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RESEARCH ARTICLE

Looking at Covid-19 vaccine hesitancy through a macro perspective. A comparative study of Italy, Poland and Portugal

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ABSTRACT: This article aims to overcome the most common interpretive paradigms on vaccine hesitancy and refusal when are limited to consider the individual or group level and provide a contextual reading. For the purpose of this study, cultural, economic and political conditions are considered constituent materials of "thinking" and "doing" in everyday life and of "problematizing" the issue of vaccines in the Covid-19 era. By adopting an analytical model derived from Sewell's pattern of contextualized structures (as a result of *schemas* and *resources*), the article compares three exemplary cases: Portugal, the country with the highest rate of Covid-19 vaccination; Italy, one of the most vaccine-hesitant western countries in Europe; and Poland, which with its vaccination rate well exemplifies vaccine-hesitant post-socialist CEE countries. By combining the *schemas* and *resources*, this study gives a social map with types of context-driven structures and offers an initial interpretative key useful to understanding the complexity of problem framing and structuring in the Covid-19 pandemic era in different sociocultural and political contexts.

KEYWORDS: Covid-19 vaccination, Italy, Poland, Portugal, Vaccination hesitancy

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1. Introduction: From individual to "country" determinants of vaccine hesitancy

Since its statement with the WHO SAGE Vaccine Hesitancy Working Group in 2011, vaccine hesitancy has been increasingly emphasised in the literature and has thus been employed to refer to parental attitudes and behaviours from full to partial nonvaccination positions. Among the main factors of vaccine hesitancy, problems of confidence (do not trust vaccine or provider), complacency (do not perceive a need for a vaccine; do not value vaccination), and convenience (access to vaccines) were taken into consideration (WHO 2014). The WHO also classified factors of vaccine hesitancy into three different categories: contextual influences (due to historical, sociocultural, environmental, institutional, economic or political factors); individual and group influences (e.g., personal beliefs and attitudes about prevention or previous experiences with vaccinations); and vaccine/vaccination-specific issues (e.g., concerns about a new vaccine or formulation or about the mode of administration or delivery) (MacDonald 2015). However, vaccine hesitancy literature and research have mostly focused on individual determinants that influence parental behaviour towards their child's vaccinations. Generally, sociodemographic variables, such as age, gender, educational level, religious beliefs and income levels of parents, have received particular attention (Dubé et al. 2014; Thomson et al. 2016; Díaz Crescitelli et al. 2020). Since vaccine policies have focused primarily on children, research has been mostly concerned with parental attitudes and opinions on vaccinations, although several indirectly involved actors have often contributed to the debate, helping to define different positions of hesitancy toward childhood vaccines (Gobo and Sena 2022).

However, some scholars have also stated that parental vaccine hesitancy could be the result of broader influences, which need to be examined in the historical, political and sociocultural context in which it occurs (Larson et al. 2011; Reich 2016; Blume 2017). Others have studied vaccination policies and hesitancy in relation to twentieth- and twenty-first-century political milestones such as colonial nationalism, decolonisation, the Cold War, economic neoliberalism and geopolitical shifts (Holmberg, Blume and Greenough 2017).

Despite growing literature on vaccine hesitancy, little attention has been given to attitudes towards adult vaccination (e.g., Peretti-Watel et al. 2014; Bricout et al. 2019). This issue has instead emerged as being of great relevance since the global launch of the Covid-19 vaccination campaign at the end of 2020 (Salomoni et al. 2021). It represented a unique case in the history of vaccination policies, since for the first time all countries in the world applied different Covid-19 vaccines to protect the adult population at almost the same time, starting with the older population and health workers that were most affected by Covid-19 in the early stages of the pandemic. Furthermore, until September 2021, vaccination still concerned the entire population aged 12 and over. Several studies have begun to analyse individual and contextual factors in relation to the acceptance or refusal of the Covid-19 vaccine in different categories of adults and in different countries. Much of the work produced has focused on the analysis of vaccine refusal, mostly in specific populations, such as students, elderly people, and healthcare professionals, reporting hesitancy reasons including vaccine side effects, mistrust in both healthcare and in information sources or particular political orientations (e.g., Biswas et al. 2021; Callaghan et al. 2021; Troiano and Nardi 2021).

Some authors have started looking at how Covid-19 vaccine confidence is influenced by political issues based on governments' and political parties' management of pandemic responses (Ward et al. 2020; Sabahelzain, Hartigan-Go and Larso 2021), strong forms of "medical" populism against the Covid-19 vaccine (Lasco 2020; Hornsey et al. 2020; Paul et al. 2021), and vaccine equity, particularly when it plays out as unfair nationalism, reinforcing an underlying distrust in global and national systems (Larson 2020). Wakefield and Khauser (2021) also noticed the important roles played by social context and group memberships in

determining people's thoughts and behaviour, emphasising how the sense of collective responsibility and community identification of a population may increase the willingness to protect others by means of getting vaccinated, whereas a low sense of community and a high sense of individualism can strongly reduce that.

Despite this growing literature, the mainstream paradigm micro perspective, flatting out again the dichotomy between pro-vax and no-vax and neglecting the problematization and complexity of vaccine hesitancy. The significant differences in vaccine confidence or refusal detected at the EU country-level highlight the need to also consider vaccination policies, healthcare systems, political management of pandemic and broader cultural and axiological contexts that affect individual vaccination behaviors and beliefs.

Therefore, this work aims to propose a new interpretative approach to the implementation of the Covid-19 vaccine in different countries that moves beyond the focus on individual attitudes towards vaccination, as in the case of parental hesitancy on childhood vaccinations, to understand "country" or "macro" specific factors that must be considered in order to explain this issue in its contextual complexity.

