

WELL-BEING AND GENERALIZED TRUST DURING THE COVID-19 PANDEMIC

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Abstract: *After some brief introductory notes, this study reviews approaches to well-being and trust during the COVID-19 pandemic. After reviews, it includes the methodology and structure of the group of 1640 respondents involved in a survey carried out by us between November 2020 and January 2021. Among the research results, this study presents a series of data related to: self-assessment of well-being on the poor-rich scale and the main predictors involved; generalized trust (in people in general) and the perception of its evolution in the first year of the pandemic; the association between well-being and generalized trust and the association between well-being, trust and attitudinal compliance (defined by compliance with prevention measures and willingness to vaccinate). The research results led to the highlighting of an association between the perception of well-being and trust, on the one hand, and between generalized trust and compliance with prevention measures, on the other hand.*

Keywords: *perceived well-being, compliance, social capital.*

1. Introduction

More than a hundred years after the Spanish flu, experts were still studying its roots and social implications, particularly in terms of well-being. Thus, Mamelund (2018, p. 307) mentioned that the pandemic of 1918-1919 killed between 50 and 100 million people in three waves and that it was long argued that this pandemic affected all social classes equally. However, Mamelund notes, later studies challenged the earlier view of mortality and found higher mortality for the poor.

Personally, I have not identified any studies that analyse the issue of trust and social capital during the Spanish flu pandemic. However, such studies were not lacking in the approaches to the H1N1 pandemic (2009-2010). During the H1N1 pandemic, experts noted, social capital (measured by trust in government and interpersonal contacts as well as feelings of obligation, reciprocity, and cohesion) functioned as a predictor of vaccination intention, handwashing, and mask-wearing behaviours (Pitas and Ehmer, 2020: 943). Considering Italy during the H1N1 outbreak, Prati, Pietrantonio and Zani (2011: 761) argued, based on research, the importance of building public trust in promoting compliance with the recommended behaviours. Research done in other countries offered similar results: two important indicators of social capital – institutional trust in health services and generalized trust appeared to be independently associated with the intention to accept the H1N1 vaccine (Rönnerstrand, 2013: 853).

Some experts say that income inequality defines social stratification in health and mortality. For example, socio-economic disparities in H1N1 mortality have been attributed to different exposure to the virus, differences in disease susceptibility and differences in access to health services, with similarities also seen in the case of COVID-19, with high transmission and negative impact higher in the poor population due to overcrowded housing and working conditions (Elgar, Stefaniak and Wohl, 2020: 1). The cited authors also estimated that the

vaccination rate may also differ from one country to another, depending on income inequality and social capital (Elgar, Stefaniak and Wohl, 2020: 5).

After these introductory notes, this study will continue with a brief review of concerns of some specialists from various fields in relation to well-being and its dynamics during the pandemic, both at the level of the enabling factors and of the pandemic impact. Similarly, the issue of trust and social capital in general, general trust in particular, is addressed. Both how social capital and trust impacted the pandemic and the impact of the pandemic on trust and social capital are considered.

A special section is dedicated to the research methodology that substantiates our study. It is a survey based on a questionnaire carried out at the end of 2020 and the beginning of 2021, in Romania, with the participation of a group of 1640 respondents who completed an online questionnaire. The presentation of the structure of the studied group is followed by some results related to: self-assessment of well-being on the poor-rich scale and the main predictors involved; generalized trust and the perception of its evolution in the first year of the pandemic; the association between well-being and generalized trust and the association between well-being, trust and attitudinal compliance defined by compliance with prevention norms and willingness to vaccinate.

Our study ends with a series of conclusions and implications for intervention aimed at stimulating, by increasing generalized trust, compliance with prevention measures specific to a pandemic period (and not only!).

