

# Echoes of the past, voices for the future: Aboriginal and Torres Strait Islander peoples' perspectives on trust in COVID-19 health communication in Australia

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## ABSTRACT

**Background:** Trust is a cornerstone of effective health communication, yet difficult to build with communities whose confidence has been eroded by trauma, systemic racism, and inequality. This challenge was amplified for Aboriginal and Torres Strait Islander peoples in Australia during the COVID-19 pandemic. **Aim:** This qualitative study explored factors influencing trust in COVID-19 health information among Aboriginal and Torres Strait Islander participants and identified trusted communication approaches and sources. **Methods:** Using an Interpretive Description approach, semi-structured interviews were conducted with 15 participants. Thematic analysis was guided by an integrated framework combining the SAGE determinants matrix, postcolonial theory, relational theory, and cultural safety. **Results:** Themes included the role of historical context; the influence of community, culture, and relational dynamics; and navigating uncertainty, fear, and conflicting information within power-laden environments. The study refines the integrated SAGE framework by illustrating how Indigenous relationality and cultural safety function as key determinants of trust. **Discussion:** Findings highlighted a disconnect between top-down communication and participant perspectives, showing that trust is relational, culturally embedded, and contingent on community partnership. **Conclusion:** Health equity requires culturally safe, community-controlled, and relationally oriented communication strategies as part of a broader commitment to systemic change and self-determination.

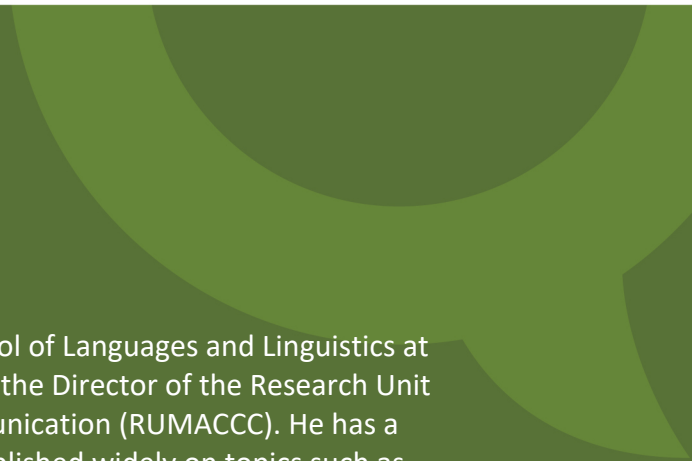
## KEYWORDS

Aboriginal and Torres Strait Islander peoples, COVID-19, cultural safety, health communication, Indigenous-led, postcolonial and relational theory, trust.

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## Introduction

Trust is essential for effective health communication, particularly when engaging with Indigenous communities who share colonial histories of displacement and assimilationist policies, such as Aboriginal and Torres Strait Islander peoples in Australia. This legacy has fostered a warranted distrust towards government institutions, including healthcare institutions, which is compounded by ongoing inequities and systemic racism that exacerbate health disparities (Graham et al., 2022; Groot et al., 2020; Vallesi et al., 2018). This pattern is not confined to 'Western' nation states: colonial sanitary regimes, medical policing and forced population reorganisation in places such as the Philippines and parts of East Africa have similarly produced long-term suspicion of official medical authority (Ileto, 1991; Vaughan, 1991). Understanding these historically rooted dynamics of distrust requires attending to both institutional trust, which refers to confidence in abstract health systems and authorities (Gilson, 2003; Goldstein et al., 2015), and relational trust, which is grounded in interpersonal connection, kinship and community accountability at personal and community levels (Graham, 1999).

While these colonial legacies create shared challenges globally, this study centres specifically on the experiences of Aboriginal and Torres Strait Islander peoples, whose situation is shaped by unique socio-political factors and the vital role of Aboriginal Community Controlled Health Organisations (ACCHOs) in providing culturally safe services that respond to community needs and priorities (Lewis et al., 2021). ACCHOs work to address severe health disparities, including lower life expectancy and higher rates of chronic disease, which are driven by adverse social determinants and barriers to accessing appropriate healthcare (AIHW, 2025; Crooks et al., 2023; Flint et al., 2010; Rudge & Massey, 2010; Yashadhana et al., 2020).

Addressing these health disparities in Australia and beyond requires health communication strategies that acknowledge historical and ongoing injustices and prioritise community engagement and cultural safety (Kyoon-Achan et al., 2018; Simonds & Christopher, 2013). This is particularly crucial during public health crises like the recent COVID-19 pandemic. During this period, pre-existing trust challenges were amplified by a complex 'infodemic', which the World Health Organization defines as an overabundance of information, including false or misleading content, circulating across digital and physical environments (Kisa & Kisa, 2024; World Health Organization, 2020a, 2020b). Despite the importance of trust in COVID-19-related health communication, a substantial gap remains regarding how Aboriginal and Torres Strait Islander community members perceive and make sense of COVID-19 health information. Therefore, this study aims to address the following research questions:

- What key factors affecting trust are raised by Aboriginal and Torres Strait Islander participants when discussing COVID-19-related health information?
- What communication approaches and information sources do Aboriginal and Torres Strait Islander participants perceive as trustworthy or untrustworthy in relation to COVID-19?

