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A Phenomenological Study to Explore the Lived Experience of Parents Accessing Online Immunization Information in Selected Villages of Tripura

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Abstract

Background: Childhood immunization is a central preventive health intervention, yet parents make vaccination-related decisions within a complex information environment that includes health professionals, family members, community networks and digital media. Online platforms such as WhatsApp, Facebook, YouTube, websites, blogs and mobile health applications can make information readily accessible, but they may also circulate incomplete, contradictory or misleading claims. In rural settings, access to information does not necessarily ensure that information is understandable, culturally relevant or trustworthy.

Aim: To explore the lived experiences of parents in selected villages of Tripura who access online information about childhood immunization, with particular attention to how they interpret, evaluate and use such information in making decisions for children aged 0–5 years.

Methods: A qualitative phenomenological design is proposed. Biological parents or primary caregivers responsible for immunization decisions for children aged 0–5 years will be recruited purposively from selected villages of Tripura. Participants should have experience of accessing online immunization information. Data will be generated through one in-depth, semi-structured interview with each participant, conducted in a language in which the participant is comfortable. With consent, interviews will be audio-recorded and transcribed verbatim; otherwise, detailed field notes will be prepared. Analysis will follow a systematic phenomenological procedure, supported by iterative coding, clustering of meaning units and development of an integrated description of the experience.

Expected contribution: The study is designed to illuminate how parents experience online immunization information in everyday family and community contexts; what makes a source credible; how digital literacy, language and emotional responses shape interpretation; and how online

information interacts with advice from frontline health workers and family members. No empirical findings are reported in this manuscript because primary interview data were not included in the supplied materials.

Keywords

Childhood Immunization; Lived Experience; Phenomenology; Online Health Information; Parents; Digital Health Literacy; Vaccine Confidence; Rural Tripura; Qualitative Research.

1. Introduction

1.1 Background

The first five years of life are a critical period for physical growth, cognitive development, emotional well-being and social development. During this period, children depend substantially on parents and caregivers for preventive healthcare, including timely immunization. Vaccines stimulate the immune system to recognise and respond to specific infectious agents. At the individual level, immunization reduces the risk of vaccine-preventable illness; at the community level, high vaccination coverage can reduce transmission and provide indirect protection to people who cannot receive particular vaccines for medical reasons.

India's Universal Immunization Programme (UIP) is a major public health initiative intended to protect children and pregnant women against vaccine-preventable diseases. Its implementation depends not only on vaccine supply and service delivery but also on parents' awareness, confidence, practical ability to attend sessions and communication with health personnel. The supplied introductory chapter highlights the contribution of frontline workers, including Accredited Social Health Activists (ASHAs), outreach activities and community awareness initiatives. It also recognises continuing challenges such as geographical barriers, cold-chain requirements, incomplete information and vaccine hesitancy.

Parents' decisions about childhood immunization are not formed in isolation. They may be influenced by their knowledge of the vaccination schedule, prior experiences, perceptions of vaccine benefits and possible adverse effects, family advice, community norms, education, socioeconomic circumstances and the accessibility of health services. A parent may support immunization in principle while remaining uncertain about the timing of a particular dose, the meaning of a reported side effect or the reliability of a message received through a social network. Such uncertainty makes the information environment an important part of the immunization experience.

1.2 The changing online information environment

The expansion of internet-enabled mobile communication has changed how parents seek and exchange health information. Online platforms offer immediate access to vaccine schedules, explanations of vaccine-preventable diseases, information about eligibility and side effects, personal accounts and discussions with other parents. Parents may search independently, watch short videos, read health websites, receive forwarded WhatsApp messages or ask questions in online groups. These activities can complement counselling provided by health workers, particularly when parents cannot immediately reach a health facility or wish to revisit information after a consultation.

The same information environment can also create uncertainty. Search results and social media feeds may place official guidance beside personal opinion, commercial content or unsupported claims. Emotional stories can be memorable and persuasive, even when they do not represent reliable evidence. A parent who encounters an alarming post may experience fear, seek reassurance from relatives, consult a health worker, search for further information or temporarily question a planned vaccination. Another parent may find an explanatory video helpful and feel more confident about attending an immunization session. The meaning of online information therefore depends on how it is encountered and interpreted, not merely on whether a parent has internet access.

