Edelweiss Applied Science and Technology
ISSN: 2576-8484
Vol. 9, No. 2, 1133-1146
2025
Publisher: Learning Gate
DOI: 10.55214/25768484.v9i2.4696

Navigating hesitancy: Lived experiences of COVID-19 vaccine resistance and public health adaptations in the Philippines

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Abstract: The COVID-19 pandemic has presented significant challenges to global public health, with vaccine hesitancy emerging as a major obstacle to achieving widespread immunity. This study examines the lived experiences of vaccine-resistant individuals in Negros Occidental, Philippines, to understand the underlying factors contributing to their hesitancy and how they navigate health protocols. Using a phenomenological approach, six unvaccinated participants were identified through snowball sampling in collaboration with local government health officials. Semi-structured interviews revealed three key themes: Navigating the Jab Maze, which explores concerns about vaccine safety and efficacy; Abiding by the Protocols for Unvaccinated Individuals, which highlights adherence to alternative preventive measures; and Embracing Health Concerns, which examines the role of personal beliefs, governance perceptions, and experiences of exclusion. Findings indicate that vaccine hesitancy stems from concerns about vaccines being experimental, personal convictions, and distrust in government policies. Despite their reluctance, participants adhered to public health measures, reflecting a complex balance between autonomy and collective responsibility. This study underscores the need for interdisciplinary strategies that integrate public health, social sciences, and policy-making to address vaccine hesitancy effectively. The findings provide insights for policymakers and healthcare practitioners in designing inclusive, trust-building interventions to enhance vaccine acceptance and public health outcomes.

Keywords: *COVID-19, Government strategies, Health Protocols, Philippines, Lived Experiences, Phenomenological Approach, Vaccine Hesitancy.*

1. Introduction

The World Health Organization (WHO) [1] identifies vaccination as one of the most cost-effective strategies to prevent illness, averting 2–3 million deaths annually and with the potential to save an additional 1.5 million lives if global vaccination rates increase. Despite this, vaccine hesitancy—a reluctance or refusal to vaccinate despite vaccine availability—was recognized in 2019 as one of the top ten threats to global health [2, 3]. This hesitancy is driven by factors such as lack of confidence, inconvenience, and complacency [4]. The emergence of the novel coronavirus in 2019 spurred efforts to develop effective vaccines. However, in the Philippines, a Pulse Asia survey revealed that 47% of Filipinos were unwilling to receive the COVID-19 vaccine, citing safety concerns as the primary reason. Among unvaccinated individuals, fear of vaccine safety influenced 69% to refuse and 79% to express uncertainty (as cited in Cheong, et al. [5]). While the Philippines has received 150 million COVID-19 vaccine doses, only 67.1 million individuals, representing 61.2% of the population, are fully vaccinated

History: Received: 17 December 2024; Revised: 23 January 2025; Accepted: 23 January 2025; Published: 10 February 2025
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[6]. Achieving widespread immunity is essential to ending the pandemic, with vaccination as the safest pathway [2].

To address this, the Philippine Department of Health launched the "*Resbakuna*" campaign, part of the National Deployment and Vaccination Plan for COVID-19 Vaccines, to promote vaccination and strengthen public immunity. Nevertheless, a significant portion of the population remains unvaccinated, reflecting the autonomy individuals exercise in their decision-making [7]. With these having said, the current study seeks to investigate the lived experiences of unvaccinated individuals regarding COVID-19 vaccine hesitancy. By exploring the causes and implications of hesitancy, this research aims to contribute to the understanding of vaccine reluctance and its impact on the healthcare sector, particularly for frontline workers.

The significance of this study lies in its focus on the concept of lived experience, which encompasses the multifaceted dimensions of an individual's journey through a specific phenomenon [8, 9]. In the context of vaccine hesitancy, it delves beyond statistics to explore personal narratives, beliefs, and perceptions that shape the decisions of those who remain unvaccinated. By examining the underlying factors of vaccine hesitancy, this research recognizes that such decisions are not one-size-fits-all but are deeply influenced by unique individual and contextual circumstances. Understanding these experiences holds implications beyond academic curiosity. The insights gained from this study can inform public health strategies to address vaccine hesitancy more effectively. By shedding light on the nuanced reasons behind reluctance, this research may guide tailored interventions that respect individual autonomy while promoting collective well-being. Furthermore, it highlights the broader impact of vaccine hesitancy on the healthcare sector, particularly for frontline workers who continue to bear the burden of mitigating the effects of the pandemic. Ultimately, this study aims to bridge the gap between public health initiatives and the lived realities of unvaccinated individuals, contributing to more empathetic and effective healthcare strategies.

