Pregnant during a pandemic:
Lived experiences of women who gave birth during COVID-19 pandemic in Saskatchewan

Saskatchewan Health Authority

RESEARCH DIVISION, INSIGHTS FOR BETTER HEALTH
SASKATCHEWAN HEALTH AUTHORITY

JIM PATTISON CHILDREN'S HOSPITAL FOUNDATION

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ABBREVIATIONS AND ACRONYMS

COVID-19	-	Coronavirus Disease 2019
C-Section	-	Caesarean Section
FDG	-	Focus Group Discussion
MS	-	Microsoft
NE	-	North East
NW	-	North West
SE	-	South East
SW	-	South West
SHA	-	Saskatchewan Health Authority
SHRF	-	Saskatchewan Health Research Foundation
SK	-	Saskatchewan
OB-GYN	-	Obstetrician-Gynecologist

EXECUTIVE SUMMARY

Introduction

High-quality prenatal care plays a critical role in supporting healthy pregnancies and reducing the risk of adverse health outcomes for both mothers and babies (Heaman, 2019; Wagner, 2020). In March 2020, when the COVID-19 pandemic arrived in Saskatchewan, pregnant women, their partners, and care providers were forced to navigate the spread of the virus and a constantly evolving pandemic response. The emergence of the pandemic prompted the health system to deprioritize non-emergency care services, thus temporarily reducing access to routine healthcare services, such as prenatal care. Lockdowns and mobility restrictions changed how pregnant women interacted with their caregivers, family and communities.

Evidence suggests that there was a global reduction in maternal healthcare during the pandemic (Townsend, 2021). However, little is known about the impact of the pandemic response on pregnant women and their newborns in Saskatchewan. To address the gap in local knowledge, a broader (mixed-methods) study was conducted to examine the impact of the COVID-19 pandemic on maternal healthcare utilization, and outcomes on both mothers and their babies. The qualitative component, detailed here, explored the lived experiences of women who gave birth during the pandemic, to understand the challenges mothers and their families faced in accessing prenatal, perinatal and postnatal care. By understanding the lived experiences of mothers who gave birth during this unprecedented time, this study seeks to inform healthcare delivery strategies in Saskatchewan and to highlight the importance of maternal and infant health services during public health emergencies.

Study

This qualitative study was conducted between December 2023 and March 2024. Participants were recruited from communities in northern, southern, rural, and urban regions of the province. Using the WebEx virtual platform, data were collected from 51 women who gave birth during the active phase of COVID-19 pandemic (March 2020-December 2022) through interviews and focus group discussions. De-identified transcripts were analyzed using thematic analysis.

Key findings

1 Mothers' views on pandemic measures

Mothers participating in interviews and focus groups had mixed views on the measures implemented during the pandemic. While they felt that action was necessary, many viewed the measures as being overly restrictive and described negative impacts on their pregnancy and birthing experiences. These views highlighted a tension between understanding the public health need for pandemic measures and the personal impact those measures had on their care experiences. Some mothers struggled with the balance of protecting themselves and their babies, while also trying to maintain some sense of normalcy. The inability to have support persons present during critical appoinments was a significant concern, contributing to feelings of isolation and stress.

2 Impact of pandemic measures on perinatal care

I. Positive experiences

a. Increased family bonding

The pandemic restrictions led to more time spent at home, which some mothers saw as an opportunity for enhanced family bonding. The increased presence of partners and the focus on home-based activities created a close-knit family environment.

b. Supportive healthcare providers

Access to supportive and knowledgeable healthcare providers was a critical enabler in mitigating stress and uncertainty during the pandemic. These providers offered reassurance and reliable information, which helped to alleviate some of the anxiety.

c. Quality and continuity of care

Many mothers appreciated the quality of care they received, even with the constraints of the pandemic, particularly valuing the attentiveness of healthcare providers. Continuity in care, even with the virtual appointments, provided reassurance and consistency for mothers during their pregnancy.

II. Negative experiences

a. Psychosocial and health impacts

Participants described a range of psychosocial and health-related challenges that emerged during their pregnancies amid the COVID-19 pandemic. Public health measures, including restrictions on gatherings and the closure of community spaces, contributed to a heightened sense of isolation and decreased opportunities for physical activity. These changes were often accompanied by increased stress, anxiety, and concern—particularly regarding potential health risks posed by the virus to both mothers and their newborns.

The uncertainty surrounding the virus, coupled with its evolving nature, added to the emotional strain. First-time mothers appeared especially affected, given their limited frame of reference and the absence of previous pregnancy experience to draw upon. Without access to in-person support or familiar social rituals, many felt a deeper sense of vulnerability and unease.

The move to virtual prenatal care, though necessary under the circumstances, raised concerns for some participants. Women with high-risk pregnancies, in particular, expressed uncertainty about whether remote care could fully meet their needs. The lack of face-to-face interaction with providers sometimes left individuals feeling unheard or less confident in the care they were receiving.

In addition, the cancellation of in-person services such as prenatal classes and support groups contributed to feelings of unpreparedness and disconnection. Many described a sense of loss related to missed milestones, including baby showers and family visits. Though often considered secondary, these events hold significant emotional value and their absence was deeply felt by many expectant mothers.

b. Restricted access to maternal health care services

Disruptions to maternal healthcare services were also a significant concern, particularly during the early months of the pandemic. Some participants experienced delays in essential services such as ultrasounds and routine prenatal visits, and found it increasingly difficult to secure timely appointments. While service availability improved as systems adapted, the initial reduction in access left many feeling uncertain about the continuity and quality of their care.

The rapid transition to virtual appointments, while pragmatic, brought mixed experiences. Some participants found the format less personal, and expressed concern about limited communication and the challenges of building rapport with providers in a virtual setting.

For those living in rural areas, longstanding barriers to healthcare were further compounded. Participants noted that the pandemic-related travel restrictions intensified existing challenges, often resulting in increased travel times and financial burden. These factors created additional stress for expectant mothers already navigating limited local resources.

Hospital experiences were also shaped by new safety protocols. Restrictions on support persons during labor, as well as mask requirements, sometimes made communication more difficult and created a more clinical or isolating environment. The absence of family during and after delivery was particularly difficult for many, contributing to a sense of emotional distance during a time when connection and reassurance were needed.

III. Mixed experience

Adapting to healthcare changes—Virtual care

The pandemic necessitated a shift to virtual prenatal care after the introduction of hospital restrictions, leading to mixed feelings among the participants. Some mothers appreciated the convenience of virtual visits, while others missed the personal connection typically found in in-person appointments, and concerns about the effectiveness of virtual care. The sudden shift in care models left many feeling unsupported.

3 Concluding thoughts

The findings in this report highlight several pre-existing and new challenges that pregnant women have faced in accessing quality care in Saskatchewan. Financial constraints, transportation issues, and provider availability were among the most common challenges that limited access to care. Also, mothers' experiences were further exacerbated by reduced access to ultrasounds, restrictions on in-person visits, lack of continuity of care, and challenges in accessing postpartum care. The intent of this report is to describe the experiences of women throughout the province to inform future public health emergency planning and to improve maternal care services.