For rural parents, the distinction between access and meaningful use is particularly important. A smartphone or internet connection does not guarantee the ability to identify an authoritative source, interpret medical terminology, compare conflicting claims or apply general information to a child's circumstances. Language, literacy, digital skills, network quality, cost of data and the availability of trusted health professionals may all shape the experience. Short videos, familiar languages and clear visual explanations may be more accessible than lengthy technical text.

1.3 Rationale for a phenomenological inquiry

Much of the literature summarised in the supplied review uses cross-sectional surveys, structured questionnaires or mixed-method designs to examine parental knowledge, attitudes, vaccine confidence and immunization practices. Such studies are useful for identifying patterns and associations. However, numerical measures alone may not explain how parents experience the process of searching for information, what they feel when they encounter conflicting claims, how they decide whom to trust or how digital information becomes part of family discussions.

A phenomenological approach is appropriate because the central concern is the meaning of an experience as described by the people who have lived it. Rather than measuring the frequency of internet use or estimating a causal effect, this study seeks to understand how parents experience accessing online immunization information in their everyday lives. It will attend to the sequence of

events, feelings, interpretations, relationships and practical decisions that parents describe. The approach is especially relevant where the same online message may be reassuring to one parent and confusing or alarming to another.

1.4 Statement of the problem

Parents in selected villages of Tripura may use online platforms to obtain information about childhood immunization, yet the ways in which they experience, interpret and use that information are not adequately understood from the materials available for this study. Online information may increase awareness and reassurance, but it may also produce confusion when content is contradictory, emotionally charged, difficult to understand or inconsistent with advice received from health workers. There is a need to explore parents' lived experiences of accessing online immunization information and to understand how these experiences enter their decision-making for children aged 0–5 years.

1.5 Aim and objectives

Aim: To explore the lived experience of parents accessing online immunization information in selected villages of Tripura.

The specific objectives are:

1. To explore parents' perceptions and attitudes towards immunization information found on online platforms.
2. To understand how parents describe the influence of online platforms on their decision-making regarding childhood immunization.

1.6 Research questions

1. How do parents in selected villages of Tripura describe their experiences of seeking and accessing online information about childhood immunization?
2. What features of online information influence parents' perceptions of its credibility, relevance and usefulness?
3. How do parents experience and respond to helpful, confusing, contradictory or alarming online immunization content?
4. How do parents reconcile online information with advice from health workers, family members and community networks?
5. In what ways, if any, do parents describe online information as influencing their questions, confidence, plans or actions concerning their child's immunization?

2. Review of Literature

2.1 Parental knowledge, attitudes and immunization practices

The supplied literature review describes studies from Delhi, Jaipur, rural Assam, Maharashtra, Kerala, Punjab, Rajasthan, West Bengal, Varanasi, Bangalore and other settings. Across these studies, a recurring pattern is that favourable attitudes towards immunization may coexist with incomplete knowledge of schedules, uncertainty about vaccine-preventable diseases and misconceptions about possible adverse effects. For example, the reviewed studies from Delhi and rural Punjab report gaps in schedule awareness despite generally positive attitudes. Research summaries from Jaipur and Maharashtra also point to relationships between parental education and knowledge or timely immunization.

These findings suggest that vaccine acceptance should not be treated as a single, uncomplicated attitude. Parents may believe vaccines are beneficial but still have questions about the number and timing of doses, the reason for booster doses, simultaneous administration or the management of post-vaccination symptoms. The literature also identifies practical barriers such as travel, waiting time, work responsibilities, service availability and the absence of reminder systems. Consequently, a parent's reported decision is shaped by both information and the conditions under which immunization services are accessed.

The review further notes the importance of antenatal and postnatal counselling, community health workers and communication at the point of service. Studies described from rural and tribal communities identify fear of side effects, cultural beliefs and limited access to understandable information as concerns requiring locally responsive health education. These findings are relevant to Tripura because they indicate that parental understanding is embedded in social and service contexts rather than determined by formal education alone.

2.2 Online information as a source of awareness and reassurance

The second group of studies in the supplied review examines online information and parental decision-making. The reviewed work describes parents using government health portals, professional websites, social media pages, online videos, parenting blogs and mobile applications. When information is credible, clear and accessible, it may improve awareness of vaccine benefits, schedules and safety. Expert-led videos, visual explanations, interactive question-and-answer formats and reminders are described as potentially useful forms of communication.