2. Literature Review

2.1. Hesitancy to Vaccine in the COVID-19 Era

Global research indicates that vaccine hesitancy ranges from 8% to 15% in prevalence [2]. Even in prior COVID-19 studies, vaccine acceptance rates are generally lower among unemployed individuals and those with lower incomes, although some studies found no direct correlation between income and vaccine attitudes [10, 11]. Education levels also play a role, with individuals having less education demonstrating lower vaccine acceptance rates Salali and Uysal [12]. Danis, et al. [13] similarly noted that there exists no correlation between economic hardship and vaccine refusal, but rather identified economic factors as contributors to hesitation. Interestingly, somehow while higher education can lead to critical decision-making about vaccines, it may also result in higher rates of vaccine refusal among certain groups. Furthermore, religiosity has also been identified as a significant factor negatively linked to COVID-19 vaccine acceptance [14]. Within seminal and current literature, religious beliefs, such as considering vaccines incompatible with faith or associating them with Satanism, have deterred some individuals from immunization [15, 16]. Additionally, age and risk perception influence vaccine hesitancy [17]. Younger individuals were less willing to receive the vaccine, while those more fearful of illness were likelier to accept it. Perceptions of risk play a critical role, with those perceiving less danger often engaging in riskier behaviors or fewer preventive measures [2, 18].

Common reasons for vaccine refusal include general opposition to vaccination, safety concerns about rushed production, mistrust in vaccine efficacy, and doubts about its necessity, especially for COVID-19 [19]. Other reasons cited include beliefs in natural immunity and fear of improper administration or side effects [20]. Misconceptions about vaccines also contribute to hesitancy, with some individuals misunderstanding their disease-specific nature or assuming vaccines are primarily for children. The most frequent justification for refusing COVID-19 vaccination, as highlighted by Troiano and Nardi [2] wherein the belief that vaccines are unnecessary and lacks tangible benefits. These attitudes reflect

Edelweiss Applied Science and Technology
ISSN: 2576-8484
Vol. 9, No. 2: 1133-1146, 2025
DOI: 10.55214/25768484.v9i2.4696

a broader mistrust and misperception about vaccines' purpose and efficacy, highlighting the need for targeted education and communication to address these barriers effectively.

2.2. Cultural Factors Influencing Vaccine Hesitancy

The World Health Organization defines vaccine hesitancy as a delay in accepting or refusal of vaccines despite their availability [21]. A 2019 study by Shen and Dubey [22] in Canada revealed that while 19% of parents expressed caution about vaccinations, only 3% refused all immunizations for their children. For many, vaccine hesitancy is driven by a lack of trust in vaccine safety and efficacy, complacency about the perceived low risk of contracting preventable diseases, and challenges related to accessibility and cultural contexts of immunization services [23]. This reluctance has persisted since the development of the first vaccines [24]. According to Robinson, et al. [25] factors influencing vaccine hesitancy can be categorized into three areas: *convenience*, *complacency*, and *confidence*. Accessibility, particularly in remote areas, is a major barrier to vaccination. Complacency arises from underestimating the importance of vaccines, while confidence is undermined by concerns about their safety and efficacy. In addition, cultural norms and community traditions also play a significant role in shaping attitudes toward immunization [26]. Furthermore, research by Hasnan and Tan [27] found that vaccine hesitancy in families is influenced by emotional discomfort, negative past experiences, and misinformation, while in physicians, it is primarily driven by attitudes and motivation. The healthcare system's lack of rigorous oversight, transparency, and enforcement further exacerbates vaccine reluctance. Insufficient communication about the disease and vaccines, coupled with inadequate monitoring of misinformation, significantly contribute to the problem. Addressing these cultural and systemic barriers is crucial to overcoming vaccine hesitancy and ensuring widespread immunization.

2.3. Managing COVID-19 Vaccine Hesitation

The success of vaccination programs depends on scientific evidence supporting vaccine safety, high public acceptability, and broad population coverage [28]. However, vaccine hesitancy—characterized by a lack of trust in vaccines or complacency about their importance—poses a significant challenge to the effectiveness of COVID-19 vaccination campaigns. Factors such as the rapid development of COVID-19 vaccines, misinformation on social and mainstream media, the polarized sociopolitical environment, and the logistical complexities of mass vaccination efforts can undermine public trust and foster vaccine hesitancy [29]. The recent surges in COVID-19 infections underscore the urgent need for widespread vaccination. Addressing vaccine hesitancy requires evidence-based, multi-level strategies to influence behavior and ensure vaccine uptake. Surveys conducted in the United States reveal substantial vaccine hesitancy, emphasizing the need for targeted interventions to bridge this gap [30]. Therefore, a robust healthcare response is essential, encompassing initiatives at the community and policy levels to improve vaccine access and acceptance. To enhance population adoption of COVID-19 vaccination, interpersonal, individual-level, and organizational interventions should be implemented within clinical and community settings [31]. Hence, leveraging insights from social, behavioral, communication, and implementation science, these strategies can effectively promote vaccination and address hesitancy. A coordinated effort between healthcare systems, policymakers, and community organizations is critical to overcoming barriers and building public confidence in COVID-19 vaccines [32].