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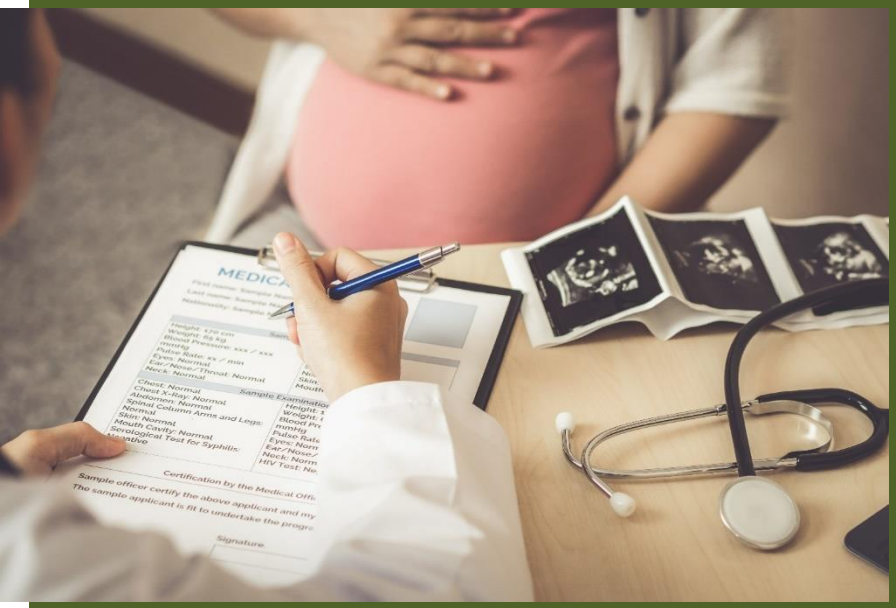
Background



Quality perinatal care plays a critical role in supporting healthy pregnancies and reducing the risk of adverse health outcomes for mothers and babies (Heaman, 2019; Wagner, 2020). However, in Saskatchewan, the geographically dispersed population poses challenges in ensuring equitable access to obstetrical care, potentially leading to disparities. During times of crisis (such as the COVID-19 pandemic), existing health inequities tend to worsen, disproportionately affecting ethnic minorities, socioeconomically disadvantaged individuals, and those with limited resources (Ala, 2021).

The emergence of the COVID-19 pandemic brought about significant disruptions to routine healthcare services globally, with public health measures like lockdowns and stay-at-home orders being implemented to curb the spread of the virus. As part of the health system response in Saskatchewan, non-emergency services such as elective surgeries, diagnostic procedures, and outpatient appointments were de-prioritized during the early pandemic waves to free up resources for COVID-19 patients. While the temporary shifting of resources may have been seen as necessary at the time, it led to a backlog of patients and increased wait times for non-COVID-19 healthcare, hence creating additional challenges to accessing routine and essential care (Anton, 2021; Eneas & Issa, 2021; Quon, 2021). Also, the subsequent socioeconomic and healthcare disruptions have led to a wide range of direct and indirect effects on the health and well-being of pregnant women and newborns (Kotlar, 2021).

Some pregnant women avoided healthcare facilities for fear of contracting COVID-19 from healthcare workers or other patients, leading to an increased preference for home deliveries (CIHI, 2021; Czeisler, 2022; Gildner, 2021; Stober, 2021; Taylor, 2020).

In response, the Society of Obstetricians and Gynecologists of Canada (SOGC) recommended integrating virtual care into maternal health services to improve accessibility and reduce in-person visits to curtail the spread of COVID-19. This included telemedicine for prenatal consultations. While virtual care platforms facilitated communication between pregnant women and their healthcare providers through video calls and phone consultations, the transition to virtual care has raised concerns about potential missed healthcare needs, particularly for high-risk pregnant women (Bayrampour, 2022). These concerns arose from the difficulties associated with assessing complex medical conditions through remote means, the potential for delayed interventions, and the difficulty in establishing a comprehensive care plan without in-person examinations. To mitigate some of these issues, hybrid care models that combined both virtual and in-person visits were developed.

Why is it important?

Given the unique challenges faced by pregnant mothers due to restrictions and changes in healthcare practices, there is an opportunity to understand how these changes impacted the experiences of women who gave birth during this unprecedented period in the province. This knowledge will help the health system to understand the effects of pandemic mitigation measures on this vulnerable group for future pandemic planning and virtual care design. This report aims to address the gap in knowledge regarding the quality of prenatal care in Saskatchewan during the COVID-19 pandemic. By assessing the impact of the pandemic on perinatal and postnatal care availability and demand, this study will help inform healthcare delivery strategies and prioritize maternal and infant health services in the face of public health emergencies.

2.0

Methods

2.1. Study design

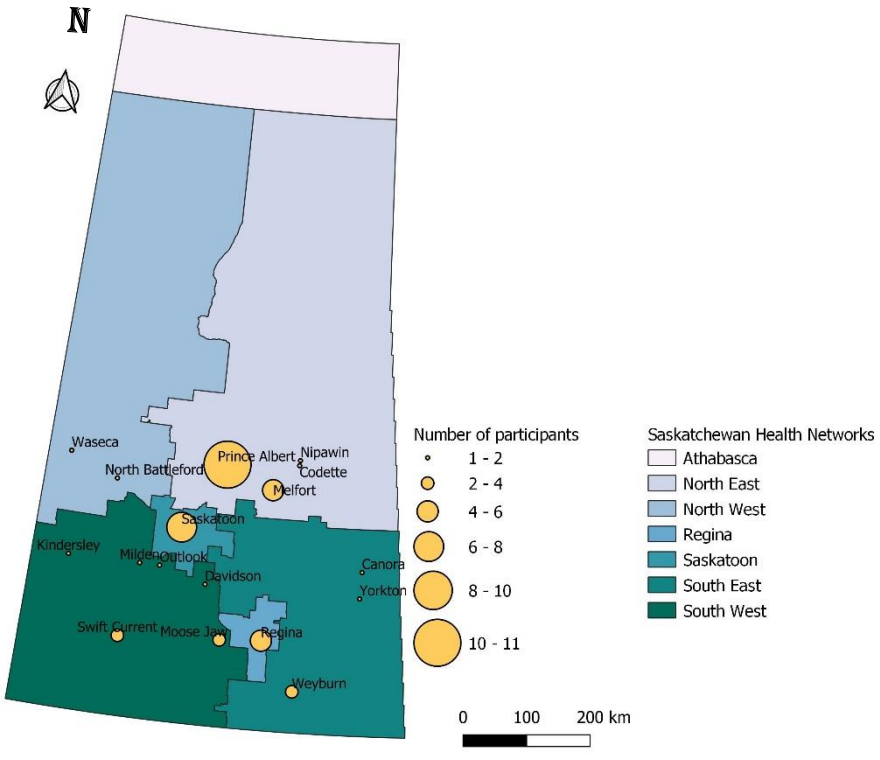
This qualitative study adopted an interpretive phenomenology approach through which semi-structured interviews and focus group discussions (FDGs) were conducted with 51 women who gave birth during the active phase of COVID-19 pandemic (March 2020-December 2022). This approach allowed us to delve into the lived experiences of pregnant women who accessed perinatal care services during the pandemic. By exploring their perspectives, we aimed to capture the essence of their experiences, detailing both what they went through and how they felt throughout the process. Data were collected remotely from **35 interviews** and **three FGDs** with 16 participants (4–7 participants in each group), using the WebEx virtual platform. The study ensured equitable representation across Saskatchewan, with data collection spanning from December 2023 to March 2024. Ethics approval was obtained from the Behavioural Research Ethics Board at the University of Saskatchewan *(BEH-4131)*, and operational approval from the Saskatchewan Health Authority (*OA-UofS-4131)*.

