

Tracing the Importance of Mother Blame

Retracer l'influence de l'histoire, de la politique et de la culpabilisation des mères

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[See table of contents](#)

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Article abstract

During a health crisis, vaccines can curb the spread of diseases and provide much-needed immunity for all those deemed at risk. To reach herd immunity and successfully curb disease spread, a significant portion of the population needs to get vaccinated. Thus, it is vital to consider the conditions under which people will accept or refuse vaccinations. Using a case study from the 2009 H1N1 pandemic, this paper examines how historical cases of iatrogenesis, medical intervention on women’s bodies, societal practices of blaming mothers for children’s ill health, and the provincial government’s record on healthcare funding and support worked together to inform women’s vaccination decisions. The findings, based on 19 qualitative semi-structured interviews, indicate that during the 2009 H1N1 pandemic, pregnant women were concerned about making the wrong decisions due to societal mothering blame and gendered responsibility within the field of medicine. Their decision to get vaccinated was made in consideration of medical surveillance and scrutiny of pregnant bodies and their feelings of (dis)trust in the provincial government. The research findings allow for a more complex understanding of health decisions by situating women’s vaccination decisions within a larger historical and sociopolitical context. Moreover, the findings indicate that trust cannot be readily invoked in moments of crisis but requires a sustained and ongoing dedication to examining issues of gender inequity within medical practices and governmental policies.

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Tracing the Importance of Mother Blame

by Irene Shankar

Abstract: During a health crisis, vaccines can curb the spread of diseases and provide much-needed immunity for all those deemed at risk. To reach herd immunity and successfully curb disease spread, a significant portion of the population needs to get vaccinated. Thus, it is vital to consider the conditions under which people will accept or refuse vaccinations. Using a case study from the 2009 H1N1 pandemic, this paper examines how historical cases of iatrogenesis, medical intervention on women's bodies, societal practices of blaming mothers for children's ill health, and the provincial government's record on healthcare funding and support worked together to inform women's vaccination decisions. The findings, based on 19 qualitative semi-structured interviews, indicate that during the 2009 H1N1 pandemic, pregnant women were concerned about making the wrong decisions due to societal mothering blame and gendered responsibility within the field of medicine. Their decision to get vaccinated was made in consideration of medical surveillance and scrutiny of pregnant bodies and their feelings of (dis)trust in the provincial government. The research findings allow for a more complex understanding of health decisions by situating women's vaccination decisions within a larger historical and sociopolitical context. Moreover, the findings indicate that trust cannot be readily invoked in moments of crisis but requires a sustained and ongoing dedication to examining issues of gender inequity within medical practices and governmental policies.

Keywords: vaccination decisions; H1N1; trust; surveillance; risk; responsibility; mothering blame; gender

Résumé : Lors d'une crise sanitaire, les vaccins peuvent freiner la propagation des maladies et conférer une immunité essentielle à toutes les personnes considérées comme à risque. Pour atteindre l'immunité collective et réussir à freiner la propagation des maladies, une part importante de la population doit être vaccinée. Il est donc essentiel de prendre en compte les facteurs qui amènent les gens à accepter ou à refuser la vaccination. À partir d'une étude de cas menée lors de la pandémie de grippe H1N1 de 2009, cet article examine comment des cas historiques d'iatrogénèse, des interventions médicales sur le corps des femmes, les pratiques sociales consistant à culpabiliser les mères pour la mauvaise santé des enfants, ainsi que le bilan du gouvernement provincial en matière de financement et de soutien aux soins de santé ont conjointement orienté les décisions des femmes en matière de vaccination. Les résultats, fondés sur 19 entretiens qualitatifs semi-structurés, indiquent que pendant la pandémie de grippe H1N1 de 2009, les femmes enceintes craignaient de prendre les mauvaises décisions en raison de la culpabilisation sociale des mères et de la responsabilité liée au genre au sein de la profession médicale. Leur décision de se faire vacciner a été prise en tenant compte de la surveillance et du regard médical portés sur les corps des femmes enceintes et de leur sentiment de confiance ou de méfiance à l'égard du gouvernement provincial. Les résultats de l'étude offrent une compréhension plus approfondie des décisions en matière de santé en replaçant les décisions des femmes en matière de vaccination dans un contexte historique et sociopolitique élargi. De plus, les résultats indiquent que la confiance ne s'établit pas facilement en période de crise, mais qu'elle nécessite un effort constant et continu pour examiner les enjeux de l'inégalité entre les hommes et les femmes dans les pratiques médicales et les politiques gouvernementales.

