and 3 pharmacists

Group #	Audience	Region/Language	Time
Monday, November 21, 2022			
1 (SC)	Adults 18+	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
2 (SC)	Health care professionals	Atlantic Canada (EN	6:00 pm ET / 7:00 pm AT / 7:30 pm NT
3 (DA)	Adults 18+	Ontario (EN)	6:00 pm ET
4 (SC)	Health care professionals	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
5 (DA)	Adults 18+	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Tuesday, November 22, 2022			
6 (SC)	Adults 18-39	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
7 (SC)	Adults 18-39	Quebec (FR)	6:00 pm ET
8 (DA)	Adults 18-39	Ontario (EN)	6:00 pm ET
9 (SC)	Adults 18+	Quebec (FR)	8:00 pm ET
10 (DA)	Adults 18-39	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Wednesday, November 23, 2022			
11 (DA)	Indigenous off-reserve	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
12 (DA)	Indigenous off-reserve	Ontario (EN)	6:00 pm ET
13 (SC)	Health care professionals	Quebec (FR)	6:00 pm ET
14 (DA)	Indigenous off-reserve	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
15 (SC)	Health care professionals	Ontario (EN)	8:00 pm ET

Thursday, November 24, 2022			
16 (SC)	Indigenous off-reserve	Quebec (FR)	5:30 pm ET

Respondent's name:
Respondent's phone number: (work)
Respondent's phone number: (cell)
Respondent's email:
Sample source: panel random client referral

Interviewer:
Date:
Validated:
Quality Central:
On list:
On quotas:

Hello/Bonjour, this is _______________ calling on behalf of Earnscliffe, a national public opinion research firm. Would you prefer that I continue in English or French? Préférez-vous continuer en français ou en anglais ?

NOTE: If at this point the respondent prefers to respond in French, then the interviewer must be able to either proceed with the interview in French or read the following statement: « Je vous remercie. Quelqu'un vous rappellera bientôt pour mener le sondage/ le questionnaire/ la preselection en français. »

We are looking for health care professionals who would be willing to participate in a 90-minute online discussion group. Up to 10 participants will be taking part and for their time, participants will receive an honorarium. May I continue?

Yes CONTINUE
No THANK AND TERMINATE

Participation is voluntary. We are interested in hearing your opinions; no attempt will be made to sell you anything or change your point of view. The format is a 'round table' discussion led by a research professional. All opinions expressed will remain anonymous and views will be grouped together to ensure no particular individual can be identified. The information you provide will be administered according to the requirements of the *Privacy Act*, the *Access to Information Act*, and any other pertinent legislation.

I would like to ask you a few questions to see if you or someone in your household qualify to participate. This will take about three minutes. May I continue?

Yes CONTINUE
No THANK AND TERMINATE

Monitoring text:

READ TO ALL: "This call may be monitored or audio taped for quality control and evaluation purposes.
ADDITIONAL CLARIFICATION IF NEEDED:
To ensure that I (the interviewer) am reading the questions correctly and collecting your answers accurately;
To assess my (the interviewer) work for performance evaluation;
To ensure that the questionnaire is accurate/correct (i.e. evaluation of CATI programming and methodology – we're asking the right questions to meet our clients' research requirements – kind of like pre-testing)
If the call is audio taped, it is only for the purposes of playback to the interviewer for a performance evaluation immediately after the interview is conducted or it can be used by the Project Manager/client to evaluate the questionnaire if they are unavailable at the time of the interview – all audio tapes are destroyed after the evaluation.

24. Which of the following best describes your professional designation?

Physician – general practitioner	1	2 PER GROUP
Physician – specialist	2	THANK AND TERMINATE
Registered nurse	3	4 PER GROUP (3–5)
Nurse practitioner	4	
Licenced practical nurse/Registered practical nurse	5	
None of the above	9	

25. [IF NONE OF THE ABOVE] Which of the following, if any, describes your line of work or profession?

Social worker or case manager	1
Health system navigator	2
Shelter worker or community health worker	3
Personal support worker	4
Pharmacist	5
Therapist (e.g., occupational, physio, speech, respiratory, recreational)	6
Counsellor (e.g., psychologist, spiritual/non-spiritual counsellor)	7
Dietician	8
NONE OF THE ABOVE [THANK AND TERMINATE]	9

IF IDENTIFIES AS A PHARMACIST (5), CONTINUE. FOR ALL OTHER RESPONSES, THANK AND TERMINATE. PLEASE RECRUIT 3 PER GROUP.