2.2. Participants and sampling approach

Through a purposive sampling approach, women in Saskatchewan who gave birth during the study period were recruited. Also, the eligibility criteria required participants to be at least 18 years old, able to speak English, and give consent for themselves.

Recruitment was done through posters in clinics, emails, and social media advertisements. The geographical representation was diverse and inclusive. The sampling approach for this study was to deliberately include more pregnant women from rural and northern regions. Since these women are underrepresented in maternal care studies, we oversampled from northern regions whose voices are not typically included in maternal and child health studies. In addition, some healthcare workers who met the inclusion criteria (22%) were recruited to provide valuable insights into maternal care practices and challenges during this unique period, enriching the study by integrating both lived maternal experiences and professional perspectives. Using the Saskatchewan Health Networks, 22 participants were from the northern region, 16 participants were from the southern region, and 13 participants were from either Saskatoon or Regina. The geographical distributions of the participants' locations are shown in Figure 1.

Figure 1: Regional representation of pregnant women



2.3. Procedures

In-depth interview and focus group guides were developed based on the literature and programmatic experiences of the multidisciplinary research team that included a patient partner, obstetrician, and Saskatchewan Health Authority (SHA) leaders, with expertise in perinatal health, primary health care and Indigenous health. The interview and FGD questions were all open-ended and in English language. Following ethical approval and permission from the SHA to proceed with this study, we contacted the participants who had volunteered to participate and met the inclusion criteria. Participants chose to take part in either an in-depth, one-on-one interview or focus group discussion. Prior to each interview or focus group discussions, participant's informed consent, demographic information, and obstetric histories were gathered through a written questionnaire. One research specialist led all interviews and focus group discussions to ensure consistency across the two data collection methods. An informal, conversational approach was adopted for both individual interviews and FGDs. Sessions lasted 20-90 minutes for interviews and 60-120 minutes for FGDs and were audio-recorded. Participants described their pregnancy and delivery experiences and discussed the impact of COVID-19 on perinatal care services. After the interview and FGDs sessions, the moderator (research specialist) checked with the participants to see if they felt the transcripts accurately reflected their shared perspectives or if they wanted to amend (i.e., member check). Some participants expanded on their initial comments, but none changed their original viewpoints. At the end of each session, participants received an honorarium of $50 for their participation. Data saturation was inferred when no new responses from the participants emerged.

2.4. Data analysis

The data files were imported and analyzed manually in a password-protected folder using a SHA designated work laptop that had pre-installed Windows and Microsoft software. The audio recordings were transcribed and quality-checked manually by the research specialist to ensure accuracy. De-identified transcripts were used for manual analysis to maintain confidentiality in the final report. A sample of these transcripts were independently reviewed by a co-Principal Investigator to facilitate independent theme identification and enhance the rigor of the study. Data analysis was guided by Braun and Clarke's six steps for thematic analysis (Braun & Clarke, 2006).

Braun and Clarke's six steps for data analysis process

Familiarization of data.

Generation of codes.

Combining codes into themes.

Reviewing themes.

Determine significance of themes.

Reporting of findings.

The analysis employed both deductive and inductive approaches. The deductive analysis utilized a predefined coding framework that was developed by the research team based on the study's objectives: views on pandemic measures, positive experiences, negative experiences, and mixed experiences. This approach allowed for the integration of familiar concepts into the analysis, while inductive analysis facilitated the identification of new or emerging ideas. The data were initially fine coded to capture detailed descriptions, which were then organized into the most prominent or common themes.

3.0

Results

The demographic and obstetric information for all the participants are summarized in Tables 1 and 2, respectively. Of the 51 mothers who participated in this study, 50 of them completed the demographic survey and 49 women completed the obstetric questionnaire.

3.1. Demographic characteristics

The mean age of participants was 31 years (standard deviation: 4 years), ranging from 24 to 40 years. There was a fair representation from different regions of Saskatchewan– urban (Saskatoon/Regina): 26%, northern: 43% and southern: 31%. Most participants were Canadian citizens by birth (69%), married (92%), had a Bachelor's, graduate or professional degree (58%), and were working class (72%). One out of every five participants (20%) reported an annual household income below $50,000.

3.2. Obstetric history

The total number of children per mother (parity) ranged from 1 to 3, with 42% of the participants being first-time mothers. Also, 50% of the index pregnancies were delivered in 2020. In terms of gestational age at delivery, the majority (88%) were full-term, while 12% were pre-term. The sex of the children at birth was almost equal, with 48% being female and 52% male.

Most participants began prenatal care at an average gestational age of 7.9 weeks, with a standard deviation of 3.9 weeks. Most mothers (92%) started prenatal care during the first trimester. Regarding prenatal care services received, 27% of participants were solely cared for by a family physician, 16% by a midwife, and 37% by an obstetrician. In addition, 2% received care from both a family physician and a doula, while 18% received care from both an obstetrician and a family physician. In terms of delivery, obstetricians supported most of the births (55%), followed by midwives (25%), family physicians (16%), and others (4%). Most births (96%) took place at health facilities, with the remaining 4% occurring at home.

3.3. COVID-19 related history

As shown in Table 3, 41% of the participants reported that they were either COVID-19 positive or had a household member who was, while 55% indicated that they were not diagnosed with COVID-19. Also, most participants (76%) confirmed they had received at least one dose of COVID-19 vaccine before or during their last pregnancy.

