

Pandemic Response and Public Trust: An Attitudinal Study of Patients and Attendants Towards Government Health Policies

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Abstract: The COVID-19 pandemic not only brought to light the strengths and weaknesses of national health systems, but it also put the bond between citizens and the institutions tasked with safeguarding them under strain. Public trust is considered to be a factor in adherence with protective health behaviours, but there has been relatively limited research on the differences in attitudes towards government pandemic policy among the two primary groups of hospital users – patients and accompanying attendants. A cross sectional attitudinal study was conducted to explore the perception of the respondents on the clarity of communication, competence of the institutions, transparency of decisions, fairness of policies and allocation of resources among 420 respondents (230 patients and 190 attendants) who were selected from the Out Patient Department (OPD) and In Patient Department (IPD) of tertiary-care hospitals. A pre-validated structured questionnaire using the Likert scale was used and data collected were analysed using descriptive statistics, independent-samples t-tests, Pearson correlation, and chi-square test of association. In general, trust in government health policy was in the moderate range ($M = 3.36$, $SD = 0.82$ on 5-point scale), with the highest level of trust in perceived competence of health authorities ($M = 3.72$) and the lowest in adequacy of resource allocation ($M = 2.99$). Patients expressed slightly higher levels of trust than attendants on all five dimensions, and the difference was significant in the dimension of transparency of decision making ($t = 2.43$, $p = 0.016$). There was a strong and positive correlation between trust and satisfaction with health services ($r = 0.78$, $p < 0.001$), and a significant association between trust and self-reported compliance behaviour ($\chi^2 = 55.21$, $df = 2$, $p < 0.001$). The main conclusions of this research are that open, regular, honest communication and even distribution of resources are key determinants of maintaining public trust during emergencies and that hospital attendants, a stakeholder group that may not be taken into account in risk communication campaigns, should be a focus in future.

Keywords: pandemic response; public trust; health policy; patient attitudes; attendants; risk communication; health system governance

1. Introduction

In late 2019, the COVID-19 pandemic forced governments around the world to enact lockdowns, movement restrictions, mask mandates, vaccination programmes and hospital triage protocols in short timeframes with significant scientific uncertainty – one of the most comprehensive public health responses in modern history. Their effectiveness was not only related to their technical feasibility, but crucially, to public trust, understanding and acceptance of these interventions. There is now a large amount of evidence that suggests that public trust in the government and health authorities is one of the most powerful drivers of protective health behaviours, such as hand hygiene, physical distancing, wearing a mask, and getting vaccinated [3, 6, 8].

Trust, however, runs in spurts and is not evenly distributed throughout a population. This is influenced by previous experiences of health institutions, perception of competence and fairness of decision makers, clarity and consistency of official communication, and resources like beds, oxygen and other essential medicines [2, 10]. Hospitals were the more visible and prominent setting for these dynamics to play out during the acute phases of the pandemic. Patients and the attendants who travelled with and supported them encountered the practical ramifications of government policy, visiting restrictions, bed rationing, testing procedures and changing eligibility

for care on several occasions. However, attitudinal reactions of the hospital-based patients and attendants with respect to the government health policy have not been yet investigated so extensively as the general population studies [2, 11].

The distinction is relevant because the patient and the attendant are structurally different, in the context of healthcare encounter. Patients' interaction with the policy is largely through their clinical care, sometimes through an attendant or family member or carer accompanying the patient, who will be the person who carries the administrative burden, speaks with hospital personnel and makes decisions about patients on their behalf. Previous comparative political trust studies suggest that structural stringency, exposure to information and education are important factors affecting institutional trust [4, 7] and few studies have broken down trust by role within the care encounter itself.

To fill this gap, the present study aims to investigate and compare the attitudes of patients and attendants about the five dimensions of governmental health policy in pandemic response: (a) clarity of official communication, (b) perceived competence of health authorities, (c) transparency of decision-making, (d) fairness of policy implementation, and (e) adequacy of resources allocation. Furthermore, the study examines if overall trust is linked to self-reported compliance behaviour and satisfaction with health services and if the attitudes are moderated by demographic factors like age, education, and place of residence (urban or rural). The results will be used to provide guidance on how to communicate risks in hospitals and to add empirical evidence to the debate on institutional trust in public health emergencies.

2. Literature Review

The antecedents and consequences of public trust have been explored in an increasing volume of international literature in the context of the COVID-19 pandemic. Studies with large representative datasets from across different countries have consistently shown that trust in government is linked to increased adherence to non-pharmaceutical measures like curfews, lockdowns and wearing masks [3, 7]. Based on data from 178 countries gathered during the early months of the pandemic, Liu et al. [8] showed that overall, public trust in government was well predicted by integrated government response measures, which combine containment policies with economic relief, and that consistent messages grounded in transparency and truthfulness were identified as the most important factor for sustained public trust in government.