26. In your work, do you provide vaccine-related information to patients and/or clients?

Yes	1	CONTINUE
No	2	THANK AND TERMINATE

27. In which care setting do you spend most of your time? [ENSURE GOOD MIX]

Primary care	1
Outpatient clinic	2
Long-term care facility/Residential care	3
Home care	4
Community care	5
Hospital/Rehabilitation centre	6
Local pharmacy	7
Shelter	8
Community health centre/clinic	9
Another care setting	10

28. In what year did you start practising/working in your profession? [RECORD YEAR] [ENSURE GOOD MIX]

29. In which province or territory do you live?

ATLANTIC CANADA	
Newfoundland and Labrador	1
Nova Scotia	2
New Brunswick	3
Prince Edward Island	4
QUEBEC	5
ONTARIO	6
WEST/NORTH	
Manitoba	7
Saskatchewan	8
Alberta	9
British-Columbia	10
Nunavut	11
Northwest Territories	12
Yukon	13

30. What gender do you identify with? [ENSURE GOOD MIX]

Male	1
Female	2
Non-binary person	3
Two spirit	4
Another gender identify	5
Prefer not to answer	9

31. What is your racial and/or ethnic background? [SELECT ALL THAT APPLY.]

Black (African, Afro-Caribbean, African-Canadian descent)	1
East Asian (Chinese, Korean, Japanese, Taiwanese descent)	2
Indigenous (First Nations, Inuit, Métis)	3
Latin American (Hispanic descent)	4
Middle Eastern (West Asian or North African descent, e.g. Afghan, Egyptian, Iranian)	5
South Asian (Indian, Pakistani, Sri Lankan, Indo-Caribbean descent)	6
Southeast Asian (Filipino, Vietnamese, Cambodian, Thai descent)	7
White (European descent)	8
Prefer not to answer	9

32. Have you participated in a discussion or focus group before? A discussion group brings together a few people in order to know their opinion about a given subject.

Yes	1	MAX 2 PER GROUP, ASK Q10, Q11
No	2	SKIP TO Q12
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

33. When was the last time you attended a discussion or focus group?

If within the last 6 months	1	THANK AND TERMINATE
If not within the last 6 months	2	CONTINUE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

34. How many of these sessions have you attended in the last five years?

If 4 or less	1	CONTINUE
If 5 or more	2	THANK AND TERMINATE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

This research will require participating in a video call online.

35. Do you have access to a computer, smartphone or tablet with high-speed internet which will allow you to participate in an online discussion group?

Yes	CONTINUE
No	THANK AND TERMINATE

36. Does your computer/smartphone/tablet have a camera that will allow you to be visible to the moderator and other participants as part of an online discussion group?

Yes	CONTINUE
No	THANK AND TERMINATE

37. Do you have a personal email address that is currently active and available to you?

Yes	CONTINUE, PLEASE RECORD EMAIL
No	THANK AND TERMINATE

INVITATION

38. Participants in discussion groups are asked to voice their opinions and thoughts. How comfortable are you in voicing your opinions in front of others? Are you…? (READ LIST)

Very comfortable	1	MINIMUM 4 PER GROUP
Fairly comfortable	2	CONTINUE
Comfortable	3	CONTINUE
Not very comfortable	4	THANK AND TERMINATE
Not at all comfortable	5	THANK AND TERMINATE
Don't know/Prefer not to answer	9	THANK AND TERMINATE

39. Sometimes participants are asked to read text, review images, or type out answers during the discussion. Is there any reason why you could not participate?

Yes	1	ASK Q17
No	2	SKIP TO Q19
Don't know/Prefer not to answer	9	THANK AND TERMINATE

40. Is there anything we could do to ensure that you can participate?

Yes	1	ASK Q18
No	2	THANK AND TERMINATE
Don't know/Prefer not to answer	9	THANK AND TERMINATE

41. What specifically? [OPEN END] ***INTERVIEWER TO NOTE FOR POTENTIAL ONE-ON-ONE INTERVIEW***

42. Based on your responses, it looks like you have the profile we are looking for. I would like to invite you to participate in a small group discussion, called an online focus group, we are conducting at [TIME], on [DATE]. As you may know, focus groups are used to gather information on a particular subject matter. The discussion will consist of up to 10 people and will be very informal.