2. Well-being and the COVID-19 pandemic

2.1. Well-being at community, regional and national level

Approaching the theme of well-being yielded the most interesting results in analyses that promoted the community perspective on the COVID-19 pandemic. Thus, the rural-urban discrepancies were frequently considered in the analysis of the links between the community and the spread/control of COVID-19. In Canada for example, as Ervin pointed out, rural communities had the poorest population compared to urban and peri-urban areas. Rural and remote communities had many marginalized populations who lacked sources of social power such as money and expertise. It was the Amish communities, the immigrant communities, the Native American tribes. On top of all this, mistrust of government has created barriers to health care, thus generating a unique medical ethics problem (Erwin, Aultman, Harter et al., 2020). Describing a map of the vulnerability and resilience of US communities, Peters pointed out that around 30% of rural US communities were highly susceptible to COVID-19 due to the presence of the elderly and those in poor health, due to insufficient aged care facilities. Also, major vulnerabilities in rural areas included: fewer doctors, lack of mental health services, high numbers of people with disabilities and uninsured persons. Poor telemedicine connections were also noted. The cited author believed that the lack of social capital and social services could prevent local control of the pandemic (Peters, 2020: 446). In New York, a metropolis strongly affected by COVID 19, a series of comparative studies were carried out on neighbourhoods and it was concluded that in communities characterized by poverty, low access to health services and little education, more cases of diabetes, obesity and high blood pressure were identified, the percentage of these chronic diseases being higher in communities severely affected by COVID-19 (Harlem, 2020: 468). Harlem found that a high percentage of black people and Latinos severely affected by COVID-19 was synonymous with a high percentage of pre-existing chronic diseases, low education, and overcrowding (Harlem, 2020: 469). In the US, many problems have also been raised by immigrant communities. Thus, a study carried out by Center and collaborators highlighted the fact that in the provinces of Benton and Washington, the state of Arkansas, while people of Marshallese and Hispanic origin represented 19% of the

population, they totalled 64% of the illnesses and 57% of deaths caused by COVID-19 (Center, Da Silva, Hernandez et al., 2020: 1807).

As regards the community welfare inequalities, the warning was issued that it is very likely that COVID-19 could amplify existing inequalities both through the immediate consequences resulting from measures taken to prevent the spread and through long-term consequences (Fisher, Languilaire, Lawthom et al., 2020: 247). As Ferreira et al. observed, the COVID-19 pandemic has brought massive declines in well-being worldwide (Ferreira, Sterck, Mahler et al., 2021). For the case of Germany, specialists have documented the link between well-being and the impact of the pandemic in its various phases. For a first phase, a positive association was identified between the wealth of a district and infection rates and a negative association with indicators of social deprivation. It was the phase of the virus entering Germany through those who had been skiing in the Alps and on international trips and who were more affluent people. During the second phase, wealthier areas and areas with a higher share of university-educated employees saw fewer new infections, while the initial advantage of more socially disadvantaged areas disappeared. In the second phase, Plümper and Neumayer (2020, p. 1) pointed out, the further spread of the virus depended on the ability of individuals to distance themselves socially, an ability that was, to some extent, socially stratified.

2.2. Trust during the COVID-19 pandemic

In relation to the COVID-19 pandemic, studies conducted at the level of large populations in urbanized areas of the world considered a number of variables such as social capital or ethnic and racial diversity to explain disparities in the spread of SARS-CoV-2 in community level. Thus, considering wider communities such as provinces/counties in the USA, it was concluded that areas with a high level of social capital were at risk in the first phase of the COVID-19 pandemic due to the high level of interactions, over time the norms of trust and reciprocity contributing to reducing the impact of the pandemic (Borgonovi, Andrieu and Subramanian, 2020: 1). Researchers have also found in the case of cognitive social capital, in the form of trust and norms, a stronger impact than structural or network capital, in the form of activism or political participation. This result suggested that, in principle, social capital affects the response to COVID-19 by facilitating cooperation and self-sacrifice for the common good and by promoting public acceptance and compliance with control measures (Wu, 2021: 45-46). Social capital, as it results from other research, is associated with a great trust and relationship in a community, it can endow people with a greater care towards others, a fact that leads to the observance of hygiene rules and social distancing (Makridis and Wu, 2021: 1). Although it should rather lead to the spread of the virus through greater social interaction, social capital has a significant negative effect on infections and the spread of the virus (Makridis and Wu, 2021: p. 14). Hence the conclusion that health interventions cannot be disconnected from social forces that are at the local level. By investing in social capital and interpersonal relationships, experts believed, we help manage negative shocks and maintain levels of interconnectedness and well-being (Makridis and Wu, 2021: 15).