Overall, the literature reveals that vaccine hesitancy is influenced by a complex interplay of personal beliefs, cultural norms, systemic barriers, and accessibility challenges. Mistrust in vaccine safety, fueled by misinformation and the rapid development of COVID-19 vaccines, has heightened public reluctance. Emotional discomfort, past negative experiences, and societal pressures further complicate the issue, while gaps in healthcare communication and transparency exacerbate distrust. Addressing these challenges requires a holistic approach, combining culturally sensitive communication, community engagement, and policy-driven initiatives to foster trust and accessibility. This aligns with the study's objective of exploring the lived experiences of unvaccinated individuals, offering valuable insights to inform strategies that address vaccine hesitancy effectively.

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3. Materials and Methods

3.1. Study Design

The study employed a qualitative methodology with a phenomenological approach to explore the lived experiences of COVID-19 vaccine hesitancy among unvaccinated individuals. According to Polit and Beck [33] this method uses in-depth inquiry to understand participants' experiences with a specific phenomenon, focusing on the underlying reasons for their thoughts, behaviors, and perspectives. Data were collected through face-to-face, one-on-one in-depth interviews using an open-ended, semi-structured format guided by a list of predetermined topics or questions [34]. This approach allowed the researcher to delve deeply into participants' beliefs, actions, and emotions, enabling the identification of themes and providing meaningful insights into their experiences [35]. The method was well-suited for this study as it facilitated a thorough exploration of the perspectives and feelings of unvaccinated individuals, offering a multi-perspective understanding of their vaccine hesitancy.

3.2. Participants and Recruitment

The study included six (6) participants who met the inclusion criteria set by the researcher Patton [36]. The participants were required to: (a) be willing to participate in the study, (b) be between 18 and 59 years old, (c) have reached at least high school or college level, (d) be able to share their lived experiences of being unvaccinated against COVID-19, (e) reside in rural or urban communities within the *Northern Province of Negros Occidental*, and (f) have remained unvaccinated since the start of the vaccination rollout to the present. Participants were excluded if they: (a) demonstrated a lack of commitment or interest in fulfilling study requirements, (b) fell outside the specified age range of 18 to 59 years old, (c) had not reached at least high school or college level, (d) had a diagnosed medical or psychiatric condition that could compromise their ability to provide accurate and reliable information, (e) did not reside in the Northern Province of Negros Occidental, or (f) had received any COVID-19 vaccine. In line with qualitative research principles, participants were purposefully selected to provide the most meaningful insights into the research questions and enhance understanding of the phenomenon being studied Campbell, et al. [37] and Mapp [38]. Recruitment was conducted using a snowball or referral technique [39] this is done with the collaboration of the midwife in charge of the respective barangays; which is a small administrative division in the Philippines that function as the smallest local government units, often serving as communities or neighborhoods [40] within the research locale. Participants that fit the inclusion criteria were approached, provided with a detailed description and purpose of the study, and asked to give their informed consent before participation. The study protocol was reviewed and approved by the panel of evaluators of the *University of St. La Salle Graduate Program*, before conducting the interview.

Table 1 provides an overview of the six participants' demographic profiles, including pseudonyms, gender, age, marital status, number of children, occupation, and educational level. All participants are married, with ages ranging from 27 to 59. The group consists of one male participant, Ben, aged 59, who is a church minister (pastor) and a college graduate. The remaining five participants are females, with diverse occupations and educational backgrounds. Three participants (*Martha*, *Beth*, and *Alicia*) are housewives, with Martha and Beth having five children each, while Alicia has 10 children. Their education levels vary, with Martha and Alicia having completed high school and Beth attaining a college-level education. Elsa, aged 43, works as a teacher and is a college graduate with two children. Meriam, aged 55, is a farmer with four children and a high school graduate. This diversity in age, occupation, and educational attainment provides valuable insights into the participants' lived experiences of COVID-19 vaccine hesitancy.

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Table 1.
Background demographics of the participants.