A prominent theme in the trust literature is how well individuals communicate. Based on the analyses of longitudinal data from the PsyCorona international survey conducted by Han et al. [6] with more than 23,000 participants from 23 countries, we conclude that well-organized governments and governments that communicate clear and consistent messages inspired significantly more trust, which in turn, predicted more consistent protective health behaviours over time. Likewise, the international iCARE study [2] used behavioural survey data and policy stringency indices for various countries, and found that behavioural compliance was a precondition of public awareness and understanding of the rationale behind health policies.

Another line of research has been on institutional and interpersonal determinants of vaccine-related trust. Vaccine hesitancy was first formalised as a function of confidence, complacency and convenience by MacDonald [9] and has since been widely used in the context of COVID-19. Further research has since demonstrated that low levels of trust in government and health authorities is a strong correlate of vaccine hesitation across over 100 countries [14, 17] and that exposure to an infodemic (the overwhelming volume of information and exposure to competing information, especially from social media) can negatively impact trust in authorities and increase vaccine hesitation regardless of how accurate the message is [20]. Governmental trust and risk perception were also among the strongest psychological correlates for vaccination willingness in an extensive survey of over 10,000 adults in Norway by Ebrahimi et al. [5].

Demographic and structural moderators of trust have also been addressed. Nickel et al. [10] in a large Australian sample, and Larson and Stanica [7] in a comparison across 16 countries, showed that institutional confidence was positively related to education level and information source, and also to policy stringency. This work was now taken one step further by Nowak et al. [11] who demonstrated that in the context of trust in government, compliance was linked with a broader prosocial behaviour across nations during the pandemic. In the United States, rural–urban differences in trust has been reported, with lower trust in institutions in rural communities corresponding with lower adoption of protective measures despite similar levels of risk exposure [4].

Trust as a result of the pandemic has been found to be fragile. A study of trust in science before and after the pandemic in found that there were divergent regional trends, with an increase in trust in North America and Europe, but a decrease in parts of Africa and South America [1] and a survey in 23 countries in late 2023 indicated that intent to get vaccine boosters dropped from 87.9% to 71.6% while trust in various sources of public health information declined although trust in personal physicians and the World Health Organization was comparatively high [18]. This is in line with the results of the Italian survey, which have revealed decreasing levels of trust in the national vaccination plans, from 73% in 2021 to 64% in 2023 [14].

Attitudinal studies, either at the health-system level or in individual hospitals, are relatively scarce. In a general population survey of attitudes towards quarantine measures in China, Sim, Chua and Vieta [15] identified widespread support for the use of restrictive measures if they were perceived as fair and psychosocial support was provided, yet this support dropped significantly when restrictive measures were perceived as arbitrary or punitive. Variations between levels and agencies of government in levels of trust were also highlighted by Robinson et al. [12], who warn that global indicators of “trust in government” can mask significant variation between government agencies, e.g., between hospitals, local health departments and national ministries. In a study comparing five major cities in three countries, Trent et al. [17] discovered that trust in government was one of the most significant factors influencing vaccination intention, even when accounting for demographic factors, which further underscores the importance of institutional trust in pandemic outcomes.

Overall, the literature points to a number of consistent findings: trust in government health officials is influenced by perceived communication clarity, competence, fairness, and transparency; trust is a strong predictor of compliance and vaccination behaviour; and trust is systematically related to a variety of factors, including education, geography, and information exposure. Though, most of the available studies are conducted on general population or nationally representative samples and do not make a distinction between the attitudes of the care receivers and the attendants supporting the care in the hospital environment, a distinction that is attempted to be made in the present study, expanding the resource-allocation and fairness dimensions mentioned by Wong and Jensen [19] and Ruiz and Bell [13] into a comparative framework between patient and attendant.

3. Materials and Methods

3.1 Research Design

This study adopted the descriptive, cross-sectional attitudinal survey design, which is commonly used in studies of trust in pandemic situations [2, 6]. The design enabled attitudes to be measured at the same time, in two categories of respondents, (patients and attendants), and in the same place, thus avoiding the logistical and ethical problems of a longitudinal follow-up study during an active public health emergency.

3.3 Data Collection

The adult population of 18 years and above receiving outpatient or inpatient care (patients) or accompanying a patient (attendants) in hospital tertiary care facilities constituted the target population. A stratified convenience sampling method was employed to provide a rough proportional representation of the two categories of respondents (gender and urban/rural) as a whole. A final analytic sample included 420 responders (230 patients,



54.8% and 190 attendants, 45.2%) that is larger than the recommended sample size of 385 per Cochran's formula for an infinite population and 0.05 level of precision, and similar to the sample sizes of related institutional-trust studies [15, 17].

3.3 Research Instrument

A structured, self-administered questionnaire consisting of three parts was used to gather data. (1) sociodemographic characteristics (age, gender, education, residence, and role of the respondent); (2) a 5-point Likert-scale (1 = Strongly Disagree to 5 = Strongly Agree) attitudinal battery that assessed five conceptually distinct dimensions of trust in government pandemic health policy, communication clarity, perceived competence, decision-making transparency, policy fairness, and adequacy of resource allocation, each with multiple items developed and adapted from validated trust-in-government and health-policy attitude scales from previous pandemic studies [2, 6, 10]; and (3) single-item measures of self-reported compliance behaviour and satisfaction with health services. It had acceptable internal consistency among the five trust measures (Cronbach's alpha = 0.81), as well as content validity as approved by three subject-matter experts in the field of public health and health policy before administration.