2. Looking at vaccine hesitancy through a cultural lens

The contribution of this research intends to apply the concept of "problematization" (Foucault 1984), which considers the conditions that make possible the existence of Covid-19 vaccine hesitancy, in a given historical period. In addition to the emergence of certain questions, it also captures the conceivability of certain answers in order to provide an explanation of vaccine attitudes at a macro level. These attitudes are formed as a result of the cultural, political and value differences of a country, the ability to nurture the processes of public thematization of different perspectives, general behaviours and positions on vaccination.

The term problematization does not offer one single correct connotation and does not have to be used in only one way. Problematizations generally refer to the outcomes of the processes of problematizing and always signal a critical intent, which focuses specifically on "problems". Problems are regarded as forms of construction contrary to the current emphasis on problem-solving and evidence-based policy, based on a positivist posture treating "problems" as fixed and readily identifiable (Bacchi 2015). Within this, problematization has different meanings in the different traditions of thought, and there are some specific analytic traditions that have included this concept in their analytical repertoire (Alvesson and Sandberg 2013). This paper does not aim to define the "correct" meaning or the correct use of problematization; rather, the following description intends to situate the present work and to clarify the specific meaning of problematization, which is derived from the mix between the social constructionism and cultural turn perspectives, driving the entire work.

With reference to the first point, social problems are to be considered in terms of what people think they are, what people "think" about them and, more importantly for empirically based social science research, how such thinking is visible in what they do in "action"; this should be the guide to inquiry (Schneider 2018). This concern is evident in both constructivism and social constructionism but within two very different interpretative frameworks that, at a very basic level, can be distinguished with reference to the process of social construction, parallel to the previous distinction between agential (interpretivism) and anti-essentialist (poststructuralism) perspectives (Bacchi 2015). In constructivist approaches, problematizations focus on how policy actors (e.g., policymakers, workers, citizens, etc.) shape problematizations in ongoing policy processes. Problematizations are competing understandings or interpretations of a problem that people put forward (Colebatch, Hoppe and Noordegraaf 2010). In contrast, in social constructionism approaches, problematizations are deeply embedded ways of thinking (conceptual schema) that shape (to different degrees) who we are and how we live. It follows that constructivists are primarily interested in the people engaged in problematizing and the challenges they face in developing shared understandings of a problem, described as a

shared problematization, while social constructionist analysis examines how issues have been problematized in governmental practices to draw attention to the way in which problems are constituted by them (Rose and Miller 1992). In doing this, the social constructionism approach emphasises the extent to which our understandings of the world are the product of different social forces (Burr 2003) and focuses on how subjects are constituted (or formed) within a set of knowledge that shapes understandings of "problems".

Second, interpreting the constructionist statutory, which considers what people do almost inevitably draws upon a set of existing concepts, ideas, plot lines, or other cultural elements in light of the culturalist turn perspective, assumes a very distinctive meaning. In this article, contextualised structures are considered a constituent material of "thinking" and "doing". By doing this, we consider as crucial the cultural turn and Sewell's perspective, which theorizes structures as dual and constituted by mutually sustaining cultural *schemas* and sets of *resources* that empower/ constrain social action and tend to be reproduced by that action (Sewell 2005). With the aim of providing an initial and exploratory way of contextualising nonvaccination practices in different countries, our analysis will adopt Sewell's analytical model, and particularly distinguish between cultural *schemas* and *resources*. The two dimensions will be analysed separately but always taking into regard the duality of the structures' meaning, which considers *schemas* as the effects of *resources* and *resources* as the effects of *schemas* (Ibid.). "Schemas not empowered or regenerated by resources would eventually be abandoned and forgotten, just as resources without cultural schemas to direct their use would eventually dissipate and decay. Sets of schemas and resources may properly be said to constitute structures only when they mutually imply and sustain each other over time" (Ibid.: 137).

Schemas refer to "virtual" assets – "a sort of mental structures" (Ibid.: 146) – which are the fundamental tools of thought, conventions, recipes, scenarios, principles of action, and habits of speech. "To say that schemas are virtual is to say that they cannot be reduced to their existence in any particular practice or any particular location in space and time: they can be actualized in a potentially broad and unpredetermined range of situations" (Ibid.: 131-132). Patterns of *schemas* create a meaning system for a particular cultural group, with cultural *schemas* accounted for as socially shared heuristic representations deployable in automatic cognition. In operational terms, specific considerations concerning the specific country value and cultural characteristics – or *schemas* – will be introduced by providing some general orientations derived from Hofstede's map of (national) culture (Hofstede, Hofstede and Minkov 2010). For this study, we focused on three dimensions derived from Hofstede and collaborators (power distance index; individualism vs. collectivism; and uncertainty avoidance index) as specifically related to vaccine hesitancy. The first one is considered as a proxy for estimating the general preference for a centralised or decentralised power system, the second one is useful for estimating the sense of community or individuality as action orientation and the third one is considered in its link with a preference to look at norms and rules as a shield against uncertainty.

