ULUSLARARASI SOSYAL ARAŞTIRMALAR DERGİSİ
THE JOURNAL OF INTERNATIONAL SOCIAL RESEARCH

Uluslararası Sosyal Araştırmalar Dergisi/The Journal of International Social Research
Cilt: 16 Sayı: 99 Nisan 2023 & Volume: 16 Issue: 99 April 2023
Received: April 03, 2023, Manuscript No. jisr-23-96948; Editor assigned: April 06, 2023, PreQC No. jisr-23-96948 (PQ); Reviewed: April 20, 2023, QC No. jisr-23-96948; Revised: April 24, 2023, Manuscript No. jisr-23-96948 (R); Published: April 28, 2023, DOI: 10.17719/jisr.2023.96948
www.sosyalarastirmalar.com ISSN: 1307-9581

Socioeconomic Status and Perceived Threat: Factors Contributing to Vaccine Hesitancy during the COVID-19 Pandemic

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Abstract

The COVID-19 pandemic has had a significant impact on public health, economies, and societies around the world. The emergence of vaccines has been a significant milestone in the fight against the pandemic, but vaccine hesitancy remains a concern for many countries. In recent months, researchers have been exploring the factors that contribute to vaccine hesitancy, including socioeconomic status, perceived threat, and healthism.

Socioeconomic status refers to a person's position in society, determined by factors such as income, education, and occupation. Several studies have found that individuals with lower socioeconomic status are more likely to be vaccine hesitant. This may be due to a lack of trust in the healthcare system, limited access to healthcare services, or a lack of information about vaccines.

Keywords: COVID-19 pandemic, Vaccine Hesitancy, Socioeconomic Status, healthism.

Introduction

Perceived threat is another factor that contributes to vaccine hesitancy. People who perceive the threat of COVID-19 as low may be less likely to get vaccinated. This may be due to a lack of understanding of the

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severity of the disease, misinformation, or conspiracy theories. On the other hand, those who perceive the threat of the disease as high may be more likely to get vaccinated.

Healthism is a concept that describes the belief that individuals are responsible for their health outcomes and that healthy lifestyles are a moral imperative. This belief can contribute to vaccine hesitancy because some individuals may feel that they do not need to get vaccinated because they believe that their healthy lifestyles will protect them from the disease. This belief can also lead to stigmatization of those who do not conform to certain health behaviors.

The intersection of these three factors - socioeconomic status, perceived threat, and healthism - can significantly impact vaccine hesitancy. For example, individuals who belong to low socioeconomic groups may have limited access to accurate information about vaccines, which can lead to higher levels of perceived threat and hesitancy. Additionally, healthism can lead to stigmatization of those who do not conform to certain health behaviors, which can exacerbate vaccine hesitancy. Addressing vaccine hesitancy requires a multifaceted approach. First, healthcare professionals and policymakers must work to provide accurate information about vaccines to all communities, including those with lower socioeconomic status. This can include outreach programs, community education efforts, and partnerships with trusted community leaders.

Second, efforts must be made to address healthism and the stigmatization of those who do not conform to certain health behaviors. This can be achieved by promoting a more inclusive and understanding approach to health, recognizing that individuals have different circumstances and experiences that may impact their health outcomes.

Studies have shown substantial between- and within-country variance in vaccine hesitancy, which refers to doubts, concerns and negative attitudes toward vaccines, or rejecting or delaying one's own or a child's vaccine uptake. Studies indicate that lower vaccine uptake, higher vaccine hesitancy and anti-vaccine attitudes are generally linked to lower economic and social resources, including lower income, education, social support, and knowledge and health literacy. For example, higher educational levels have been linked to more positive vaccine attitudes, partly due to increased knowledge and awareness of vaccine benefits gained through education. More highly educated individuals may have fewer difficulties searching for and interpreting information related to immunization and vaccines. At the same time, higher income provides people with better access to healthcare and physician continuity, enabling more effective communication about vaccine safety and efficacy.

