

“I live in a very bourgeois world, I don’t live in the outskirts”: childhood non-vaccination and the intersection of race, class and gender

“Eu vivo num mundo muito burguês, não moro na periferia”: não vacinação infantil e a intersecção entre raça, classe e gênero (resumo: p. 17)

“Yo vivo en un mundo muy burgués, no vivo en la periferia”: no vacunación infantil y la intersección entre raza, clase y género (resumen: p. 17)

Camila Carvalho de Souza Amorim Matos^(a)

<camila.carvalho@ufsc.br> 

Jeane Saskya Campos Tavares^(b)

<jeanesctavares@gmail.com> 

Marcia Thereza Couto^(c)

<marthet@usp.br> 

^(a) Departamento de Ciências da Saúde, Universidade Federal de Santa Catarina. Rodovia Governador Jorge Lacerda, 3.201, Jardim das Avenidas. Araranguá, SC, Brasil. 88906-072.

^(b) Centro de Ciências da Saúde, Universidade Federal do Recôncavo da Bahia. Santo Antônio de Jesus, BA, Brasil.

^(c) Departamento de Medicina Preventiva, Faculdade de Medicina, Universidade de São Paulo. São Paulo, SP, Brasil.

This article analyzes how race, gender, social class and spatiality markers intersect and are reflected in health decision-making, more specifically in childhood (non)vaccination. This qualitative study was conducted in two Brazilian cities: Florianópolis (SC) and São Luís (MA), and included families with children up to six years old. This article analyzes the narratives of 19 caregivers in Florianópolis who chose not to vaccinate (fully or partially) the child(ren) under their responsibility. In-depth interviews and thematic content analysis were conducted. Gender was an important marker in intra-family decision-making, while social class, race and spatiality emerged as important markers in the perception of who are the “us” who don’t need vaccines and the “others” who do. The findings are discussed using the theoretical framework of whiteness and neoliberal parenting studies.

Keywords: Vaccination. Vaccine hesitancy. Intersectional framework. Qualitative research.



Introduction

The questioning and resistance to vaccines are as old as the vaccination itself, being directly related to the historical, social and cultural context of each time and place¹. Owing to the concern about the rising mistrust and rejection of vaccines worldwide, the World Health Organization (WHO) has been paying increasing attention to the issue, especially in the last decade^{2,3}.

In 2014, the WHO defined 'vaccine hesitancy' as the delay or refusal to receive recommended vaccines, despite their availability². Based on criticism and the views of the Social Sciences in Health in particular, in 2022 the concept was replaced and defined as "Motivational state of being conflicted about, or opposed to, getting vaccinated; includes intentions and willingness"³ (p. viii).

The history of vaccination practices in Brazil is inseparable from the very history of the genesis of the country: diseases and, consequently, vaccines, have occupied different and important places from the constitution of the Brazilian population to the reorganization of labor relations in the post-abolition period¹. At present, despite being considered a world reference in "immunization culture" thanks to the success of the National Immunization Program (PNI), the country has been facing a scenario of a sharp drop in vaccination coverage⁴.

Although more and more national and international health agencies are highlighting the need to understand the social, political and economic contexts related to vaccine hesitancy, research tools and practical guides for assessing this phenomenon focus on looking for aspects such as beliefs and fears, known as the "drivers" of vaccine hesitancy³. However, the institutional and structural dimensions shaping perceptions and behaviors - or the way of being in the world - also play an important role in health decision-making.

Anthropological studies^{5,6} have questioned medicine's triumphalist perspective on vaccination and proposed a shift in emphasis from diseases and resistance to vaccination to people, environments, power relations and processes of acceptability. Another promising approach in the recent discussion is intersectionality. By focusing on the relationships between mutually constituted processes that create inequalities, it allows us to examine how social structures and institutional dynamics operate to produce systemic advantages and privileges⁷ and their impacts on vaccine hesitancy processes.

Intersectionality has been increasingly used as an analytical tool in the field of health, as it allows us to understand how the position occupied in the web of social markers also defines a way of experiencing health processes. We understand social markers of difference as social constructions which, when articulated, produce greater or lesser social exclusion, depending on the position the subjects occupy in the classification matrices, acting in the formation of social identities⁸. In the case of Brazil, its specific slavery, colonialism and dictatorship history "shaped distinct patterns of intersectional power relations in terms of race, gender and sexuality"⁷ (p. 42).