Mots clés : décisions relatives à la vaccination; H1N1; confiance; surveillance; risque; responsabilité; culpabilisation des mères; genre

Author: Irene Shankar's scholarship and teaching is embedded within the critical intersections of marginalization and inequality. A Professor of Sociology at Mount Royal University, Dr. Shankar's main areas of research and teaching are Feminist Theories, Sociology of Gender, Critical Race Theory, Qualitative Methodology, and the Sociology of Health and Illness. Dr. Shankar's ability to use her critical scholarship to inspire activism and change has resulted in numerous commendations for her leadership in both teaching and research, such as MRU Distinguished Faculty Award and the Faculty of Arts Outstanding Researcher Award.

Introduction

All health decisions, including vaccination decisions, are made in a larger sociopolitical and historical context (Blume 2006). Misinformation, mistrust in medicine and/or government officials, public skepticism of medical discoveries due to past cases of iatrogenesis, and lack of sufficient understanding of scientific studies, vaccination testing, and approval processes impact how the public responds and/or adheres to medical advice (Kitta 2012; Lupton 2007). Moreover, our understandings of medicine, health, and governance, along with gendered roles and expectations, determine whether we follow or refute health advice (Blume 2006; Lupton 1997). For example, early inoculation attempts by Edward Jenner were met with fear of contamination, along with apprehension about Jenner's vaccination being "rushed" (Kitta 2012). The discourse of "rushed" vaccinations, which has persisted over time, speaks to the public's fear of vaccines being produced without sufficient scientific rigour, leading to a lack of knowledge about their potential side effects.

Accordingly, this paper examines how women who were pregnant during the 2009 Human Swine Influenza (H1N1) pandemic made their vaccination decisions. Within most heterosexual households, vaccination decisions are made by women (Matoff-Stepp et al. 2014; McCarroll et al. 2016). Thus, I consider how discourses of fear and perceptions of risk, along with their varying levels of trust in medicine and local government, impacted their vaccination decisions during the H1N1 pandemic. By situating individual health decisions in a larger context of gendered responsibility and mothering blame, and the participants' experiences of neoliberal governing practices, this paper examines how trust in medicine and government impacts vaccine uptake. The neoliberal mandate seeks to reduce the role of government in maintaining or enhancing population health. This individualized focus ignores the much-needed social determinants of the health framework and serves to justify the ongoing reduction in healthcare funding and services (Chappell and Penning 2009). As a resource-dependent economy, Alberta (the province in which this study was completed) has historically dealt with low oil prices through significant cuts in education and healthcare spending instead of tax increases, a trend that it has continued to present day. It is within these budget cuts and the resulting public outrage that the study participants found themselves making decisions regarding the H1N1 vaccination. Thus, I consider this larger sociopolitical context (such as health care decisions and other social welfare practices being implemented by the provincial government) that facilitate the enactment of trust, such as concrete and demonstrable commitment to public health and well-being by health and government officials, commitments that are contrary to prevailing neoliberal mandates of governing bodies (Armstrong 1995; Lupton 1997; Raphael 2016).

Background

Immunizations are often referred to as the heart of modern medicine and are responsible for saving two to three million lives worldwide each year (WHO 2016). A high immunization rate creates herd immunity for the wider community by preventing outbreaks, which protects vulnerable groups. Without immunization, as demonstrated during the COVID-19 pandemic, communicable disease resulted in widespread death and devastation (Bandini et al. 2023). To curb the spread of contagious diseases, a widespread uptake of the vaccination is needed, along with an equitable and accessible distribution system of vaccines. Structural barriers, such

as a lack of health care services and infrastructure, transportation, and adequate storage, result in vaccine inaccessibility for marginalized communities.

Despite the accessibility of COVID-19 vaccines in Canada, the vaccination rates for children remained low. For instance, as of August 2022, 82.03% of Canada's total population had completed the primary series of vaccination and 85.24% of Canadians had received at least one vaccine (PHAC 2022). During the same period, only 55% of children between the ages of 5 to 11 had received at least one dose and 42.44% had completed the primary series. This may be due to parental hesitancy to vaccinate their children. Humble et al.'s (2021) study shows that when the COVID-19 vaccine became available in Canada in 2021, only 27% of parents reported willingness to get their child vaccinated.