## Literature review

Trust shapes how individuals interpret and act upon health messages and has the potential to influence public health outcomes (Lazarus et al., 2024; Williamson & Tarfa, 2022). This principle is particularly vital when engaging with diverse communities, including migrants, refugees, and especially Aboriginal and Torres Strait Islander peoples within Australia, who often encounter distinct historical, systemic, and cultural barriers which can impact their interactions with health information and services (Crooks et al., 2023; Karidakis et al., 2023; Hajek et al., 2022).

Although these barriers are well-documented in Australia, comparative research shows that such patterns of distrust are mirrored among Indigenous peoples globally, arising from locally distinct yet parallel colonial histories. For instance, intergenerational trauma stemming from historical healthcare segregation and assimilationist policies, such as the child removal practices and systemic injustices documented by the Truth and Reconciliation Commission of Canada (2015), continues to foster contemporary scepticism towards state-led health initiatives in that country. Recent research across major settler-colonial contexts, including Australia, Aotearoa New Zealand, Canada and the United States, underscores that while institutional distrust is a shared phenomenon, the narratives and communication strategies used to build confidence must be adapted to the unique political-legal and cultural contexts of each specific nation (Ignacio et al., 2023; Labbé et al., 2024; Martell et al., 2025).

Conceptually, trust in these settings is often understood as having dual dimensions. Institutional trust is defined as the cognitive evaluation of a system's reliability and its perceived commitment to the community's best interests (Gilson, 2003). This form of trust is contingent on two primary factors: perceived integrity and historical consistency (Goldstein et al., 2015). In contrast, relational trust is an affective and interpersonal construct, relying on the strength of kinship ties and shared community values (Graham, 1999). As the following section explores, when institutional integrity is undermined by a history of colonial interference, these relational networks become the primary determinants of health information engagement.

In the Australian context, a core historical barrier driving this distrust is anchored in the legacy of the Stolen Generations and the Aboriginal Protection Acts, which mandated child removal and health segregation (cf. Vallesi et al., 2018). This legitimate mistrust is further reinforced by ongoing systemic racism and culturally unsafe practices in mainstream health services (Gone et al., 2019; Graham et al., 2022). Lack of trust thus functions as a mediating factor, negatively impacting health service engagement, most notably during the high-stakes environment of a public health crisis (Gone et al., 2019; Graham et al., 2022).

To counter this deep-seated and historically rooted distrust, effective health communication must therefore move beyond simple information dissemination to acknowledge historical contexts, prioritise community engagement, and embed principles of cultural safety (Simonds & Christopher, 2013). Central to this is partnership with community-controlled entities like ACCHOs, which are highly trusted because they are embedded within community and deliver culturally safe, responsive care (Boer et al., 2025; Lewis et al., 2021). Communication must also employ culturally appropriate practices that resonate with Indigenous worldviews of health, and in this context, specifically with Aboriginal and Torres Strait Islander holistic understandings of wellbeing, which connect physical well-being to spiritual, social, and

emotional dimensions (National Indigenous Australians Agency, 2022; Karidakis et al., 2023). Thus, building trust requires transparency, empathy, and respect, enacted through clear messaging that is delivered via trusted channels (Groot et al., 2020; Schoch-Spana et al., 2021).

## Analytical lens and methodological grounding

This study is underpinned by an interpretivist research paradigm (Thorne, 2016). This paradigm acknowledges that understanding of a phenomenon is co-constructed from participants' subjective experiences and the researchers' own informed interpretation. Guided by this stance, this study employs an integrated theoretical framework to analyse the complexities of trust in health communication for Aboriginal and Torres Strait Islander peoples. No single theory captures the interplay of historical legacies, socio-cultural dynamics, interpersonal relationships, and systemic influences. Therefore, this study synthesises four complementary frameworks: the World Health Organization's Strategic Advisory Group of Experts (SAGE) vaccine hesitancy determinants matrix (MacDonald, 2015), postcolonial theory, relational theory, and the principles of cultural safety.

The SAGE matrix provides a structured typology of influences on health decisions, categorising them into contextual, individual/group, and vaccine-specific factors (see Table 1). Within this framework, communication appears in two ways: first, as a contextual determinant shaped by the broader information environment; and second, as an intervention lever that can influence key determinants. This is particularly evident in the role of 'confidence', an indicator of institutional trust that encompasses the perceived integrity of health systems and providers (Goldstein et al., 2015). However, to fully understand how to build trust and communicate effectively in Indigenous contexts, this framework requires a more holistic and complex theoretical framing.

**Table 1.** *The SAGE vaccine hesitancy determinants matrix.*

| Category                                                                                                                                                        | Determinant                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| <b>Contextual influences</b><br>(Influences arising due to historic, socio-cultural, environmental, health system/institutional, economic or political factors) | communication and media environment                                                                   |
|                                                                                                                                                                 | influential leaders, immunisation programme gatekeepers and anti- or pro-vaccination lobbies          |
|                                                                                                                                                                 | historical influences                                                                                 |
|                                                                                                                                                                 | religion/culture/gender/socio-economic                                                                |
|                                                                                                                                                                 | politics/policies                                                                                     |
|                                                                                                                                                                 | geographic barriers                                                                                   |
|                                                                                                                                                                 | perception of the pharmaceutical industry                                                             |
| <b>Individual &amp; group influences</b><br>(Influences arising from personal perception of the vaccine or influences of the social/peer environment)           | personal, family and/or community members' experience with vaccination, including pain                |
|                                                                                                                                                                 | beliefs, attitudes about health and prevention                                                        |
|                                                                                                                                                                 | knowledge/awareness                                                                                   |
|                                                                                                                                                                 | health system and providers – trust and personal experience                                           |
|                                                                                                                                                                 | risk/benefit (perceived, heuristic)                                                                   |
|                                                                                                                                                                 | immunisation as a social norm vs. not needed/harmful                                                  |
| <b>Vaccine/vaccination-specific issues</b><br>(Directly related to vaccine or vaccination)                                                                      | risk/benefit (epidemiological and scientific evidence)                                                |
|                                                                                                                                                                 | introduction of a new vaccine or new formulation or a new recommendation for an existing vaccine      |
|                                                                                                                                                                 | mode of administration                                                                                |
|                                                                                                                                                                 | design of vaccination programme/mode of delivery e.g., routine programme or mass vaccination campaign |