Along the analytical path of this manuscript, we use intersectional lenses to look through at identities that were once considered universal - whiteness and masculinities, for example. Therefore, intersectionality will be used here as an analytical lens in reverse, that is, pointed not at the place of disadvantage - as recurrently used in the literature - but rather at the social groups that experience symbolic and practical advantages in the Brazilian social web.

Multiracial societies whose history was founded under the aegis of European imperialism and colonialism will necessarily reflect raciality as a fundamental differentiator in their social hierarchy⁷. Although the association between material disadvantages and the past enslavement of black and indigenous peoples is well established, studies on race, until recently, disregarded the material and symbolic advantages that white people enjoy due to the same historical past⁹. Until then, white people were seen as the universal model of humanity, in what has been called the “phenomenon of transparency”, i.e. the non-racialization of white people¹⁰.

In those systems founded on difference, these material and symbolic advantages shape both those who have them and those who are oppressed by them¹¹. National and international studies have already pointed out how positions of symbolic advantage in the social web - represented, for example, by high income and schooling - are reflected in the decision-making processes of (not) vaccinating children^{12,13}.

Here we will use studies on whiteness as a reference and analytical lens to understand the subjectivity of the narratives, understanding that colonization and racism were reflected not only in the subjectivity of blacks, but also, and above all, of whites¹⁰.

Whiteness is understood here as a continuously experienced social position of privilege (economic, political and racial), a place occupied by individuals who, due to the consequences of colonialism and imperialism, enjoy material and symbolic advantages, even if this raciality is unnamed and considered neutral^{9,14}. It is a place from which people who hold such advantages look at themselves and others, and whose practices are so naturalized as universal that they are unnamed and unassociated with this place of structural advantage^{9,11}.

In this study, we aimed to analyze how the markers of race, gender, social class and spatiality intersect and are reflected in health decision-making, more specifically in the (non)vaccination of young children. We would like to emphasize the unprecedented nature of this study in the field of health and vaccination, as no studies similar to the one proposed here have been found in available indexed databases.



Methodology

This is a qualitative study directed to analyze the opinions, meanings and understandings about childhood vaccination of adults responsible for children up to six years old, using the in-depth interview technique¹⁵. The empirical material that supports the analysis presented is part of a larger study conducted in two Brazilian capitals, Florianópolis (SC) and São Luís (MA), and included 48 guardians in 33 families (19 guardians in São Luís and 29 in Florianópolis).

Included families were responsible for at least one child up to six years old. Families were interviewed with different opinions and behaviors in relation to vaccinating their child(ren): those who vaccinated in full, those who selected some vaccines or postponed/make up their own schedule and those who did not vaccinate for any vaccine on the regular schedule. Considering that in the field research no family was found to be hesitant about vaccines in São Luís based on these criteria, while in Florianópolis 12 families were hesitant, we have outlined the analysis presented here based only on the empirical material from the Florianópolis families, totaling 19 caregiver narratives.

We aimed to interview two people per family separately, who were considered to be the two main caregivers of the child. In addition to single-parent families (in which only one caregiver was interviewed), in some other families it was also only possible to access one of the caregivers (usually the mother), either because we were unable to get back in touch with the other caregiver (father) or because he was unavailable. We also prioritized the diversity of sociodemographic characteristics, with the aim of including families from different social classes, racial groups, educational levels and living in different areas of the respective cities.

Regarding race/color, we used self-declaration. As for class, due to the inherent complexity of categorization, we used information on schooling as a starting point and the Brazilian Economic Classification Criteria tool from the Brazilian Association of Research Firms (ABEP), which places individuals in social strata according to consumption patterns and ownership of goods. Based on this classification, at the beginning of the interviews, we sought to access the participants' self-declaration of their social class position. This category was therefore considered as a relational category that positions individuals, qualifying them mainly by the unequal distribution of economic goods, preferential division of political prerogatives and discriminatory differentiation of cultural values¹⁶.

Participants were recruited using the "snowballing" procedure, a strategy that is appropriate for identifying hard-to-reach populations¹³, such as families who select, postpone or do not vaccinate their children.

The initial interviewees were families unrelated to the researchers, referred by people in their personal and professional circles. Based on the initial referrals, and according to the social strata considered, each family was asked to refer other families to take part in the study.

The empirical data was produced through in-depth interviews, whose pre-defined and tested script is available as supplementary material. In Florianópolis, the fieldwork took place between March and June 2021 and was conducted by the executing researcher and first author of the article. The final number of interviewees was defined by the criterion of saturation, i.e. the field was closed when it was found that no more new facts or units of meaning emerged from it¹⁷.