A similar low uptake of vaccines was evident during the 2009 H1N1 pandemic in Canada, with only approximately 41% of Canadians opting for the H1N1 vaccination (Gilmour and Hofman 2010). H1N1 is a respiratory illness with similar symptoms to the flu. By April 2009, approximately 18,449 deaths in 214 countries were attributed to H1N1 (WHO 2009 as cited in Brien et al. 2012). Canada had two waves of the H1N1 pandemic: the first wave took place from April to July 2009, and the second wave occurred from October to December 2009, resulting in around 428 deaths in total (IPAC 2014). Upon Health Canada's approval of the H1N1 vaccine, Canadian Federal Health Minister at the time, Leona Aglukkaq, declared the adjuvanted vaccines as safe and effective for use and "encourage[d] all Canadians to get vaccinated, since there is simply no better way of fighting the H1N1 virus" (CBC 2009a). Children, the elderly, people with compromised immune systems, and pregnant women were understood to be particularly at risk for the H1N1 virus and were strongly urged to get vaccinated. However, only about 37 percent of Albertans and 41 percent of Canadians were vaccinated in 2009 (Gilmour and Hofman 2010). Specifically, within the province of Alberta, the overall vaccination rate remained at 36%, with 53% for children aged 6 months to 4 years and 35% for pregnant women (Government of Alberta 2010). With approximately 47% uptake in the United States and Canada, most pregnant women in North America did not get vaccinated despite the public messages that warned pregnant women that they and their fetuses were at risk of contracting H1N1.

Vaccination rates, in general, tend to be low among pregnant women (Cox et al. 2023). There was a similar low uptake of vaccines during the COVID-19 pandemic. Despite the increased rate of hospitalization, the vaccination rate for COVID-19 among this group remained low, with only 25% of pregnant women in the United States and approximately 60% of pregnant women in Alberta and 68% in Ontario, Canada, being vaccinated in 2021 (Centre for Health Informatics 2021). These statistics implore us to ask why some pregnant women, despite being cautioned of the risk, do not get vaccinated. Importantly, how do women, who tend to be the primary vaccination decision-makers in heterosexual households (Kitta 2012; McKenzie, Tomkinson, and Attwel 2024), make vaccination decisions for themselves and their families?

Methods

The COVID-19 pandemic motivated me to revisit the data set for the H1N1 vaccine collected in 2011. Using the 2009 H1N1 pandemic as a case study, I examined the socio-political considerations that inform pregnant women's vaccination decisions. Despite being told that they were at high risk for succumbing to H1N1 and with health officials urging them to get the adjuvanted H1N1 vaccination, the overall vaccination adherence rates for pregnant women during the 2009 pandemic remained low, with an immunization rate of approximately 47.2% for pregnant women in Canada (Gilmour and Hofman 2010). In Alberta, where this study was conducted, only 35% of pregnant women received the H1N1 vaccine (Government of Alberta 2010). Accordingly, using purposive sampling to select participants due to their expertise and knowledge of a particular issue (Campbell et al. 2020), I interviewed 19 women who were pregnant during the 2009 H1N1 pandemic to understand how they made their vaccination decisions during the pandemic.

This study received ethics approval from the Mount Royal University's Human Research Ethics Board and was funded by Mount Royal University's Internal Research Grant. The primary participants for this study were recruited in 2011 from daycare centres, preschools, and an undergraduate university. The secondary interviews were completed using a snowball sampling technique, where the primary participants were asked for suggestions for other women to interview in the Calgary and Edmonton areas. All the participants were pregnant during the 2009 H1N1 pandemic. The participants ranged in age from 29 to 43 years, and all held post-secondary degrees. Among the 19 participants, 12 were vaccinated during the pandemic, while the remaining 7 had declined H1N1 immunization. Except for two participants who were adamantly anti-vaccination, all participants identified themselves as pro-vaccine and had immunized their children. Due to the aims and focus of this paper, data from the two women who identified as anti-vaccinators were not used in these findings. The quotes used in this paper are identified using a pseudonym and contain their vaccination decision and occupation. All identifying information has been removed from the data.

The data for this study was collected through semi-structured interviews in which the researcher relied upon a set of predetermined open-ended questions but was open to asking about other areas identified by the participant. Within the interviews, particular attention was paid to their overall experiences during the H1N1 pandemic; their understandings and perceptions of childhood immunization; the process through which decisions for children's vaccination were made within their household; the participants' relationship to the field of medicine; their apprehensions, and fears during the pandemic; and where they sought assistance with and information for their vaccination decisions. Each interview took approximately 1 to 1.5 hours to complete and took place at the location of participants' choosing, such as their homes, workplaces, or coffee shops. The interviews were recorded and professionally transcribed.

Participants spoke strongly about the state of health care and education within Alberta, the history of medicine, specifically how women and their concerns have been treated and/or ignored within the field of medicine, and gendered caregiving responsibilities. They placed their vaccination decisions firmly within their sociopolitical context. The transcribed interviews were coded using NVivo software and analyzed through a Critical Discourse Analysis (CDA) framework. Discourse is a general domain of statements which includes all texts, statements, representations, and meanings that exist about a particular subject and/or object (Mills 2004). In other words, discourse encompasses knowledge, representations, and/or understandings about a particular concept. CDA framework allows for the examination of the larger socio-political and historical context (such as provincial funding for healthcare, education, and other social welfare resources and services) within which vaccination decisions were made by those deemed to be at risk, with attention to the issue of gender inequality and enactment of power.