|  |                                                                                                      |
|--|------------------------------------------------------------------------------------------------------|
|  | reliability and/or source of supply of vaccine and/or vaccination equipment                          |
|  | vaccination schedule                                                                                 |
|  | costs                                                                                                |
|  | the strength of the recommendation and/or knowledge base and/or attitude of healthcare professionals |

Note. The SAGE vaccine hesitancy determinants matrix (MacDonald, 2015) serves as the structural scaffold for the analysis. The interpretation of these determinants is critically deepened by the study's integrated framework, which also incorporates postcolonial theory, relational theory, and the concept of cultural safety to distinguish between institutional and relational trust dimensions.

While Table 1 provides the structural scaffold, the three additional theories are applied as analytical lenses to interrogate and interpret the data within these SAGE categories. Postcolonial theory provides a critical lens on how colonial power operates as an ongoing structural force, reframing SAGE's 'historical influences' as active structural determinants shaping health systems and trust relations (Moreton-Robinson, 2015). Relational theory, particularly when informed by Indigenous concepts of relationality, highlights how relational trust, grounded in interpersonal and community ties, shapes health engagement when institutional confidence is low (Graham, 1999). Finally, the cultural safety perspective challenges the power imbalances inherent in healthcare, positing that safe and trustworthy communication is defined by the recipient, not the provider (NHMRC, 2018b). By integrating these approaches, this study advances the application of the SAGE framework, demonstrating that trust is deeply entwined with broader socio-political and relational factors.

## Methods

### Overall study design and rationale

This study was conducted by a non-Indigenous team using an Interpretive Description methodology, selected for its suitability to applied research and its focus on generating practice-relevant insights (Thorne, 2016). This approach supported the development of a rich, contextualised understanding of how trust in COVID-19 health information is co-constructed within the socio-historical contexts of Aboriginal and Torres Strait Islander participants.

### Participant recruitment and sample

The overall design, including participant identification and engagement strategies, was shaped by consultation processes with First Nations broadcasting, media and communications organisations, an Aboriginal Community-Controlled Health Service and an Aboriginal language centre. These consultations, further detailed in Karidakis et al. (2023), were crucial for ensuring culturally appropriate research protocols and helped to define the key areas of inquiry in this study.

Following these consultations, initial participants were identified using a purposive sample, drawing upon professional and community networks known to the research team. This process led to recruitment of a total of 15 Aboriginal and Torres Strait Islander participants

(12 female, 3 male) residing in Queensland, South Australia, New South Wales, and the Northern Territory. The sample comprised community members, alongside a separate group of participants working in community-facing professional roles (e.g., health and community workers), providing a breadth of perspective on personal and systemic health communication experiences. Eligibility criteria included identifying as Aboriginal and/or Torres Strait Islander and being aged 18 years or older. All participants spoke English, while some indicated knowledge of regional Aboriginal or Torres Strait Islander languages. All elected to conduct the interview in English.

## Data collection

Data were collected using semi-structured interviews between June and October 2021. These interviews were conducted by telephone, accommodating participant availability and preference and adhering to the COVID-19 restrictions in place at the time. Interviews followed a semi-structured guide designed to explore experiences with, and trust in, COVID-19 health information sources, perceived influences on trust (positive and negative), and communication preferences. The guide allowed flexibility for probing and exploring emergent themes raised by participants. Interviews were audio-recorded with explicit participant consent and typically lasted between 30 and 60 minutes. Throughout data collection, the team used active listening and respectful communication strategies to mitigate power imbalances and foster the relationality necessary for establishing rapport over the phone.

## Data analysis

### *Data preparation*

Automated transcription software (Sonix) was used to transcribe the interviews verbatim. Each transcript was then thoroughly reviewed and corrected against the audio recording by members of the research team to ensure accuracy. Transcripts were de-identified using alpha-numerical codes prior to conducting the analysis.

### *Analytical approach*

The data were analysed using a reflexive thematic analysis, following the six-phase process outlined by Braun and Clarke (2006, 2021). The analysis employed a hybrid approach, combining a deductive process guided by an adapted SAGE vaccine hesitancy determinants matrix (MacDonald, 2015) with an inductive approach to capture emergent, data-driven concepts. The SAGE framework, chosen for its comprehensive structure and inclusion of 'contextual influences' like history and trust, was adapted for this study to focus specifically on trust in health information within the COVID-19 'infodemic,' rather than vaccine uptake alone. Microsoft Excel was used to manage the coding and thematic analysis process.