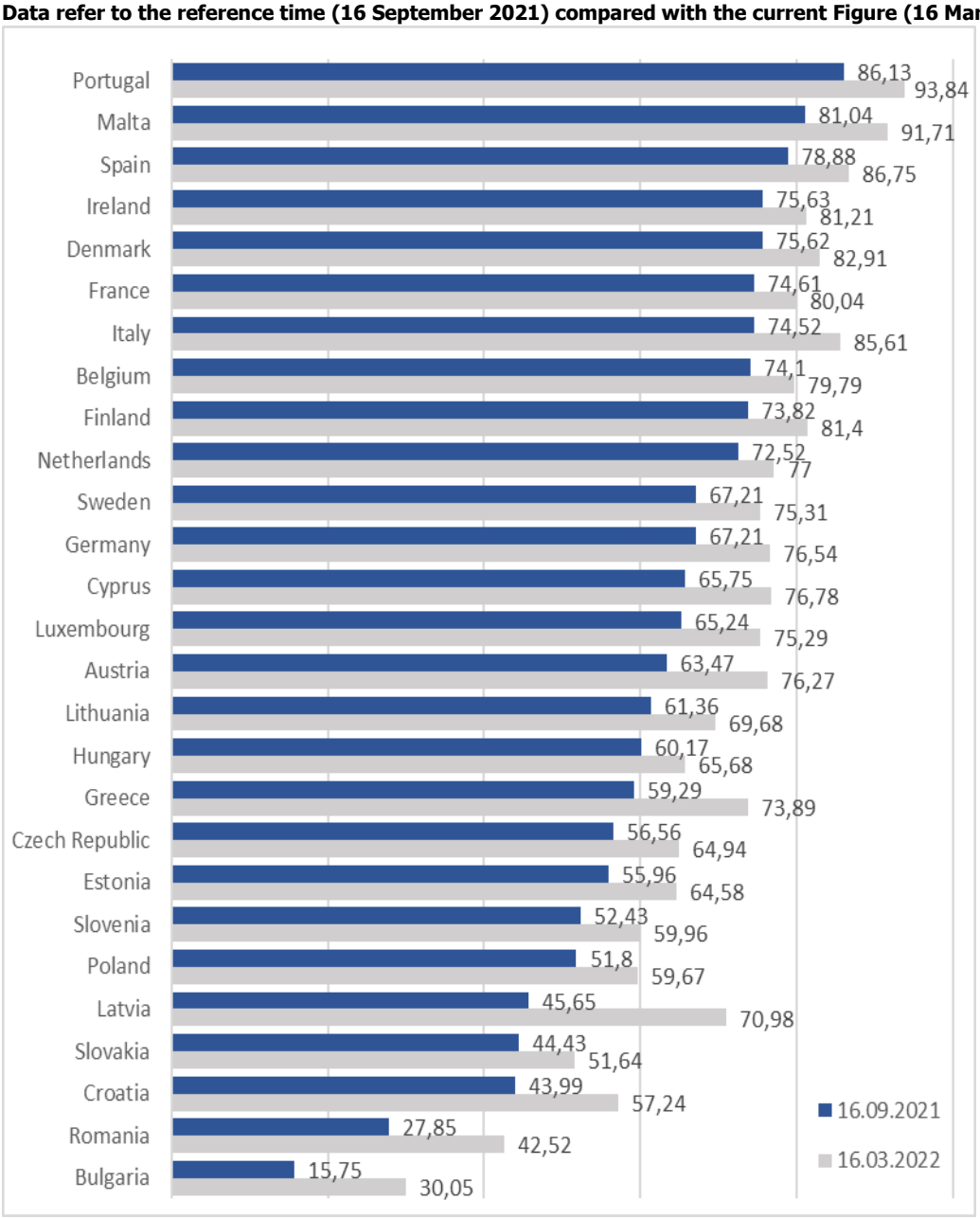
Conversely, *resources*, in Sewell's perspective, are actual rather than virtual and are read like texts to recover the cultural *schemas* they instantiate. In this study, we specifically considered some *resources* referring to the characteristics of public health in the pre- and post-pandemic eras, such as vaccination policies and the organisation of health structures, also considering the response measures to Covid-19 by impacted countries.

3. Covid-19 vaccination trends in European Countries

To explore the problematization of macro level differences in vaccine hesitancy, we first consider Covid-19 vaccination coverage at the EU country level detected on September 16, 2021. This reference date is representative of vaccination coverage rates in times of broad availability of vaccines for all adults in the European population. Coverage rates are placed within a very wide spectrum ranging from Portugal to

Bulgaria, which cannot be explained merely at the micro and individual levels through a reference to sociodemographic variables (see Figure 1).

Figure 1 - Coronavirus (Covid-19) vaccinations - Percentage with at least 1 dose per total population by EU countries. Data refer to the reference time (16 September 2021) compared with the current Figure (16 March 2022).



Source: *prepared by the authors on AGENAS data (https://www.agenas.gov.it/Covid-1919/web/).*

Although the Covid-19 vaccine has become available in all European Union (EU) countries in the same period at no cost to the population, some countries, particularly all former Communist countries from Central and Eastern Europe (CEE), reported lower vaccination rates than Western European countries, such as Portugal, the Netherlands and Spain, occupying the last positions in terms of vaccination rates (all ages) in Europe (Berniell et al. 2021). While in Denmark, the Netherlands and Spain, more than 95% of the 50+

population had received their first dose by mid-July, Romania and Bulgaria had only vaccinated 28 and 22% of their 50+ population.

Intending to adopt a comparative approach, based on different positions in this range, the Italian case was compared with that of two countries that could be attributed to the two opposite poles. Within the first polarity Portugal was chosen. In the second one, the largest countries were isolated and then Poland was chosen considering, on the one hand, the uniqueness of Bulgaria and Romania which require the adoption of specific interpretations that are not applicable to other European contexts (Mărcău, Purec and Niculescu 2022) and, on the other, the position of Poland as an exemplary case of for vaccine-hesitant post-socialist CEE countries (Sowa et al. 2021). Therefore, by adopting a choice of case studies we considered three countries in particular: Portugal, Italy and Poland.