The first level of coding involved close reading of the transcripts and identification of broad patterns within the data. This was followed by a second level of coding of emergent themes and the relationship among them. Throughout coding and analysis, I paid particular attention to how participants understood and constructed notions of risk, responsibility, surveillance, and governance. The results highlight participants' struggles with gendered responsibility, refutation of medical dominance, distrust of political governance, and their understanding of risk. Following the qualitative research framework, this qualitative case study demonstrates the nuances and complexities of vaccination decisions for a specific group of women in Alberta in 2009. As such, the results are not generalizable to other groups. However, the overarching themes of this study have been contextualized through an in-depth literature review of vaccination hesitancy and decision-making. Together, these qualitative findings and incorporated research demonstrate the impact of the larger sociopolitical context on vaccination decisions. These findings have been grouped into three interrelated sections below.

Results: Fear and Trust

The results show that during the 2009 H1N1 pandemic, highly educated and well-informed women were reluctant to get vaccinated due to their concern about mothering blame and their lack of trust in medicine and

the governing party. Within this ever-present culture of mothering blame, these participants reported feeling overwhelmed and stressed about making the “right” decision during their pregnancy, without adequate resources and information. To reiterate, all the participants included in this paper are highly educated women who think of themselves as pro-vaccination, making the findings particularly informative about how vaccination decisions are made during a health crisis.

Fear

During the 2009 H1N1 pandemic, health officials deemed pregnant women to be at high risk of contracting and getting ill or dying from H1N1 and thus, strongly urged pregnant women to get vaccinated (Alphonso 2009; Tucker Edmonds et al. 2011). The participants of this study, all of whom were pregnant during the pandemic, were counselled by their doctors to get vaccinated. While medical professionals were urging vaccination in the best interest of the public, the participants felt scared and panicked.

It was really scary, and people were going to die ... you should go get your immunizations.... (Joliot, stay at home parent, vaccinated)

I did it [get the vaccination] out of fear ... it was scary, I mean at work it was a scary place to be and ... we were panicked because it was literally like pandemonium. (Gertrude, nurse, vaccinated)

I don't like to be feared into something, like for me it needs to be more educating than fear to get me to do it...and fear is powerful, it would force me ... I don't know if that is their intention, but that is what happened both times: people get panicked. (Ada, stay-at-home parent, not vaccinated)

Some of the participants reported being scared and were vaccinated out of fear. Others, like Ada, became angry and resisted the vaccination in refutation of the discourse of fear, which they felt was being intentionally mobilized to secure vaccine compliance. Interestingly, while all the participants believed the health messages that said they were at an increased risk of getting ill and/or dying from H1N1, their responses varied. This is consistent with Tucker Edmond et. al.'s study (2011), which found that 51.8% of pregnant women believed that they had an increased risk of encountering severe effects of the H1N1 virus without the vaccine. However, as noted earlier, this understanding of being at increased risk did not translate into adherence to vaccination advice. While the participants were concerned about contracting H1N1, in some cases their fear of the virus was eclipsed by their fear of the vaccine. Instead, the participants wanted information about vaccination safety.

There was no good information presented to us at all. We were basically, I think, pressured into it by people—and as in “people,” I say the news, the, you know, medical directors, or even my management team being like, “Do this. Do this. Do this. Do this. Do this. Do this. Do this” ... they wouldn't even give it to you when you asked because I think they ... maybe they didn't have time, or else maybe it just didn't exist. So, one word to sum it up was a lot of pressure into it. (Gertrude, nurse, vaccinated)

There was no information about whether the vaccine, at least early on—there was no information on whether the vaccine was safe for pregnant women.... (Jocelyn, lawyer, vaccinated)

It had never been tested on pregnant people. And they didn't really know, I mean. They tell you it's safe, but you don't [know], right? You just don't really know. So that was my concern. (Lera, legal assistant, vaccinated)

The participants reported that they felt responsible for making urgent health decisions for themselves and their children during a global pandemic without adequate information about the vaccine. In particular, all of the participants asked doctors and other health officials for information on drug trials and any potential side ef-

fects of the vaccination. Quite revealing is the participants' fear about the potential side effects of the vaccine on the fetus.