Participant (Pseudonyms)	Gender	Age	Marital status	Number of children	Occupation	Educational level
P1: Ben	Male	59	Married	2	Church Minister	College graduate
P2: Martha	Female	34	Married	5	Housewife	High school graduate
P3: Beth	Female	42	Married	5	Housewife	College level
P4: Elsa	Female	43	Married	2	Teacher	College graduate
P5: Meriam	Female	55	Married	4	Farmer	High school graduate
P6: Alicia	Female	27	Married	10	Housewife	High school level

3.3. Interview Protocol and Procedure

An interview guide was developed by the researcher to ensure that all essential topics were covered and relevant information was gathered to fully understand the lived experiences of the participants [41]. The guide included one overarching question and three probe questions designed to explore the perspectives of six unvaccinated individuals residing in the Northern Province of Negros Occidental. Questions addressed their views and perceptions on COVID-19 vaccination, reasons for hesitancy, challenges encountered, and coping mechanisms. The overarching question was: "*How would you describe your experience being unvaccinated against COVID-19?*" with the following probes: (1) "*Why did you choose not to be vaccinated?*" (2) "*How do you keep yourself healthy and safe?*" and (3) "*What social barriers have you encountered as an unvaccinated individual?*"

As noted earlier, participants were purposefully selected through coordination with the local government unit. The researcher sought permission from the Barangay Captain (sort of a district leader; an elected official representing the neighborhood or community) to access COVID-19 vaccination records through the barangay midwife. Individuals meeting the inclusion criteria were identified, and letters of invitation were sent to them. Only those who willingly responded were included as participants. An initial visit was conducted to establish rapport, explain the study, and obtain signed informed consent. Semi-structured interviews were then scheduled at times and locations convenient for the participants. The interviews were conducted one-on-one, face-to-face, with strict adherence to health protocols such as mask-wearing and physical distancing. Interviews were audio-recorded with participants' consent. The private and quiet settings, typically within the participants' residences, minimized interruptions and ensured comfort during the discussions. Importantly, participants were allowed to discontinue the interview at any time if they wished. Each interview lasted 45 minutes to one hour. After the interviews, the researcher returned to confirm the transcribed data for accuracy and completeness. Confidentiality was strictly maintained by using pseudonyms and securely storing all personal information separately from the research data.

3.4. Qualitative Data Analysis

To analyze the raw data from the recorded interviews, the researcher employed [42] seven-step descriptive phenomenological method. The process began with familiarization, where the researcher transcribed the interviews and repeatedly read each participant's story to gain a comprehensive understanding of the data. Next, significant statements directly related to the study topic were identified and extracted from the transcripts. These statements were then analyzed to formulate meanings, which were summarized and refined to reflect the essence of the phenomenon being studied. The formulated meanings were subsequently grouped into clusters, allowing the researcher to identify common themes across all participants' accounts. The findings were then synthesized into an exhaustive description of the phenomenon, integrating all relevant insights into a detailed narrative. From this description, the essential structure of the phenomenon was identified, highlighting the critical elements that define the participants' lived experiences of COVID-19 vaccine hesitancy. To ensure accuracy and authenticity, the researcher returned the analyzed results to the participants for validation, allowing them to verify and confirm whether the findings accurately captured their experiences. This systematic and thorough approach provided a comprehensive understanding of the phenomenon under investigation.

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ISSN: 2576-8484
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3.5. Research Ethics

Ethical standards were rigorously maintained throughout this study, adhering to the guidelines set forth by the institution. The researcher, with prior training and experience in qualitative research, ensured participants were handled with care during the interview process. Informed consent was obtained after providing participants with a clear explanation of the study's purpose, risks, benefits, and their right to withdraw at any time. Confidentiality was upheld by using pseudonyms, removing identifying information, and securely storing data on encrypted devices and password-protected drives. Face-to-face interviews were conducted following minimum health protocols, and participants were free to skip questions or decline topics that caused discomfort. A mental health professional was available in case of emotional distress. Voice recordings were used with participant permission, and data will be securely stored and deleted two years after the study's completion. Findings will be presented in an anonymized, aggregated format to prevent identification. To ensure the robustness of the study, data saturation was monitored, with additional participants included only until no new insights were generated. This thorough approach safeguarded participant privacy, well-being, and the integrity of the research process.