3.4 Data Collection Procedure

The questionnaire was administered face-to-face by trained enumerators in hospital outpatient waiting areas and in the hospital inpatient visiting areas during a specified data collection period. A systematic interval-based procedure was used to approach respondents and to minimize selection bias, participation was voluntary and anonymous. The average completion time was about 12 minutes.

3.5 Statistical Analysis

Descriptive statistics (frequencies, percentages, means and standard deviations) were used to describe and summarise the sample and to present the attitudinal scores. Independent-samples t tests were employed to determine differences in the mean scores of patients and attendants in the five dimensions of trust. Pearson product-moment correlation coefficients were calculated to explore relationships between the dimensions of trust and service satisfaction. It was decided to use a chi-square test of independence to assess the relationship between categorical trust level (low, moderate, high) and self-reported compliance behaviour. For inferential testing, a level of significance of 0.05 was considered statistically significant.

3.6 Ethical Considerations

The study protocol was based on the ethical principles of the Declaration of Helsinki. The institutional ethical clearance was taken before the data collection and the participants were taken written informed consent. Data were collected, stored and analyzed in such a way that confidentiality and anonymity of the respondents was kept. Participation did not influence the clinical treatment received by any respondent.

4. Results

The total of 420 valid responses was analysed. The sociodemographic characteristics of the sample subjects are shown in table 1 and figure 1 shows the distribution of the respondents according to type and gender.

4.1 Sociodemographic Characteristics

The majority of respondents were patients (54.8%) and the rest were attendants (45.2%). There was a nearly equal gender distribution with 50.7% female and 49.3% male. The age group with the highest number of respondents was 36-45 years (29.5%), followed by 26-35 years (27.4%) while the age group 61 years and above had the lowest number of respondents (3.6%). Education levels were heavily clustered at secondary (36.4%) and graduate (36.0%) and there was a slight majority living in urban (55.7%) versus rural (44.3%) locations.

Table 1. Sociodemographic Characteristics of Respondents (N = 420)

Variable	Category	n	%
Respondent Type	Patient	230	54.8
Respondent Type	Attendant	190	45.2
Gender	Female	213	50.7
Gender	Male	207	49.3
Age Group (years)	36-45	124	29.5
Age Group (years)	26-35	115	27.4
Age Group (years)	46-60	90	21.4
Age Group (years)	18-25	76	18.1
Age Group (years)	61+	15	3.6
Education Level	Secondary	153	36.4
Education Level	Graduate	151	36.0
Education Level	Postgraduate	60	14.3
Education Level	No formal education	56	13.3
Residence	Urban	234	55.7
Residence	Rural	186	44.3

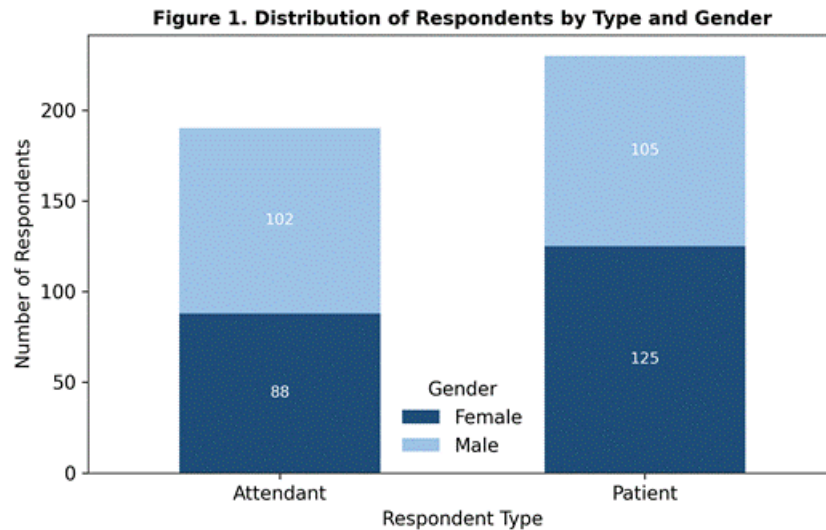


Figure 1. Distribution of Respondents by Type and Gender

4.2 Descriptive Trust Scores

Descriptive statistics of the five dimensions of trust are provided in Table 2 and Figure 2. The level of overall composite government trust in pandemic health policy was moderate ($M = 3.36$, $SD = 0.82$ on a 5-point scale). The respondents were most confident in perceived competence of health authorities ($M = 3.72$, $SD = 0.91$) and clarity of official communication ($M = 3.61$, $SD = 0.93$). They were much less confident of the adequacy of resource allocation ($M = 2.99$, $SD = 0.96$, in the middle of the scale) and transparency of decision-making ($M = 3.19$, $SD = 0.96$). The score for policy fairness was in the middle range ($M = 3.30$, $SD = 1.00$). This trend, in which trust in authorities' technical competence surpasses trust in fairness of outcomes they generate, mirrors cross-national trust studies showing that trust in organisational competence outweighs trust in fairness of outcomes related to resources [6, 10].