I mean, these are the children I am talking about; I am not just dealing with myself like this is the health of my children, so I wanted to make sure I was getting information which I would feel good about. (Mae, photographer, not vaccinated)

The vaccination decision was not only burdensome due to the lack of information about vaccination trials and side effects, but participants felt an added responsibility to make the right decision for their unborn children's health. All the participants spoke with their doctors and also independently researched whether the vaccine was safe for pregnant women and their fetuses, specifically.

When I was contacted by Occupational Health and Safety ... I said, "Well, what studies have been done? How many pregnant women have been immunized with this vaccine?" and she was like, "Oh, well it is safe," and I said, "How safe? Give me the numbers. Like, give me the statistics" because that is what I want to know and the study she cited something ... was like 400 people that were in the study and I said, "That is all ... if you want people to get immunized then you need to be able to present them with real statistics.... (Shirley, nurse, not vaccinated)

[Public health officials] need to be sensitive to the needs of pregnant women, which is not a blanket assurance of safety, especially when you [referring to public health officials] cannot back that assurance with data, to help women understand how to make informed choices about whether or not to vaccinate. (Marie, teacher, vaccinated)

Instead of being referred to scientific studies and data to address participants' concerns regarding vaccination safety, many of the participants were provided with a blanket statement of safety. Without addressing the specific questions about vaccine trials, medical professionals kept reinstating that the vaccines were safe for pregnant women and their fetuses, which participants found to be dismissive of their concerns. Blanket safety assurance was perceived as a lack of care or willingness to engage with the patient's specific fear. As explained by Gertrude above, these women were being told what to do but were not being given the information they needed to make their vaccination decisions. In the absence of empirical information, they were told to trust their medical professionals and governments, who had their best interests at heart. As seen below, some participants trusted their medical professionals while others found the blanket assurance of safety, along with the discourse of trust, to be dismissive of their fears, infantilizing, and patriarchal.

Trust

During a health crisis, the public needs to be able to trust that the health advice and protocols being offered are in their best interest. As seen in the current COVID-19 pandemic, distrust of health and government officials contributes to vaccine hesitancy and lack of adherence to recommended health measures (Liu, Zhao and Wan 2021). The participants of this study spoke at length about the role of trust in facilitating their vaccination decisions. For some participants, it was their trust in their doctor that led them to get vaccinated.

I think I really trusted my doctor, and she was pretty clear about "yeah, I think this is something worth doing," and ... I think it was general public awareness, having a conversation with a doctor that I really, really trusted and...also wanting to do the right thing for the baby.... (Rita, program officer, vaccinated)

Other participants felt apprehensive that they were being asked to trust medical professionals and the government in the absence of facts and other empirical evidence. These participants also spoke about their ongoing

distrust of medicine and the government, which made them more apprehensive about adhering to the health advice. Below, I discuss their precarious trust in medicine, followed by their distrust of governance.

Refutation of Trust in Paternalistic Medicine

Personal perception of health, illness, diseases, and the field of medicine can determine whether someone will act upon or refute various health promotion messages disseminated during health pandemics (Blume 2006; Lupton 1997). Accordingly, some of the participants were skeptical of vaccination advice being offered because they had a history of their pain and ailments being dismissed by their medical professionals and being denied a medical diagnosis for their health concerns. To maintain participants' confidentiality, I will not discuss their highly specific and personal medical experiences. However, there are historical and contemporary examples along with research on how women's health concerns have been dismissed by medical professionals (Cleghorn 2021; Comen 2024). For example, historically, menstrual pain has been deemed to be exaggerated or indicative of a woman's "unhealthy lifestyle" (Lupton 2007,149). Women in pain continue to be dismissed by medical professionals, particularly poor, racially minoritized, older, and/or disabled women (Comen 2024; Mukherjee, Reis and Heller 2003; Quintner 2020). The participants situated their personal experiences within the lingering patriarchal practices of the medical field that facilitate the ongoing erasure and/or under-research of women's pain and ailments while simultaneously increasing medicalization and surveillance over their bodies (Cleghorn 2021; Comen 2024).

In Western societies, women's bodies and lives are heavily medicalized. For instance, from menstruation to menopause, women are often expected to refer to medical advice and products to manage their bodies (Lupton 2007; Chappell and Penning 2009). Medicalized surveillance and dominance are heightened during pregnancy, with women being told what to eat, how and how much to exercise, and even how to sleep (Lupton 2007). Participants in this study, such as Marie and Rosalinda, spoke at length about the prevailing paternalism within medicine, which infantilizes pregnant women and renders them powerless over their bodies.