Due to the COVID-19 pandemic, all the interviews in Florianópolis took place in a virtual environment on the Zoom® platform. The average length of the interviews was 61 minutes. All interviews were recorded in full and transcribed by the researcher. The interviews were then checked for reliability.

The process of thematic analysis was oriented by the perspective of intersectionality, based on Hancock's assumptions¹⁸, which involves considering the relevant social markers that emerge from the empirical and the variable relationships between them. The iterative categorization technique proposed by Neale¹⁹ was used. After an immersive reading of the transcripts, highlighting the units of meaning, the codes were listed. A Microsoft Excel® spreadsheet was used to list the codes, after abstracting the participants' accounts, and to group the codes into categories, from which themes emerged. This process was initially carried out by the first author, with subsequent verification and validation by each of the other authors.

In a next step, an initial interpretative synthesis was produced according to the expression of the social markers that emerged in the themes, highlighting the strength of articulation between them according to the parameters of advantages and disadvantages they operate. The final synthesis was made in the light of the proposed objective, the literature on the theme/object and the theoretical framework of intersectionality. The broader research was approved by the Ethics Committee of the Hospital das Clínicas of the Faculty of Medicine of the University of São Paulo, in compliance with the precepts of Brazilian National Health Council Resolutions 510 of 2016 and 466 of 2012, and approved under CAAE No. 37536320.2.0000.0068.

Results

The results presented here are the result of the analysis of interviews conducted in Florianópolis (SC) with 12 families (19 guardians), all of whom had postponed or not vaccinated (totally or partially) the children under their responsibility, by their own decision, despite the availability of vaccines. These guardians were mothers (n = 11) and fathers (n = 8); most of them self-declared white (n = 16), belonging to socioeconomic strata A and B (n = 14), with higher education or postgraduate degrees (n = 12). One interviewee declared herself to be yellow, one did not want to declare his race/color and one declared himself to be brown skin. Frame 1 shows the characterization of the interviewees.



Frame 1. Sociodemographic characterization of interviewees.

Identification	Age	Race/color*	Profession	Self-declared social class	Abep social stratum	Age of child(ren)**
F-H-01.Mãe	31	White	Doula	Middle	B2	2y10m, 13y11m
F-H-01.Pai	36	White	Civil police	Middle	A	
F-H-02.Mãe	43	White	Engineer	Middle	B2	4y2m
F-H-02.Pai	37	Brown	Professor	Middle	B1	
F-H-03.Mãe	42	White	Researcher	Middle	A	5y
F-H-03.Pai	43	N/D	Administrator	Middle	A	
F-H-04.Mãe	34	White	Cultural producer	Middle	B2	1y, 3y3m
F-H-05.Mãe	42	White	Architect	Middle	B2	4y5m
F-H-05.Pai	39	White	Trade representative	Middle	C1	
F-H-06.Mãe	38	White	Teacher	Middle	B1	5y6m
F-H-06.Pai	43	White	Writer	Middle	B1	
F-H-07.Mãe	30	White	Student	Middle	C2	6y
F-H-08.Mãe	24	White	Autonomous	Middle	C2	2y5m
F-H-08.Pai	26	White	Craftsman	Middle	C2	
F-H-09.Mãe	43	White	Autonomous	Middle	B2	4y11m
F-H-09.Pai	53	White	Therapist	Middle	B2	
F-H-10.Pai	33	White	Doctor	Middle	B2	3y11m, 5y9m
F-H-11.Mãe	37	White	Housewife	Lower	C2	4y6m
F-H-12.Mãe	34	Yellow	Autonomous / Therapist	Middle	B2	3y9m

N/D = Not declared.

* Self-declared.

** Children's age at time of interview, in years (y) and months (m).

Us: intra-family dynamics crossed by gender and social position/work and income

The family proved to be a rich space for analyzing gender dynamics. Since the two people considered to be the main carers were invited to take part in the study, they were often a woman/mother and a man/father.

Although, in general, the interviewed parents reinforced the participation of both in daily tasks and those related to health, the role of organizing and controlling the demands of the home and the child was the responsibility of the woman/mother:

Normally the one who takes more charge of these [health-related] issues is [the mother], who is more connected with it, right? I feel less connected as a father. (F-H-09.Pai – 53y, white, stratum B2)

Me. I take on more [health demands], we have shared custody, but I take on more [...] I was also the one who looked for the pediatrician, sometimes he didn't agree because 'are you going to pay for all this? I do my best to honor his paternity, which he also has the right to express. (F-H-12.Mãe – 34y, yellow, stratum B2)



This division of roles was often justified by work: the division was generally based on the role of men as those who spent more time on non-domestic work than women, even when the latter also had jobs/professions.