4. Results and Discussions

The exploration of the lived experiences of COVID-19 vaccine hesitancy among unvaccinated individuals in the Northern Province of Negros Occidental reveals multi-perspective themes that provide a deeper understanding of this complex phenomenon. This discussion identifies three overarching themes, each offering a unique perspective on the research inquiry and further enriched by their corresponding subthemes. The first theme, "*Navigating the Jab Maze*," highlights common concerns regarding vaccine safety and side effects, with subthemes such as *Challenging the Efficacy Puzzle* and *Coiling Trust*, which examine the participants' doubts about vaccine reliability and trust in health authorities. The second theme, "*Abiding by the Protocols for Unvaccinated Individuals*," explores the precautionary measures adopted by participants to protect their health, as reflected in the subthemes *Bounding Inward* and *Questing Health*. Finally, the third theme, "*Embracing Health Concerns*," delves into the collective narratives of the participants, focusing on the interplay of personal beliefs, governance dynamics, and experiences of exclusion. These are encapsulated in the subthemes *Interplaying Personal Beliefs*, *Exploring the Tapestry of Governance*, and *Perceiving Exclusion*. Together, these themes and subthemes offer valuable insights into the multifaceted nature of vaccine hesitancy in this context.

4.1. Navigating the Jab Maze

As noted earlier from the literature review, the rapid development and distribution of COVID-19 vaccines have raised concerns among unvaccinated individuals about their safety, efficacy, and long-term effects. Participants expressed apprehension regarding the accelerated vaccine approval process, perceiving the vaccines as experimental. Pastor Ben explained, "*The vaccine must be in trial three to five years, but in a short while, vaccine shots were already given to people.*" Similarly, Elsa shared her concern about potential side effects, stating, "*One reason perhaps for my hesitancy is the possible side effects of the vaccine.*" These concerns reflect the complexity of navigating the uncertainties surrounding COVID-19 vaccination, encapsulated in the theme, which is further divided into two subthemes: *Challenging the Efficacy Puzzle* and *Coiling Trust*.

4.1.1. Challenging the Efficacy Puzzle

Participants frequently questioned the effectiveness of the COVID-19 vaccine, citing its perceived short lifespan and limited testing. Beth noted, "*The vaccine's lifespan only lasts six months, then another booster shot is needed*—unlike *the vaccines we had as children that lasted for years.*" This comparison highlights participants' belief that longer development times equate to better efficacy. Similarly, Meriam emphasized her skepticism, stating, "*We stand firm that the vaccine is experimental. We can't believe*

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ISSN: 2576-8484
Vol. 9, No. 2: 1133-1146, 2025
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something we haven't seen or experienced ourselves." Martha also expressed uncertainty about the vaccine's contents, saying, "*We are not certain about the vaccine—all of us question what substances are incorporated into it.*" Alicia echoed these sentiments, describing the vaccine as something entirely unfamiliar: "*COVID was something new to us, and the vaccine was something we do not know about as well.*" These statements underscore participants' doubts about the vaccine's safety and effectiveness, particularly given its rapid development. Their views align with broader findings in the literature, which suggest that accelerated vaccine production raises concerns about safety and long-term effects [43].

4.1.2. Coiling Trust

Trust in the vaccine and the institutions responsible for its development and distribution was a significant barrier to vaccine acceptance. Beth shared anecdotal evidence, saying, "*We have friends who were healthy, but after getting vaccinated, they started feeling unwell and had flu-like symptoms.*" Similarly, Pastor Ben expressed distrust, citing reports of adverse effects: "*There are many after-effects—pregnant women losing their children, even professionals experiencing health issues. How about those who are already sickly?*" While, Martha's hesitancy stemmed from concerns about her health and that of her family. She explained, "*I don't want to be vaccinated because I'm not well, and I fear my condition might worsen. I also don't want my children vaccinated because their cough and colds haven't gone away.*" Alicia added that her fear was influenced by reports of severe outcomes: "*We heard of people who died after getting vaccinated, including young ones. That's why we're scared—it might bring us health issues.*" Elsa, on the other hand, shared specific incidents involving acquaintances: "*Two people I know died weeks after being vaccinated, and my niece developed allergies to foods she used to eat without issues. These experiences* made *me afraid, especially since I have hypertension, gallstones, and other conditions.*" These accounts reveal how personal experiences and secondhand stories contribute to a collective mistrust of the vaccine, echoing findings in previous studies [44].

Overall, these findings highlight that vaccine hesitancy among participants stems from a combination of perceived risks, distrust in vaccine efficacy, and fear of adverse effects. Participants' skepticism was fueled by the rapid development of the vaccine, the lack of long-term data, and anecdotal evidence of post-vaccine health issues. These concerns are consistent with the literature, which identifies safety concerns, mistrust in institutions, and fear of adverse effects as common drivers of vaccine hesitancy [45, 46].