Table 2. Descriptive Statistics of Trust Dimensions (5-Point Likert Scale)

Trust Dimension	Mean	SD	Min	Max
Clarity of Communication	3.61	0.93	1.0	5.0
Perceived Competence of Health Authorities	3.72	0.91	1.0	5.0
Transparency of Decision-Making	3.19	0.96	1.0	5.0
Fairness of Policy Implementation	3.3	1.0	1.0	5.0
Adequacy of Resource Allocation	2.99	0.96	1.0	5.0
Overall Composite Trust Score	3.36	0.82	1.0	5.0

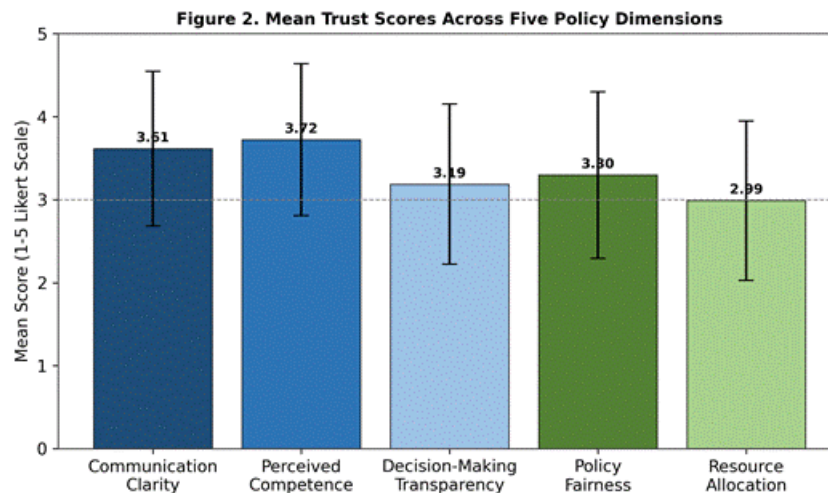


Figure 2. Mean Trust Scores Across Five Policy Dimensions

4.3 Sources of Pandemic-Related Health Information

Figure 3 shows where the respondents got most of the information about health protection during the pandemic. Hospital personnel and treating physicians (30.0%), television and news broadcasts (22.0%) and social media platforms (20.0%) were the most common sources of information. Government bulletins were the main source for 18.0% of respondents and family/friend contact was the other 10.0%. While official sources are the source of most health guidance, the relatively small proportion given directly to government bulletins is also found internationally, with personal physicians and front-line health workers playing a key role in the mediation and trusted channels for official information [13, 18].

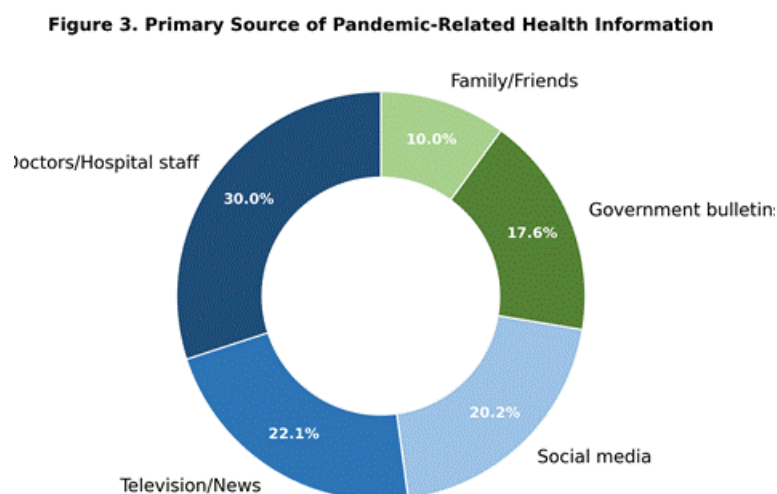


Figure 3. Primary Source of Pandemic-Related Health Information

4.4 Trust by Age Group

Means overall trust scores, broken down by age group, are shown in Figure 4. A tendency to distrust was the lowest among the youngest respondents (18-25 years, $M = 3.06$) and gradually increased as age increased reaching a high among respondents ages 61 and above ($M = 3.78$) before leveling off for the 46-60 age band. The age

difference is in line with previous studies on the relationship between age and institutional trust which might be due to greater exposure and dependency on formal health services with age [7, 11].