    It will last up to 90 minutes and you will receive an incentive of… [FAMILY PHYSICIANS/GENERAL PRACTITIONERS] $400; [NURSES AND PHARMACISTS] $350

    …as a thank you for your time. Would you be willing to attend?

Yes	1	RECRUIT
No	2	THANK AND TERMINATE
Don’t know/Prefer not to answer	9	THANK AND TERMINATE

PRIVACY QUESTIONS

Now I have a few questions that relate to privacy, your personal information and the research process. We will need your consent on a few issues that enable us to conduct our research. As I run through these questions, please feel free to ask me any questions you would like clarified.

P1) First, we will be providing a list of respondents’ first names and profiles (screener responses) to the moderator so that they can sign you into the group. Do we have your permission to do this? I assure you it will be kept strictly confidential.

Yes	1	GO TO P2
No	2	GO TO P1A

We need to provide the first names and background of the people attending the focus group because only the individuals invited are allowed in the session and this information is necessary for verification purposes. Please be assured that this information will be kept strictly confidential. GO TO P1A

P1a) Now that I’ve explained this, do I have your permission to provide your first name and profile?

Yes	1	GO TO P2
No	2	THANK & TERMINATE

P2) A recording of the group session will be produced for research purposes. The recordings will be used by the research professional to assist in preparing a report on the research findings and may be used by the Government of Canada to inform their work in this subject area.

Do you agree to be recorded for research and reporting purposes only?

Yes	1	THANK & GO TO P3
No	2	READ RESPONDENT INFO BELOW & GO TO P2A

It is necessary for the research process for us to record the session as the researchers need this material to complete the report.

P2a) Now that I've explained this, do I have your permission for recording?

Yes	1	THANK & GO TO P3
No	2	THANK & TERMINATE

P3) Employees from the Government of Canada may also be online to observe the groups.

Do you agree to be observed by Government of Canada employees?

Yes	1	THANK & GO TO INVITATION
No	2	GO TO P3A

P3a) It is standard qualitative procedure to invite clients, in this case, Government of Canada employees, to observe the groups online. They will be there simply to hear your opinions firsthand although they may take their own notes and confer with the moderator on occasion to discuss whether there are any additional questions to ask the group.

Do you agree to be observed by Government of Canada employees and employees of the creative agency?

Yes	1	THANK & GO TO INVITATION
No	2	THANK & TERMINATE

INVITATION

Wonderful, you qualify to participate in one of our discussion sessions. As I mentioned earlier, the group discussion will take place on [DATE] at [TIME] for up to 90 minutes.

Group #	Audience	Region/Language	Time
Monday, November 21, 2022			
1 (SC)	Adults 18+	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
2 (SC)	Health care professionals	Atlantic Canada (EN	6:00 pm ET / 7:00 pm AT / 7:30 pm NT
3 (DA)	Adults 18+	Ontario (EN)	6:00 pm ET
4 (SC)	Health care professionals	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
5 (DA)	Adults 18+	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Tuesday, November 22, 2022			
6 (SC)	Adults 18-39	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
7 (SC)	Adults 18-39	Quebec (FR)	6:00 pm ET
8 (DA)	Adults 18-39	Ontario (EN)	6:00 pm ET
9 (SC)	Adults 18+	Quebec (FR)	8:00 pm ET
10 (DA)	Adults 18-39	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
Wednesday, November 23, 2022			
11 (DA)	Indigenous off-reserve	Atlantic Canada (EN)	4:00 pm ET / 5:00 pm AT / 5:30 pm NT
12 (DA)	Indigenous off-reserve	Ontario (EN)	6:00 pm ET
13 (SC)	Health care professionals	Quebec (FR)	6:00 pm ET
14 (DA)	Indigenous off-reserve	West/North (EN)	8:00 pm ET / 7:00 pm CT / 6:00 pm MT / 5:00 pm PT
15 (SC)	Health care professionals	Ontario (EN)	8:00 pm ET
Thursday, November 24, 2022			
16 (SC)	Indigenous off-reserve	Quebec (FR)	5:30 pm ET

Can I confirm your email address so that we can send you the link to the online discussion group?

We ask that you login a few minutes early to be sure you are able to connect and to test your sound (speaker and microphone). If you require glasses for reading, please make sure you have them handy as well.