4.2. Abiding by the Protocols for Unvaccinated Individuals

This theme explores how unvaccinated individuals navigate the challenges of the COVID-19 pandemic by adhering to precautionary measures. Despite their vaccine hesitancy, participants actively engaged in practices that prioritized personal and communal safety. Pastor Ben shared, "*Whenever we leave our community, we follow protocols, take vitamins, and care for our health, with or without COVID.*" Similarly, Elsa described her cautious approach: "*We limit going out as much as possible and avoid crowded places, knowing that we are not vaccinated and therefore not protected against the virus.*" These accounts highlight the participants' commitment to protecting themselves and others, even in the absence of vaccination. This theme is divided into two subthemes: *Bounding Inward* and *Questing Health*, which further detail these precautionary measures.

4.2.1. Bounding Inward

The practice of self-quarantine emerged as a key strategy for unvaccinated individuals to safeguard their health and prevent the potential spread of COVID-19. Alicia explained, "*My child is the one who goes to the market to buy food, while the rest of us stay home and avoid mingling with others.*" Similarly, Pastor Ben emphasized the importance of limiting contact: "*We, the unvaccinated, avoid vaccinated individuals because we believe the virus may be embedded in them. Less contact means less contamination for us.*" For Elsa, self-isolation was a deliberate choice to mitigate risks: "*We limit going out and avoid crowded places, knowing*

Edelweiss Applied Science and Technology
ISSN: 2576-8484
Vol. 9, No. 2: 1133-1146, 2025
DOI: 10.55214/25768484.v9i2.4696

that we are not protected against the virus." While, Beth described the initial fear that led to self-quarantine: "*During the onset of COVID, we worried and stayed hidden to avoid getting infected because we feared how severe the illness could be.*" These narratives reflect a proactive stance among participants to protect both their personal well-being and that of the broader community. Research supports the efficacy of such measures, with studies by Zhang, et al. [47] and Girum, et al. [48] indicating that self-quarantine, physical distancing, and travel restrictions are effective strategies to curb the spread of COVID-19 when implemented consistently and early.

4.2.2. Questing Health

Participants also emphasized the importance of maintaining their health through proactive self-care. Beth shared her approach: "*When I felt flu-like symptoms, lost my sense of smell, and had no appetite, I focused on eating healthy, sleeping adequately, and taking care of myself. I recovered without needing the vaccine.*" Pastor Ben echoed this sentiment, stating, "*No matter how effective a vaccine is, it becomes useless if you don't eat nutritious food...*" These practices demonstrate participants' belief in natural methods to boost immunity and maintain wellness. For some, the geographical isolation of their communities influenced their health practices. Martha explained, "*We take care of ourselves because we don't go out of our place, and we are far from the city.*" This sentiment highlights the participants' reliance on self-sufficiency and preventive measures in managing their health. These findings align with research by [49] which suggests that some unvaccinated individuals believe good nutrition and self-care can serve as effective defenses against COVID-19. Additionally, Domosławska-Żylińska, et al. [50] found that unvaccinated individuals often perceive high susceptibility to infection yet prioritize self-efficacy and personal responsibility in mitigating risks.

Generally, these findings reveal that unvaccinated individuals adopt a range of precautionary measures to safeguard their health, including self-quarantine, limiting exposure to others, and engaging in proactive self-care. These practices reflect a commitment to minimizing risks and protecting their communities despite their hesitancy toward vaccination. Participants' actions demonstrate a sense of personal responsibility and an effort to balance their autonomy with public health considerations. The participants' reliance on non-vaccine preventive measures aligns with previous studies emphasizing the role of self-efficacy and perceived susceptibility in shaping health behaviors [50]. However, these strategies alone may not provide sufficient protection against COVID-19, underscoring the need for public health initiatives to address vaccine hesitancy through culturally sensitive communication and education. By understanding the perspectives of unvaccinated individuals, health authorities can design interventions that bridge the gap between personal health practices and collective safety.

4.3. Embracing Health Concerns

This final theme explores the multifaceted factors influencing the participants' collective health narratives and their vaccination decisions. Participants expressed varying perspectives shaped by personal beliefs, governance dynamics, and experiences of exclusion. Pastor Ben dismissed COVID-19 as "*just an ordinary virus,*" while Alicia relied on her faith, stating, "*I will choose not to vaccinate because it has been stated in the Bible. Anyways, we all die in the end.*" Meanwhile, Beth expressed frustration with perceived injustices in government policies, emphasizing, "Vaccination should be voluntary; it's unfair if we are forced." These viewpoints reflect the intricate dynamics shaping participants' attitudes toward health and vaccination. This theme is divided into three subthemes: *Interplaying Personal Beliefs*, *Exploring the Tapestry of Governance*, and *Perceiving Exclusion.*