On the other hand, the link between education and anti-vaccine attitudes at the aggregate level does not follow the same pattern. Several between-country studies indicate that the public in countries with higher modernization levels—including high economic development and educational levels—increasingly expresses anti-vaccine attitudes and vaccine hesitancy. High socioeconomic development, robust healthcare systems and extensive vaccine coverage have almost eradicated many vaccine-preventable diseases in high-income countries. Paradoxically, this has also decreased the perceived threat of communicable diseases among the public and increased vaccine scepticism.

Coinciding with its high socioeconomic development and strong healthcare system, however, the data for Slovenia show a low uptake of vaccines for several vaccine-preventable diseases, for example, seasonal influenza, rotavirus and human papillomavirus. Low vaccine confidence was also evident during the COVID-19 pandemic, as Slovenia has reached among Europe's lowest COVID-19 vaccine uptakes, with only 58% uptake at the beginning of 2023. Low COVID-19 vaccine uptake may result from the increased general vaccine hesitancy of the Slovenian public compared with populations in other countries.

The macro-level link between higher socioeconomic development and vaccine scepticism is recently also being detected at the individual level. Generally, low-SES groups tend to overestimate various types of risks, e.g., the risk of vaccines, and perceive vaccines to be less safe, resulting, as mentioned, in lower vaccine acceptance among low-SES groups. However, in recent years, studies in several high-income countries have indicated that high-SES individuals, i.e., those with more social, economic and educational resources available to them, are more likely to be vaccine-hesitant. The paradoxical link at the individual level between one's higher resources and vaccine scepticism can be explained by the concept of healthism.

Discussion

The present study analysed the impact of socioeconomic status, healthism and perceived threat on vaccine hesitancy among the Slovenian public. The findings indicate that vaccine hesitancy is more widespread among women, those with higher incomes and those who have lower perceptions of the threat of infectious diseases. In addition, vaccine sceptics were more likely to be those who expressed healthist attitudes-an individualistic approach to their health and higher distrust in the Slovenian healthcare system and medical institutions.

The study findings are broadly consistent with previous research on vaccine hesitancy, attitudes and healthism, in which individuals who expressed healthism, lower perceived threat and higher SES also proved to hold anti-vaccine attitudes. Interestingly, higher income proved to be a significant predictor of

vaccine hesitancy in the present study. Other research shows that more socially privileged individuals are more sceptical and less trusting of medicine, which is one of the characteristics of a risk society and the ideology of healthism. Healthist attitudes may be pervasive within the model of neoliberal parenting, whereby parents see their children as unique and feel they know what is best for their child healthwise, including by seeing unitary immunization programmes as problematic or even dangerous.

Although the present study presents evidence on the importance of healthism and threat perceptions for vaccine attitudes, it has several limitations. Firstly, it was cross-sectional; therefore, causality cannot be ascertained. Secondly, the sample was not representative, so there should be caution with interpreting the results. Thirdly, several potential confounders of vaccine acceptance were not examined, such as social trust, beliefs in conspiracy theories, perceptions of alternative medicine, political attitudes and health status. In addition, only one dimension of perceived threat was examined, as the questionnaire did not include items on the perceived severity of vaccine-preventable diseases. Future research should aim to overcome these limitations.

Conclusion

In conclusion, vaccine hesitancy is a complex issue that is influenced by various factors, including socioeconomic status, perceived threat, and healthism. Addressing these factors requires a comprehensive approach that involves healthcare professionals, policymakers, and public health officials working together to provide accurate information, address healthism and stigmatization, and address the perceived threat of COVID-19. By taking a collaborative approach, we can work towards increasing vaccine uptake and protecting public health during the COVID-19 pandemic and beyond.

In addition, healthcare workers should be particularly attentive to communicable disease risk perceptions when communicating with their patients. High-SES individuals may have previously acquired more (mis)information about vaccines and their potential side effects. Healthcare workers should aim to adapt their communication strategies taking into account the recent trends in increased patient autonomy and the scope of health-related information patients acquire daily. Policymakers should consider these findings when formulating policies and strategies to increase favourable vaccine attitudes among the public. Increasing trust in medical institutions and communicating the perceived risk of communicable diseases might have several positive consequences, including improving the quality of patient–doctor communication and increasing patients' positive vaccine attitudes.

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