Anticipating that many studies will be developed on the topic of trust in the control of the COVID-19 pandemic, Devine analysed in 2021 a series of works that appeared during the first waves. The work on this topic, Devine found, confirmed that *trust was associated with greater compliance with political measures*. Some potentially conflicting results were also identified: while trust was associated with lower mortality rates, it was also linked to later adoption of restrictive isolation measures. Studies also showed how trust increased considerably at the start of lockdown measures, with *institutional trust* feeding *social trust*, but direct exposure to COVID-19 reduced trust (Devine, 2021: 282).

Thoresen and collaborators were interested in the impact of the pandemic on generalized trust. The identified levels of generalized trust in an early phase of the pandemic

(May 2020, on a representative sample of the Norwegian population) did not differ significantly from the expected levels based on pre-pandemic research. Increased trust was identified for people who reported personal experience with COVID-19 (tested positive, hospitalized, or lost someone to the disease). Pandemic worry and a high health threat were both associated with lower levels of generalized trust. The authors hypothesize that people who had personal experience with the disease may have had direct experiences with kindness and helpfulness from medical staff or others, which may have transferred into increased trust in others. The results, Thoresen et al. believed, suggested that generalized trust in other people can be affected by disasters and problems, both positively and negatively, depending on the personal experiences of individual disasters (Thoresen, Blix, Wentzel-Larsen et al., 2021).

The researchers also analysed the impact of the pandemic on *social trust*. For example, Kye and Hwang (2020) concluded that trust in Korean society, people, central and local authorities increased substantially while trust in the judicature, media and religious organizations decreased. Elgar, Stefaniak, and Wohl (2020) considered data on income inequality, data on four dimensions of social capital (trust, group affiliation, civic responsibility, and trust in public institutions), and data on COVID-19 deaths from 84 countries on a period of 30 days. They found that mortality was positively associated with income inequality, trust and group affiliation, and negatively associated with civic engagement and trust in state institutions.

3. Research on well-being and generalized trust

3.1. Method and studied group

The method used in our research was questionnaire survey. The research was carried out between November 6, 2020 and January 26, 2021. It was the period in which the highest number of infections was reached in Romania for the year 2020, i.e. over 10,000 cases per day. The survey took place online, with participants being contacted directly, through the Facebook network, or indirectly, through our students and other collaborators. The main themes of the survey referred to: concerns and fear, attitudes towards prevention measures and willingness to be vaccinated, quality of life, trust and tolerance. As already suggested, in the present paper we will consider only some aspects of well-being and trust. Other important aspects were the subject of several studies published by us in the last two years (Pascaru, 2021a, 2021b, 2022).