This multi-layered coding process began with data familiarisation (phase 1). In phase 2, the adapted SAGE matrix was used to create the deductive 'scaffold' to identify factors of institutional trust, such as historical influences and perceptions of system integrity. For

instance, a participant's discussion of past government mistreatment, such as P6 stating, "They lied to us for so long," was deductively coded under the SAGE category of 'historical influences'. The three critical theories were then applied as analytical lenses to interrogate and interpret the data within these SAGE categories, moving beyond simple description.

To ensure analytic transparency, we outline below how the theoretical lenses were applied during coding and theme development. Firstly, postcolonial theory was used to analyse the structural determinants of institutional mistrust. For example, when a participant expressed a fear about their community being treated as "guinea pigs of the government" (P7), this lens was used to interpret the statement not as simple vaccine misinformation, but as a fear deeply rooted in the historical and ongoing power imbalances of colonialism. Secondly, relational theory was applied to identify drivers of relational trust, such as community accountability and kinship ties. The high credibility assigned to "Aboriginal-led organisations and ... media" like NITV (P2), was analysed beyond seeing them as 'media channels'. Instead, they were interpreted as entities in an accountable, trusted relationship with the community. Finally, cultural safety was used as a lens to evaluate whether communication shifted power to the recipient. For instance, the use of brochures in both "English and in Kriol" (P7) was analysed as a deliberate act that created a culturally safe environment by demonstrating respect and shifting informational power.

Alongside this framework-driven analysis, inductive open coding captured important concepts that fell outside the initial structure. For instance, the concept of a 'coercive choice' emerged directly from the data, as participants like P13 grappled with being told they had a "personal choice" while simultaneously facing exclusion for not being vaccinated. In the final phases (3-6), all codes were systematically collated, reviewed, and developed into the overarching themes presented in the findings.

### *Rigour and trustworthiness*

Study rigour was pursued through several connected strategies consistent with an interpretivist and reflexive qualitative approach. To enhance credibility and confirmability, the research team held regular debriefing sessions to critically discuss coding, thematic interpretation and researcher bias (Cutcliffe & McKenna, 1999). Central to this process was sustained critical reflexivity regarding our positionality as a non-Indigenous research team, including how our social locations, assumptions, and disciplinary backgrounds shaped data interpretation (Puch-Bouwman, 2014). This reflexive stance was vital for honouring participant perspectives, and for interpreting expressions of distrust as grounded, rational responses to systemic inequity rather than as simple 'hesitancy'. Although individual member checking was not feasible, credibility was further supported using thick description and illustrative quotes in the findings. Finally, an audit trail including the codebook and analysis notes was maintained for confirmability.

### *Ethical considerations*

The University of Melbourne Humanities and Applied Sciences Human Ethics Sub-Committee granted ethical approval for this research (Reference: 21033.3.6, approval date: December 8,

2020). Our study followed the National Health and Medical Research Council (NHMRC, 2018a) guidelines for ethical research with Aboriginal and Torres Strait Islander Peoples and communities. This included obtaining informed consent from all participants before interviews, clearly explaining the purpose of the study, data usage, confidentiality measures, and their right to withdraw. We also implemented the core NHMRC (2018a) principles of respect, reciprocity, and responsibility through clear communication, building rapport with participants during interviews, and ensuring the study's focus on trust aligned with community priorities for health information access. Data management procedures ensured participant confidentiality.

## Results

The analysis of the data revealed three major interconnected themes that highlight the dynamics of trust in health communication for Aboriginal and Torres Strait Islander peoples. These themes do not operate in isolation; instead, they form a continuous loop where historic context and systemic distrust (Theme 1) establish a baseline of scepticism. This scepticism necessitates a reliance on community, culture and relational pathways (Theme 2) to authenticate and navigate health messaging. These relational ties serve as essential anchors for participants as they navigate a complex information environment characterised by fear and shifting official advice (Theme 3). The following sections unpack how these dynamics intersect to shape health engagement.

### Theme 1: the key role of historical context and systemic distrust

A dominant theme was a deep-seated distrust directed towards government officials and other authorities, which participants explicitly linked to historical and ongoing experiences of colonisation and systemic racism. This shaped their evaluations of official communication, with many questioning the honesty and intent behind messages. This scepticism is evident in P5's hesitation to accept information at face value [Extract 1] and P4's belief that communications were purely instrumental [Extract 2]:

Extract 1: "Yeah. Are they being truthful to the population? You know, without sounding paranoid or something, but that's what I don't trust information now coming out." P5

Extract 2: "No, it's just like, you know, they're saying what they've got to say to get everyone in there to get vaccinated." P4

The analysis noted the frequent use of the distancing pronoun "they" when referring to authorities [Extracts 1, 2], which underscored a sense of separation and a power imbalance between the community and official bodies.

This distrust was also often articulated through metaphors reflecting alienation and exploitation. P7 noted the term "sheep" was used for those seen as blindly following rules, and that questioning this view was "almost an argument-starter," highlighting the emotional intensity of the topic:

Extract 3: "They just say: 'Oh, you know, they don't believe what the government says it is and that is just, you know, just all being sheep'. The word sheep has come up so many times, just being the sheep following the rules and things like that. If they are asked any questions, they're very defensive and don't want to give

an answer, so I haven't been able to probe a bit more. It seems like it's almost an argument-starter if you ask the question." P7

Separately, fears of being treated as "guinea pigs of the government" were reported among P7's clients [Extract 4], reflecting deeper anxieties about exploitation and historical trauma associated with medical interventions:

Extract 4: "... coming from my clients, I think, they just don't want to be guinea pigs of the government...in their words. They don't want to be experimented on." P7