Portugal, with a vaccination rate at 86.13%, constitutes the country with the highest rate of Covid-19 vaccination in the time period studied. It occupies the 2nd position in the world and the first position in Europe in the list of countries with the highest percentage of population that received at least one dose of vaccine against Covid-19. This trend was also confirmed in the following months, reaching more than 90% of the vaccinated population.

Italy was reported to have a 74.52% vaccination rate, but it also represents one of the most vaccination hesitant Western countries in Europe, despite being the most affected by the pandemic in terms of both the number of cases and of deaths. Looking back to the 'cultural climate' prior to the Covid-19 pandemic, the data show a rather high vaccination hesitancy in Italy, with a rate of 56% of vaccine confidence in parents (Hadjipanayis et al. 2020). In contrast, Portugal has the highest level of vaccine confidence in Europe (85%; Ibidem) and Poland is at the opposite extreme with a majority of hesitant population (the confidence level is 45%; Ibidem). Accordingly, the cases of Portugal and Poland may be deemed representative of the two opposite poles on vaccine hesitancy in Europe while Italy is characterised by the inconsistency between confidence rates and vaccination rates.

In terms of vaccination rates, Poland with 51.8% vaccination coverage, and more recently at 59.6% fully vaccinated citizens, occupies a position at the other end of the vaccination spectrum when compared to Italy or Portugal. The Polish vaccination rate is much below the average for the European Union (the difference equals 13,8%) and, if we also consider partial vaccination—even below the global average. Furthermore, Poland's vaccination coverage is characterised by two features that render the country's situation even more complex: first, a relatively low vaccination rate in the elderly population (70 and older) and second, an uneven distribution of vaccination coverage throughout the country (Structural Research Institute 2022). Both of these factors are seen as a crucial reason for the devastating toll that the pandemic has taken in Poland.

The characteristics in terms of Covid-19 vaccination rates and different levels of vaccine confidence recorded before the pandemic in these three European countries appear significant to begin an exploratory comparative analysis in relation to their differences in *schemas* and *resources*, as defined above.

Our analysis focuses on the influence of the following contextual or macro-level factors: a) the National Health System; b) the National Vaccination Policies; and c) political management during the pandemic.

4. Vaccine Hesitancy and the Covid-19 Pandemic in Portugal

Portuguese are the Europeans who most trust vaccines (Soares et al. 2021). This high vaccination confidence was confirmed by the Covid-19 vaccination rate (see Figure 1). What explains this particular confidence in vaccines with respect to other European and world countries?

Before proceeding with the macro factors detected for our analysis, it is appropriate to clarify the positioning of Portugal in Hofstede's map as a general framework for the diachronic and synchronic overview of *schemas*

and *resources* offered in the paragraph (Hofstede, Hofstede and Minkov 2010). Portuguese accept hierarchical distance and prefer centralised power. In comparison to other European countries, Portugal is the most collectivist, and its loyalty is paramount and overrides most other societal rules and regulations. It also has a very high preference for avoiding uncertainty (UAI= 99, where the maximum score is 100), and adopting rigid codes of belief and behaviour and security is an important element in individual motivation.

a) National Health Service and social trust

The Covid-19 pandemic crisis arrived when Portugal was recovering from the financial crisis that hit the country hard between 2011 and 2015, resulting in the unprecedented implementation of cuts in social and health expenditures (Serapioni and Hespanha 2019). The pandemic has further deepened the existing structural weaknesses of the NHS, with a risk of aggravating existing social and geographic inequalities in health. In fact, in 2019, public expenditures on health were only 60%, and household out-of-pocket payments amounted to approximately 30% of total expenditures. These data are not entirely consistent with a public universal health system. However, despite the catastrophic predictions, based on the limited or insufficient resources of the healthcare system and implemented public health policies, the impact of Covid-19 on the Portuguese NHS was far from devastating (Varanda et al. 2020). The quality of the NHS response to people with suspected infection and to patients with Covid-19 and the performance of health professionals brought an additional citizens' trust and confidence in the provision of care (OPSS 2021; Saúde and Dia 2021). In the context of a pandemic, the NHS has been recognised by the population and political parties as a key actor for the nation and the community. The government managed to strengthen the NHS by increasing both personnel and technical means (OPSS 2021), which contributed to increasing the confidence of the population and promoting a collaborative and collective response to the pandemic crisis. In this regard, an international investigation showed that the Portuguese “trust people in the health field, such as doctors, epidemiologists”, and have "low trust in digital social networks and digital influencers as a source of information on Covid-19” (Gonçalves et al. 2021, 180). High levels of Portuguese trust in the health structure correlates with high Covid-19 vaccination rates among the population.

b) The National Vaccination Program

The National Vaccination Program (NVP) is an important key resource of the Portuguese NHS due to its level of structuring and consolidation. It was established in 1965 and is highly valued by the Portuguese, who attribute a significant reduction in infant mortality rate (IMR) and the continual increase in life expectancy of population (Simões et al. 2017). The NVP includes 12 vaccines established by the Directorate-General for Health to protect the health of the overall Portuguese population (i.e., hepatitis B, diphtheria, tetanus, pertussis, etc.) (Simões et al. 2018, 145). However, Portugal has achieved high immunisation rates through voluntary vaccination, which is strongly recommended but not mandatory. Only tetanus and diphtheria vaccines are mandatory for all children attending schools. The good results obtained for vaccination since the 1960s show a high level of trust and vaccine confidence among citizens, which persists to date (Simões et al. 2018). According to recent data published by the NHS, Portugal has exceeded the target recommended by the WHO regarding adult vaccination against influenza, with 88.3% in the group aged 65 and over and 64.4% of health professionals in direct contact with patients. “This strength - comments Fernandes (2021, 11), the director of the NVP - comes from 55 years of deep roots in the public health services and in the culture of the Portuguese”.