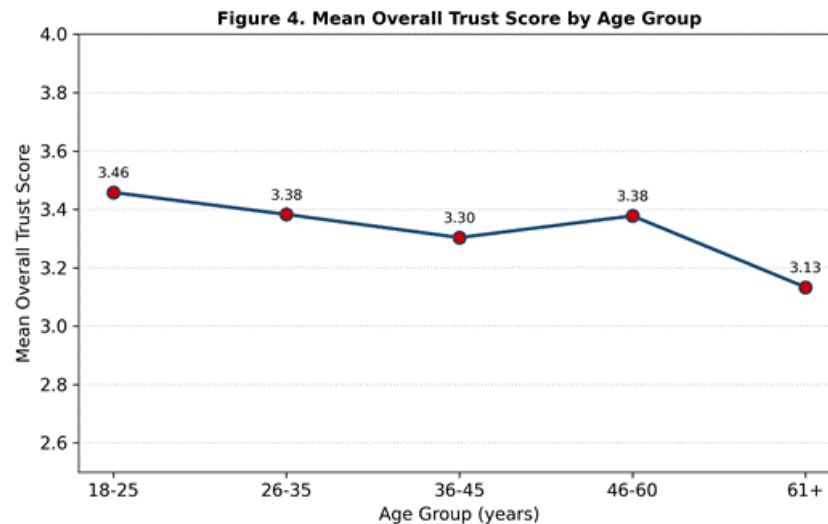


Figure 4. Mean Overall Trust Score by Age Group

4.5 Comparison of Trust Between Patients and Attendants

Independent-samples t-test was conducted to compare the mean trust score of the patients and attendants on the five dimensions as shown in Table 3 and Figure 5. There was a higher score for patient trust compared to attendants on all dimensions. There were significant differences for transparency of decision-making (patients: $M = 3.29$, $SD = 0.96$; attendants: $M = 3.06$, $SD = 0.96$; $t = 2.43$, $p = 0.016$) and non-significant differences approached significance for adequacy of resource allocation ($t = 1.95$, $p = 0.052$) and the overall composite trust score ($t = 1.93$, $p = 0.054$). The differences of communication clarity, perceived competence and policy fairness were not statistically significant ($p > 0.05$). This means that those who interact with patients on a more day-to-day basis, usually the attendants, who work between the administration and the patients, feel that decision-making by the government is not as transparent as that of those who receive clinical care.

Table 3. Independent-Samples t-Test Comparing Trust Scores Between Patients and Attendants

Trust Dimension	Patients M (SD)	Attendants M (SD)	t	p
Clarity of Communication	3.66 (0.90)	3.56 (0.97)	1.12	0.263
Perceived Competence of Health Authorities	3.79 (0.87)	3.64 (0.96)	1.65	0.099
Transparency of Decision-Making	3.29 (0.96)	3.06 (0.96)	2.43	0.016
Fairness of Policy Implementation	3.35 (1.02)	3.24 (0.98)	1.13	0.258

Adequacy of Resource Allocation	3.07 (0.91)	2.89 (1.01)	1.95	0.052
Overall Composite Trust Score	3.43 (0.79)	3.28 (0.85)	1.93	0.054

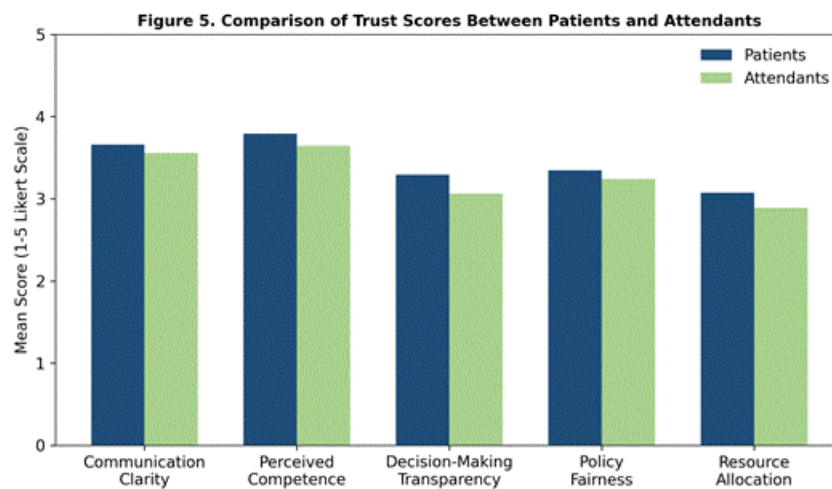


Figure 5. Comparison of Trust Scores Between Patients and Attendants

4.6 Correlation Among Trust Dimensions and Satisfaction

Table 4 and figure 6 show the Pearson correlation matrix between the five dimensions of trust and satisfaction with health services. As expected, given the derivation of the composite overall trust score, it was very strongly related to each individual dimension ($r = 0.84\text{--}0.87$) and all five of the trust dimensions were strongly and positively intercorrelated ($r = 0.64\text{--}0.68$), supporting their conceptualisation as related facets of an underlying trust construct. There was also a strong correlation between overall trust and satisfaction with health services ($r = 0.78$, $p < 0.001$), meaning that there was a high level of correlation between general trust and satisfaction with health services received.