Crucially, participants explicitly framed this contemporary distrust as being actively rooted in a history of mistreatment. These historical legacies functioned as a filter through which current health communication tended to be interpreted, evident in expressions of perceived dishonesty [Extract 5] and experiences of broken promises linked to systemic racism [Extract 6]:

Extract 5: "They lied to us for so long." P6

Extract 6: "A lot of things have been promised and said and it never does happen - and a lot of judgment just because of their skin colour." P4

This scepticism was further intensified with fears of exploitation, drawing on historical parallels with other populations and contemporary anxieties about potential exclusion from society:

Extract 7: "And they've done that with African countries as well. They've tested them before other populations." P5

Extract 8: "They're all saying: 'look, you know, if you want to stop people from using your services or not, you've got every right'. And that's what concerns me too: 'Are we going to be let in in the community?'" P10

Finally, this distrust was exacerbated by a confusing information environment, where participants felt confronted by conflicting narratives about the vaccine:

Extract 9: "But the vaccine is sort of just... it's more like saying it's either one side saying: 'It's really good', and then the other side saying: 'Oh, all these people have got sick from it and stuff or like blood clots and stuff like that'. Yeah." P3

Such factors, including fears of exploitation, potential exclusion, and perceived message inconsistencies, further entrenched the historically rooted distrust when participants evaluated information sources.

## Theme 2: the primacy of community, culture, and relational trust

Analysis revealed that community norms, peer experiences, and relational ties had the potential to sway individual attitudes, sometimes reinforcing scepticism and hesitancy, while at other times fostering crucial trust through culturally safe interactions.

Perceptions of widespread community scepticism could validate and reinforce an individual's own hesitancy, showing the influence of peer norms:

Extract 10: "A lot of the people I know don't trust it. I haven't met one person yet that got it, but maybe that's just my community." P3

Beyond general community sentiment, direct, anecdotal accounts of negative experiences from within close social networks held considerable weight, often proving more powerful than

abstract data. For instance, P10 described a friend's severe reaction to the vaccine in vivid, relatable terms:

Extract 11: "I know a friend of mine, she was bedridden for a week and a half. Just recently she went and had the Pfizer and she's been sick, coughing, cold, sweats, aches and pains ... couldn't go to work. You know what I mean? Like crook as a dog." P10

Conversely, trust could be anchored in a single positive personal relationship. Extract 12 highlights how trust in a known individual can act as a gateway, fostering confidence in broader systems like science:

Extract 12: "My mum works in healthcare and I just trust that side of things like I trust science." P10

This relational trust was also evident in the high credibility assigned to Aboriginal and Torres Strait Islander organisations and Indigenous-controlled media platforms (like NITV). These sources were seen as positive, encouraging, and accountable to the community:

Extract 13: "I have found that the information shared on some of the Facebook groups like NITV and things like that has been positive and encouraging to people to have their vaccinations and that sort of thing. Also, the positive impact of Aboriginal-led organisations and in particular Aboriginal-led media in disseminating information in Aboriginal and Torres Strait Islander languages." P2

Participants attributed enhanced trust in Indigenous-led sources to community ownership counteracting perceptions of government imposition [Extract 14], and to the use of culturally appropriate and accessible communication formats. Providing information in relevant local languages like Kriol [Extract 15], for example, demonstrated respect and facilitated understanding.

Extract 14: "I really just think if it's coming from our communities more, the positive information, that it will hopefully take that stigma away from it, so the people aren't seeing it as that government trying to control everybody sort of scenario." P7

Extract 15: "We just encourage our clients to go and get the COVID injections and stuff like that. We have brochures and flyers that are in English and in Kriol that we give to our patients, so we just encourage them to go get the jab." P7

Finally, trust in alternative knowledge frameworks, such as a reliance on one's own immune system or bush medicine, represented another prevalent discourse, reflecting assertions of autonomy and cultural continuity:

Extract 16: "I know a lot of...not from our lore, but from our families. I know that a lot of people, Aboriginal people that are more traditionally minded, more inclined to let their body look after itself - as in its own immune system but also rely on bush medicine. So just yeah... or they prefer not to get the vaccine and rely on their immune system." P8

### **Theme 3: navigating uncertainty, fear, and a complex information environment**

Participants navigated a complex information environment characterised by pervasive uncertainty and fear. This underlying sense of uncertainty often stemmed from a perceived lack of reliable information, which contributed to indecision and distrust. For some, feeling uninformed was a direct barrier as P3 articulated:

Extract 17: "I don't trust it. I don't really know enough about it." P3

Fear manifested in multiple ways, from apprehension about unknown side-effects [Extract 18] to distinct anxieties about coercive implementation processes and loss of autonomy [Extract 19]:

Extract 18: "A bit scared of what's to come when you get jabbed with that needle, but you know, a lot of people are dying." P3

Extract 19: "That's really sad. I don't want them knocking on my doorstep, like that's what I been also told, that the streets are going to be filled with soldiers and stuff like that, going door to door knocking and they're going to be pushing or forcing." P12

This uncertainty operated as an active barrier, one that required a conscious decision to overcome, as described by P8 [Extract 20]:

Extract 20: "That's right. People are uncertain. I was uncertain myself for a good while until I just bit the bullet and just said: 'Go have it...'" P8