4.3.1. Interplaying Personal Beliefs

Participants' personal beliefs significantly influenced their vaccine hesitancy. Pastor Ben stated, "*The coronavirus is just an ordinary virus. God gave us natural immunity, which is stronger than any vaccine.*" This belief in divine protection echoed among participants like Alicia, who shared, "*Our decision not to*

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vaccinate is influenced by our faith. I had a dream where an elder told me to prepare because a sickness is coming to Earth." Similarly, Martha downplayed the severity of COVID-19, comparing it to "*an ordinary flu with symptoms like headaches and runny noses.*" Others, like Elsa, hesitated due to recurring health issues, stating, "*Every time I plan to get vaccinated, I feel unwell, so I'm not ready yet.*" Despite this, she found comfort in her faith, adding, "*My family and I prayed every night during the pandemic, trusting that God is our refuge.*" These personal beliefs and spiritual perspectives highlight how faith and mistrust in science shape participants' resistance to vaccination, aligning with studies indicating that strong religious faith often correlates with vaccine hesitancy [51, 52].

4.3.2. Exploring the Tapestry of Governance

Participants also expressed their distrust in government strategies and policies related to vaccination campaigns. Martha noted, "*The health center explained the vaccine's benefits, but despite understanding it, we still chose not to vaccinate.*" Pastor Ben criticized the lack of transparency, stating, "T*here are many post-vaccine effects, but they are not being recorded or reported in the media.*" Similarly, Beth questioned the fairness of mandatory vaccination, arguing, "*It's supposed to be voluntary. Why are people being forced?*" Some legal provisions of the Philippine government, which stipulate that vaccine cards are *not mandatory for work or education* [53] were cited by participants like Elsa and Meriam to support their stance. Meriam explained, "*We know the vaccine is experimental, and the law says it's not mandatory.*" These sentiments reveal a tension between government initiatives and individual autonomy, with participants perceiving vaccination campaigns as coercive rather than voluntary. Studies have shown that mistrust in governance and concerns over accelerated vaccine development exacerbate hesitancy and resistance [54, 55].

4.3.3. Perceiving Exclusion

Importantly, unvaccinated participants often felt socially and emotionally excluded, facing discrimination and isolation. Elsa shared, "*Being unvaccinated is difficult because people discriminate against you if they cannot understand.*" She recounted being denied entry to accompany her husband at a medical facility and being segregated at work: "*The school provided a separate office for unvaccinated staff, as if we were contagious.*" While, Martha and Beth described how unvaccinated children were barred from school. Martha stated, "*My kids were told they couldn't attend school without being vaccinated, but we still chose not to vaccinate.*" Beth added, "*One of my kids in college couldn't return to school because of her vaccination status. It's unfair that we are deprived of education despite the law stating vaccines are voluntary.*" This exclusion extended to workplaces, with Beth observing, "*Some people are forced to vaccinate to keep their jobs. If they don't, they lose their livelihood.*" These accounts underscore the social and psychological challenges faced by unvaccinated individuals, highlighting how societal and institutional pressures exacerbate feelings of isolation. Research confirms that unvaccinated individuals often face hostility, prejudice, and marginalization, which can deepen their initial reluctance to vaccinate and further polarize society [56].

Overall, these findings illustrate how personal beliefs, governance dynamics, and social exclusion intersect to shape vaccine hesitancy. Participants' reliance on faith, mistrust in government policies, and experiences of discrimination contribute to their resistance to vaccination. These factors align with studies showing that vaccine hesitancy stems from a combination of mistrust in institutions, fear of adverse effects, and perceived infringement on personal autonomy. To address these challenges, public health initiatives must prioritize transparent communication, culturally sensitive engagement, and policies that balance public health goals with individual rights. By understanding the varied experiences of unvaccinated individuals, stakeholders can design strategies that reduce mistrust, promote inclusivity, and encourage vaccination without alienating hesitant populations.

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5. Conclusions

This study explored the lived experiences of vaccine hesitancy among unvaccinated individuals, revealing complex themes and subthemes:

- Navigating the Jab Maze – Participants exhibited hesitancy due to perceptions of vaccines as experimental, stemming from the rapid development and approval process during the pandemic. Concerns about safety and efficacy were central to their reluctance.
- Abiding by the Protocols for Unvaccinated Individuals – Despite their hesitancy, participants adhered to health protocols, such as wearing masks, social distancing, and maintaining healthy lifestyles, recognizing the importance of collective well-being.
- Embracing Health Concerns – Vaccine hesitancy was influenced by personal beliefs, government policies, and social experiences, including exclusion and stigma. The participants' decisions highlighted the interplay between individual autonomy and public health priorities.