Online communities may also provide emotional reassurance. Parents can compare experiences, ask questions and receive support from people who have faced similar concerns. Peer narratives can make immunization feel like a familiar and socially supported practice. The literature synthesis suggests that online communication is not only the transfer of facts; it can also provide affirmation, belonging

and an opportunity to express anxiety. For phenomenological inquiry, this means that participants should be invited to describe not only what they read or watched but also how the interaction made them feel and what meaning they attached to it.

2.3 Misinformation, contradictory messages and vaccine hesitancy

The supplied review also identifies the potential harms of unverified or vaccine-critical online content. Forwarded messages, anecdotal claims, conspiracy narratives and emotionally intense posts may amplify perceived risk or distrust. Research discussed in the review, including work on vaccine-critical websites and social media exposure, indicates that online environments can influence risk perceptions and public attitudes. However, the literature does not justify assuming that every parent exposed to negative content becomes hesitant, or that all social media content is misleading.

A more nuanced understanding is required. A parent may encounter both reliable and unreliable material on the same platform. The parent may accept one message, reject another, or seek confirmation from a health worker. Some parents may not regard a forwarded message as authoritative but may still feel unsettled by it. Others may find personal accounts more understandable than technical explanations. The proposed interviews will therefore explore concrete experiences and the reasoning participants describe, without presuming that online exposure has a uniformly positive or negative effect.

2.4 Digital health literacy, trust and language

Digital health literacy concerns the ability to locate, understand, assess and use online health information. The supplied review links digital literacy with vaccine confidence and highlights the difficulty some rural parents may experience when online content uses unfamiliar medical language. Access to a device is therefore only one part of digital inclusion. Parents also need opportunities to judge the source, interpret the message and determine whether it is relevant to their child.

Trust is similarly layered. Parents may trust government health information because of its institutional authority, a doctor because of professional expertise, a frontline worker because of an ongoing relationship, or another parent because of shared experience. These forms of trust can reinforce one another, but they can also conflict. A parent may receive an alarming online message and then ask a relative, ASHA worker, nurse or doctor to explain it. The study will examine how participants rank and reconcile these sources rather than assuming that one source always dominates.

2.5 Synthesis and research gap

Taken together, the reviewed literature identifies parental knowledge, perceived benefits and barriers, education, social norms, prior experiences, online exposure, digital literacy, trust and access to health services as interrelated influences on immunization-related decisions. Yet the lived process through which parents in selected villages of Tripura encounter, interpret and use online immunization information remains the central question for this study. A phenomenological investigation can contribute contextual detail about preferred platforms and languages, the credibility cues parents use, the emotional meanings attached to online content and the ways online information interacts with frontline health advice.

The gap is therefore not simply a lack of information about whether parents use the internet. It is a lack of sufficiently detailed understanding of what the experience means to parents: how they begin searching, what they notice, how they judge information, whom they consult, how uncertainty is managed and whether the experience changes a question, intention or reported action. The study addresses this gap through one in-depth interview with each participant, consistent with the delimitation described in the supplied introductory chapter.

3. Conceptual Orientation

The study will use a sensitising conceptual orientation rather than a causal model. Online immunization information is understood as entering a wider family, community and health-service environment. The parent's experience is shaped by the source and format of the content, its perceived credibility, language and clarity, the parent's digital health literacy, prior beliefs and experiences, emotional response, family and peer discussion, and access to trusted health workers.

Information environment	**Interpretive experience**	**Possible decision-related responses**
Online sources: government/health websites, social media, videos, blogs, forums, apps and forwarded messages	Credibility appraisal; digital literacy; language and comprehension; emotional response; prior beliefs; peer/family discussion; health-worker advice	Greater awareness or confidence; further information-seeking; clarification from a professional; continued uncertainty; altered plans; delay or refusal; or no perceived change
Contextual conditions: education, socioeconomic circumstances, culture, internet/device access and	These conditions shape access, interpretation, trust and the practical ability to act	Reported decisions remain situated within family responsibilities and service availability

local immunization services		

This orientation guides the interview domains and interpretation. It does not assume that exposure causes a particular decision. It allows the analysis to remain open to positive, negative, mixed or negligible influence as described by participants.

4. Methodology

4.1 Research design

A qualitative phenomenological design will be employed to explore the lived experiences of parents accessing online immunization information. Phenomenology is concerned with how a phenomenon is experienced and made meaningful by individuals. In this study, the phenomenon is the experience of seeking, encountering, interpreting and using online information about childhood immunization. The design is appropriate because the research questions focus on participants' accounts, feelings, interpretations and meanings rather than on estimating prevalence or testing causal relationships.