At first, I remember that we shared, but it wasn't equal, [...] I was much more immersed in my work. And gradually she [mother] felt the great need to have to work [...]. This was a bit difficult for me because I was going to have to divide up my time a lot, which was already very little for me, but we ended up dividing it up as equally as possible. (F-H-08.Pai – 26y, white, stratum C2)

The reports of the decision-making process in relation to non-vaccination also bring important elements to the discussion of gender: in general, this process takes place in different ways depending on whether the choice not to vaccinate comes from the man/father or the woman/mother. The issue of non-vaccination more commonly came from women/mothers, who accessed information about vaccines in their social circles and studies on pregnancy and motherhood. In these families, the man was generally a passive consumer of the information actively brought by his partners, culminating in mutual agreement.

And then I came to him [the child's father] [...] and sort of gave him a diagnosis of my study. And I always asked him 'do you agree? [...] The research came more from me. But I always brought something or other to show him, so that he believed more in what I was saying, you know? (F-H-07.Mãe – 30y, white, stratum C2)

In the few cases in which the issue of non-vaccination came from the man/father, the process was less dialogical, with partial or total disagreement on the part of the woman/mother. It should be noted that two of the three men/fathers who led the decision not to vaccinate were foreigners.

It started in the prenatal period, when he [the man/father] didn't want her to take vitamin K when she was born and there's BCG, which she takes when she's born, which he didn't want. But I thought he wouldn't be so tough, I thought he would give in [...]. But then it was horrible... it was very traumatic. The doctor forbade [the child to leave the hospital], [the father] wouldn't give in, nobody would, and the doctor called in the Guardianship Council [stops, breathes, voice quavers a little] and forced [the baby] to have the vaccine. And so began a very difficult period in our lives. (F-H-05.Mãe – 42y, white, stratum B2)

In the case of couples who disagree about vaccination, regardless of whether one of them is for or against it, it was the women/mothers who mentioned a fear that something would happen to the child because the father's/man's wishes had not been followed:

I just think that way, nothing can happen to her, because anything that happens will be the vaccine's fault. (F-H-05.Mãe – 42y, white, stratum B2)

The others: social belonging crossed by class and race

The decision to (not) vaccinate has also been shown to be a reflection of each family's social belonging. That is, the position each family occupies in the structures of social class, race and spatiality, for example.

The general premise guiding the discourse on the relativization of vaccination was that of individuality. Thus, the particular context and conditions in which the family/child lives must be taken into account when deciding whether or not to vaccinate. Also noteworthy is the mention of the important role of health professionals in this relativization, advising families on which vaccines (not) to take depending on their socioeconomic status.

The doctor explained the following: "Look, this vaccination is very much aimed at communities that are very poor in terms of basic sanitation, right? You really come into contact with venomous animals". (F-H-03.Pai – 43y, undeclared skin color, stratum A)

In general, this aspect is expressed in the narratives about what the family has access to: quality of life (food, hours of sleep and physical activity, for example), rights (basic sanitation and drinking water) and quality health services (with a few mentions of private health plans).

[...] children don't die of H1N1, almost none of them, especially upper middle-class children with private health insurance [...]. So I consciously chose not to give them influenza and rotavirus, which I know aren't contagious, and also, for our social class, where we have access to fast medicine, I don't think they're going to die of dysentery or the flu, you know? (F-H-03.Mãe – 42y, white, stratum A)

If I lived in the center of São Paulo, working 8 hours a day, plus four hours in traffic, I would have given her everything, all the vaccinations [laughs], everything, right? But if I had the privilege of living by the beach, of my daughter being born at home, of having excellent care from the health center at the time, all of that... (F-H-07.Mãe – 30y, white, stratum C2)

Access to information is also mentioned as an advantage that these families consider they have. Speaking other languages is considered an important factor in accessing information from other countries which, according to these families, have a greater accumulation of knowledge about (non)vaccination - referring especially to the European continent and the United States.

So in this respect I live much more from this experience, from this awareness, from the Northern Hemisphere's know-how about these events, which perhaps hasn't even arrived here in Brazil yet. (F-H-05.Pai – 39y, white, stratum C1)



The socio-spatial organization of the city, beyond the question of basic sanitation, was mentioned several times as a factor that should be taken into account when deciding (not) to vaccinate, as well as contact (or the lack of it) with people from certain areas of the city.