Table 1: Demographic characteristics of the participants

n

Demographic characteristics	Frequency (n)	Percentage (%)
Maternal age (year)	**31 (4)***	
Education		
High school graduation	1	2
Some college, trade school or university	4	8
College or trade school certificate or diploma	16	32
Bachelor's degree	19	38
Graduate or professional degree	10	20
Marital status		
Married	45	91.8
In a domestic partnership	3	6.1
Widowed	1	2
Location		
Urban	13	25.5
Northern	22	43.1
Southern	16	31.4
Status in Canada		
Canadian by naturalization	14	28.6
Canadian by birth	34	69.4
Newcomer	1	2
Occupation		
Education/training	10	20
Healthcare	11	22
Administrative/ supportive roles	5	10
Business/ finance	6	12
Creative/ design	2	4
Customer service	1	2
Public service	1	2
Not working	14	28
Annual household income (before for taxes)		
≤$25K	6	12
$26K - $50K	4	8
$51K - $75K	14	28
$76K - $100K	11	22
>$100K	14	28
Prefer not to answer	1	2

**Mean (standard deviation)*

Table 2: Obstetric histories of the participants

Obstetric history	Frequency (n)	Percentage (%)
Parity		
1	21	42
2	25	50
3	4	8
Year of delivery of index pregnancy		
2020	25	50
2021	14	28
2022	11	22
Gestational age (at delivery)		
Full-term (≥37 weeks)	43	87.8
Pre-term (<37 weeks)	6	12.2
Sex of child (at birth)		
Female	24	48
Male	26	52
Time prenatal care first received (weeks)		
First trimester (≤13)	44	91.7
Second trimester (14-26)	4	8.3
Prenatal care services by healthcare providers		
Family physician	13	26.5
Midwife	8	16.3
Obstetrician	18	36.7
Family physician and doula	1	2.0
Obstetrician and family physician	9	18.4

Table 3: COVID-19 histories of the participants

COVID-19 history	Frequency (n)	Percentage (%)
COVID-19 diagnosis (yourself or household members)		
Yes	20	40.8
No	27	55.1
Don't know	2	4.1
Received COVID-19 vaccine		
Yes	37	75.5
No	12	24.5

Themes and subthemes

Four primary themes were identified: 1) Views on pandemic measures, 2) Negative experiences, 3) Positive experiences, and 4) Mixed experiences. These themes were further broken down into 13 subthemes. The lived experiences of mothers during pregnancy and childbirth in the context of the COVID-19 pandemic were captured across these four overarching themes and their corresponding subthemes, as outlined below.

3.4. Views on pandemic and response measures

3.4.1. Perceived uncertainty and concerns about exposure to COVID-19 virus

A key subtheme that emerged from mothers' experiences during the pandemic was a deep sense of concern and uncertainty about the risks of being pregnant and giving birth in such an unprecedented time. They questioned how the virus might impact their pregnancies and whether they were putting their families at risk. One mother living in an urban area, reflected:

> *"I wondered... what could it mean for people who are pregnant? Was I being irresponsible, or dangerous for my family and this potential baby?"*
>
> 36 years old, Urban, Delivered in 2020, Interview (P101)

This uncertainty was exacerbated by the rapidly changing nature of the pandemic and the lack of clear, consistent guidance about what precautions were necessary. Another participant shared,

> *"I felt like it affected me greatly because we were carrying a lot of the unknown day to day... trying to keep our families safe and everything like that. So, I felt like that was stressful."*
>
> 40 years old, Southern, Delivered in 2021, Interview (P114)

Also, most mothers feared that exposure to the virus, particularly in crowded urban settings, could get them infected and then lead to complications or affect the health of their babies, hence creating a constant sense of apprehension. A first-time mother reflected on her experience saying:

> *"... the fear of getting infected yourself... If you get infected, it could affect your baby. You may experience pregnancy complications, such as preterm birth, which can impact the baby's development, possibly even cognitive development. Also, there is a risk of losing the pregnancy."*
>
> 29 years old, Urban, Delivered in 2020, Interview (P110)

Other mothers expressed their fears, stating:

> *"My concern was that I might contract COVID while pregnant, which could lead to respiratory distress and result in the early delivery of a stillborn baby. I was therefore very concerned about contracting COVID, especially given that my work in a hospital setting carried a higher risk."*
>
> 29 years old, Southern, Delivered in 2020, Interview (P117)

> *"One of the challenges I faced was the fear of being infected and exposing my baby to the pandemic. That was one of the major challenges I faced."*
>
> Northern-4, FGD

3.4.2. Perception of COVID-19 precautions

3.4.2.1. Trust in safety measures

Many mothers expressed confidence in the safety measures implemented during the COVID-19 pandemic. Also, they understood and accepted the need for restrictions, recognizing that these measures were put in place to protect both themselves and their babies. A healthcare worker who contracted COVID-19 at 38 weeks of gestation during the Omicron-dominated wave and self-isolated to protect her family explained:

> *... I felt that it was really good. At that time, I was still supportive of the restrictions. I supported measures like getting people to work from home, limiting the number of people in hospitals, and ensuring that systems were in place for people to get vaccinated if they wanted to.*
>
> 40 years old, Urban, Delivered in 2021, Interview (P107)

Another mother noted that,

> *I'd say the regulations are good precautions because they are designed to protect both me and the baby.*
>
> 29 years old, Urban, Delivered in 2020, Interview (P110)

However, even those who recognized the importance of these precautions acknowledged the challenges that came with them, especially during labor and delivery. While the safety of both mother and baby was critical, the adjustments required by the pandemic—such as mask wearing or following restricted visitation policies—sometimes added layers of inconvenience or discomfort.

> *The mask was an inconvenience as I could say and it's probably not ideal having a mask on while you're going through labor.*
>
> 33 years old, Southern, Delivered in 2021, Interview (P109)

> *...Not being able to have my husband there [at the prenatal appointment] also made it harder and a little bit sadder.*
>
> 29 years old, Urban, Delivered in 2020, Interview (P102)

> *It was hard not having my husband able to go to the appointments with me because of COVID restrictions, which allowed only one person to attend.*
>
> 30 years old, Urban, Delivered in 2021, Interview (P112)

> *I was worried that my husband wouldn't be allowed to be there during labor. I would have to wear a mask during that time, and get tested. Maybe, I wouldn't receive the same kind of care as I normally would.*
>
> 38 years old, Southern, Delivered in 2022, Interview (P120)

Despite questions about the safety of the new vaccine for the developing fetus and the exclusion of pregnant and lactating women from early clinical trials, most mothers received the COVID-19 vaccine. One mother shared her experience of getting vaccinated within a family where there were concerns about the safety of COVID-19 vaccination.

> *I just didn't want to get sick, especially since I was vaccinated. I was just being cautious. It doesn't help that my in-laws are very anti-COVID. There was a lot of pressure because of that.*
>
> 32 years old, Urban, Delivered in 2022, Interview (P127)

In the vaccine decision-making process, mothers faced a conflict between their personal health concerns and the vast, often contradictory information found online. While some sources highlighted the vaccine's safety, others focused on risks and personal stories of complications. The guidance from family doctors, who offered tailored advice based on individual's specific circumstances, played a crucial role in motivating the decision to get vaccinated.