These underlying factors of fear and uncertainty directly shaped how policies were perceived. A lack of sufficient information could solidify a decision against vaccination [Extract 21], while policies seen as coercive created a conflict between official messaging and lived experience, reinforcing feelings of being controlled rather than empowered [Extract 22]:

Extract 21: "No, I haven't received any information on it. I fully myself don't want to be vaccinated." P4

Extract 22: "I do think that vaccination is a personal choice, even though it's not portrayed that way at the moment. They're saying that we've got a personal choice, but then if you don't get the vaccine, you're going to be excluded from so many things. I'm usually pro-vaccination, but I do think people have a choice - their right to free choice. No, not without consequences." P13

Finally, perceived inconsistencies from official health sources were particularly detrimental to trust. Shifting advice on vaccine safety, mask-wearing, age eligibility, and the need for boosters generated confusion and undermined health institution credibility:

Extract 23: "Because it's all conflicting. There's so many conflicting stories - conflicting directions - you know, like 'AstraZeneca, it's perfectly safe'. Then you find out that some, you know, some people can actually get thrombosis from it." P8

Extract 24: "One minute they're saying: 'Wear a mask'. And then they said: 'No, the mask does nothing'. And then all of a sudden: 'Yes, you have to wear a mask again'". P15

Extract 25: "So, the vaccine wasn't safe for a certain age group. Then all of a sudden, it is safe for a certain age group." P15

Extract 26: "You get two shots and then you may need a booster in six months, so does that mean you need a booster every six months because it's not working?" P8

Together, these three themes form an interconnected account of how trust is negotiated in this context. As summarised in Table 2, the historical legacies of Theme 1 provide the interpretive filter through which the participants view the uncertainty and shifting narratives of Theme 3. When official communication is perceived as inconsistent or culturally unsafe, participants pivoted towards the relational and Indigenous-led networks of Theme 2 to validate information and manage fear. This mapping shows how systemic barriers (institutional) and community strengths (relational) interact to facilitate health engagement.

**Table 2.** *Synthesis of thematic findings and integrated theoretical framework.*

| Theme | Key findings / sub-themes | Corresponding SAGE Determinant(s) (MacDonald, 2015) | Key insights from complementary theoretical lenses |
|-------|---------------------------|-----------------------------------------------------|----------------------------------------------------|
|-------|---------------------------|-----------------------------------------------------|----------------------------------------------------|

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| Theme 1:<br>Historical context<br>& systemic distrust                | <ul style="list-style-type: none"> <li>perceived dishonesty /manipulation (e.g., use of 'they'; metaphors)</li> <li>historical roots: colonisation, racism, mistreatment</li> <li>experiences of broken promises</li> <li>lack of transparency from official sources</li> <li>exposure to conflicting messages</li> </ul>                                                                                                                                                                                                   | <p>Contextual influences:</p> <ul style="list-style-type: none"> <li>historical influences</li> <li>politics/policies</li> <li>trust in institutions (specifically, distrust)</li> <li>communication &amp; media environment</li> </ul>                                                                                                                                                                                                                                                                                                                   | <p>Postcolonial theory:</p> <ul style="list-style-type: none"> <li>illuminates systemic distrust as rooted in historical power imbalances, colonial legacies, and ongoing experiences of systemic racism.</li> <li>explains 'they' as a marker of alienation.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                              |
| Theme 2:<br>Community, culture & relational dynamics                 | <ul style="list-style-type: none"> <li>influence of community norms and peer experiences (e.g., scepticism, negative anecdotes)</li> <li>importance of relational trust (e.g., with family, known individuals)</li> <li>trust placed in Indigenous organisations and media (e.g., NITV, ACCHOs)</li> <li>value of culturally appropriate practices (e.g., use of Kriol language)</li> <li>desire for community ownership of initiatives</li> <li>reliance on alternative knowledge systems (e.g., bush medicine)</li> </ul> | <p>Individual/group influences:</p> <ul style="list-style-type: none"> <li>personal, family and/or community members' experience with vaccination</li> <li>beliefs and attitudes about health</li> <li>trust in health systems &amp; providers</li> <li>immunisation as a social norm (or lack thereof)</li> </ul> <p>Contextual influences:</p> <ul style="list-style-type: none"> <li>influence of community leaders</li> <li>religious and cultural factors</li> <li>communication &amp; media environment (specifically, Indigenous media)</li> </ul> | <p>Relational Theory &amp; Indigenous Relationality:</p> <ul style="list-style-type: none"> <li>highlights the primacy of interpersonal connections, kinship, and community networks in trust formation</li> <li>explains trust in Indigenous-led entities</li> </ul> <p>Cultural Safety:</p> <ul style="list-style-type: none"> <li>underscores the importance of culturally appropriate practices and Indigenous-defined safe communication as essential for trust</li> </ul> <p>Postcolonial Theory:</p> <ul style="list-style-type: none"> <li>frames community ownership and Indigenous-led initiatives as acts of self-determination</li> </ul> |
| Theme 3:<br>Uncertainty, fear, and a complex information environment | <ul style="list-style-type: none"> <li>pervasive uncertainty and knowledge gaps</li> <li>prevalence of fear regarding vaccine side effects, perceived coercion, loss of autonomy</li> <li>difficulties navigating conflicting information</li> <li>impact of inconsistencies in official advice (e.g., regarding AstraZeneca, masks, eligibility, boosters)</li> </ul>                                                                                                                                                      | <p>Individual/group influences:</p> <ul style="list-style-type: none"> <li>level of knowledge/awareness</li> <li>perceived risk/benefit balance</li> <li>existing beliefs and attitudes</li> </ul> <p>Vaccine/vaccination-specific issues:</p> <ul style="list-style-type: none"> <li>concerns around the introduction of a new vaccine</li> </ul>                                                                                                                                                                                                        | <p>Postcolonial Theory:</p> <ul style="list-style-type: none"> <li>explains how perceived coercion and loss of autonomy resonate with historical experiences of state control and power imbalances</li> </ul> <p>Cultural Safety:</p> <ul style="list-style-type: none"> <li>highlights how an information environment lacking</li> </ul>                                                                                                                                                                                                                                                                                                             |