Table 4. Pearson Correlation Matrix of Trust Dimensions and Service Satisfaction

	Comm.	Compet.	Transp.	Fairness	Resource	Overall	Satisf.
Clarity of Communication	1.0	0.67	0.68	0.7	0.65	0.86	0.67
Perceived Competence of Health Authorities	0.67	1.0	0.65	0.67	0.64	0.84	0.69

Transparency of Decision-Making	0.68	0.65	1.0	0.66	0.65	0.85	0.63
Fairness of Policy Implementation	0.7	0.67	0.66	1.0	0.68	0.87	0.69
Adequacy of Resource Allocation	0.65	0.64	0.65	0.68	1.0	0.85	0.66
Overall Composite Trust Score	0.86	0.84	0.85	0.87	0.85	1.0	0.78
Service Satisfaction	0.67	0.69	0.63	0.69	0.66	0.78	1.0

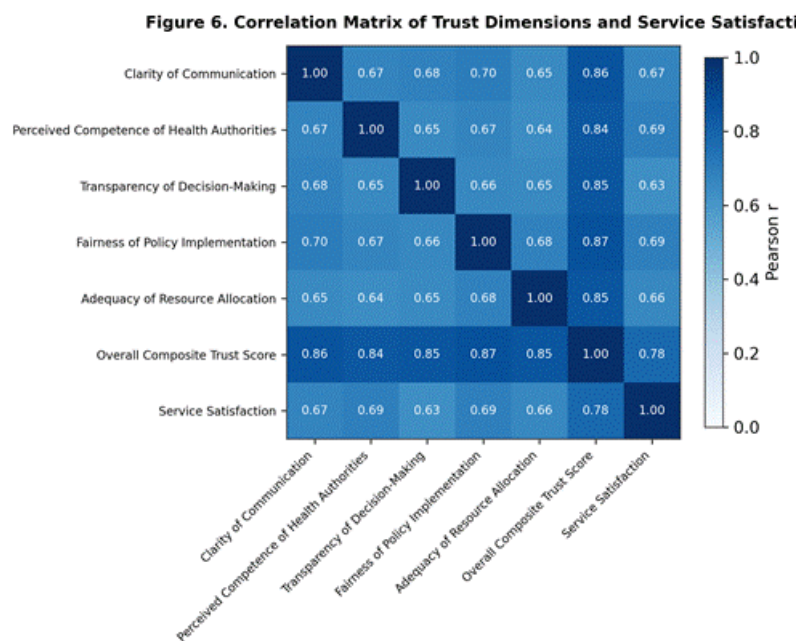


Figure 6. Correlation Matrix of Trust Dimensions and Service Satisfaction

4.7 Association Between Trust and Compliance Behaviour

The cross tabulation of the categorical trust level and self-reported compliance behaviour is shown in table 5. Among those who rated their trust as high, 75.4% rated their compliance with recommended health measures as

high; those who rated their trust as moderate, 51.6% rated their compliance with recommended health measures as high; and those who rated their trust as low, only 25.8% rated their compliance with recommended health measures as high. This association was statistically significant using a chi-square test ($\chi^2 = 55.21$, $df = 2$, $p < 0.001$), indicating a strong relationship between institutional trust and self-reported adherence to pandemic health guidance, which is found in adherence to health directives literature reviewed above [3, 6, 8].

Table 5. Cross-Tabulation of Trust Category and Self-Reported Compliance Behaviour ($\chi^2 = 55.21$, $df = 2$, $p < .001$)

Trust Category	High Compliance	Low Compliance	Row Total
Low Trust	17	49	66
Moderate Trust	82	77	159
High Trust	147	48	195

5. Discussion

This study aimed to explore and compare attitudes to governmental pandemic health policy of patients and attendants, which is a stakeholder divide in the field of institutional trust that is rarely studied. There are three findings that warrant special discussion.

First, this general pattern of trust – high levels of confidence in the technical competence and communication of health authorities and much lower levels of confidence in the fairness in allocating resources – is parallel to that found in several international studies at various stages of the pandemic [2, 6, 8, 10]. The disconnect between trust in institutional competence and trust in distributive justice points to the fact that, although essential, communication plans that highlight scientific legitimacy may not be sufficient to meet public demands for “fair” treatment during a public health crisis. Liu and colleagues [8] suggest that, in the context of limited resources such as oxygen, intensive care beds and necessary drugs, health systems under such resource constraints may need to use competence-focused messaging coupled with explicit, transparent explanations regarding the allocation of limited resources.

Second, the large discrepancy in perceptions of transparency between patients and attendants, to our knowledge, represents a relatively new finding in the trust literature, which has tended to focus on general population or single role samples [2, 15, 17]. Attendants have a unique role in the sense that they frequently face administrative obstacles, visiting-hour policies, bed placement, documentation processing, and other administrative issues without being the ones for whom clinical decisions are being made. The structural role of attendants could make them more vulnerable to the procedural aspects of policy, and less so to its clinical aspects, which could account for their generally lower level of confidence in transparency of policy decision-making. Hospital leaders and public health communicators might therefore want to consider creating additional points of communication for attendants—whether in the form of a designated liaison position to address questions or in the form of information signage, for example—that will make it easier for them to understand the why behind visiting and resource policies, as this messaging may not be as easy to digest or as reassuring to accompanying family members as it is to the patient.