Yves Léonard (quoted by Arrighi 2022, 1), author of Histoire du Portugal Contemporain, denies that mass vaccination in Portugal depends on the temperament of submission to authority inherited from the Salazar dictatorship that fell in 1974. As he reports, it is important to remember the terrible epidemics of measles and

poliomyelitis that hit the country before the 1970s. The Portuguese population therefore has a strong awareness of the usefulness of vaccination campaigns.

c)Political alignment during the pandemic

Another important factor explaining the high level of the vaccination rate in Portugal is the political cohesion in the most critical decisions regarding the management of the Covid-19 pandemic, both among the main political institutions of the State (President of the Republic, Parliament and Government) and among the main political parties, either from the government or from the opposition (OPSS 2021). There has been substantial political alignment both in measures to restrict individual freedoms during the first phase of the pandemic and in the recognition of vaccination as the most important public health strategy to face the pandemic crisis. The first state of emergency in March 2020 was approved by a large majority in Parliament. The different positions among experts generated some debate on issues such as school closures, the mandatory use of masks or the most appropriate time to start the deconfinement. However, this did not result in strong tensions and open conflicts. Even in the media, the public discourse and the narrative on pandemic management were "rather homogeneous" during the period of deconfinement (Silva et al. 2021, 14). Varanda and colleagues (2020, 294) comment that a national convergence emerged in the face of the pandemic crisis: "all parties represented in the national assembly supported the government's line". Even the political party Chega (Enough), newly constituted in 2019 and considered a populist party, approved the state of emergency, decreed by the President of the Republic. Thus, there was no dissent, either in parliament or on the streets. The strong sense of local community has been one of the main virtues of the country in facing the Covid-19 pandemic (Varanda et al. 2020).

From March 2020, the government began to promote regular meetings of a task force composed of technicians and researchers from sectors linked to the pandemic and with the main political actors in the country (Silva et al. 2021). Sharing high-quality information across these sessions has contributed substantially to the alignment observed across much of the Portuguese political system (OPSS 2021). In summary, there was a general consensus on health measures taken by the government with scarce presence of no vax (or no green pass) debates. Some disagreements between political parties emerged around the issue of how to face the emerging economic and social crisis during the deconfinement process.

5. The case of vaccine hesitancy and the Covid-19 pandemic in Italy

Italy was the first European country to be severely affected by Covid-19, with very high mortality rates. However, the anti-Covid-19 vaccination attitude has not been fully accepted by the population. What might be the reasons for this apparently contradictory behaviour?

From the point of view of *schemas* obtainable by Hofstede's map (2010), we notice that, in relation to PDI (power distance), Northern Italy tends to prefer equality and a decentralisation of power and decision-making, whereas in the south, the value is higher and favourable to the centralisation of power. Italy is also characterised by an individualistic orientation (IDV), with a "me"-centred culture, especially in the large and economically prosperous cities of the North. This dimension does vary in Southern Italy, where less individualistic behaviour can be observed in favour of a familistic culture. The positioning on PDI and IDV accentuates the aversion of being controlled and told what to do, although Italians are not comfortable in uncertain situations (UAI). Although the law is considered relevant, the Italian penal and civil codes are very complicated, and Italians do not always comply with them, as they learn very early that some are important and some are not. Basically, from the point of view of *schemas*, the picture that emerges is very disjointed and heterogenous.

a) The National Health System

The Italian *schemas* seem to be consistent with the health system as a *resource* and the transformation processes that have affected the Italian state organisation, including the Health Sector, towards decentralisation and subsidiarity. One of the pillars of the Italian National Healthcare Service (NHS) is the universal coverage for all citizens (Law n.833/1978), which is funded through direct and indirect taxation, while residuals are derived from the incomes of the regional health institutions and from tickets to be paid directly by patients (Cicchetti and Gasbarrini 2016). The originally centralised system has undergone a process of "regionalization", enforced by law n. 229/1999, which became actual "federalism" with the reform of the title V of the Constitution (D.Lgs.vo 56/2000) and its modification in 2009. As a result, the NHS is organised at the central, regional and local levels. Decentralisation is based on the idea that local decision-makers are 'nearest to citizens' needs and, therefore, can provide better, more efficient services. The national level sets the fundamental principles and goals of the health system and allocates national funds to the regions that are responsible for organising and delivering health care. The local level delivers public health, community health services and primary care directly and secondary and specialist care directly or through either public hospitals or accredited private providers. Even though the health system paradigm is based on hospital modes of care, primary care represents a relevant *resource* for the entire system, as it has a gatekeeping role (Ferré et al. 2014). The process of health regionalisation/federalisation has had the side effect of internal allomorphism[1] but, at the same time, this has played an increasingly important role for patients/citizens within the system. In terms of *schema*, health engagement seems to have a relevant effect on the people's self-image and on a sense of belonging, as it was positively related to the intention to vaccinate (Graffigna et al. 2020).

b) Vaccination policies and no-vax opposition

The health sector structure as a *resource* must also be carefully considered when discussing vaccine policy adherence. While Italy used to be a country with a long-standing tradition of high coverage of vaccinations, during the first decade of the new millennium, infant immunisation coverage has decreased alarmingly.