I think within health care, there is a bit of a problem of paternalism, too, right? This idea that, um, health-related knowledge is privileged information that only doctors and nurses have, and that as a member of the public, I can't have. That somehow, being involved in my own healthcare decisions either makes me rebellious, or annoying or ... you know what I mean? I think that whole paternalism within the health care system is a problem.... (Marie, teacher, vaccinated)

I wouldn't say I rejected the medical approach to birth, but I certainly felt ... it takes a woman's power away from her when a doctor says, "Well, you have to do this, and this and this," and again the whole cycle of intervention, like if you get induced then you are more likely to ... the contractions are more likely to get the best of you and you are more likely to need an epidural. If you get an epidural, you can't walk around, and you are more likely to have other complications which lead to a C-section, where they have more control, and it is more about the doctor's experience and the doctor being able to control what is happening, and it is less about honouring a woman's own ability and power in that respect. (Rosalinda, professor, vaccinated).

The ever-increasing medical surveillance of and intervention on pregnant women's bodies (Lupton 2007) shaped participants' responses to H1N1 medical directives, whereby vaccination advice during the pandemic was interpreted as further control and dominance over their pregnant bodies. For these participants, the medical advice to get vaccinated without the offer of information about vaccine safety for pregnant women was seen as another manifestation of patriarchal practices within medicine, requiring their complete and uncritical compliance with medical professionals.

I don't know, it [H1N1 vaccination advice] is similar to the whole "don't eat fish" and "don't do this, this and this," like women have been birthing babies for centuries, you know? In plague conditions, flu, and stuff, you know? (Lise, professor, not vaccinated)

I don't just take their [doctors'] word for it [vaccination] either. I suppose this started when I was pregnant because I was so concerned about how the medical model treats pregnant women, like in terms of pregnancy as an illness or a disease, and you have to be hospitalized. If everything is totally healthy and normal, I think it really takes the agency away from the woman by putting her in a position where all those decisions are made for her. (Marie, teacher, vaccinated)

While the H1N1 vaccinations had been demonstrated to be safe for pregnant women, the information about vaccine trials and safety was not shared with the participants while they struggled to make their vaccination decisions even when they had explicitly asked for this information. During the 2009 H1N1 pandemic, the blanket assurance of safety without the provision of detailed evidence of vaccine safety was taken up by the participants as a retrenchment of doctors' medical authority, whereby the doctor is presented as the experts who "know the best" and pregnant women are not allowed to question medical professional's authority or advocate for their own medical need. As seen above, the copious amount of advice being issued to pregnant women due to the prevailing hyper-surveillance of pregnant women within biomedicine (such as advice on what to eat during pregnancy) led to some participants being skeptical of medical advice being issued during the pandemic. Exhausted by the medical gaze, whereby their every decision and action are heavily scrutinized for their potential impact on the fetus, this study's participants found themselves pushing back against yet another narrative of risk and responsibility.

It's not that I think vaccines are unsafe. I just think they need to be tried and studied, and all this came out so quickly, you know?... I remember specifically like where I lined up and what the building looked like and all that kind of stuff... I kept the paperwork, like who keeps their flu shot paper? But I kept it because obviously, I was like "If there is something wrong with this baby, I've got this paperwork!" [laughter]. (Lera, legal assistant, vaccinated)

And you know, to be perfectly honest, I did sort of think in my head, you know, if the baby has some sort of problem developmentally or ... you know? And it's like, "Where did this come from?" I was definitely going to raise the red flag and say, like, "I had this vaccination because I felt like I was working in an environment where I was really, really high risk. Maybe you guys need to have a look at this the next time, right? But luckily everything was fine and [name of the child] is great, and there was no issue, but it was always in the back of your head...." (Gertrude, nurse, vaccinated)

Moreover, participants found themselves in the difficult position of having to make a health decision during a global pandemic without access to the empirical evidence (such as data from immunization trials) to provide assurance that the vaccination would not negatively impact their fetus. Their fears regarding vaccination need to be contextualized within historical iatrogenic health interventions on pregnant women, such as thalidomide, a drug given to pregnant women for nausea, which resulted in severe fetal damage (Bradby 2009). Not only were the participants worried about potential negative reactions from the vaccine, but they were also worried about being held responsible for making the decision that could potentially harm their fetus. They were worried that they would be blamed for getting vaccinated. Their fear of being blamed is due to the prevalence of mothering blame, whereby women are held responsible for their children's ill health. The participants were unsure which decision (whether to get vaccinated or not) would be most effective in mitigating any potential risk to their fetus. Along those lines, their risk of being labelled as bad mothers was contingent upon them making the "right decision," a decision they felt unequipped to make. It is not surprising that Leah gathered evidence (her vaccination record) that would allow her to refute the label of "bad mother" in case her fetus experienced a vaccination-induced iatrogenic disorder.