At the end of the survey, a group of 1,640 people answered the questionnaire. We have chosen to present here only the characteristics that will be used as independent variables in this research. By gender, 639 respondents (representing 39% of all respondents) were male and 994 (60.6%) were female, with seven people (0.4%) not declaring their gender. Depending on age, the group included 625 people between 18-29 years old (38.1% of the total), 336 people (20.5%) between 30 and 39 years old, 319 people (19.5%) between 40 and 49 years, 194 people (11.8%) between 50 and 59, 115 people (7%) between 60 and 69 and 45 people (2.7%) 70 and over. Six people (0.4%) did not want to declare their age. According to what was declared, 9 respondents (0.5%) had graduated from primary school, 95 (5.8%) from secondary school, 438 (26.7%) from high school and 1069 (65.2%) were university graduates. 29 respondents (1.8%) did not specify their last graduated school. Regarding marital status, the respondents declared that they were: married (754, representing 46% of the total), single (624; 38%), divorced (105; 6.4%), widowed (52; 3.2%) and in consensual union (55; 3.4%). 50 respondents (3.0%) did not declare their marital status. Regarding the occupational status, 982 respondents (59.9%) declared themselves employees, 91 respondents (5.5%) said they were employers, 10 respondents (0.6%) declared themselves farmers, 37 respondents (2.3%) were unemployed, 142 respondents (8.7%) were retired and 324 (19.8%) declared themselves students. A number of 54 respondents (3.3%) did not declare their occupation. The type of locality in which the respondents declared that they lived the most during the pandemic was a rural locality for 418 respondents (25.5%) and an urban locality for 1211 respondents (73.8%). 11 respondents

(0.7%) did not declare the type of locality. The non-declaration of gender, age or type of locality can be attributed to the very sensitive subject of the investigation, being probably a reflex to protect the identity.

Another characteristic of the group of respondents, also important for this work, was the experience with COVID-19: 137 respondents (8.4%) declared that they had been infected with the new coronavirus, 1167 (71.2%) that they had not been infected and 326 (19.9%) that they do not know whether they were infected or not. In relation to this aspect, 10 respondents (0.6%) refused to give an answer. The lack of an answer to the questions related to the experience with COVID-19, must also be related to their sensitive subject.

3.2. Results

According to our research data, almost 45% of respondents tended to place themselves in the first half of the rich-poor scale, while more than 55% placed themselves in the second half of the proposed scale. The average for the whole group was 5.86, so higher.

The predictors proposed by us were not associated with significant placement differences (greater than 1 point/step). However, we note some small differences that seemed to be based on schooling (average 6.39 for those with secondary school versus 5.00 average for those with primary school and 5.86 average for the whole group), occupation (6.34 for employers and freelancers compared to 5.43 for the unemployed and 5.60 for farmers), ethnicity (7.25 for those of German ethnicity compared to 5.32 for those of Hungarian ethnicity, as also results from Table 1). Infection with SARS-CoV-2 was also not associated with differences in the perception of well-being.

Table 1: On a scale from 1 to 10 (1- very poor, 10- very rich) where do you stand? * Ethnicity

Ethnicity	Mean	N	Std. Deviation
Romanian	5.87	1573	1.557
Hungarian	5.32	28	1.307
Romani	6.14	7	1.952
German	7.25	4	1.893
Other	5.81	21	1.632
Total	5.86	1633	1.558

More than two-thirds of respondents with valid answers (79.8%) considered that they are as rich or poor as they were before the pandemic, 15.3% that they are poorer and 4.9% that they are richer. Men more than women reported changes in well-being, both in terms of impoverishment and enrichment. By age category, more of those between 18 and 29 (16.6%) and fewer of those over 60 (9.8%) declared poverty. Those between the ages of 18 and 29 (6.3%) declared that they had become richer. All those with primary school and almost a fifth of those with high school studies (19.9%) declared themselves poorer. Most of those who declared impoverishment were among the unemployed (48.6%), followed by employers and freelancers (27.8%). Among the last category, there were also more people who declared enrichment (6.8%). By ethnicity, more Hungarians declared impoverishment (29.6%) and more Romanians declared wealth (5.1%). More than a fifth of those divorced or cohabiting (22.8% and 22.2% respectively) said they had become poorer and a higher percentage of those who were single (6.7%) said they had become richer. Neither the place of residence during the pandemic nor the infection with Sars-CoV-2 was particularly associated with the respondents' impoverishment or enrichment.

Regarding trust, as can be seen in Table 2, only 37.8% of the respondents stated that they have a lot of trust in people in general. Less than 3% declared a lot of trust.