> *I was worried about potential long-term effects of COVID on the baby and had concerns about the vaccine, which I discussed with my doctor. I had encountered conflicting information online—some sources claimed the vaccine was safe, while others reported severe complications. After speaking with my doctor, I felt reassured about its safety and decided to get vaccinated.*
>
> 32 years old, Northern, Delivered in 2022, Interview (P129)

> *My obstetrician did not pressure me to get the COVID vaccine. I know that, like in other places, I had heard a lot about how pregnant women should get it and how important it is. However, I did not feel pressured by my care provider to do so. I was happy that she respected my decisions. I ended up getting sick with COVID during my pregnancy.*
>
> 30 years old, Southern, Delivered in 2022, Interview (P106)

3.4.2.2. Skepticism about COVID-19 vaccines

Some mothers remained skeptical about the safety of COVID-19 vaccination, worrying that it might have long-term side-effects, both on their health and their unborn babies. These mothers avoided the vaccines, even after pregnant women were made eligible, emphasizing the difficulty of decision-making under conditions of uncertainty. The added pressure of making decisions that could impact not only one's own health but also the health of an unborn child added a layer of complexity and emotional burden.

> *I know they said the vaccine was safe in pregnancy, but I really felt like a guinea pig. So, I did not get the vaccine when I was pregnant… I was worried about the future long-term side effects could have on my unborn child.*
>
> 35 years old, Urban, Delivered in 2022, Interview (P136)

> *I didn't want to get vaccinated while I was pregnant because, from my understanding, there wasn't enough research on the effects it could have on the unborn baby. My physician was very adamant that I needed to get it done. She continued to lecture me, essentially saying that I was a bad person for choosing not to get vaccinated at the time. It got to the point where she actually said, I'm not even going to see you anymore.*
>
> 32 years old, Northern, Delivered in 2021, Interview (P121)

3.4.1.3. Frustration with public behavior

Mothers felt at risk, not just because of personal behaviors but because of the behaviors of others in their immediate environment. Their vulnerability was compounded by the inability to control the actions of people around them, particularly those who disregarded social distancing or were skeptical of vaccinations.

> *My main concerns were that people weren't taking those precautions seriously. Maybe it's just the circle of people I was in, but they weren't following social distancing guidelines and were very skeptical about vaccinations. They often didn't take these measures seriously, which, in turn, made me feel more at risk while carrying my baby.*
>
> 30 years old, Urban, Delivered in 2021, Interview (P112)

> *I felt like a lot of people were becoming more relaxed about the pandemic, but I never really was, because I saw people I knew and people from our community not adhering to the measures put in place.*
>
> 40 years old, Southern, Delivered in 2021, Interview (P114)

3.5. Negative experiences

3.5.1. Disruption of access to perinatal care

3.5.1.1. Geographic limitations

The pandemic exacerbated pre-existing barriers to perinatal care in rural and northern communities. Geographic disparities in Saskatchewan, combined with pandemic-related restrictions, created significant challenges for pregnant women trying to access healthcare. With the movement restrictions in place, traveling to the hospital became difficult. This was particularly concerning for those with urgent healthcare needs, who required specialized care for complicated pregnancies. Unfortunately, many essential healthcare services were severely limited, leaving vulnerable individuals without the timely care they needed. Some participants in remarked on the difficulties of obtaining care due to geographic distance.

> *Well, I am [several] kilometers away from [a city in northern region], which is my closest access to an OBGYN... We do have family doctors, I think one or two located in [another city in northern region], but it's extremely difficult to get an appointment with them. So, I think rural people really suffered in the sense that they have to travel.*
>
> 34 years old, Northern, Delivered in 2022, Interview (P125)

> *One of the challenges was the limited access to healthcare. During the pandemic, movement was restricted, so it was difficult to travel from home to the hospital… Accessing healthcare can sometimes be urgent, such as for pregnant women, who require special attention in case of health issues. However, during the COVID-19 pandemic, these healthcare services were limited.*
>
> 29 years old, Urban, Delivered in 2020, Interview (P110)

Also, a participant from a focal group discussion in northern region stated:

> *Everyone was on lockdown, and everyone was home. It was quite difficult to access some healthcare facilities due to the lockdown and other restrictions. So, it was really challenging for me.*
>
> FGD 1, Northern

3.5.1.2. Financial constraints

For some mothers, financial strain brought on by the pandemic made it even harder to access necessary perinatal care. A first-time mother shared her experience:

> *One factor is finances, but I'm happy because my partner stepped in and helped me. There was a time when I was supposed to visit the health facility, the clinic, but I wasn't financially able to. However, my partner stepped in for me, and everything went well. That is one of the challenges I faced.*
>
> 25 years old, Northern, Delivered in 2020, Interview (P111)

Another participant shared:

> *It negatively impacted people's daily lives because the cost of transportation was quite high… I have limited access to perinatal services due to a lack of finances.*
>
> FGD 1, Northern

3.5.1.3. Limited availability of healthcare providers

Mothers expressed frustration with scheduling appointments with healthcare providers. The closure of in-person services, coupled with lockdown measures, led to delays in and a cascade of cancellation of appointments. Moreso, some doctors were unable to return after visiting their families abroad, leaving patients to have to change doctors. The impact on quality of care was evident, as many women expressed frustration over these challenges.

> *As for visits to my family physician and OB-GYN, there were delays. Many appointments had to be postponed or limited due to social distancing measures.*
>
> 26 years old, Southern, Delivered in 2020, Interview (P134)

> *It was hard because, during COVID, a couple of my different doctors, including my family doctor, ended up leaving to visit their families in their home countries and got stuck there, unable to return. So, I had to keep switching doctors.*
>
> 32 years old, Urban, Delivered in 2022, Interview (P127)

> *The appointments we had were canceled several times due to the outbreak of the pandemic, the fear of being infected, and limited access to resources.*
>
> FGD 1, Northern

> *There was a delay in getting my midwife's services because she wasn't staying close, and movement restrictions made it difficult to access services.*
>
> FGD 3, Northern

> *The lack of physical contact was a problem. Due to the pandemic, I couldn't easily meet with a doctor in person, and when I did get an appointment, it often took a long time to schedule.*
>
> FGD 1, Southern

3.5.2. Increased wait times and resource strain

The overwhelming influx of patients during the pandemic led to longer wait times. This increased demand, compounded by the need for additional safety measures, created a bottleneck in service delivery. Some women described receiving what they felt like "bare minimum" care due to the overwhelming strain on healthcare resources. A mother remarked on the busy atmosphere of the clinics:

> *The office seemed much busier during COVID, and wait times were longer. It was probably because they had to allow extra time for sanitizing and patient turnover.*
>
> 35 years old, Urban, Delivered in 2022, Interview (P136)

3.5.3. Communication breakdown

A recurring theme among participants was the sense of being unheard during their interactions with the care providers. Many mothers stated that they hardly had the chance to ask questions or express themselves because of the hurried nature of consultations. With care providers preoccupied by the logistical challenges posed by the pandemic, the quality of patient-provider communication suffered. This led to an environment where patients felt their concerns were not adequately addressed because they felt rushed and often found it difficult to engage meaningfully with their providers. This interaction diminished their overall experience with care.