My son, who we take more care to feed, who has a more suitable environment, is forced to take [the same] vaccine as that child who lives in the favela, who has poor sanitary conditions, who doesn't eat well, whose mother can't give him that support, right? (F-H-09.Mãe – 43y, white, stratum B2)

They even say that we have a social responsibility to get vaccinated [...]. But anyway, I kind of live in a very bourgeois world, right? I don't live on the outskirts, I don't have contact with people from the outskirts, who are children who are more... susceptible, with people who are more likely to have these diseases, right? [...] And then I think that when I try to put them in public schools, they'll say that they have to have a card [...] and that's right, right? Because then he'll be in contact with a lot of children who I don't know what their condition is. (F-H-02.Mãe – 43y, white, stratum B2)

Also noteworthy is the fact that these families constantly reinforce their class consciousness, through statements and laments about the socio-economic inequalities that mark the Brazilian reality, including highlighting their place of privilege. Or even highlighting the privilege they see in the spaces they attend (such as school, as in the excerpt below). Even so, in their narratives, they reinforce the place of families from lower socio-economic strata as unstructured or uninformed.

We're a very privileged family, right? We know what children often come from unstructured families, who don't have the chance to talk to the child about the need for this kind of preventive medicine - in fact, suddenly they don't even know what preventive medicine is. We make an assessment based on our reality, right? (F-H-03.Pai – 43y, undeclared skin color, stratum A)

There was a year when they [children] went to the Waldorf kindergarten, and then I got upset. Then I got upset because I saw that sea of unvaccinated blonde children, right [laughs]. [...] Because it's rubbing privilege in the face, right? Maybe in fact those unvaccinated children won't be the ones affected by not being vaccinated. It's fucking unfair that they have that choice, you know? [...] and in fact I don't have any statistics on that, I don't know that, but they're blondes [laughs]. (F-H-10.Pai – 33y, white, stratum B2)



An intersectional look at social facilities: schools, health services and the guardianship council as spaces for reproducing privilege

Although all the families mentioned here belong to the same group in terms of their choice not to vaccinate all or part of their children, their economic status and symbolic capital differentiate them in terms of their use of social facilities. Access to private schools allows children to move around freely even if they are not vaccinated, while the need to secure a place in a public school makes less well-off families vaccinate even against their will.

Honestly, today I only vaccinate to the letter, so to speak, she only has all the vaccinations because we need the place at the nursery school. That's all. Because if it wasn't a prerequisite for her to get into the municipal nursery, I wouldn't vaccinate her the way I do. (F-H-08.Mãe – 24y, white, stratum C2)

Some of the families interviewed had already been approached by the Guardianship Council at some point. In almost all cases, it was the public primary health care service that reported the situation to the Council. It is noticeable that families with better economic conditions make what we will call here 'customized use of health', looking for health professionals in the private network who are aligned with their opinions about (non) vaccination - in general, homeopathic and anthroposophical pediatricians. Access to these professionals and the services they offer (such as homeopathic vaccines, for example) allows these families to back up their decision not to vaccinate with medical support.

The school wouldn't accept my daughter without the vaccine, right? [...] But before the school, the health center reported me to the guardianship council, even twice. That's when I went to a homeopathic doctor and we started a process of homeopathic immunization. Other doctors questioned it, but that's what the guardianship council accepted. Then the school also demanded it, and it was very easy for me to sort it out with a statement from the [homeopathic] doctor, right? (F-H-11.Mãe – 37y, white, stratum C2)



Discussion

Our findings should be considered within the context in which they were collected. Florianópolis is the capital of the state of Santa Catarina, located in the south of Brazil. It has a good Human Development Index (HDI), a low infant mortality rate (7.78) and high coverage of adequate sanitation (87.8%). Its population is mostly white (84.76%)²⁰. Florianópolis has low vaccination coverage for the infant immunization scheme, and this coverage is significantly lower in socioeconomic stratum A than in stratum E²¹.

The findings in relation to gender roles in the family are in line with what is often found in the health literature. Studies on parental care in general, and specifically on child vaccination, almost always focus on mothers, and the role of men/fathers in this area of parental care is little known²².

The attribution of women as caregivers goes hand in hand with the history of vaccines. Women became the focus of health policies during the Vargas era, which aimed to create a “new national race”. This was to be achieved through hygienic practices aimed at the black and indigenous populations²³.

Childcare was established in France at the end of the 19th century, and was implemented to standardize the care of children, aiming for “perfect health”⁴. Pediatrics and childcare were strengthened in Brazil from the 1970s onwards under the eugenicist aegis, and vaccination played an essential role in this context, since the beautiful and healthy childhood that would build Brazil’s greatness presupposed properly vaccinated children²⁴.