Refutation of Trust in Governance

These interviews were conducted during the 43-year reign of the Conservative provincial government in Alberta, during which the government has made significant funding cuts to public spending, including the provincial health care system. The participants were perplexed that they were being asked to trust the same government which was making decisions detrimental to the population's health.

Also, we know in Canada, and our province specifically when you have such a high percentage of people who can't get a family doctor, you know like health care is obviously being mismanaged at a governmental level in this province, and then you have scandal after scandal in health care, uh ... you know? So, all of those things seem to fit with all this other stuff that seems—well is—completely inappropriate in terms of leadership. (Marie, teacher, vaccinated)

The H1N1 pandemic took place while Canadians were struggling with doctor shortages and the implications of significant cuts to healthcare spending. In response to the reduction of government spending, the United Nurses of Alberta President, Heather Smith, warned that the incoming cuts would be akin to the “destruction of the 1990s” as “the last thing Albertans want now is longer waits in Emergency rooms and another huge shortage of staff and beds” (United Nurses of Alberta 2009). Faced with health directions from government officials during the pandemic, the participants were wary of trusting a government that they felt had reduced their access to health care.

Well, I guess I don't trust the Alberta government that much ... Almost all my hospital experiences have been horrible, come to think of it! I broke my collarbone when I was in my twenties, really badly, and it took three hours to even get seen and ... it was horrible. And then I remember they finally took an X-ray and then they started freaking out saying I needed surgery, then ... anyways, in the end, they didn't do anything—which was fine—but, like, now it has like, healed all crooked and whatever ... I don't know, I have had so many bad experiences I could go forever, but yeah, I just don't really trust them that much. I mean, we are all human; they are educated and they know a lot, but I don't necessarily think that they are always right. (Ada, stay at home mom, not Vaccinated)

Within this larger sociopolitical context, some participants, like Ada, had “many bad experiences” that led to their distrust of the provincial government in charge of the healthcare services and influenced their vaccination decision during the 2009 H1N1 pandemic. For others, like Gertrude, the slow uptake of information from the front-line staff and being perplexed by decisions made by the administrators, despite being a healthcare worker herself, led to her distrust of governing bodies.

Yeah, and sort of just from watching, like, you know, the guys at sort of the top of the pyramid in health care, the medical directors, the health boards, all that kind of stuff, honestly, how long it takes the information from the ground floor to work its way up to them guys take a really long time! And to be quite honest, I feel like they have no understanding at all of even what they are talking about... (Gertrude, nurse, vaccinated).

Discussion

Discourses of risk and responsibility are often utilized within public health messages designed to inform the public about health risks and how to avoid such dangers through responsible management of risk (Petersen and Lupton 2000). Within such a narrative, individual risks and health effects are presented as the consequences of a person's choices and, as such, the sole responsibility of the decision-maker (Petersen and Lupton 2000). This individualized focus and “the emphasis on risk factors which are within the control of the individual contributes to the confirmation of [the] active citizen, the self who can be, and indeed ought to be, in

control of his or herself” (Nettleton 1997, 215). However, as seen in this case study, the reiteration of risk can also become an obstacle to meaningful responses in situations when fear is the only thing that is being offered. The participants found themselves fearful of the pandemic but without the information on vaccine safety and any potential side effects that they needed to make the “right” decision. The continual and individualized focus on risk led them to dismiss health directives as an overt attempt by medical professionals to control their bodies.

Moreover, instead of a meaningful discussion of vaccine safety, the participants’ request for information was met with a blanket reassurance, which many women found dismissive and infantilizing. This dismissiveness was seen as another manifestation of the authority and control that medical institutions exercise over pregnant women. Participants’ questions regarding vaccine safety are understandable. Without clear information from medical professionals, many of the participants reported doing their own research, which might have led to unreliable and incorrect information. For instance, a review of 722 anti-vaccination sites found that every single website claimed that vaccines cause harm and vaccination policies are profit-driven (Wolfe, Sharp, and Lipsky 2002 as cited in Kitta 2012, 5-6).

Despite the lack of information, the participants felt an intense responsibility to make the right decision. Women tend to be the primary decision-makers for their family’s health, including decisions on vaccinations (Matoff-Stepp et al. 2014; McCarroll et al. 2016). In this study, participants struggled with their vaccination decisions due to their fear of making the wrong decision, which may harm the fetus. This pressure to make the “right” decision is located within a larger context of gendered responsibility, whereby mothers are held responsible for the health of their children (Lupton 2007; Singh 2004). Within this punitive discourse of mothering blame, women are held responsible for the well-being of their children, to the omission of social determinants of health factors such as accessible healthcare, affordable food, safe housing, and quality education (Marya and Patel 2021). The findings from this qualitative study, while not generalizable, are an important reminder that there can be dire and unforeseen implications of holding women solely responsible for their children’s health and well-being. During a health crisis, such as the COVID-19 pandemic, this individualized and gendered discourse of mothering blame could lead to pregnant women’s hesitancy to get vaccinated for fear of making the “wrong” decision. These findings remind us that there remains an urgent need for medical health professionals and governing bodies to actively dismantle mothering blame and gendered responsibility within medical discourse.