The study should specify in the final approved protocol whether it adopts a descriptive (transcendental) or interpretive (hermeneutic) phenomenological tradition. For consistency with the emphasis on describing participants' experiences, the present draft recommends a descriptive phenomenological orientation. The researcher should maintain reflexive awareness of personal assumptions about vaccination, digital media and parental decision-making, and should avoid imposing those assumptions on participants' accounts.

4.2 Study setting

The study will be conducted in selected villages of Tripura, India. The supplied introductory chapter does not identify the names of the villages, districts or administrative blocks. These details must be inserted after confirmation of the actual study sites. The final paper should briefly describe the relevant rural context, including access to mobile networks, common languages, health facilities and immunization services, using verified local information rather than assumptions.

4.3 Study population

The target population will comprise biological mothers, biological fathers or primary caregivers who are responsible for immunization-related decisions for a child aged 0–5 years and reside in one of the selected villages. The focus on parents and primary caregivers follows the operational definition in the supplied introductory chapter.

4.4 Inclusion and exclusion criteria

Proposed inclusion criteria:

- A biological parent or primary caregiver of at least one child aged 0–5 years.
- Residence in one of the selected villages of Tripura.
- Responsibility for, or meaningful involvement in, the child's immunization-related decisions.
- Personal experience of accessing online information related to childhood immunization, whether through a smartphone, another person's device or a shared digital account.
- Willingness and ability to provide informed consent and participate in one interview.
- Proposed exclusion criteria:
- Individuals who are not involved in the child's immunization-related decisions.
- Individuals unable to provide informed consent.
- Individuals who have no experience of accessing or receiving online immunization information, if the study retains its specific focus on online information access.

4.5 Sampling technique and sample size

Purposive sampling is recommended because participants must have direct experience of the phenomenon. Recruitment should seek variation in parents' age, gender, educational background, occupation, village, preferred language, internet access and frequency or mode of online information use. This variation may help the researcher understand different forms of experience without treating the sample as statistically representative.

The supplied chapters do not specify a sample size. A fixed number should therefore not be invented in the manuscript. The researcher should determine the final sample in accordance with the depth and richness of interviews, the diversity of experiences sought, feasibility and the adequacy of the information collected. The rationale should be documented transparently. Recruitment may stop when the research team judges that the interviews provide sufficient depth to address the research questions and further interviews are no longer adding meaningful dimensions to the account; the chosen stopping principle should be stated in the approved protocol.

4.6 Data collection procedure

Data will be collected through one individual semi-structured, in-depth interview with each participant, reflecting the one-session delimitation in the supplied introductory chapter. Before the interview, the researcher will explain the purpose of the study, voluntary nature of participation, confidentiality arrangements, audio-recording procedure and right to withdraw. Written informed

consent will be obtained. Interviews will be conducted in a language selected by the participant and in a private, convenient location where the participant can speak freely.

The interviewer will use open-ended questions and neutral probes. Participants will be encouraged to describe specific occasions when they searched for, received or discussed online immunization information. Questions should avoid suggesting that online information is necessarily beneficial or harmful. The interviewer may ask what happened next, what the participant thought or felt, how the source was judged, whom the participant consulted and whether any decision or plan changed. With permission, interviews will be audio-recorded. If recording is declined, detailed notes will be taken. Field notes should document relevant contextual observations and the researcher's immediate reflections without substituting interpretation for participants' words.

4.7 Proposed semi-structured interview guide

1. Can you tell me about the last time you looked for or received information online about your child's immunization?
2. Which online platforms or digital sources have you used for immunization information, and how did you come across them?
3. What were you hoping to find when you searched for this information?
4. Can you describe an online message, video or post that you found especially useful? What made it useful to you?
5. Have you ever encountered information about vaccines online that confused or worried you? Please describe what happened.
6. How do you decide whether an online source or message is trustworthy?
7. How easy or difficult is it for you to understand the language, medical terms, images or explanations used in online immunization information?
8. Do you discuss online information with family members, other parents, ASHA workers, nurses or doctors? How do those conversations affect your understanding?
9. Can you describe a time when online information led you to ask a health worker a question or seek further clarification?
10. Has online information ever influenced how you planned for, attended, postponed or considered an immunization visit? Please explain in your own words.
11. What kind of online information or support would make immunization information easier for parents in your village to understand and use?