> *All other healthcare services I accessed during my pregnancy were delayed, and I barely had the chance to ask questions or express myself because it felt like everyone was in a hurry.*
>
> FGD 3, Northern

Also, some women expressed frustration over how vital information was not effectively relayed, which made patients to feel neglected and uninformed. The lack of communication or late notifications disrupted perinatal care access, especially for patients who had to travel long distances to receive such care.

> *There was a postponement due to the lack of communication.*
>
> FGD 3, Northern

Another participant emphasized the need for healthcare providers to understand their patients' unique needs and communicate effectively.

> *I did not receive enough care as a new mom, and because of that, I am not able to do much. My labor was very rough, and they did not explain how I should go to the bathroom, clean myself, or administer my pain medication.*
>
> 38 years old, Southern, Delivered in 2021, Interview (P103)

3.5.4. Delays in periodic screening and diagnostic testing

Some pregnant women experienced significant delays in accessing essential healthcare services during the pandemic. This impacted their ability to receive timely ultrasounds and diagnostic testing, which are crucial for monitoring the health of both the mother and fetus. Also, there were unacceptably long wait times at the diagnostic service centers.

> *There were many delays, especially with lab test results and exam services. It wasn't just normal delays; we had to wait extra days for responses.*
>
> 32 years old, Southern, Delivered in 2022, Interview (P132)

> *There was a delay in doing the ultrasound, because I was supposed to take the ultrasound around late February, but I had to take it in mid-March because of the pandemic.*

25 years old, Northern, Delivered in 2020, Interview (P111)

> *I didn't get the first ultrasound until much later than I had with my firstborn.*

29 years old, Urban, Delivered in 2020, Interview (P102)

> *It was challenging to have physical contact due to the pandemic, which led to delays in scheduling the ultrasound.*

29 years old, Southern, Delivered in 2020, Interview (P130)

3.5.5. Psychosocial and health impacts during pregnancy and delivery

3.5.5.1. Fear of COVID-19 infection

Many mothers reported increased anxiety and stress levels during pregnancy due to the pandemic. Concerns about contracting COVID-19 and its potential impact on their health and the baby's health were prevalent. They felt overwhelmed by the constant news of rising death tolls due to COVID-19. A first-time mother noted:

> *Speaking of the effect of the pandemic on my mental health, ... it was negative for me ... created a fear of who might be next. ... my distant uncle was diagnosed with COVID-19, and he did not survive. ... I felt mentally drained and emotionally traumatized.... I almost regretted being pregnant.*

32 years old, Southern, Delivered in 2022, Interview (P132)

> *My main concern was: What is going to happen during my delivery? I saw younger kids as being vulnerable, and I was scared of getting infected or my kid getting infected. I tried to let go of some fears. My concerns, I think, changed over time.*

30 years old, Northern, Delivered in 2020, Interview (P124)

3.5.5.2. Fear and anxiety due to hospital protocols

Many mothers expressed heightened fears during labor, particularly regarding COVID-19 precautions in the hospitals. There was concern over the presence of COVID-19 patients in healthcare settings. A first-time mother shared,

> *Just know that when I was in the hospital to deliver, there were about seven COVID patients... I kept thinking, 'Oh my God, there are seven COVID patients here,' so I was really paranoid... you always have those fears and concerns when you're about to deliver....*

36 years old, Northern, Delivered in 2020, Interview (P104)

Also, the requirement for masks and other pandemic measures added to the anxiety during labor, as mothers felt emotionally disconnected from their support networks. The inability to see facial expressions due to masks made it harder for partners to communicate and provide reassurance, which contributed to heightened stress levels during labor.

> *The one thing that was a little bizarre was that my partner had to wear a mask... not being able to see his face or facial expressions created some anxiety for me during labor... I told him, 'You're going to have to smile with your eyes more during labor so I know everything's okay.*

35 years old, Urban, Delivered in 2021, Interview (P115)

3.5.5.3. Emotional distress and isolation from social distancing

The COVID-19 social distancing measures and lockdown restrictions significantly contributed to emotional distress and a sense of isolation among pregnant women and new mothers. A major source of this distress stemmed from the inability to have support persons, such as family members or partners, present during key moments—particularly labor and medical appointments. For many, these restrictions disrupted their expectations of shared experiences during pregnancy and birth, leading to a profound sense of loss.

> *I missed out on a lot of firsts... I wanted to voice some of my concerns... who else was I going to tell about not having my sister in the delivery room?*
>
> 36 years old, Northern, Delivered in 2020, Interview (P104)

> *For first-time parents, I can totally understand how incredibly difficult it would be if they couldn't have a support person with them during labor.*
>
> 35 years old, Urban, Delivered in 2021, Interview (P115)

Many women also highlighted the emotional impact of attending prenatal appointments alone due to restrictions on support persons. The absence of companionship during critical moments, such as first ultrasounds, increased their stress levels and intensified feelings of vulnerability.

> *I think the social barrier was that no one could go to the appointments with me.... I was really sad and probably shouldn't have been driving or going into appointments by myself.... those first ultrasounds—moments you usually share with your partner—I just missed that.*
>
> 29 years old, Urban, Delivered in 2020, Interview (P102)

3.5.5.4. Fear about future and finances

Expectant mothers reported feelings of insecurity regarding the future, and financial stability, leading to heightened emotional distress during pregnancy.

> *Mentally, I experienced a lot of anxiety and fear because I wasn't sure about the future, especially regarding finances. I wasn't sure when the pandemic would end or when I could start working again.*
>
> FGD 1, Northern

3.5.5.5. Inactivity and limited exercise

Many women reported a significant reduction in physical activity, as they could not join fitness or prenatal exercise classes due to pandemic restrictions and closure of recreational facilities, leading to a more inactive lifestyle.

> *I was rather inactive. I stopped going out again because I didn't want to expose myself or others. I didn't join any prenatal exercise groups, support groups, or anything of that nature... I think once you isolate yourself at home, it really changes your mental health as well. So, that was definitely a more challenging period.*
>
> 33 years old, Southern, Delivered in 2021, Interview (P109)

> *I couldn't go outside and do light exercises. Due to the pandemic, we had to stay indoors, and, unfortunately, we were told not to take walks or go on nature walks. So, physically, I was affected because I couldn't do exercises.*
>
> FGD 1, Northern

> *It did affect me negatively in ways like not being able to go out and exercise, so I didn't feel free during the pregnancy. My movements were restricted, and I couldn't meet my friends, so it was just boring staying home all day.*
>
> 28 years old, Northern, Delivered in 2020, Interview (P122)

3.5.6. Postpartum experiences

3.5.6.1. Postpartum depression

Postpartum depression was experienced by many mothers especially new mothers. They struggled to connect with their newborns amidst pandemic pressures.