Third, the high positive correlation between overall trust and satisfaction and compliance confirms within a hospital setting that the consistent international finding that trust acts as a behavioural lever during public health

emergencies [3, 6, 8, 17] is also true in this sample. The size of the compliance gap between the high-trust and low-trust groups (75.4% versus 25.8% reporting high compliance) highlights the real-world consequences of trust erosion, with even small drops in trust for institutions, as seen internationally between 2021 and 2023 [1, 14, 18] potentially leading to materially lower compliance with future public health guidance. This strengthens the literature that calls for the integration of trust-building in government pandemic preparedness planning, and not as a side issue of communication [12, 16].

Also, the fact that hospital personnel and doctors, and not government communications, were the most commonly cited source of information is aligned with evidence that, even when people may have doubts about other governmental organizations, they have greater trust in frontline healthcare providers and personal contacts [13, 18]. This indicates that during future health emergencies, more effective communication with patients and attendants might be achieved by translating and disseminating official health directives via trusted clinical intermediaries instead of through top-down government communication alone.

The age gradient in trust observed here, where older individuals are more likely to trust than younger, is consistent with previous cross-national results [7, 11] and could be a result of differing experiences with the healthcare system, risk perception or generational trends in institutional deference. The comparatively lower trust score among younger respondents is of interest because they are the primary drivers of transmission during many infectious disease outbreaks and have been shown to use social media at a disproportionately high level as a source of information; this is independently associated with greater hesitancy and distrust in previous studies [20].

6. Limitations

The results need to be interpreted in light of several limitations. First, the cross-sectional design does not allow causal inferences; although there was a strong correlation between trust and compliance or satisfaction, it cannot be determined if these relationships are unidirectional or bi-directional, or if reverse causation took place, for example, high satisfaction leading to more trust. Second, the convenience sampling used in hospital settings – needed for access to the target population in the active public health context – might restrict the generalisability of results to community members who do not access hospital-based services and who may have systematically different attitudes. Third, self-reported compliance behaviour is prone to social desirability bias and may not completely match objectively observed adherence. Lastly, data collection was cross sectional, with only one site included; the dynamics of change in attitudes over the various stages of the pandemic response were also crucial, as revealed by international, longitudinal studies [1, 18].

7. Conclusion and Recommendations

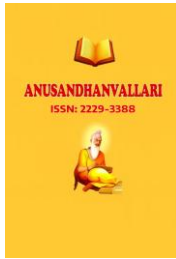
In the present study, two stakeholder groups, patients and attendants, who are structurally different and dependent on each other in the hospital setting, are compared in terms of their perceptions of the government's pandemic health policy. The overall outcome of trust was moderate with relatively high trust in institutional competence and communication, and comparatively lower trust in fairness of allocation of resources. The trust of attendants in transparency of government decision making was significantly lower than of patients, with implications for designing risk communication at the hospital level. Trust, in turn, was closely associated with satisfaction with services and reported adherence to health advice, further highlighting the importance of trust in effective pandemic response.

The results point to a number of practical steps for policy-makers and hospital administrators: (1) Risk communication strategies need to explicitly include the fair and rational aspects of resource-allocation, in addition to the scientific basis of interventions; (2) attendants should be recognised as a communication target group in their own right, and with dedicated channels for communicating procedural and administrative aspects of policies; (3) physicians and front line hospital personnel should be identified as trusted clinical intermediaries and mobilised as key gatekeepers for distributing government health guidance; and (4) future pandemic preparedness

planning should include mechanisms for ongoing monitoring and rebuilding of institutional trust, as this is known to be fragile after the acute phase of a health emergency. Future studies using longitudinal, multi-site design in both hospital and community settings would help to further elucidate the causal pathways of institutional trust, satisfaction and compliance behaviour found in this study.

References:

- [1] Bacon, S. L., Lavoie, K. L., Boyle, J., Stojanovic, J., & Joyal-Desmarais, K. (2021). International assessment of the link between COVID-19 related attitudes, concerns and behaviours in relation to public health policies: Optimising policy strategies to improve health, economic and quality of life outcomes (the iCARE Study). *BMJ Open*, 11(3), e046127. <https://doi.org/10.1136/bmjopen-2020-046127>
- [2] Bargain, O., & Aminjonov, U. (2020). Trust and compliance to public health policies in times of COVID-19. *Journal of Public Economics*, 192, 104316. <https://doi.org/10.1016/j.jpubeco.2020.104316>
- [3] Chan, H. F., Skali, A., Savage, D. A., Stadelmann, D., & Torgler, B. (2021). Risk attitudes and human mobility during the COVID-19 pandemic. *Scientific Reports*, 11, 3843. <https://doi.org/10.1038/s41598-021-83400-8>
- [4] Ebrahimi, O. V., Johnson, M. S., Ebling, S., Amundsen, O. M., Halsøy, Ø., Hoffart, A., Skjerdingsstad, N., & Johnson, S. U. (2021). Risk, trust, and flawed assumptions: Vaccine hesitancy during the COVID-19 pandemic. *Frontiers in Public Health*, 9, 700213. <https://doi.org/10.3389/fpubh.2021.700213>
- [5] Han, Q., Zheng, B., Cristea, M., Agostini, M., Bélanger, J. J., Gützkow, B., Kreienkamp, J., PsyCorona Collaboration, & Leander, N. P. (2021). Trust in government regarding COVID-19 and its associations with preventive health behaviour and prosocial behaviour during the pandemic: A cross-sectional and longitudinal study. *Psychological Medicine*, 53(1), 149–159. <https://doi.org/10.1017/S0033291721001306>
- [6] Larson, S., & Stanica, C. (2022). Trust in government and COVID-19 response policy: A comparative approach. *Journal of Comparative Policy Analysis: Research and Practice*, 25(2), 156–171. <https://doi.org/10.1080/13876988.2022.2103672>
- [7] Liu, J., Shahab, Y., & Hoque, H. (2022). Government response measures and public trust during the COVID-19 pandemic: Evidence from around the world. *British Journal of Management*, 33(2), 571–602. <https://doi.org/10.1111/1467-8551.12577>
- [8] MacDonald, N. E. (2015). Vaccine hesitancy: Definition, scope and determinants. *Vaccine*, 33(34), 4161–4164. <https://doi.org/10.1016/j.vaccine.2015.04.036>
- [9] Nickel, B., Pickles, K., Cvejic, E., Copp, T., Dodd, R. H., Bonner, C., Seale, H., Steffens, M., Meyerowitz-Katz, G., & McCaffery, K. (2022). Predictors of confidence and trust in government and institutions during the COVID-19 response in Australia. *The Lancet Regional Health – Western Pacific*, 23, 100490. <https://doi.org/10.1016/j.lanwpc.2022.100490>
- [10] Nowak, B., Brzóska, P., Piotrowski, J., Sedikides, C., Żemojtel-Piotrowska, M., & Jonason, P. K. (2022). Trust in government and public health behaviors during the COVID-19 pandemic: A cross-country study. *Current Psychology*, 41, 5468–5478. <https://doi.org/10.1007/s12144-020-01151-6>
- [11] Robinson, S. E., Gupta, K., Ripberger, J., Ross, J. A., Fox, A., Jenkins-Smith, H., & Silva, C. (2021). Trust in government agencies in the time of COVID-19. Cambridge University Press.
- [12] Ruiz, J. B., & Bell, R. A. (2022). Trust in health information sources and vaccine hesitancy during COVID-19. Contributions of trustworthiness, health literacy, and self-efficacy in communicating with COVID-19 vaccine-hesitant audiences: Web-based survey study. *Journal of Medical Internet Research*, 24(8), e37138. <https://doi.org/10.2196/37138>
- [13] Schernhammer, E., Weitzer, J., Laubichler, M. D., Birmann, B. M., Bertau, M., & Zenk, L. (2021). Correlates of COVID-19 vaccine hesitancy in Austria: Trust and the government. *Journal of Public Health*, 44(1), e106–e116. <https://doi.org/10.1093/pubmed/fdab122>



-
- [14] Sim, K., Chua, H. C., & Vieta, E. (2020). Public attitude towards quarantine during the COVID-19 outbreak. *Asian Journal of Psychiatry*, 53, 102378. <https://doi.org/10.1016/j.ajp.2020.102378>
- [15] Solís Arce, J. S., Warren, S. S., Meriggi, N. F., Scacco, A., McMurphy, N., Voors, M., Syunyaev, G., Malik, A. A., Aboutajdine, S., Adejo, O., Anigo, D., Aisha, A., Broadhead, D., Bejarano, M. E., Ehimwenma, F., Chaudhry, A., Fesselet, J.-F., Fowler, R., Green, A., ... Omer, S. B. (2021). COVID-19 vaccine acceptance and hesitancy in low- and middle-income countries. *Nature Medicine*, 27, 1385–1394. <https://doi.org/10.1038/s41591-021-01454-y>
- [16] Trent, M., Seale, H., Chughtai, A. A., Salmon, D., & MacIntyre, C. R. (2022). Trust in government, intention to vaccinate and COVID-19 vaccine hesitancy: A comparative survey of five large cities in the United States, United Kingdom, and Australia. *Vaccine*, 40(17), 2498–2505. <https://doi.org/10.1016/j.vaccine.2021.06.048>
- [17] World Health Organization. (2024). Influence of COVID-19 on trust in routine immunization, health information sources and pandemic preparedness in 23 countries. *Nature Medicine*, 30, 1553–1564. <https://doi.org/10.1038/s41591-024-02939-2>
- [18] Wong, C. M. L., & Jensen, O. (2020). The paradox of trust: Perceived risk and public compliance during the COVID-19 pandemic in Singapore. *Journal of Risk Research*, 23(7–8), 1021–1030. <https://doi.org/10.1080/13669877.2020.1756386>
- [19] Xu, P., & Cheng, J. (2022). Infodemic, institutional trust, and COVID-19 vaccine hesitancy: A cross-national survey. *International Journal of Environmental Research and Public Health*, 19(13), 8033. <https://doi.org/10.3390/ijerph19138033>