The interviewer may use probes such as “What did that mean to you?”, “How did you feel at that moment?”, “What happened afterwards?” and “Can you give me an example?” Probes should clarify experience without directing the participant towards a preferred answer.

4.8 Data management and transcription

Audio files and transcripts will be assigned participant codes and stored securely. Names, phone numbers, village-level identifiers that could reveal an individual and other direct identifier will be removed from transcripts. Interviews conducted in a local language should be transcribed in the original language before translation. Where quotations are translated into English, the researcher should check the translation against the original recording or transcript to preserve meaning, tone and context. A record of translation decisions should be maintained.

4.9 Data analysis

A descriptive phenomenological analysis is recommended. The researcher should work closely with the complete interview accounts and move from individual descriptions towards a synthesis of the shared structure of the experience. A transparent sequence may include the following steps:

1. Read each transcript repeatedly to gain an overall sense of the participant’s account.
2. Identify significant statements that directly relate to the experience of accessing online immunization information.
3. Formulate meanings from these statements while remaining close to participants’ descriptions and avoiding premature theoretical interpretation.
4. Cluster related meanings into themes or theme components, noting similarities, differences and contradictory experiences.
5. Develop an exhaustive description of the phenomenon using the themes and supporting evidence from the transcripts.
6. Condense the description into a fundamental structure that captures the essential features of the experience while preserving variation among participants.
7. Return to the transcripts and, where feasible, invite participant feedback on the clarity of the account or discuss interpretations with a qualitative research supervisor or peer.

The analysis should preserve negative cases and divergent accounts. For example, some parents may report that online information strengthened confidence, others may describe confusion, and others may report no meaningful influence. These differences are analytically important. The final report should distinguish participant statements from researcher interpretation and support each reported theme with carefully selected, anonymised verbatim quotations.

4.10 Trustworthiness and rigour

The study should address credibility, dependability, confirmability and transferability. Credibility can be strengthened through careful interviewing, adequate engagement with each account, use of verbatim quotations and, where feasible, participant feedback on summaries. Dependability requires a clear audit trail documenting recruitment, interview procedures, transcription, coding decisions and theme development. Confirmability can be supported through reflexive notes, discussion of interpretations with a supervisor or peer and explicit separation of data from assumptions. Transferability can be enhanced by providing a sufficiently detailed description of the setting, participant characteristics and context, while protecting confidentiality.

The researcher should maintain a reflexive journal throughout the study. It should record prior beliefs about vaccines and online media, expectations about what parents may say, emotional responses during interviews and decisions made during analysis. Reflexivity is not an attempt to remove the researcher from the research process; it makes the researcher's influence visible and open to scrutiny.

4.11 Ethical considerations

Ethical approval must be obtained from the relevant institutional ethics committee before recruitment or data collection. Participants should receive clear information about the study's purpose, procedures, possible discomforts, confidentiality and voluntary nature. They should be free to decline any question or withdraw without penalty. Written informed consent should be obtained, including separate consent for audio-recording.

Because the study concerns children's health, participants may share sensitive family or medical information. The interviewer should avoid collecting unnecessary identifiers and should not provide individual medical advice. Questions about vaccine schedules, contraindications or adverse effects should be referred to qualified health professionals and official health services. Data should be stored in password-protected or otherwise secure systems accessible only to the research team. Any quotations used in publication must be anonymised so that participants cannot reasonably be identified.

5. Proposed Analytical Domains and Results Presentation

No interview transcripts or completed fieldwork findings were included in the two source chapters used for this manuscript. It would therefore be methodologically inappropriate to present themes as if they had emerged from actual participants. The following domains are sensitising areas for analysis, not findings, predictions or tested propositions. The final Results section must be written only after the interviews have been conducted and analysed.

5.1 Encountering online information in everyday parenting

The analysis may examine the circumstances in which parents first seek or receive online information: a child's upcoming immunization appointment, a question about a vaccine, a reported symptom, a discussion with another parent or a forwarded message. Participants' accounts may illuminate whether information-seeking is planned or incidental, individual or shared, and prompted by curiosity, uncertainty or concern. The researcher should retain the specific sequence described by each participant rather than compressing all online use into a single category.

5.2 Judging credibility and negotiating trust

A second domain concerns the cues parents use to decide whether information is credible. These may include the identity of the author, institutional affiliation, professional credentials, references to official guidance, consistency with a health worker's advice, presentation style or recommendations from people known to the parent. The analysis should identify how parents explain their judgements and what they do when sources disagree. It should not assume that a source is trusted simply because it is official or rejected simply because it is social media.