As we are only inviting a small number of people, your participation is very important to us. If for some reason you are unable to attend, please call us so that we may get someone to replace you. You can reach us at [INSERT PHONE NUMBER] at our office. Please ask for [NAME]. Someone will call you in the days leading up to the discussion to remind you.

So that we can call you to remind you about the discussion group or contact you should there be any changes, can you please confirm your name and contact information for me?

First name
Last Name
email
Daytime phone number
Evening phone number

If the respondent refuses to give his/her first or last name, email or phone number please assure them that this information will be kept strictly confidential in accordance with the privacy law and that it is used strictly to contact them to confirm their attendance and to inform them of any changes to the discussion group. If they still refuse THANK & TERMINATE.

Appendix F: Discussion guide (general population)

Introduction (5-minute section / 5 minutes total)

- Good afternoon/Good evening and welcome everyone! My name is Stephanie/Doug and I use [she/he/they] pronouns. I will be leading our conversation today.
- Before we begin, I would like to acknowledge that I am joining from the traditional, unceded territory of the Algonquin Anishinaabe nation. I recognize that we are all joining from different places and encourage you to share the Indigenous traditional territory you are joining from as part of your introduction later.
- As mentioned, when we invited you to participate in this discussion group, we're conducting research on behalf of the Government of Canada and Health Canada, more specifically. The main focus of our discussion is to better understand perspectives related to the COVID-19 pandemic.
    - Your perspectives are very important and will help Health Canada in their efforts to develop policies and messaging on key vaccine confidence issues such as mis-or-disinformation.
- I also want to acknowledge the sensitive nature of our conversation today and to reassure you that you should feel completely at ease declining to answer any questions you prefer not to answer. We would like to create a safe space, and what you share will be treated respectfully.
  [FOR GROUPS WITH INDIGENOUS PEOPLES]
    - As the final outputs of this research are for all audiences, we want to emphasize the importance of strengthening cultural competence in health care messaging as integral to building a stronger and more culturally inclusive and supportive society. We are here to listen to your thoughts and invite you to provide your feedback in the safe space of this focus group.
- Role of moderator: to ask questions, make sure everyone has a chance to express themselves, keep track of the time, assures participants that moderator has no special interest in, or knowledge of, the issues discussed.
- Role of participants: speak openly and frankly about opinions, remember that there are no right or wrong answers and no need to agree with each other.
- Results are confidential and reported all together/individuals are not identified/participation is voluntary.
- The length of the session (1.5 hours).
- The presence of any observers, their role and purpose, and the means of observation (observers viewing and listening in remotely).
- The presence and purpose of any recording being made of the session.
- Confirm participants are comfortable with the platform and some of the specific settings such as: how to mute and unmute themselves; where the hand raise button is; and the chat box. Don't be afraid to use the chat box if you have something to contribute but are having trouble jumping in verbally.

Establishing rapport (10-minute section / 15 minutes total)

[Moderator will go around the table and ask participants to introduce themselves.]

- As you know, my name is Stephanie. I have been in public opinion research for 25 years and have a passion for qualitative research and getting to meet and speak with interesting people like yourselves.

- As you know, my name is Doug. I became a researcher 30 years ago and I have come to truly love finding out what people think about all kind of different topics and issues.

- Now let us go around the virtual room. Please tell us what you feel comfortable being referred to for your first name and anything else you would like to share (if comfortable sharing). Please feel free to introduce yourselves in the chat as well if you're more comfortable.

Context and stage setting (2-minute section / 17 minutes total)

To begin, I would like to remind you that the aim of this discussion is to understand your thoughts/views regarding your COVID-19 pandemic experience.

This includes your thoughts/opinions on vaccines, the broader health and safety measures that were suggested or required by public health officials over the course of the COVID-19 pandemic, how this may have affected you and if you think you have experienced some pandemic fatigue. Pandemic fatigue is the stress you may be feeling as a result of spending extra time and energy dealing with what has been part of your pandemic experience (e.g., illness, job, family, or other lifestyle changes) and we will have questions about this later.

For the purposes of our discussion, I would like to remind everyone that the impacts of the COVID-19 pandemic have been different for everyone. This is a judgment free zone and one where I want people to be able to share their feelings and experiences without judgment and with respect.

COVID-19 infection experience (23-minute section / 40 minutes total)

- We would like to begin by asking if anyone has experience with being infected with COVID-19 or sharing a household with someone who had been infected, that they would be willing to share. Again, given that this pandemic has impacted everyone differently, please do not feel obligated to share feedback at this point if this is distressing in any way.