Over the following decades, the duties of the “good mother”, responsible for the proper development of her child, were defined, as was the exaltation of maternal love and the ability of women/mothers to procreate and breastfeed. The man/father, on the other hand, occupies the position of material provider for the family⁴. Although there are variations depending on the family format and socio-economic position, in general, these duties were reinforced by the interviewees in this survey.

It should be noted, however, that the historical process described here was neither linear nor homogeneous between different economic and racial groups. According to Velho²⁵, it is mainly in the urban and educated middle classes that there was a growing appreciation of the individuals as unique beings and protagonists of their own trajectory. These are the social groups that value autonomy and freedom of choice, also based on a discourse of supposed equality, which reflects bourgeois, capitalist and, at the same time, neoliberal values^{25,26}.

This study found that the main rationale behind not vaccinating children were the premises of individuality. This view also justifies what we called the customized use of health, i.e. the search for professionals who reinforce the autonomy and freedom of those responsible for making decisions.



One of the few qualitative studies that, beyond the drivers of vaccine hesitancy, delves into the structural aspects that shape parental perceptions, pointed to the uniqueness of each child, informed decision-making and intensive parenting as essential elements in contemporary parental norms¹³. Under the premise that each child is unique, universal interventions such as vaccination are criticized. This is what Reich²⁶ calls the neoliberal parenting paradigm. In the same vein, the idea that the child's body is pure and should be protected from contamination also emerged frequently in the narratives, in line with the results of other studies⁴. In this case, for hesitant parents, the "contamination" is the vaccine.

Although there is not universally a single direction in the relationship between social class and (non)vaccination, both data from the city of Florianópolis and national data point to lower vaccination coverage the higher the social stratum²¹. Other qualitative studies show that, although the majority of caregivers have doubts and concerns about vaccines, it is those in the higher socioeconomic strata who can channel their resources into dealing with these issues²⁷. The hesitant caregivers belonging to the middle and upper classes in different countries are the ones who feel authorized to question state policies and bear the possible consequences of non-vaccination^{13,26,27}.

This understanding was very marked in the narratives of the interviewees, who emphasized their various accesses (to information, to health/quality of life, to rights) as what allowed them to question vaccines, not vaccinate their children or not follow the protocols of public social facilities. These accesses standardize this group as "us", in relation to the "others".

Identities are relational and therefore individuals and social groups organize themselves into "us" and "them" groups based on the collective identity that define these boundaries¹⁴. Despite the well-described material disadvantages associated with racial inequalities, social class does not explain the entire scenario experienced by the "others" in Brazil. We align ourselves with Guerreiro Ramos²⁸, one of the precursors of studies on whiteness in Brazil, in a position contrary to the tendency of Brazilian sociology to justify racial inequalities in Brazil by social class. The claim that prejudice in Brazil is linked to class was one of the strongest and most systematic ways of denying Brazilian racism¹⁴. Since whiteness is the normative and hegemonic standard, in other words, one lives without noticing oneself racially, everything that doesn't meet the white norm is considered "the other"⁹.

Something in the division between "us" and "them" was very marked in the narratives of the hesitant guardians: spatiality. Both referring to the other as living in the 'favela' or 'periphery' and defining 'us' as living in areas with basic sanitation or "in a very bourgeois universe" are ways of demarcating the spatial segregation of bodies¹. According to Schucman¹⁴, "spatial markers" demarcate the division between "us" and "others"; in other words, racial perceptions are also constructed from the spatial distribution of cities, structuring public life and how racial groups relate to each other in social space.



This author also draws attention to two important intra-group markers that delimit differences between “us whites”: social class and access to material goods; and gender. In other words, the experiences of being rich or poor white are certainly very different, and masculinities and femininities operate in complex relationships with racial categories¹⁴. This is very evident when discussing the use of social facilities: although multiple accesses and systemic privileges delimit the “us” as a group, the social stratum will define who, for example, depends on public schools and will need to be vaccinated to guarantee a place.

Racism, as a power device that “operates as a disciplinarian, ordering and structuring social and racial relations”²⁹ (p. 70), makes the racial division of labor and social spaces so naturalized that it becomes a habitus, producing inequalities in everyday living conditions¹⁴. The “we” interviewed here often stress their discontent with the Brazilian social inequality that plagues the “others”, in a rather paradoxical discourse.

According to Bento⁹, the fact of not seeing oneself implicated in the structure that determines power relations is a characteristic of whiteness, in other words, there is an understanding of social inequalities, but there is no understanding that one is part of this structure. Thus, the identification of these inequalities and any action against them is seen as altruism⁹.