Similarly, the medical surveillance of pregnant women also has far-reaching consequences. The participants of this study, already under medical surveillance as pregnant women, interpreted the calls for vaccination as another mode of control by medical professionals. In this case study, the heightened medical surveillance during pregnancy remained a source of frustration for many women, contributing to their disregard and skepticism of medical advice to get vaccinated during a global health crisis.

Some participants refused to get vaccinated during the 2009 H1N1 pandemic because of their underlying distrust of the medical field and the provincial government. As discussed earlier, participants reported an ongoing discomfort with the unquestioned medical authority of doctors and other patriarchal practices within the field of medicine. There is a long history of doctors being dismissive of women’s health concerns and engaging in infantilizing discourse toward patients who identify as women to reassert their medical authority. For instance, women complaining about pain that cannot be easily discerned through medical technology are often dismissed as mentally unwell (Cleghorn 2021; Mukherjee, Reis and Heller 2003; Quintner 2020). Thus, the participants’ concerns in this case study need to be contextualized within the ongoing practice of women’s health being ignored within the field of medicine. The field of medicine must not only identify and eliminate the patriarchal practices embedded within medical practices, there also needs to be active consideration of and reflection on the ways women’s experiences of being dismissed and infantilized continue to shape their subsequent medical care and response to public health messages.

Trust is an important factor in vaccination uptake (Liu, Zhao and Wan 2021; Sturgis Brunton-Smith and Jackson 2021). This qualitative case study provides a more nuanced understanding of how trust (or lack of it) is created over time and requires a sustained commitment to public health and well-being. In this case study, the Alberta government's record of drastic cuts in health spending and the participants' prior compromised medical treatment led to their lingering distrust of the provincial government. As a result, the participants of this case study were unwilling to trust that the government had their best interests at heart. A similar trend was evident in the COVID-19 pandemic, whereby those with reduced trust in the government had lower vaccination rates and more refusal of pandemic health measures (such as physical distancing, quarantine guidelines, and mask mandates) (Leblang, Smith and Wesselbaum 2024; Viskupič, Wiltse and Meyer 2022). This case study demonstrates that trust requires a sustained and demonstrable commitment to population health and well-being and cannot be invoked in moments of crisis.

Collectively, these participants' experiences indicate that health decisions are seldom made solely based on the health advice being provided. Rather, people's willingness to adhere to medical directive(s) is dependent on a larger sociopolitical context. For many of the participants, their trust (or lack of it) in the government shaped their willingness to abide by the health directives. A significant finding of this study is that the participants' trust, or lack thereof, did not stem from a single instance but was shaped over a lifetime of experiences. In other words, how health care is managed and whether it is adequately resourced shapes individuals' trust in a given political party and overall healthcare policies and practices.

Unfortunately, instead of considering the larger sociopolitical historical context within which women make their health decisions, public health messages continue to prioritize an individualized and gendered discourse of risk and responsibility. The gendered discourses of risk and responsibility facilitate a shift in responsibility for the child and maternal health to women – a strategy that has not only proven to be ineffective but also will continue to dissuade women from trusting medical and government officials in moments of crisis.

Conclusions

In this 2009 H1N1 pandemic case study, the participants, who were pregnant at the time and deemed to be at high risk of illness from the virus, reported being fearful due to risk-centred public health messages. The various risks presented by the disease heightened the participants' fear and, in some cases, led to an outright refusal to get vaccinated. As seen in the overwhelming loss of life and social upheaval caused during the COVID-19 pandemic, there are significant risks to population health and overall well-being during a pandemic. Accordingly, warnings about potential dangers are warranted, as such information can help keep people safe through increased vaccine uptake (Hilverda and Vollmann 2022). Emergency health planning can be strengthened by studies that show how people deemed to be at high risk respond to health messages.

During the COVID-19 pandemic, the vaccine adherence rates among pregnant women remained low (Galanis et al. 2022). In consideration of these statistics, health officials and researchers must examine the larger sociopolitical conditions under which such health decisions are made. In this qualitative case study, pregnant women's decision regarding the H1N1 vaccination was shaped by their experiences of medical surveillance, dismissiveness of their concerns, and their ongoing distrust of the local provincial government. While the findings from this qualitative study cannot be generalized, there are some important findings to consider for increasing vaccine adherence during future health crises.

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