The respondents' gender did not induce major differences in the declaration of generalized trust. A higher percentage of people over 50 say they don't trust people in general at all, with the peak being reached in people 70 and over (7.3% compared to 4.2% for the whole group). None of those with a primary school degree reported trusting people very much in general, with 22.2% of them saying they did not trust people at all.

Overall, the share of those who declared a lot of trust increased with education level, and correspondingly, the share of those who declared that they did not trust people at all decreased. None of the farmers and the unemployed expressed much trust in people.

The highest percentage of those who declared a lot of trust in people was registered among employers and freelancers (5.5%). Farmers and retired people stated more than other categories that they do not trust people at all (11.1% and 7.4%, respectively).

Table 2: How much trust do you have in people in general?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very high level of trust	48	2.9	3.0	3.0
	High level of trust	573	34.9	36.0	39.0
	Little trust	684	41.7	43.0	82.0
	Very little trust	218	13.3	13.7	95.7
	No trust at all	68	4.1	4.3	100.0
	Total	1591	97.0	100.0	
Missing	I don't know/ I don't answer	49	3.0		
Total		1640	100,0	100.0	100.0

In an important proportion (14.3%), Hungarians declared a very high trust in people. The same percentage was recorded among the Romani who declared that they did not trust at all. A higher percentage of widowed people declared that they did not trust people at all (9.8%), followed by those who lived in consensual union (5.7%) and those who were not married (5.1%).

The share of rural respondents who declared that they did not trust people at all was more than twice that of urban respondents (6.9% versus 3.3%).

Percentage-wise, twice as many people who had been infected with SARS-CoV-2 reported a lot of trust in people compared to those who had not been infected (1.5% vs. 3.2%). But three times fewer infected people also said they did not trust people at all.

The association between well-being and trust reveals some interesting aspects. As can be seen in Table 3, the average of self-situation on the poor-rich scale decreased as trust decreased. Below the general average (5.85) were all those who did not declare very high and high trust in people in general.

Table 3: On a scale from 1 to 10 (1- very poor, 10- very rich) where do you stand? * How much trust do you have in people in general?

How much do you trust people in general?	Mean	N	Std. Deviation
Very high level of trust	6.08	48	1.933
High level of trust	6.07	573	1.522
Little trust	5.76	684	1.469
Very little trust	5.68	218	1.544
No trust at all	5.31	68	1.949
Total	5.85	1591	1.548

Above the average were those whose trust in people had increased during the pandemic or remained the same (6.79 respectively 5.89) and below the average were those who declared that their trust had decreased (5.74).

Before addressing the associations between well-being, trust, and compliance, we want to dwell on the connections between well-being and fear, on the one hand, and generalized trust and fear, on the other. As can also be seen from Table 4, fear appears to be lower as reported well-being increases.

Table 4: On a scale from 1 to 10 (1- very poor, 10- very rich) where do you stand? * Is there any fear in the state you are experiencing now?

Is there any fear in the state you are experiencing now?	Mean	N	Std. Deviation
Yes, very big fear	5.70	144	1.374
Yes, but moderate fear	5.83	1144	1.502
No, I don't live in any kind of fear	6.07	345	1.741
Total	5.87	1633	1.548

Of those who said they trusted people very much in general, only 6.2% said they felt very afraid, while of those who said they did not trust people at all, 27.7% said they felt very afraid. It is interesting, however, that also in the category of those who declared that they did not trust people at all, there was also the highest share of those who claimed that they did not live in any kind of fear (38.5% compared to 20.7% overall).

Self-perceived well-being was associated with greater differences in attitudinal compliance with disinfectant use and social distancing. Thus, those who agreed with the use of disinfectants and keeping distance were on a lower rung on the poor-rich scale compared to those who did not agree with these measures.

Those who strongly wanted to vaccinate ranked themselves slightly higher on the poor-rich scale, but not by very large differences from those who then did not very much want to vaccinate (5.96 versus an average of 5.85).