With regard to vaccination policies, Italy ranks as an example of a hybrid with few coherent attempts at abandoning coercion and then unsystematically resumed in different periods, with inevitable consequences in the eyes of citizens and their behaviour in terms of assumption of responsibility duties and exercise of their individual freedoms of choice. Even though childhood vaccinations have often been mandatory by law (Italian Law n. 891/1939, n. 292/1963, n.51/1966 and n. 165/1991), the weak effectiveness of the sanctioning system, and the changes introduced by Italian Constitutional Law n. 3/2001 (devolution of almost all the competences and responsibilities in health matters to the Regions and the Autonomous Provinces) generated and developed radically different and changing vaccine policies, increasing the tendency to decline vaccinations and parents' mistrust in pharmaceutical companies and health policies (Crenna, Osculati and Visonà 2018). Vaccines as a public issue have been emerging during the early years of the 2000s, in line with what has happened in other European countries. However, it should be pointed out that it only reached a national echo when Veneto Region approved the suspension of mandatory childhood vaccinations in 2007, in contrast with the Ministry of Health (Cioffi 2020). In 2017, the Italian Parliament issued a new law, the so-called Lorenzin decree (decree law no. 73), prescribing children to be immunised against 10 diseases (e.g., tetanus, poliomyelitis, hepatitis B, etc.) in order to register for kindergartens, maternal schools, and compulsory schools. In addition to the ten mandatory vaccinations, free of charge for all, four other vaccines were also considered 'recommended' and offered free of charge but without any obligation. The increasing attention gained by the Lorenzin decree in the public

[1] The regionalisation process has had an impact both on the balance between public hospitals or accredited private providers, and on the role of primary services, which are decidedly central in some regions and completely neglected in others (Cicchetti and Gasbarrini 2016).

sphere found support from some representatives of the scientific community, physicians, paediatrics, politicians, public opinion leaders and so on, feeding a long, articulated and sometimes conflicting debate on vaccinations (Gobo and Sena 2022). The strongest opposition to the Lorenzin decree was carried out inside and outside the governing coalition by the League and the Five Star Movement, considered populist parties in the Italian political landscape. The League has always opposed the vaccination obligation, sustaining a voluntary approach. The Five Star Movement, born as a populist and anti-government party, has thus far assumed an ambivalent position: before the 2018 elections, several exponents of the Five Star Movement expressed opinions very close to the 'no-vax' movements, whereas after the elections, the Movement instead issued more cautious statements (Casula and Toth 2018).

Anti-vax movements are particularly strong in Italy. From recent research (Lello 2020), they can be considered a relatively compact group in the views towards institutions and science but, at the same time, jagged in the positions around vaccines. Therefore, more reasonable and moderate components than those that are more extreme, conspiratorial or alienated from the institutional context cannot be distinguished on the basis of mere cultural and political level or their sociodemographic characteristics.

c) The political management of the Covid-19 pandemic

Italy experienced four large and dramatic waves of the pandemic from January 2020 to March 2022. During this period, the management of the pandemic crisis changed considerably, going from national lockdown – where only essential economic activities were permitted – in the first wave while throughout the second and third waves activities were managed on a region-based restriction policy – differentiated according to territorial risk assessment – to the introduction of Green Pass (EU Digital Covid-19 Certificate). Introduced on July 23, 2021, Decree Law n. 105 has passed through a regulatory evolution that has changed its nature and application, differentiating itself into basic and super certificates and becoming compulsory for an increasing target population and a growing number of collective activities (Moccia et al. 2022) [2].

It can be said that the Italian government has taken an attitude of "medical populism" (Lasco 2020, 1418), dramatizing the pandemic itself as an exceptional threat to gain 'emergency powers', while imposing dramatic measures of 'lockdown' in the first phases and a compulsory Green Pass. As the vaccine campaign expanded, these measures have become increasingly anchored to anti-Covid-19 vaccination as necessary to safeguard public safety. The ample recourse to disciplinary and security measures, similar to a paternalistic approach, created many tensions with the biopolitical logic of health apparatuses, especially with the growing individual autonomy and responsibility of public health and the freedom to cure oneself (Pellizzoni and Sena 2021).

Thus, the relatively high level of vaccine adherence (74,52% in Sept. 2021, see Figure 1), in a context of high level of vaccine hesitancy (Larson et al. 2016), needs to be considered as a result of those contrasting dynamics – i.e., paternalism and disciplinary approaches (such as compulsory vaccination policies) – which are also the basis of the radicalisation of opposing positions. In doing so the governing coalition embodied the medical populism, while, on the other side, the populist opposition parties, such as Lega and Fratelli d'Italia, stood as protectors of neoliberal individual autonomy in health care, and gained increasing spaces in the socio-political and institutional organisation of the Italian context (Talani and De Bellis 2021). In this case, *schemas* and *resources* seem to mix up, reinforcing the conflicting attitude towards vaccination as emblematic of public health in Italy.

[2] The initial Italian version of Green Pass, entered into force on the 6th August 2021, certified that the holder has been vaccinated, tested negative or recovered from Covid-19. The double certification level came into force on 6th December 2021. The first level (*Basic Green Pass*) records of a negative test while the second level (*Super Green Pass*) testifies to complete vaccination or recovery from Covid-19.

6. Vaccine Hesitancy and the Covid-19 Pandemic in Poland

Polish attitudes towards vaccination against Covid-19 and pandemic management strategies in general are both paradoxical and exemplary for the region of East and Central Europe. Paradoxically, interest in anti-Covid-19 vaccination, after an initial substantial peak, remains, as indicated above, one of the lowest in the EU, while the mortality rate due to Covid-19 is significantly higher than the EU's average. Simultaneously, this trend of diminishing interest in anti-Covid-19 vaccination is exemplary of other countries of the region (Sowa et al. 2021).