Overall, vaccine hesitancy among participants was shaped by personal beliefs, perceived vaccine risks, and external influences, such as government strategies. Despite their resistance, they demonstrated a commitment to public health measures, reflecting a nuanced balance between personal and collective responsibility.

5.1. Recommendations

Based on the findings, the following are recommended:

- Enhanced Communication - Health authorities, particularly the Department of Health, should adopt empathetic, culturally sensitive strategies that incorporate personal stories and real-life examples to address barriers such as misinformation, fear, and limited access.
- Community Engagement - Local government units should collaborate with community organizations, leaders, and influencers to amplify vaccination messages. Trusted figures can play pivotal roles in shaping attitudes and encouraging behavior change.
- Policy Development - Local government units should use these insights to craft policies addressing vaccine hesitancy's root causes, including improving access to healthcare, disseminating accurate information, and fostering community engagement initiatives.
- Support for Health Practitioners - Nurse practitioners can leverage these findings to offer personalized, empathetic education and communication that addresses individual concerns, building trust and promoting vaccination within diverse communities.
- Reducing Stigma - By humanizing the experiences of unvaccinated individuals, this study promotes empathy, reduces judgment, and fosters inclusive environments where concerns can be addressed without fear of stigmatization.

5.2. Suggestions for Future Research

Based on the findings of this study, several avenues for future research are recommended to further understand and address vaccine hesitancy. A quantitative study could be conducted to examine the motivations, concerns, and social contexts that shape the decisions of unvaccinated individuals. Additionally, qualitative research could explore the impact of vaccine hesitancy on social relationships, providing insights into how these decisions affect interpersonal dynamics and community cohesion. The roles of social media and online communities in shaping perceptions and attitudes toward vaccination warrant further investigation, as these platforms play a significant role in influencing public opinion. Research could also delve into how community structures and cultural factors contribute to vaccine hesitancy, shedding light on localized influences that affect decision-making. Finally, replicating this study in different locations with a broader and more diverse participant base could provide comparative insights and deepen understanding of vaccine hesitancy across varying contexts.

Edelweiss Applied Science and Technology
ISSN: 2576-8484
Vol. 9, No. 2: 1133-1146, 2025
DOI: 10.55214/25768484.v9i2.4696

5.3. Limitations

This study has several limitations that should be considered when interpreting the findings. First, the sample size was limited to six participants, which, while appropriate for a phenomenological approach, may not capture the full diversity of experiences and perspectives of unvaccinated individuals in broader populations. Second, the study focused solely on individuals residing in rural and urban communities within the Northern Province of Negros Occidental, limiting the generalizability of the findings to other geographic locations or cultural contexts. Third, the reliance on self-reported data during in-depth interviews may introduce biases such as social desirability or recall bias, potentially affecting the accuracy of the accounts shared by participants. Lastly, the study focused on the perspectives of unvaccinated individuals and did not include viewpoints from healthcare providers or vaccinated individuals, which could provide additional insights into the dynamics of vaccine hesitancy.

Funding:
This study received no specific financial support.

Institutional Review Board Statement:
The study was conducted in accordance with the Declaration of Helsinki. Study protocols were evaluated and approved by the panel of evaluators of the University of St. La Salle Graduate Program.

Transparency:
The authors confirm that the manuscript is an honest, accurate and transparent account of the study that no vital features of the study have been omitted and that any discrepancies from the study as planned have been explained. This study followed all ethical practices during writing.

Competing Interests:
The authors declare that they have no competing interests.

Authors' Contributions:
Conceptualization, A.G.S. and S.M.T.; methodology, A.G.S. and S.M.T.; software, G.S.C.; validation, A.G.S., S.M.T. and G.S.C.; formal analysis, A.G.S.; investigation, A.G.S., S.M.T. and G.S.C.; resources, A.G.S., S.M.T. and G.S.C.; data curation, A.G.S.; writing—original draft preparation, A.G.S.; writing—review and editing, A.G.S., S.M.T. and G.S.C.; visualization, G.S.C.; supervision, S.M.T.; project administration, A.G.S. and S.M.T.; funding acquisition, A.G.S., S.M.T. and G.S.C. All authors have read and agreed to the published version of the manuscript.

Acknowledgments: The authors would like to express their sincere gratitude to the reviewers for their invaluable feedback and constructive insights, which significantly improved the quality of this work. The authors would also like to extend their heartfelt thanks to the unvaccinated individuals who participated in this study. Their willingness to share their personal experiences and perspectives made this research possible. The authors deeply appreciate their trust, openness, and courage in contributing to this important discussion on vaccine hesitancy.

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