Final considerations

Vaccine hesitancy is known to be a complex and multi-causal phenomenon, which concerns not only individual decisions, but a whole social, economic and political context.

Gender positions express the intra-family dynamics of parental care, with implications for both the performance of daily tasks and the tensions caused by health decision-making. Social class, race and spatiality demarcate positions in the social web and systemic privileges, serving as a boundary between “us” and “them”, but also defining intra-group positions and differentiating hesitant families between those who have or don't have the symbolic capital to afford the decision not to vaccinate in the face of state facilities.

Understanding vaccine hesitancy as a social and political phenomenon is essential to avoid the reductionism that associates non-vaccination with misinformation or negligence. The findings analyzed here, from an intersectional perspective, enhance the effort to critically understand how class positioning, gender identity and race shape experiences of vaccination and childcare, revealing unequal distributions of power, prestige and privilege. Our findings show that the decision not to vaccinate, far beyond a position on vaccines, is also a way of positioning oneself in the social web, of belonging to a group and of communicating values and beliefs.



Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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References

1. Chalhoub S. *Cidade febril: cortiços e epidemias na corte imperial*. São Paulo: Companhia das Letras; 1995.
2. World Health Organization. Report of the SAGE working group on vaccine hesitancy [Internet]. Geneva: WHO; 2014 [citado 7 Mar 2024]. Disponível em: https://www.who.int/immunization/sage/meetings/2014/october/1_Report_WORKING_GROUP_vaccine_hesitancy_final.pdf
3. World Health Organization. Behavioural and social drivers of vaccination: tools and practical guidance for achieving high uptake [Internet]. Geneva: WHO; 2022 [citado 7 Mar 2024]. Disponível em: <https://apps.who.int/iris/handle/10665/354459>
4. Barbieri CLA. *Cuidado infantil e (não) vacinação no contexto de famílias de camadas médias em São Paulo/SP [tese]*. São Paulo: Universidade de São Paulo; 2014.
5. Sobo EJ. Theorizing (vaccine) refusal: through the looking glass. *Cult Anthropol*. 2016; 31(3):342-50.
6. Moulin AM. A hipótese vacinal: por uma abordagem crítica e antropológica de um fenômeno histórico. *Hist Cienc Saude Manguinhos*. 2003; 10 Supl 2:499-517.
7. Collins PH, Bilge S. *Interseccionalidade*. São Paulo: Boitempo; 2021.
8. Couto MT, Oliveira E, Separavich MAA, Luiz OC. La perspectiva feminista de la interseccionalidad en el campo de la salud pública: revisión narrativa de las producciones teórico-metodológicas. *Salud Colect*. 2019; 15:e1994.
9. Bento C. *O pacto da branquitude*. São Paulo: Companhia das Letras; 2022.
10. Silva PE. O conceito de branquitude: reflexões para o campo de estudo. In: Müller TMP, Cardoso L, organizadores. *Branquitude - Estudos sobre a identidade branca no Brasil*. Curitiba: Appris; 2017. p. 19-32.
11. Frankenberg R. A miragem de uma branquitude não marcada. In: Ware V, organizador. *Branquidade - Identidade branca e multiculturalismo*. Rio de Janeiro: Garamond; 2004. p. 307-38.
12. Barbieri CLA, Couto MT. Decision-making on childhood vaccination by highly educated parents. *Rev Saude Publica*. 2015; 49:1-8.
13. Kuan C-I. Vaccine hesitancy and emerging parental norms: a qualitative study in Taiwan. *Sociol Health Illn*. 2022; 44(3):692-709.
14. Schucman LV. *Entre o encardido, o branco e o branquíssimo: branquitude, hierarquia e poder na cidade de São Paulo*. São Paulo: Veneta; 2019.
15. Fontana A, Frey JH. The interview: from structured questions to negotiated text. In: Denzin N, Lincoln Y, organizers. *Handbook of qualitative research*. 2th ed. Thousand Oaks: Sage Publications; 2004. p. 61-106.
16. Bourdieu P. Capital simbólico e classes sociais. *Novos Estud Cebrap*. 2013; 96:105-15.
17. Francis JJ, Johnston M, Robertson C, Glidewell L, Entwistle V, Eccles MP, et al. What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychol Health*. 2010; 25(10):1229-45.
18. Hancock AM. Intersectionality as a normative and empirical paradigm. *Polit Gend*. 2007; 3(2):248-54.
19. Neale J. Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction*. 2016; 111(6):1096-106.



