

Beyond vaccine hesitancy: Understanding systemic barriers to getting vaccinated

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Throughout the pandemic, much discussion about COVID-19 transmission focused on individual-level decisions, making it easy to blame the unvaccinated. Credit: Pixabay

The term "vaccine hesitancy" was in wide use years before the World Health Organization (WHO) declared COVID-19 a pandemic. The term focuses on individual-level attitudes toward vaccines. Throughout the pandemic, much [popular](#) and [scholarly discussion](#) about COVID-19 transmission focused on individual-level decisions, making it easy to

[blame the unvaccinated.](#)

By focusing on individual decisions, it is easy to overlook other reasons for suboptimal vaccine uptake. These include politicization, [distrust of the health system due to systemic racism](#), [social inequities](#), and [barriers to access and acceptance](#).

The perspective that health is the result of only individual behaviors falsely disconnects well-being from [important factors](#) like systemic [social inequities](#), community well-being and [environmental health](#) (such as [One Health](#)). The [focus on individual decisions](#) also reinforces widespread social norms and [sanctions \(such as the stigmatization of the unvaccinated\)](#), which [make individuals personally responsible](#) for keeping themselves healthy, including getting vaccinated to protect others.

Although there have been efforts across Canada to improve COVID-19 vaccine accessibility and acceptability among underserved populations, the success of these efforts is [isolated to specific communities](#) and [ongoing efforts are needed](#) to reduce inequities. As a result, many individuals who are blamed for being unvaccinated are often also denied [equal access](#) to health care and vaccination services, and credible information about vaccines from trusted sources.

We are a group of researchers whose work explores [inequities](#) in vaccination [intentions](#), [access](#) and [uptake](#) among [underserved populations](#), as well as public health [communications](#) and [inequities resulting from pandemic responses](#). We also research [vaccine hesitancy](#), [public health communications](#) and the use of vaccine [information and misinformation](#) to show how social inequities shape vaccine uptake.

What is vaccine hesitancy?

The Strategic Advisory Group of Experts (SAGE) on Immunization at the WHO defines [vaccine hesitancy](#) as a "[delay in acceptance or refusal of vaccination despite availability of vaccine services](#)" for various reasons, including convenience. Convenience refers to the absence of barriers to accessing and accepting vaccines. This includes availability, location accessibility, affordability of vaccination, understandability of vaccine information and appeal of vaccine services.

Systemic social issues affect vaccine access and acceptability. Yet, [the term vaccine hesitancy often overlooks these, and reduces the multiple factors that affect vaccine uptake](#) to individual-level decisions.

Researchers have also [critiqued the focus on vaccine hesitancy](#) because it distracts from the responsibility of government institutions to [ensure vaccines are accessible](#) and acceptable to the population.

Social inequities create barriers to vaccination

Pre-pandemic research shows [substantial barriers to getting vaccinated exist](#), especially for certain populations. These include racialized and [Indigenous Peoples](#), people with disabilities, people living in rural and remote areas, and those with low income. For example, a recent review of studies about barriers to adult vaccination listed access [among the most frequently reported barriers](#).

In Canada and internationally, the uptake of COVID-19 vaccines has been much higher than for other [pandemic](#) and routine vaccines. Yet, it has been harder for those with fewer resources to get vaccinated.

[Participants in our research](#) identified many barriers to getting vaccinated in Spring 2021 when COVID-19 vaccines first became widely available across Canada. These barriers include technology access, language requirements, accessible transportation and childcare, [gaps in accommodations for disability](#) or health conditions, rigid work

schedules and feeling unsafe.

Similar barriers have been previously recognized with [routine childhood vaccines](#), [adult vaccines](#) and seasonal [vaccines](#).

For racialized and Indigenous populations, whom Canada's National Advisory Committee on Immunization identified as being at [increased risk](#) of severe illness from [COVID-19 disease](#), major [barriers to accepting COVID-19 vaccines](#) also include [contemporary](#) and [historical](#) medical racism, disregard and mistreatment.

Improving vaccine access and acceptance

Throughout the pandemic, local non-profit, community and Indigenous organizations tailored vaccine rollouts for the people they serve.

For example, urban Indigenous health service providers sought [to improve the accessibility](#) of culturally appropriate care for First Nations, Métis and Inuit communities, including people without shelter. However, some still noted lower uptake than in non-Indigenous populations.

[Across Canada](#), [First Nations](#), [Métis](#), [Inuit](#) and [Indigenous-led](#) initiatives provided culturally and linguistically appropriate [clinics](#), [information](#) and wellness support.

Similarly, local organizations worked to improve vaccine accessibility for diverse peoples, including [newcomers](#), [racialized populations](#) and [people with disabilities](#).

Provincial health authorities also worked to [diversify vaccination services](#), providing [mobile](#), [walk-in](#), [drive-through](#) and [pop-up](#) clinics. Federal, provincial and territorial governments also provided pandemic and vaccine information in [multiple languages](#) to improve accessibility.

However, many of these efforts were initiated after mass vaccine clinics opened to the general public. This made it harder for populations that were recommended for vaccination early in rollouts to access the first available doses of COVID-19 vaccines.

Although these initiatives improved vaccination accessibility for some underserved communities later in the rollout, [barriers to vaccination](#) remained high for many throughout the initial rollout, even for people who [wanted to be vaccinated](#).

Addressing barriers

The overemphasis of research and public discussion on vaccine hesitancy makes systemic barriers to getting vaccinated invisible to the public. Instead, individuals are blamed for not getting vaccinated, even when access to vaccines is not equitable.

Without resolving barriers to vaccine access and acceptability, efforts solely focused on reducing vaccine hesitancy will not optimize vaccine uptake. Vaccine programs must be intentionally designed for those with the greatest barriers, starting with the initial rollout.

To improve vaccine access and trust, rollouts must occur in a contextualized way and in partnership with organizations that have community trust and experience working to improve access to health care and social justice. As modeled by local non-profit, community and Indigenous organizations, [vaccine](#) programs must be embedded in wider efforts to improve social equality and access to [health care](#).

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