|  |  |                                                                                                                                                                                          |                                                                                                                                          |
|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
|  |  | <ul style="list-style-type: none"> <li>perceived lack of or conflicting scientific evidence on risk/benefit</li> <li>strength of recommendation from healthcare professionals</li> </ul> | transparency, consistency, or respect for Indigenous concerns can be experienced as culturally unsafe, exacerbating fear and uncertainty |
|--|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|

## Discussion

The findings reveal a clear disconnect between official communication systems and the lived experiences of Aboriginal and Torres Strait Islander participants. While the SAGE matrix (MacDonald, 2015) provides a structural map of influences, the results indicate that trust is a negotiated process occurring at the intersection of historical legacies, relational networks, and cultural safety. By moving beyond the SAGE 'Confidence' category, this study identifies a relational turn in trust formation, where institutional distance necessitates a reliance on kinship ties and culturally safe communication frameworks.

### Institutional perspectives: the active legacies of colonialism and systemic distrust

The pervasive distrust of government identified in this study is best understood through the lens of postcolonial theory. This framework challenges the view that 'historical influences' are a passive backdrop, arguing instead that they remain an active and structural force in the present, a concept central to the work of scholars like Said (1978), Moreton-Robinson (2015), and Wolfe (1999). From this perspective, participant accounts linking current scepticism to past mistreatment, such as P6 stating, "they lied to us for so long," are understood as expressions of a rational distrust rooted in these ongoing colonial structures and inequalities.

This perception of authorities as a powerful and alien 'other' is revealed at a granular, linguistic level. While linguistics establishes that the pronoun "they" can create discursive distance and signal disapproval (Greenbaum & Quirk, 1990; van der Auwera et al., 2012), its function here takes on a particularly potent meaning. Viewed through a postcolonial lens, the recurring use of "they" does more than show simple distrust; it actively reproduces the power imbalances of the colonial relationship. This sense of alienation is further reinforced through metaphors of exploitation, such as the fear of being treated as "guinea pigs" (P7), which directly resonates with postcolonial critiques of colonial medical experimentation and broader patient anxieties about feeling like test subjects in health systems (Mullard et al., 2024). Thus, postcolonial theory reveals how historical legacies are actively reproduced in both the language and the perceptions of the present, creating the context for the distrust observed in this study.

These findings regarding institutional distrust align with a broader international phenomenon where Indigenous communities in Canada and the USA navigate similar legacies of colonial interference (Coates, 2014; Lomawaima & McCarty, 2025; Truth and Reconciliation

Commission of Canada, 2015). However, this comparison requires nuance. While shared principles, such as the need for community-led and culturally safe communication, are transnational, strategies require deep localisation. These approaches must be meticulously adapted to each specific national, community, or language group (Ignacio et al., 2023; Labbé et al., 2024; Martell et al., 2025). The differences in specific histories, political-legal contexts, treaty relationships, cultural/linguistic diversity, and health systems mean that avoiding generalisations is vital (e.g., Martell et al., 2025). Consequently, while the structural roots of distrust are global, the mechanisms for reclaiming trust are found in the local, relational strengths of the community.

### **Relational and community perspectives: the primacy of Indigenous relationality**

Institutional structures often foster alienation; however, this study shows that trust is reclaimed through the primacy of community and kinship networks. The dual role of these social networks in both building and eroding trust (Theme 2) is mapped onto relational theory, particularly when grounded in Indigenous concepts of relationality (Graham, 1999). This shift reflects a pragmatic response to systemic distrust, in which relational proximity becomes a key criterion for determining credibility. This exemplifies the core tenet of Indigenous relationality, where knowledge and trust are mediated through established, reciprocal relationships. According to Graham (1999) of the Kombumerri people, this worldview is rooted in a 'relational self', where one's identity is defined by a web of connections to kin and Country, in contrast to Western notions of a separate, autonomous individual.

This relational principle is empirically reflected in the way interpersonal ties mediate confidence in broader systems, where trust in an individual facilitates a connection to the wider institution. For instance, the statement from P10: "my mum works in healthcare and I just trust that side of things", demonstrates this dynamic in practice. In this context, kinship ties serve as a primary validator, grounding abstract institutional credibility within a trusted, personal relationship. This contrasts with Western, individualistic models of trust and deepens the SAGE category of 'individual and group influences' by showing that for many participants, these relationships are the primary, not secondary, determinants of trust. While these networks can also be conduits for misinformation (Larson et al., 2018), their foundational importance underscores the need for health initiatives to engage within these relational webs, not just broadcast to them (Moodie et al., 2024).