20. United Nations Development Programme, Fundação João Pinheiro, Instituto de Pesquisa Econômica Aplicada. Atlas do Desenvolvimento Humano no Brasil [Internet]. Brasília: PNUD; 2022 [citado 7 Mar 2024]. Disponível em: <http://www.atlasbrasil.org.br/>
21. Barata RB, Ribeiro MCSA, Moraes JC, Flannery B, Vaccine Coverage Survey 2007 Group. Socioeconomic inequalities and vaccination coverage: results of an immunisation coverage survey in 27 Brazilian capitals, 2007-2008. *J Epidemiol Community Health*. 2012; 66(10):934-41.
22. Gutierrez DMD, Minayo MCS. Produção de conhecimento sobre cuidados da saúde no âmbito da família. *Cienc Saude Colet*. 2010; 15 Supl 1:1497-508.
23. Silva EGF, Carvalho AB. A construção da raça nacional: estratégias eugênicas em torno do corpo da mulher. In: Batista LE, Werneck J, Lopes F, organizadores. *Saúde da população negra*. Brasília: ABPN; 2012. p. 225-44.
24. Müller TMP. A criança branca idealizada pela imprensa no século XX. In: Müller TMP, Cardoso L, organizadores. *Branquitude - Estudos sobre a identidade branca no Brasil*. Curitiba: Appris; 2017. p. 335.
25. Velho G. *Individualismo e cultura: notas para uma antropologia da sociedade contemporânea*. 2a ed. Rio de Janeiro: Jorge Zahar; 1987.
26. Reich JA. Neoliberal mothering and vaccine refusal: imagined gated communities and the privilege of choice. *Gend Soc*. 2014; 28(5):679-704.
27. Peretti-Watel P, Ward JK, Vergelys C, Bocquier A, Raude J, Verger P. 'I think I made the right decision... I hope I'm not wrong'. Vaccine hesitancy, commitment and trust among parents of young children. *Sociol Health Illn*. 2019; 41(6):1192-206.
28. Guerreiro Ramos A, organizador. *Introdução crítica à sociologia brasileira*. Rio de Janeiro: Editora UFRJ; 1957. *Patologia social do 'branco' brasileiro*; p. 171-92.
29. Carneiro AS. *A construção do outro como não-ser como fundamento do ser [tese]*. São Paulo: Universidade de São Paulo; 2005.



O artigo analisa como os marcadores raça, gênero, classe social e espacialidade se interseccionam e se refletem nas tomadas de decisão em saúde, mais especificamente na (não) vacinação infantil. Trata-se de pesquisa qualitativa conduzida nas cidades de Florianópolis (SC) e São Luís (MA), Brasil, com famílias com crianças de até seis anos de idade. Neste artigo, examinam-se, por meio de análise temática, as narrativas das/dos 19 responsáveis de Florianópolis que optaram por não vacinar total ou parcialmente a(s) criança(s) sob sua responsabilidade. Gênero revela-se um importante marcador na tomada de decisão no âmbito intrafamiliar, enquanto classe social, raça e espacialidade surgem como importantes marcadores na percepção de quem são os “nós” que não precisam das vacinas e os “outros” que precisam. Os achados são discutidos pelo referencial da interseccionalidade e de estudos teóricos sobre branquitude e parentalidade neoliberal.

Palavras-chave: Vacinação. Hesitação vacinal. Enquadramento interseccional. Pesquisa qualitativa. El artículo analiza cómo los marcadores de raza, género, clase social y espacialidad se cruzan y se reflejan en las tomas de decisión en salud, más específicamente en la (no) vacunación infantil. Se trata de una investigación cualitativa realizada en las ciudades de Florianópolis (Estado de Santa Catarina) y São Luís (Maranhão), Brasil, con familias de niños de hasta seis años de edad. En este artículo se analiza, por medio de análisis temático, las narrativas de los 19 responsables de Florianópolis que optaron por no vacunar total o parcialmente a los niños bajo su responsabilidad. El género se revela como un importante marcador en la toma de decisión en el ámbito intrafamiliar, mientras que la clase social, raza y espacialidad surgen como importantes marcadores en la percepción de quiénes son los “nosotros” que no necesitan las vacunas y los “otros” que las necesitan. Los hallazgos se discuten a partir del referencial de la interseccionalidad y de estudios teóricos sobre la blanquitud y la parentalidad neoliberal.

Palabras clave: Vacunación. Titubeo con relación a la vacuna. Encuadramiento interseccional. Investigación cualitativa.