



PART 1

Read the text below and answer questions 1–13.

VACCINE HESITANCY: A MODERN PUBLIC HEALTH CHALLENGE

A Vaccine hesitancy has become a defining challenge for contemporary public health because it sits in the grey area between acceptance and refusal. The World Health Organization describes it as a delay in accepting, or a reluctance to accept, vaccines even when services are available. That definition matters because it frames hesitancy as a spectrum rather than a binary identity. Many people who hesitate are not committed opponents of vaccination; they may accept certain vaccines yet postpone others, or they may remain uncertain while weighing perceived risks against perceived benefits. Their doubts can be shaped by concerns about safety, questions about effectiveness, or beliefs about personal necessity. At the same time, hesitancy is not only psychological: decisions are also influenced by practical convenience, the visibility of vaccination services, and levels of confidence in institutions. Because it changes across time, place and vaccine type, it cannot be addressed with a single slogan or a uniform campaign.

B One paradoxical driver of hesitancy is the success of vaccination itself. When immunisation programmes work well, they reduce the everyday visibility of diseases such as measles or polio. As a result, some communities begin to perceive infection as a remote threat, while the possibility of side effects—however rare—feels more immediate. This imbalance in risk perception is often described as complacency: the idea that people delay a preventive action because the danger it prevents no longer seems urgent. In sociological terms, vaccination alters the collective memory of disease. Older generations may remember hospital wards filled with children suffering complications, while younger parents may never have witnessed such outcomes. When the disease fades from view, the vaccine can appear less necessary, even though herd immunity depends on sustained high coverage. The irony is that the better the system performs, the easier it becomes for individuals to underestimate what the system is preventing.

C Public health communication has sometimes responded as if hesitancy were simply an information gap. This “deficit model” assumes that if people are given more facts, they will correct misconceptions and comply. Yet research in behavioural science suggests that this approach can misfire. When hesitant individuals feel they are being lectured or pressured, they may experience psychological reactance: a defensive response in which people protect their autonomy by resisting the message and entrenching their prior views. In practice, this means that “more data” can sometimes harden resistance rather than resolve doubt. Alternative strategies aim to reduce confrontation and increase dialogue.



Clinicians and outreach workers increasingly use motivational interviewing techniques, which involve asking open questions, listening carefully, and helping individuals clarify their own values and ambivalence. This does not mean withholding evidence; it means presenting information in a way that supports agency, builds rapport, and addresses specific concerns rather than delivering generic statistics.

D In many settings, hesitancy is less about ideology than about logistical barriers. People may intend to vaccinate yet delay because the clinic is far away, opening hours conflict with work, or booking systems are confusing. For families on tight budgets, the cost of transport or the loss of wages from taking time off can be decisive. Even minor frictions—long queues, repeated paperwork, lack of reminders—can reduce uptake, especially when vaccination is not perceived as urgent. For this reason, some of the most effective interventions are not persuasive campaigns but service-design improvements. Mobile vaccination units, extended evening hours, walk-in appointments, and community-based clinics can make vaccination easier to access. These changes matter because convenience interacts with psychology: when a behaviour is simple and normal, people are more likely to follow through. Reducing logistical barriers can therefore convert “hesitant in practice” into “vaccinated in fact” without changing anyone’s ideology.

E The COVID-19 pandemic pushed vaccine hesitancy into global visibility and revealed how quickly uncertainty can affect health-system capacity. During the pandemic, vaccination was not only a personal choice but a collective strategy to reduce severe illness and maintain functioning hospitals. The crisis also highlighted the importance of health literacy—people’s ability to interpret health information, understand probabilities, and judge the credibility of sources. Where communication from authorities appeared inconsistent or opaque, distrust could grow. Conversely, transparency—clear explanations, acknowledgement of uncertainty when it exists, and honest updates as evidence evolves—can support confidence even when recommendations change. The pandemic also reminded policymakers that coverage is not maintained by short-term bursts of messaging. Sustained high vaccination rates require long-term investment in relationships, infrastructure and community engagement, so that vaccination becomes the easy, normative and trusted choice rather than a contested demand.

F The digital information environment has intensified the challenge. Online platforms allow misinformation and disinformation to circulate rapidly, often packaged in highly emotional narratives that spread faster than cautious scientific language. Algorithmic amplification can prioritise content that provokes outrage or fear, increasing exposure to dramatic personal stories over statistical summaries. In addition, social media networks can form echo chambers in which users repeatedly encounter the same claims, making minority



views appear mainstream. This does not mean technology alone “causes” hesitancy; rather, it can magnify anxieties, reinforce cognitive bias, and provide social reinforcement for doubt. Once a claim becomes associated with group identity, correcting it is more difficult because the issue is no longer only factual. The platform architecture can therefore shape not just what people see, but how they feel about what they see, and whether they interpret public health advice as guidance or as interference.

G A classic illustration is the long-running claim that the MMR vaccine is linked to autism—an allegation that was thoroughly discredited by later research, yet remains socially persistent. The endurance of such stories reveals that people do not evaluate evidence in isolation. Trust in institutions, personal experience, and a sense of belonging can weigh as heavily as scientific consensus. As a result, simply repeating that a claim is false may fail to persuade, or may even deepen suspicion if it sounds dismissive. Effective communication often requires addressing underlying fear, recognising the emotional stakes, and explaining how safety monitoring works in understandable terms. Policy can also influence attitudes. Some jurisdictions require vaccination for school entry or tie certain benefits to immunisation status; these measures can raise uptake, but if introduced without engagement they may be perceived as coercive and fuel polarisation. Over time, the most durable gains tend to come from layered approaches: reliable service delivery, respectful dialogue, and institutional behaviour that consistently demonstrates competence and honesty. In that sense, vaccine confidence resembles an ongoing relationship, built through repeated experiences rather than a one-off campaign.

Questions 1–5

The text has seven paragraphs, **A–G**. Which paragraph contains the following information? Choose the correct letter, **A–G**.

- 1** The warning that overwhelming people with facts may strengthen resistance rather than reduce it.
- 2** The idea that repeated exposure online can make inaccurate claims appear widely accepted.
- 3** The view that access problems (rather than ideology) can be a major cause of delayed vaccination.
- 4** The claim that vaccine hesitancy is not simply “for” or “against”, but exists on a range.
- 5** The explanation that vaccination can seem less urgent when a disease becomes uncommon.

Questions 6–9



Complete the summary below. Choose **NO MORE THAN TWO WORDS** from the text for each answer.

Approaches to Communication

Approaches to vaccine hesitancy often fail when they rely only on information. When communication feels overly pressuring, hesitant individuals may experience **6**, while online misinformation may spread rapidly through highly **7** Social-media networks may develop into **8**, repeatedly exposing users to the same claims. In response, communicators may need to address the underlying **9** rather than simply repeating that a claim is false.

Questions 10–13

Choose **TRUE** if the statement agrees with the information given in the text, choose **FALSE** if the statement contradicts the information, or choose **NOT GIVEN** if there is no information on this.

- 10** Healthcare providers are always more trusted than community leaders in vaccine communication.
- 11** The passage suggests that technology by itself is the main cause of vaccine hesitancy.
- 12** The passage indicates that linking vaccination to school entry can increase uptake in some places.
- 13** The passage suggests that public trust develops through repeated experiences over time rather than a one-off campaign.

Answer Key

- 1. C
- 2. F
- 3. D
- 4. A
- 5. B
- 6. psychological reactance
- 7. emotional narratives
- 8. echo chambers



9. fear

10. NOT GIVEN

11. FALSE

12. TRUE

13. TRUE