5.3 Emotional responses to information

The interviews should attend to feelings such as reassurance, confidence, fear, confusion, doubt, urgency or frustration, where participants themselves describe them. The emotional quality of online content may influence whether a parent continues searching, discusses the message with someone else or seeks professional clarification. The analysis should distinguish a participant's immediate emotional response from any subsequent decision or behaviour.

5.4 Language, comprehension and digital capability

Parents may describe differences between technical text, short videos, images, voice messages and explanations in familiar languages. The analysis should explore whether content is easy to find, understand and apply; whether data costs or network access limit use; and whether parents rely on another person to search, translate or explain information. These accounts can help identify practical features of more inclusive digital health communication.

5.5 Interaction with family, community and health workers

Online information may become part of conversations with spouses, elders, relatives, neighbours, other parents and frontline health workers. The study should examine how these conversations validate, challenge or reinterpret what was found online. Particular attention should be paid to the

role of ASHA workers, nurses and doctors as sources of clarification, while allowing participants to describe any tensions or differences between professional advice and online content.

5.6 Perceived influence on immunization-related decisions

Participants may describe online information as having strengthened confidence, prompted a question, encouraged further checking, altered a plan, contributed to delay or made no difference. The analysis should use participants' own descriptions and avoid attributing a causal effect to online information where the account indicates several interacting influences. Practical constraints, including service availability and family responsibilities, should be considered alongside informational influences.

5.7 Recommended structure for reporting actual themes

After analysis, each final theme should include: (a) a concise theme name; (b) an analytic explanation of the shared meaning; (c) subthemes where necessary; (d) two or more well-chosen anonymised quotations where the data support them; (e) attention to variation or contradictory cases; and (f) a short link to the research question and relevant literature. Do not insert illustrative quotations invented by the researcher or use literature statements as substitutes for participant evidence.

6. Discussion

The proposed study is grounded in the understanding that parental immunization decisions occur within an information ecosystem. The literature supplied for this paper suggests that positive attitudes do not always correspond to complete knowledge or timely practice. Parents may value vaccination while remaining uncertain about schedules, side effects or the meaning of online claims. This distinction supports a phenomenological focus on the lived process of understanding and deciding, rather than treating parental attitude as a fixed characteristic.

The reviewed literature also indicates that online platforms can provide both informational and relational resources. Credible health content may make technical information more accessible, while peer groups may offer reassurance and shared experience. At the same time, unverified content and emotionally charged narratives may heighten perceived risk or generate confusion. A phenomenological account can help explain why similar content is experienced differently by different parents and how online messages are interpreted in relation to prior beliefs and trusted relationships.

The role of frontline health workers is particularly important in the context described by the supplied chapters. Online information need not replace interpersonal communication. It may prompt parents

to ask questions during immunization visits or provide a topic for discussion with an ASHA worker, nurse or doctor. Conversely, where parents cannot obtain timely clarification, contradictory information may remain unresolved. The study can therefore contribute to understanding how digital and community-based communication intersect in rural immunization settings.

The study's contribution will depend on the quality and depth of its fieldwork. It should not claim that online platforms increase or reduce immunization coverage unless the design and data support such a conclusion. A phenomenological study can illuminate perceived influence, meanings and decision pathways; it cannot by itself establish population-level causal effects. Its value lies in producing a contextual account that can inform communication design, frontline counselling and future research.

7. Implications

7.1 Nursing and community health practice

Nurses and frontline health workers may benefit from routinely asking parents where they obtain vaccine information and whether they have encountered messages that are confusing or worrying. A non-judgemental invitation to discuss online content can help identify concerns that might otherwise remain unspoken. Health workers should respond respectfully, clarify misinformation using understandable language and direct parents towards reliable sources. The study may also inform the development of brief counselling prompts that address common questions without dismissing parents' concerns.

7.2 Digital health communication

Public health communication should prioritise accuracy, clarity, language accessibility and cultural relevance. Short videos, simple visual explanations, local-language materials and question-and-answer formats may help parents engage with information. Official content should clearly identify its source, date and intended audience. Digital material should also explain where parents can obtain individual clinical advice, since general online information cannot replace assessment by a qualified professional.