  [FOR GROUPS WITH INDIGENOUS PEOPLES]
  In particular we are aware of the disproportionate impact the pandemic has had with many Indigenous communities, so we want to reassure you we are starting this conversation from a learning perspective.
- Thinking now of the overall implications of the COVID-19 pandemic, would anyone like to share whether and how an infection had an impact on your work and life?
- How did you cope with being infected if/when you were?
- Given the threat of risk of infection across the general population, how has your life been impacted?

- And thinking of going into this winter season, how much of a risk do you feel that COVID-19 currently poses:
  - To yourself
  - Your community
  - Your children
  - The elderly or immunocompromised
  - The health care system

COVID-19 pandemic fatigue (15-minute section / 55 minutes total)

As mentioned earlier, pandemic fatigue can be defined as the stress you may be feeling as a result of spending extra time and energy dealing with what has been your pandemic experience (e.g., illness, job, family, or other lifestyle changes).

- Based on this description, on a scale of 1-10, how you would rate your individual level of pandemic fatigue overall? (Response options: 1 = No fatigue experience at all, 10 = Worst possible fatigue experience)
  - Probe: Could you please tell us a bit more about how you determined your personal pandemic fatigue level (i.e., your number rating)?

- Do you think the public understands the impact the COVID-19 pandemic had, and continues to have, on health care professionals/workers? Can you please explain why you feel that way?

Public health measures including vaccination and vaccine-related behaviours going forward (30-minute section / 85 minutes total)

Now I would like to explore your thoughts related to the public health measures that were advised or in place over the course of the pandemic. And for the purposes of our conversation, I want to remind everyone that this is a judgment free zone. All of your thoughts and perspectives are valuable/helpful learning for us. Please consider all of the following questions only applicable if you feel comfortable sharing.

- First of all, we'd like to know if you think your experiences during the pandemic affected your intentions towards public health measures and COVID-19 vaccines in particular going forward. And if so, how?

  [IF NEGATIVELY AFFECTED]
  - What might be helpful to change these perceptions of or restore your confidence in vaccines and public health guidance?

  [IF POSITIVELY AFFECTED]
  - What was helpful during the pandemic?

  [IF POSITIVELY AFFECTED]
  - Any thoughts on why?

Now let's discuss vaccines. Reminding everyone that this is a safe space, and that people have different views/beliefs about vaccines. Again, all of your thoughts and perspectives are valuable/helpful learning for us.

- Would anyone be comfortable sharing whether you have received any COVID-19 vaccines?
- [HANDS UP] Could I please ask you to raise your hand if you received at least one COVID-19 vaccine?
  - [VACCINATED] Would anyone be comfortable sharing why you chose to receive a COVID-19 vaccine?

  - [UNVACCINATED] Would anyone be comfortable sharing why you chose not to receive a COVID-19 vaccine?
  - [UNVACCINATED] Would anyone like to share your experience in relation to this during the pandemic?

  - [PARENT/LEGAL GUARDIAN] If you are a parent or guardian, have you had your child(ren) vaccinated with a COVID-19 vaccines?

- Do you feel you are likely or unlikely to get additional COVID-19 vaccine doses in future and if so what might be motivating you?

  [LIKELY] Probe:
  - Required to be able to travel internationally
  - Helping to get things back to normal
  - Additional doses being made mandatory for various activities
  - New COVID-19 vaccine formulations that are specific to latest variants

  [UNLIKELY] If not, what might be motivating your hesitancy? Why? Probe:
  - I think I am protected enough with the current number of vaccine doses
  - I feel that the vaccine does not provide much protection as you can still get COVID-19
  - I'm concerned about the long-term side effects of the vaccine
  - I'm fed up with getting vaccinated

- As for other public health measures, would anyone like to share how consistently they were following public health measures (i.e., such as wearing a mask, quarantining, improving ventilation, proof-of-vaccination, etc.) at different times?

- Do you think these are still important? Why or why not?

- If these public health measures were once again advised, would anyone like to share how likely they think they would be to follow the guidance?
  - Are there any reasons/circumstances for which you would be more or less comfortable following public health measures (i.e., to enter a public space, restaurant, travel)?
  - Can I ask whether you think those in your social group would likely do the same? Why or why not?
  - For those of you with children, how do you think your children would feel about having to do these things again?