Looking at Poland *schemas*, according to Hofstede and colleagues (2010), Poland is a hierarchical and centralised society. This means that people accept a hierarchical order in which everybody has a place that needs no further justification. Poland is also basically an individualist society. This combination (high score on PDI and high score on IDV) creates a specific contradictory tension, which is evident in the positioning of a high uncertainty avoidance score (93/100) and in maintaining rigid codes of belief and behaviour as a control strategy.

a) Healthcare system and vaccination policies

Prior to the outbreak of the Covid-19 pandemic, anti-vaccination rhetoric was not very resonant in Polish society, and compliance with vaccination policies was high, as demonstrated by declared adherence to the obligatory national immunisation programme for children and youth (Furman et al. 2020). Simultaneously, in the last decade (2011-2020), the trend became progressively negative, and the percentage of cases of voluntary avoidance of vaccination has gradually increased (NIH 2021). The Covid-19 pandemic might then be seen as a lens that focused tensions underpinning vaccination attitudes and, more broadly, health orientations in Poland.

The actual state of the healthcare system in Poland should be seen as a crucial *resource*, that is, the 'material' aspect, which entered into a complex interplay with health symbolic (cultural) meanings and patterns of understanding and practice (*schemas*). The scarcity of health-related, state-administered resources has long been acknowledged in the grey literature of the subject: healthcare in Poland is depicted as underfinanced both in per capita figures and as a share of GDP when compared to other European countries, a factor that limits the accessibility of some therapeutic options, including ambulatory care (Supreme Audit Office 2018). Furthermore, the number of practising healthcare personnel is the lowest in the EU and distributed unevenly across the country (OECD 2021). This results in levels of out-of-pocket spending being higher than average for developed countries (Kolasa et al. 2014), which means that healthcare in Poland is to a large extent 'unofficially' privatised.

This structural scarcity and inaccessibility interact with culturally shaped *schemas* of thinking, feeling and acting towards health issues, such as the individualisation of some health-related practices and orientations. For example, Polish patients actively seek empowerment in the context of healthcare and wish to actively shape their own therapies (Santana et al. 2011; Kolasa et al. 2014), including turning to self-treatments (as demonstrated by, e.g., excessive consumption of dietary supplements - Polish Economic Institute 2019). Simultaneously, Polish patients are less satisfied than their European counterparts with the role they play in the treatment process (Kolasa et al. 2014). Healthcare institutions do not manage communication with dissatisfied individuals, and formal channels of communication are virtually blocked (Supreme Audit Office 2018). This reveals how *resources* and *schemas* interact: a severely underfinanced and inaccessible system 'pushes' individuals 'out', blocking their willingness to engage with healthcare institutions and mainstream medical knowledge, thus reinforcing the individualisation *schema* and perhaps vaccination hesitancy.

b) The political management of the pandemic and social distrust

A factor that contributed to the actual failure of the anti-Covid-19 vaccination campaign in Poland was the incorporation of pandemic management into the ongoing political struggle. In 2015, the Law and Justice (PiS) party came to power and began introducing illiberal democracy in Poland, leading to acute social divisions (Plattner 2019). The presidential elections of 2020 were seen both by the opposition and by large segments of society as a hope for a 'renewal' of democracy in the country and by the ruling party as a necessary step towards the consolidation of power. For this reason, immediately after a short period of national consensus on the management of Covid-19, the pandemic became a highly politicised issue. The opposition saw the lifting of the restrictions in May 2020 as a political move aimed at attracting the elderly electorate to the elections, traditionally more conservative and supportive towards the ruling party and the president in office. The ruling party claimed that it was reasonable to lift the restrictions based on low numbers of new infections. Therefore, the political campaign in the middle of the pandemic further reinforced the *schema* of distrust in political and social systems: the political management of the pandemic appeared incoherent, with highly restrictive safety measures during the first lockdown (March to April 2020), followed by an actual withdrawal of restrictions due to elections initially planned for May 2020, and finally reintroduced in October 2020. This resonated both in limited support for restrictions during the second wave of the pandemic in Poland (CBOS 2020) and in noncompliance with state-issued recommendations regarding anti-Covid-19 vaccination.

Therefore, the malfunctioning and inaccessibility of the healthcare system and the constant political struggle as *resources* have both aggravated and been embedded in the persistently low level of social trust in Polish citizens: as indicated in consecutive waves of the European Values Study, Poles are continuously distrustful towards those institutions that aim at providing social service, including healthcare and trust, which have significantly decreased during recent decades (Marody et al. 2019). Distrust towards social service institutions should be seen as a symptom of a wider propensity to perceive oneself as an entity independent or isolated from the social system. A sociolinguistic analysis of language that Polish respondents use to talk about themselves and various levels of social and political institutions (e.g., the state, the work, the healthcare, etc.) reveals the existence in Polish society of a strong inclination towards locating oneself outside of the social system and distancing the 'I' from collective forms of organisation. Most importantly, this distancing has a clearly negative valence—the system is seen as antagonistic towards the individual, blocking potential and limiting opportunities for action (Karlińska and Sawicka 2019). In other words, not subordinating oneself to the call to become vaccinated against Covid-19 turns into a legitimate practice of resistance against the oppressive social system.

7. Discussion of findings and concluding remarks

The three country cases briefly considered highlight different social, political and cultural factors that influenced vaccination attitudes. Combining the *schemas* and *resources* enables us to draft a first schematic-comparative evaluation, offering an initial interpretative key to understanding the complexity of framing and structuring Covid-19 vaccination rates and policies (see Table 1).

In terms of *resources*, we can point out that Portugal has a centralised National Health System but with a vaccination policy that is based on voluntary adherence of citizens to recommended vaccination. This policy has also been applied for the anti-Covid-19 vaccination campaign. The general compliance with the rules (medium-high PDI), the collectivist orientation, and the need to control uncertainty through strict regulatory provisions have favoured an absence of politicisation of the Covid-19 debate and a bottom-up demand for guarantees mediated by norms and rules.