Generalized trust appeared to be positively associated with attitudinal compliance. Thus, all those who said they trusted people very much and only 91% of those who said they did not trust people at all agreed with washing their hands regularly as a protective measure.

Accepting the use of disinfectants as a prevention measure were all those who declared a lot of trust in people, and only 79.7% of those who declared that they did not trust people at all. 89.4% of those who said they trusted people a lot and only 75% of those who said they didn't trust people at all agreed with keeping their distance. 84.4% of those who declared a lot of trust in people and only 55.6% of those who declared that they did not trust people at all approved the mask wearing as a prevention measure (Table 5).

A percentage of 88.9 of those who declared a very high level of trust in people (and only 59.7% of those who declared that they did not trust people at all) agreed with the quarantine of people.

Regarding the desire to be vaccinated, 40% of those who declared a very high level and a high level of trust in people and 26.2% of those who admitted very little or no trust in people wanted to be vaccinated.

Table 5: Generalized trust and agreement with wearing a mask (valid N = 1530)

How much trust do you have in people in general?		Wearing the mask		Total
		Yes	No	
	Very high level of trust	84.4%	15.6%	100.0%
	High level of trust	81.9%	18.1%	100.0%
	Little trust	72.1%	27.9%	100.0%
	Very little trust	65.4%	34.6%	100.0%

	No trust at all	55.6%	44.4%	100.0%
Total		74,4%	74.4%	74.4%

4. Conclusions and implications

The results of our research showed a self-situation of the respondents between 5 and 6 on the poor-rich scale, slightly towards the upper limit of 6, so not poor therefore. Schooling was positively associated with self-perceived well-being. Occupation, of course, also introduced differences in self-perception of well-being, from employers (richer) to unemployed and farmers (poorer). Ethnicity also highlighted a superior self-positioning of the Germans, average of the Romanians and inferior of the Hungarians. The vast majority of respondents believed they were as rich or poor as they were before the pandemic. They declared themselves poorer than before the pandemic, especially those with less schooling, the unemployed and employers, and Hungarians (by ethnicity). Poverty characterized especially those in consensual union and those divorced. From the perspective of the pandemic effects, the fact of being infected with SARS-CoV-2 was not associated with significant differences in the perception of well-being.

Among our respondents, just over a third declared a very high and high level of trust in people, with trust decreasing with age and increasing with education level. Trust was also lower among Romani or those living in rural areas. Trust was growing in the transition from the unemployed and farmers to employers and freelancers. In the perspective of the pandemic effects, the number of infected respondents who declared a lot of trust in people was much lower, but in the same category the share of those who declared that they did not trust people at all was smaller.

Regarding the association between trust and self-perceived well-being it was observed that the mean of the poor-rich scale decreased as generalized trust also decreased. Above average were those who declared an increase in trust during the pandemic.

Self-perceived well-being was not associated with relevant differences in attitudinal compliance. Generalized trust seemed to be associated with attitudinal compliance both in relation to adherence to some prevention measures and in relation to willingness to be vaccinated, also confirming the results of previous studies for the H1N1 pandemic (Rönnerstrand, 2013).

From the literature devoted to well-being and its impact on the spread and severity of COVID-19, we noted the disastrous effects of lack of well-being, through association with chronic diseases, housing congestion and poor working conditions. It would be expected that subjective well-being also manifests itself in the sense of a positive impact on compliance with prevention measures. And this all the more as its level is lower and the vulnerabilities of precariousness are assumed. The fact that the results of our research do not confirm this implies the need for further analysis in future studies. But the hypothesis of a gap between real and subjective well-being should not be rejected from the start either.

The practical implications of our research seem to be more clearly defined in relation to generalized trust because an increase in generalized trust could be associated with an increase in compliance with prevention measures. But is a program to increase generalized trust in Romanian society really possible? We leave this question open now, at the end of our study, only emphasizing the need for more in-depth research on this topic even outside of a pandemic context like the one generated by COVID-19.

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