- Do you think your experiences during the pandemic affected your intentions towards routine vaccines (e.g., shingles, flu, polio) going forward? And if so, how?

- Finally, do you think your experiences during the pandemic have affected your trust in certain sources for information related to vaccines and public health advice? Probe:
  - Scientists
  - Health care professionals/workers (e.g., doctors, nurses)
  - International health authorities (e.g., WHO)
  - Canadian federal government briefings and/or websites
  - Provincial/Territorial government briefings and/or websites
  - Newspapers, radios, podcasts, and other journalism
  - Friends and family
  - Social media (e.g., Facebook, Twitter)

- What would you have to see or learn to change these perceptions of or restore your confidence in vaccines?

Communications needs/preferences

- [HANDS UP] Out of curiosity, have any of you looked for information about COVID-19 vaccines?
  - Would anyone like to share, where you went/looked for information?
    - What did you think of the information? Did it meet your needs? How it could be improved?
  - What kind of information would you most like to know or access?
  - In what format would you like to receive or access that kind of information (e.g., in person, via email, media (radio, television, news stories), social media, video sites like YouTube, podcasts, government websites, cultural/ethnic media outlets and languages

- How did you feel Health Canada and/or your regional health authorities did in terms of communicating information about the COVID-19 vaccines?
  - Would anyone like to describe what worked and what could have been improved?

- If you wanted information about COVID-19 vaccines and/or health measures, where would you seek, like to receive, or access such information? Probe:
  - Your doctor or family physician
  - Your/Local pharmacist
  - Your provincial health authority
  - Federal government health authority
  - Website/Google search (moderator to probe for specific websites)
  - Pharmaceutical manufacturer

- Would anyone like to share who they view as a trusted source for information about vaccines? Why?

Conclusion (5-minute section / 90 minutes total)

[Moderator to request additional questions are sent via the chat box directly to the moderator and probe on any additional areas of interest]

This concludes what we wanted to cover tonight.

- Do you have any final thoughts or any advice for Health Canada?

Thank you very much for your participation. We really appreciate you taking the time to share your views. Your input is very important.

Appendix G: Discussion guide (health care professionals)

Introduction (5-minute section / 5 minutes total)

- Good afternoon/Good evening and welcome everyone! My name is Stephanie/Doug and I use [she/he/they] pronouns. I will be leading our conversation today.
- Before we begin, I would like to acknowledge that I am joining from the traditional, unceded territory of the Algonquin Anishinaabe nation. I recognize that we are all joining from different places and encourage you to share the Indigenous traditional territory you are joining from as part of your introduction later.
- As mentioned, when we invited you to participate in this discussion group, we're conducting research on behalf of the Government of Canada and Health Canada, more specifically. The main focus of our discussion is to better understand perspectives related to the COVID-19 pandemic.
  - Your perspectives are very important and will help Health Canada in their efforts to develop policies and messaging on key vaccine confidence issues such as mis-or-disinformation.
- I also want to acknowledge the sensitive nature of our conversation today and to reassure you that you should feel completely at ease declining to answer any questions you prefer not to answer. We would like to create a safe space, and what you share will be treated respectfully.
- Role of moderator: to ask questions, make sure everyone has a chance to express themselves, keep track of the time, assures participants that moderator has no special interest in, or knowledge of, the issues discussed.
- Role of participants: speak openly and frankly about opinions, remember that there are no right or wrong answers and no need to agree with each other.
- Results are confidential and reported all together/individuals are not identified/participation is voluntary.
- The length of the session (1.5 hours).
- The presence of any observers, their role and purpose, and the means of observation (observers viewing and listening in remotely).
- The presence and purpose of any recording being made of the session.
- Confirm participants are comfortable with the platform and some of the specific settings such as: how to mute and unmute themselves; where the hand raise button is; and the chat box. Don't be afraid to use the chat box if you have something to contribute but are having trouble jumping in verbally.

Establishing rapport (10-minute section / 15 minutes total)

[Moderator will go around the table and ask participants to introduce themselves.]

- As you know, my name is Stephanie. I have been in public opinion research for 25 years and have a passion for qualitative research and getting to meet and speak with interesting people like yourselves.

- As you know, my name is Doug. I became a researcher 30 years ago and I have come to truly love finding out what people think about all kind of different topics and issues.

- Now let us go around the virtual room. Please tell us what you feel comfortable being referred to for your first name and anything else you would like to share (if comfortable sharing). Please feel free to introduce yourselves in the chat as well if you're more comfortable.