> *So, I was diagnosed with postpartum depression... the biggest challenge... your baby depends on you... you just think, 'Okay, let's figure this out.' But... the mental health side of things has been the biggest cloud over the whole experience of becoming a mother.*
>
> 38 years old, Southern, Delivered in 2021, Interview (P103)

> *I went through postpartum depression.... You know, there were just things that were really hard for me.*
>
> 31 years old, Southern, Delivered in 2022, Interview (P108)

Most mothers had access to mental health resources post-partum. However, there were some mothers who faced barriers to accessing this postpartum depression. For some, the lack of in-person interaction or difficulty navigating the digital healthcare systems left them feeling further alienated.

> *I struggled with postpartum depression after my second child. But when they asked me to complete the mental health questionnaire over the phone, it just didn't feel connected. I felt like they couldn't see my responses on my face, and it made the process difficult. I think a lot of mental health issues during pregnancy in general were missed during that time.*
>
> 34 years old, Northern, Delivered in 2022, Interview (P125)

> *Postpartum was rough. I had postpartum depression, but getting an appointment with doctors was so difficult due to backlog. it's been two and a half years, and I'm still on the waitlist to see someone about it. So, there's been quite a gap, and that made it really hard to navigate afterward. You're not a new mom, but you're still a new mom, and you don't really know what you're doing.*
>
> 29 years old, Urban, Delivered in 2020, Interview (P102)

3.5.6.2. Stress from limited social and family support

Many women reported increased stress as a result of significant decrease or absence of social support, as pandemic restrictions prevented family and friends from visiting, celebrating milestones such as baby showers, or providing in-person assistance.

> *Then, leading into postpartum, I would say it was very much the same— I didn't join any groups.... COVID created a lot of uncertainty.... We couldn't have family visit, nor could we visit family.... It was a really strange experience compared to what one might expect.*
>
> 33 years old, Southern, Delivered in 2021, Interview (P109)

> *Overall, I felt it was quite isolating because I didn't have a baby shower.*
>
> 40 years old, Southern, Delivered in 2021, Interview (P114)

> *From the point where the pandemic was declared onwards, fear and isolation were the main things I remember feeling.... We were isolating away from my family ... It was a very lonely experience... no baby shower, no gatherings, and even trying to find baby clothes was difficult ... It was really tough.*
>
> 34 years old, Urban, Delivered in 2021, Interview (P115)

> *I didn't think I'd get emotional, but it's kind of when it's your first child. Yes, you know, I didn't get to experience a baby shower, so I feel like my child missed out on some things.*
>
> 36 years old, Northern, Delivered in 2020, Interview (P104)

Despite the lockdown measures that restricted in-person gatherings, and led to the cancelations of many baby showers, few mothers opted to celebrate their baby showers virtually.

> *Yeah, that was very different from what I anticipated. The baby shower was all online.*
>
> 33 years old, Urban, Delivered in 2021, Interview (P113)

3.5.6.3. Limited postpartum care

Postpartum care was delayed or limited, with some mothers struggling to access necessary healthcare services, such as lactation support, mental health, and other follow-up appointments.

> *The prenatal care was great. The postpartum care was not, I found it lacking.*
>
> 38 years old, Southern, Delivered in 2022, Interview (P120)

> *I struggled the first time too, so that was nothing new. But the first time, I felt I had support because the public health nurse would come and help me try to latch, figure things out, and make the baby comfortable. However, the second time, that support wasn't there. As a result, I ended up quitting breastfeeding fairly early with him because I had given up.*
>
> 34 years old, Northern, Delivered in 2022, Interview (P125)

> *I could not breastfeed because I couldn't sit. I couldn't lay comfortably enough to hold my child and breastfeed because I was in so much pain. I had trouble getting my daughter to latch, and we tried using a breast pump. We also had a lactation consultant, but her attitude was awful. Unfortunately, we don't have access to another lactation consultant.*
>
> 38 years old, Southern, Delivered in 2021, Interview (P103)

While mothers acknowledged the existence of some perinatal counselling services in Regina and service collaboratives across Canada, they were not known until after delivery. Some rural participants also highlighted that the postpartum women in rural Saskatchewan faced challenges in having timely access to mental health services.

> *When I look at my postpartum mental health journey, that was the biggest challenge... where most people fall through the cracks, trying to find support after that.*
>
> 38 years old, Southern, Delivered in 2021, Interview (P103)

3.5.6.4. Limited movement due to hospital policies

During the pandemic, hospitals instituted strict protocols that limited movement during and after labor. Many mothers reported feeling confined and restricted, particularly in their ability to move freely within the hospital. For instance, one participant noted the impact of these restrictions, stating,

> *I wasn't able to walk in the hallways, which was really hard postpartum.*
>
> 36 years old, Urban, Delivered in 2020, Interview (P101)

This inability to engage in simple physical activities, such as walking, increased discomfort, and increased recovery time after childbirth.

3.5.7. Extra burdens on healthcare providers

The participants who were healthcare providers faced challenges due heightened need for safety protocols to protect both family members and patients.

> *As soon as you walk through the door from work, you change your clothes, take a shower, and try to keep your family safe and everything like that. I felt like that was stressful.*
>
> 40 years old, Southern, Delivered in 2021, Interview (P114)

Figure 2: Word cloud of negative experiences of mothers who delivered during COVID-19 pandemic

3.6. Positive experiences

3.6.1. Increased family bonding

The pandemic restrictions created an unexpected opportunity for families to spend more time together at home. Many mothers found that the extra time with their partners and children fostered stronger family connections. With home-based activities taking center stage, these families experienced a deeper sense of closeness and bonding. Some participants reflected on their positive experiences:

> *We live on an acreage outside of the city, so we have lots of space for my boys to play and learn and run around.*
>
> 36 years old, Urban, Delivered in 2020, Interview (P101)

> *... we're maintaining a healthy lifestyle at home, keeping ourselves busy, and doing a lot of fun things together. With my son, I planned more activities at home or just with immediate family to keep our bubble small.*
>
> 35 years old, Urban, Delivered in 2021, Interview (P115)

3.6.2. Quality and continuity of care despite challenges

Despite the challenges brought on by the pandemic, some mothers reported receiving high-quality care from healthcare providers. The continuity of care also helped many mothers feel valued and supported.

> *I had a good family physician, and then I was referred to another physician in her clinic who specialized in babies ... She was the one who ended up delivering my baby. The continuity of care was really nice.*
>
> 36 years old, Urban, Delivered in 2020, Interview (P101)

> *For the most part, while we were in the hospital during the delivery, the nurses and doctors were phenomenal. They were great.*
>
> 36 years old, Northern, Delivered in 2020, Interview (P104)

3.6.3. Supportive healthcare providers

Many mothers recognized that having access to knowledgeable and supportive healthcare providers was crucial in easing the stress and uncertainty that accompanied their pregnancies during the pandemic. These providers offered reassurance, and a sense of stability, helping them to alleviate anxiety during a challenging time.