7.3 Policy and programme planning

Programme planners may use the eventual findings to identify gaps in local-language resources, trusted communication channels and opportunities for collaboration between digital platforms and community health workers. The findings may support community-level digital health literacy initiatives that teach parents how to check the source of a message, recognise unsupported claims and

seek clarification. Such interventions should complement, not substitute for, accessible immunization services.

7.4 Research and education

The study may provide a foundation for subsequent research comparing experiences across different rural settings, languages or levels of digital access. Future studies could combine qualitative findings with quantitative measures of digital health literacy, service access and immunization timeliness. Any such extension should preserve the distinction between understanding lived experience and estimating statistical associations.

8. Limitations

The study is geographically limited to selected villages of Tripura and is not intended to produce statistically generalisable estimates. Purposive recruitment may under-represent parents who are less connected to digital networks or who are reluctant to discuss vaccine concerns. Reliance on one interview session may limit opportunities to clarify accounts over time. Participants may also have difficulty recalling the details of past online encounters, and social desirability may influence how they describe their decisions. Translation between local languages and English may result in loss of nuance if not carefully checked.

The manuscript at this stage has an additional limitation: it is based on the supplied introductory and literature review chapters and does not contain primary interview data. Therefore, it cannot report actual participant characteristics, themes, quotations or conclusions about what parents in the selected villages experienced. These elements must be completed after approved fieldwork.

9. Conclusion

Parents' experiences of online immunization information are likely to be shaped by more than the availability of a smartphone or internet connection. The meaning of online content depends on its credibility, clarity, language, emotional tone and relevance, as well as parents' digital health literacy, prior beliefs, family discussions and access to trusted health professionals. The supplied literature supports the need to understand both the supportive and potentially confusing dimensions of online information without assuming that its influence is uniformly positive or negative.

A phenomenological study in selected villages of Tripura can provide an in-depth account of how parents encounter, interpret and use online immunization information in everyday life. By using one semi-structured interview per participant, purposive sampling and a transparent phenomenological analysis, the study can generate context-sensitive insights for nursing practice, community health

communication and digital health programme design. The final empirical conclusions must, however, be based on actual interview data and supported by anonymised participant quotations.

Declaration Of Data Status

No primary data were supplied for the preparation of this manuscript. No sample size, participant demographics, interview dates, field observations, themes or participant quotations have been fabricated. The methodological details in this paper are proposed procedures based on the objectives and delimitations in the supplied Chapter I and the research needs identified in the supplied Chapter II. They should be aligned with the institutionally approved protocol before field implementation.

References

1. Ashkenazi, S., Livni, G., Klein, A., Kremer, N., Havlin, A., & Berkowitz, O. (2020). The relationship between parental source of information and knowledge about measles/measles vaccine and vaccine hesitancy. Vaccine, 38(46), 7292–7298. https://doi.org/10.1016/j.vaccine.2020.09.044
2. Betsch, C., Renkewitz, F., Betsch, T., & Ulshöfer, C. (2010). The influence of vaccine-critical websites on perceiving vaccination risks. Journal of Health Psychology, 15(3), 446–455. https://doi.org/10.1177/1359105309353647
3. Borràs, E., Domínguez, À., Fuentes, M., Batalla, J., Cardeñosa, N., & Plasencia, A. (2009). Parental knowledge of pediatric vaccination. BMC Public Health, 9, Article 154. https://doi.org/10.1186/1471-2458-9-154
4. Brunson, E. K. (2013). The impact of social networks on parents' vaccination decisions. Pediatrics, 131(5), e1397–e1404. https://doi.org/10.1542/peds.2012-2452
5. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
6. Dubé, E., Gagnon, D., & MacDonald, N. E. (2015). Strategies intended to address vaccine hesitancy: Review of published reviews. Vaccine, 33(34), 4191–4203.
7. Moustakas, C. (1994). Phenomenological research methods. SAGE Publications.
8. Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. SAGE Publications.
9. Smailhodzic, E., Hooijsma, W., Boonstra, A., & Langley, D. J. (2016). Social media use in healthcare: A systematic review of effects on patients and health professionals. BMC Health Services Research, 16, Article 442. https://doi.org/10.1186/s12913-016-1692-7
10. Wilson, S. L., & Wiysonge, C. (2020). Social media and vaccine hesitancy. BMJ Global Health, 5(10), e004206. https://doi.org/10.1136/bmjgh-2020-004206

11. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357. https://doi.org/10.1093/intqhc/mzm042
12. Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp. 48–71). Oxford University Press.