Context and stage setting (2-minute section / 17 minutes total)

To begin, I would like to remind you that the aim of this discussion is to understand your thoughts/views regarding your COVID-19 pandemic experience.

This includes your thoughts/opinions on vaccines, the broader health and safety measures that were suggested or required by public health officials over the course of the COVID-19 pandemic, how this may have affected you and if you think you have experienced some pandemic fatigue. Pandemic fatigue is the stress you may be feeling as a result of spending extra time and energy dealing with what has been part of your pandemic experience (e.g., illness, job, family or other lifestyle changes) and we will have questions about this later.

For the purposes of our discussion, I would like to remind everyone that the impacts of the COVID-19 pandemic have been different for everyone. This is a judgment free zone and one where I want people to be able to share their feelings and experiences without judgment and with respect.

COVID-19 infection experience (23-minute section / 40 minutes total)

- We would like to begin by asking if anyone has experience with being infected with COVID-19 or sharing a household with someone who had been infected, that they would be willing to share. Again, given that this pandemic has impacted everyone differently, please do not feel obligated to share feedback at this point if this is distressing in any way.
- Thinking now of the overall implications of the COVID-19 pandemic, would anyone like to share whether and how an infection had an impact on your work and life?
- How did you cope with being infected if/when you were?
- Given the threat of risk of infection across the general population, how has your life been impacted?
- And thinking of going into this winter season, how much of a risk do you feel that COVID-19 currently poses:
  - To yourself
  - Your community
  - Your children
  - The elderly or immunocompromised
  - The health care system

COVID-19 Pandemic Fatigue (15-minute section / 55 minutes total)

As mentioned earlier, pandemic fatigue can be defined as the stress you may be feeling as a result of spending extra time and energy dealing with what has been your pandemic experience (e.g., illness, job, family, or other lifestyle changes).

- Based on this description, on a scale of 1-10, how you would rate your individual level of pandemic fatigue overall? (Response options: 1 = No fatigue experience at all, 10 = Worst possible fatigue experience)
  - Probe: Could you please tell us a bit more about how you determined your personal pandemic fatigue level (i.e., your number rating)?

- Do you think the public understands the impact the COVID-19 pandemic had, and continues to have, on health care professionals/workers? Can you please explain why you feel that way?
  - Do you think peoples' behaviours would change if they knew the impact on health care professionals?
  - Would anyone like to share any thoughts on how the consequences for the health care system and health care professionals could have been better communicated?

- Has pandemic fatigue had an impact on your relationships with your patients/clients? Can you explain how so and why.

Public health measures including vaccination and vaccine-related behaviours going forward (30-minute section / 85 minutes total)

Now I would like to explore your thoughts related to the public health measures that were advised or in place over the course of the pandemic. And for the purposes of our conversation, I want to remind everyone that this is a judgment free zone. All of your thoughts and perspectives are valuable/helpful learning for us. Please consider all of the following questions only applicable if you feel comfortable sharing.

- What has been your experience as a health care provider with COVID-19 vaccines?

- How, if at all, has your experience with the vaccination campaign over the course of the pandemic, influenced your views/thoughts on vaccines overall?
  - Do you have the sense that your patients/clients' views of vaccines have changed as a result of the COVID-19 pandemic? How so?

- Previous surveys with health care professionals have shown that various health care professionals have a high level of confidence in the importance and safety of COVID-19 vaccines. Confidence in their efficacy is somewhat lower. What are your thoughts on this?

- Do you think your experiences during the pandemic have affected your patient's trust in certain sources for information related to vaccines and public health advice? Probe for:
  - Scientists
  - Health care professionals/workers (e.g., doctors, nurses)
  - International health authorities (e.g., WHO)
  - Canadian federal government briefings and/or websites
  - Provincial/Territorial government briefings and/or websites
  - Newspapers, radios, podcasts and other journalism
  - Friends and family
  - Social media (e.g., Facebook, Twitter)

- For those of you who administered vaccines, what can you share your experiences with that process that might be helpful?

Conclusion (5-minute section / 90 minutes total)

[Moderator to request additional questions are sent via the chat box directly to the moderator and probe on any additional areas of interest]

This concludes what we wanted to cover tonight.

- Do you have any final thoughts or any advice for Health Canada?

Thank you very much for your participation. We really appreciate you taking the time to share your views. Your input is very important.