Table 1 – Comparative synthesis of *schemas* and *resources* in Portugal, Italy and Poland

Countries/ Analytical dimensions	*Portugal*	*Italy*	*Poland*
Resources			
• National Health System	Centralised	Decentralised	Centralised
• Childhood vaccination Policies	Strongly recommended vaccinations with 2 obligatory (tetanus and diphtheria)	Alternation between mandatory and voluntary vaccinations	Permanent mandatory vaccinations with some vaccines recommended
• Policy of vaccination against Covid-19	Vaccination is not mandatory for health workers, but only recommended for all. Green pass is mandatory only for hotels.	Mandatory vaccination for health workers. Mandatory Green Pass for all workers and services.	Vaccination only recommended for all; Green Pass only recommended but not required
• Political management of pandemic	Partially restrictive	Strongly restrictive	Incoherent in terms of restrictiveness
Schemas			
• Vaccination culture	High adherence to vaccination	Alternate level of adherence and with conflicting debate and different institutional positions and behaviours	High adherence to vaccinations, but in transition
• Health/Covid-19 as political issue	Not at all	Very much	Very much
• Power Distance Index (PDI)	Medium-High/hierarchical order is accepted	Medium/favourable to decentralisation of power	Medium-High/hierarchical order is accepted
• Individualism Index (IDV)	Very Low/collectivism	High/individualism	Medium-High/quite individualistic
• Uncertainty Avoidance Index (UAI)	Very High	High/aversion to be controlled	High/practices outside the system

Source: Prepared by the authors.

In such a context, it was not necessary to introduce mandatory vaccination policies because the combination of *schemas* and *resources*, already present and consolidated in the Portuguese social context, favoured practices consistent with a shared representation of the pandemic risk and a significant consensus to policy measures, such as Covid-19 vaccination, perceived as necessary and needed by all involved actors and populations. In contrast, in Italy, the progressively decentralised National Health System and the recurring alternation between mandatory and voluntary vaccination policies contributed to strengthening *schemas* related to individualism values. Those *schemas* have fired a high degree of politicization of the pandemic issue, enforced by strongly restrictive political management of pandemic and vaccination through increasing the policy of mandatory Green Pass. The result was a high vaccination rate but with ongoing vaccine hesitancy growing. In contrast, in Poland, the centralised health system and the mandatory vaccination policies regarding children and youth were not sufficient to provide social trust in political management of health, including the

pandemic, and a high level of adherence to vaccination, as in Portugal. In this case, the *schema* of distrust towards the political system seems to be an important interpretative key in this regard: all three countries considered in our analysis are characterised by a high or very high uncertainty avoidance index, but only in Poland is uncertainty managed outside of the social system, or in an antagonistic relationship with it, whereas in Portugal, uncertainty is managed through engagement due to high levels of social trust and trust in the healthcare system.

The pandemic might have accelerated the passage of Polish society from adherent to vaccination to vaccination hesitant, although the rise in the number of vaccination avoidances by parents of children subjected to mandatory vaccination was visible prior to the pandemic (NIH 2021). In other words, although Poland resembled Portugal rather than Italy in this regard in the prepandemic era, the pandemic made the shift towards distrust in official health communication more acute, while in Italy, the highly restricting political management of the pandemic seems to have rekindled the struggle over mandatory childhood vaccinations following the approval of the Lorenzin Decree in 2017.

In Portugal, the pandemic crisis has brought about consensus among the various political actors who have shared the government's action, supported by the clear and consistent voice of the health authorities. This favourable political climate, together with the high confidence in the NHS and its health professions and the strong sense of the local community in adopting lockdown measures, were important *schemas* in the country while managing the crisis, and they have also strengthened the awareness of the population on the usefulness of the vaccination campaign against Covid-19.

The *resources* and *schemas* derived from the Italian vaccination history, before the era of Covid-19, took shape starting from an intermittent positioning and a high level of conflictual debate. In a context in which public health represents a matter of political dispute, the level of Covid-19 vaccination adherence seems to represent this internal tension, highlighting the differences deriving from strong healthcare decentralisation, and reflecting the different levels of involvement and satisfaction of citizens for health policies.

The interpretative framework that connects *resources* with *schemas* allows for explaining Polish (and other CEE societies') vaccination hesitancy as the aftermath of systemic transformation, and more precisely: not only because of the collapse of one form of the system (the communist regime) but also of the period of transition into the capitalist regime and the discrepancies between health-related *resources* and *schemas*. Thus, high levels of vaccine hesitancy in the face of the Covid-19 pandemic would indeed be "a visible result—one that reflects not decades of communist rule, but rather the decades-long social consequences of its collapse" (Project Syndicate 2021) and, more specifically, the failure of post-communist states to incorporate citizens into governance processes as actual subjects.

In conclusion, the exploratory and provisional analysis presented here has tried to "problematize" the issue of vaccine hesitancy, particularly in relation to Covid-19 vaccination, through the proposal of a model derived from Sewell's perspective on *resources* and *schemas*, which considers the complexity of the social, political and cultural factors that influence social behaviour. The aim was to suggest an interpretative reading of the phenomenon of vaccine hesitancy that considers not only the individual characteristics (of parents or adults) towards vaccination but also of all those factors that actually contribute to the creation of a "system" of behaviour inevitably guided by the context in which it is produced. The differences that have occurred between the different countries in relation to adherence to the Covid-19 vaccine represent a particularly suitable area for testing this model from a comparative perspective and to better clarify the theoretical and empirical framework in which it could be more fruitfully applied.

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