### **Community control as an enactment of cultural safety and self-determination**

The finding that community-led communication is essential for fostering trust (Theme 2) represents a powerful synthesis of relational and institutional perspectives. Aboriginal Community Controlled Health Organisations (ACCHOs) and Indigenous media platforms are trusted precisely because they embody the principles of cultural safety, relational theory, and postcolonial resistance. From a cultural safety perspective, these organisations are effective because they create environments where communication is inherently safe, respectful, and defined by the community it serves (NHMRC, 2018b; Ramsden, 2002). The use of Kriol (P7) in

health communication materials, for example, functions as a culturally safe practice that affirms identity and gives recipients greater control over the information. In relational terms, these organisations earn trust by operating as an integral part of the community and remaining directly responsive to its needs. Interpreted through postcolonial theory, the call for community-led initiatives is an assertion of self-determination, directly challenging the colonial model of top-down control. This aligns with Smith's (2012) work on decolonising methodologies, arguing that Indigenous peoples must control their own narratives and health systems.

## **Misinformation and an unsafe information environment**

The challenges of navigating diverse beliefs and misinformation (Theme 3) represent the manifestation of a culturally unsafe information environment (Edwards et al., 2021; Yap, 2023). The findings suggest that a vulnerability to misinformation is not necessarily a deficit of individual knowledge; rather it is symptomatic of a potential consequence of a culturally unsafe information environment where official sources are already distrusted for valid reasons. This finding aligns with broader research indicating that Aboriginal and Torres Strait Islander peoples tend to exhibit lower trust in mainstream news and a higher reliance on social media and relational networks to validate health narratives (Australian Communications and Media Authority, 2021; Yashadhana et al., 2020).

Furthermore, a specific risk in this environment involves legitimate Indigenous narratives about health or historical experiences being wrongly categorised as 'misinformation' by external bodies lacking cultural competency (Humphery-Jenner, 2024). This creates an information environment where strategies based on simple fact-checking are often ineffective; the core issue is a lack of trust in the source of the information, not just the content of the message. Countering this dynamic requires strategies that prioritise dissemination through the trusted, community-led, and relational platforms identified in Theme 2. As shown by participants' navigation of "coercive choices", uncertainty and fear emerged as rational responses to an information environment characterised by complexity, perceived inconsistencies, and challenging power dynamics.

## **Contributions to theory: strengthening the integrated framework through Indigenous relationality**

By synthesising the SAGE matrix with postcolonial, relational and cultural safety theories, this study moves beyond the descriptive accounts of 'hesitancy' to explain the structural and relational logic of trust formation. In doing so, it offers a more nuanced application of the SAGE determinants (MacDonald, 2015). Specifically, this study reframes 'historical influences' from a static background variable into an active structural determinant that directly shapes contemporary health communication.

Furthermore, the findings suggest a need to elevate the role of interpersonal and kinship ties; currently they appear as a secondary group influence, but we have seen that these relational connections function as a primary validator for health information within Indigenous contexts. Importantly, this integrated approach expands the conceptualisation of trust by situating

information accuracy alongside a shift in informational power and the deliberate enactment of cultural safety. Such a framework ensures that health communication aligns with the principles of cultural safety, where the perceived safety of the interaction remains a central requirement for community engagement.

## Limitations and future directions

This interpretivist study prioritises conceptual depth, and while the results are specific to this setting, the identified interplay between institutional distrust and Indigenous relationality offers analytical insights that may be transferrable to other Indigenous health communication settings shaped by similar colonial legacies. Future research could extend these findings by examining trust dynamics across a wider range of Aboriginal and Torres Strait Islander communities, including diverse language groups, as well as across globally diverse Indigenous populations. Additionally, longitudinal studies could track how trust shifts in response to changing policy environments and contemporary health events. Finally, an intersectional approach incorporating factors such as age, gender, location, occupation, and socioeconomic status would further refine the understanding of how diverse identities shape trust within communities (Morales et al., 2022).

## Recommendations based on our findings

Enhancing trust and vaccine uptake requires a multi-pronged, integrated approach that focuses on the relational and structural foundations of communication. We recommend that public health initiatives:

1. Prioritise ACCHO-led communication: recognise that Aboriginal Community Controlled Health Organisations are highly trusted sources of health information. Investment should strengthen their capability to lead communication strategies that are grounded in community leadership and culturally safe engagement.
2. Resource cultural safety training: training across the health sector should address culturally unsafe communication practices and promote respectful engagement.
3. Embed co-design and community governance: these principles ensure linguistic relevance, cultural resonance, and community ownership of health communication initiatives.
4. Adopt relational communication models: shifting toward community-centric models acknowledges the central role of kinship networks in mediating health knowledge.
5. Integrate Indigenous languages and knowledge in health information: resourcing the use of diverse linguistic practices and worldviews ensures health information resonates with cultural identity.
6. Develop culturally grounded communication strategies: these approaches should address uncertainty, fear and misinformation by prioritising source credibility and relational safety.

These recommendations are highly interdependent, and their success requires holistic implementation. The underlying principles may be transnational, but concrete actions require careful adaptation considering the unique historical, cultural, political, and social contexts of diverse Aboriginal and Torres Strait Islander peoples and Indigenous communities worldwide.

## **Declarations**

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### **Conflicts of interest**

The authors declare no conflicts of interest.

### **Ethical approval**

Ethical approval was granted by the University of Melbourne Humanities and Applied Sciences Human Ethics Sub-Committee (Reference 21033.3.6, 8 December 2020). All participants provided informed consent.

### **Artificial Intelligence**

AI was only used for grammar/proof-checking.

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