> *All the healthcare professionals I encountered were polite and caring.*
>
> 29 years old, Southern, Delivered in 2020, Interview (P117)

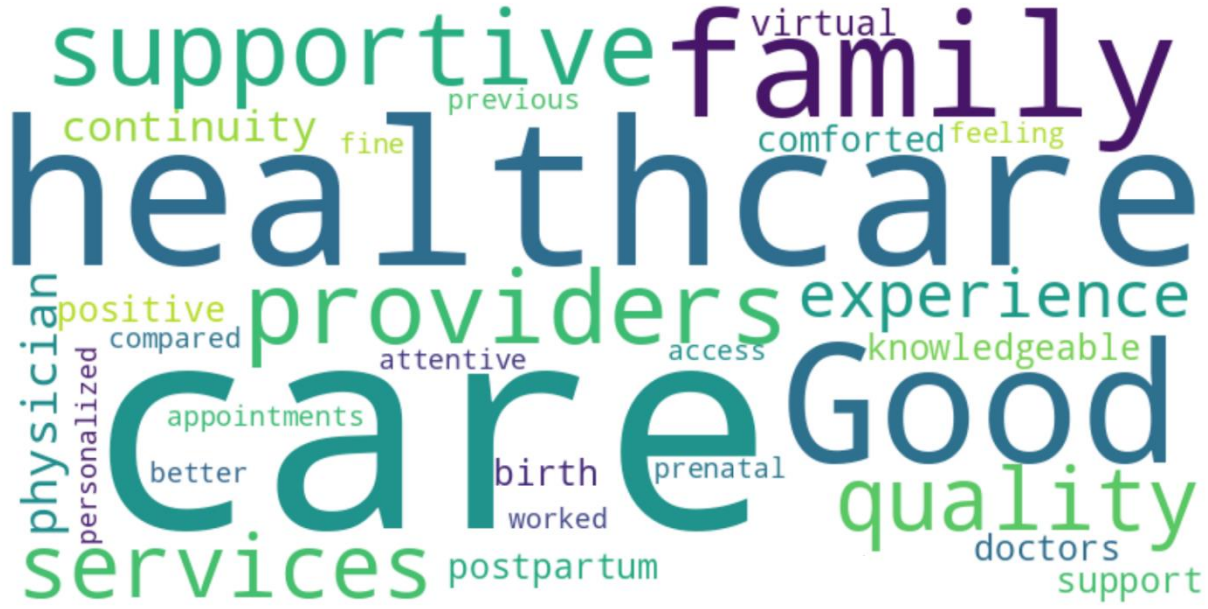
> *I would rate them maybe 99 out of 100% because I was treated so well. They listened to me and advised me accordingly. So, I can say that the services are very good.*
>
> 25 years old, Northern, Delivered in 2020, Interview (P111)

3.6.4. Prenatal care app: a valuable support resource

The Saskatchewan prenatal care app was a significant resource for a pregnant woman seeking guidance and support during her pregnancy journey. It offered a variety of helpful tips and information, making it easier for her to access vital health resources at their fingertips. She noted the utility of the app stating,

> *I know that there was a Saskatchewan health care pregnancy app that I actually use that had a lot of good tips on there.*
>
> 40 years old, Southern, Delivered in 2021, Interview (P114)

Figure 3: Word cloud of positive experiences of mothers who delivered during COVID-19 pandemic



3.7. Mixed experiences

3.7.1. Adaptability to changes in care: virtual care

The transition to virtual care during the pandemic revealed both the potential benefits and significant challenges faced by pregnant women. As face-to-face interactions with healthcare providers were limited or unavailable, telehealth became a necessary alternative. However, despite its convenience, several issues emerged, particularly regarding the lack of nonverbal communication, the inability to conduct physical examinations, and the challenges of effectively describing symptoms over audio calls.

3.7.1.1. Positive impacts of virtual care

3.7.1.1.1. Accessibility and convenience

Some mothers shared positive experiences with virtual care. The convenience of being able to connect with healthcare providers remotely was appreciated. Virtual care was seen as a viable option for managing the logistical challenges of accessing care, particularly for women living in remote or rural areas where healthcare facilities may be far away. The ability to consult with a provider from home helped reduce travel time and associated costs, making it a beneficial option for some women. Some mothers highlighted,

> *It was virtual... I was really happy about it... living a bit outside of town, it was really nice to have that immediate access. Since it was virtual, they could see what was going on with my son.*
>
> 36 years old, Urban, Delivered in 2020, Interview (P101)

> *I think that during the pandemic, people found a better way of accessing virtual care, which is a good thing in a way.*
>
> 24 years old, Urban, Delivered in 2021, Interview (P105)

Virtual care was also seen as a useful supplement to in-person visits, providing additional support without fully replacing traditional appointments.

> *I think it's great to have a virtual option to ask questions and receive guidance, but in-person care is, again, just not replaceable. I know it's really difficult right now, especially in recruiting or getting that support and filling those positions within the province, particularly in more remote communities.*
>
> 35 years old, Urban, Delivered in 2021, Interview (P115)

As the world adjusted to a post-pandemic reality, women began to reflect on their experiences with virtual care and its place in future healthcare delivery. A woman suggested,

> *Since we have started adopting virtual services, I think we should expand the telehealth services so that people can access care remotely.*
>
> FGD 3, Northern

3.7.1.2. Limitations of virtual prenatal appointments

3.7.1.2.1. Lack of non-verbal communication

Nonverbal cues, which often play a crucial role in patient-provider communication, were notably absent in virtual settings. Many mothers expressed difficulties in articulating their concerns over audio calls. They highlighted their discomfort with relying solely on phone calls, emphasizing the importance of face-to-face interactions for certain aspects of care. They shared,

> *I think virtual care would have been better for postpartum situations if it were done through a video call, rather than just over the phone. It feels more personal when you can actually see the person... You can see their facial expressions, which makes you feel like you're on the right track. But over the phone, it's harder to gauge that. Nonverbal communication is missing.*
>
> 36 years old, Northern, Delivered in 2020, Interview (P104)

> *I was not that comfortable. I had some information I needed to share. There were things I needed to ask, and some things I needed to discuss with the physician in-person, but because of the communication online isn't the same. I couldn't disclose everything to them.*
>
> FGD 1, Southern

3.7.1.2.2. Absence of physical examination

Many expectant mothers reported struggling with virtual prenatal appointments due to the absence of physical examinations and direct monitoring of their pregnancies. One mother shared,

> *But nothing was ever 100% because we weren't seeing each other face to face... I could describe my symptoms and how I was feeling, but those things always appear differently to others. Doctors are trained to notice things that we don't... The virtual appointments were harder because we're all trained in different ways for different things.*
>
> 29 years old, Urban, Delivered in 2020, Interview (P102)

Another mother highlighted,

> *I didn't have a blood pressure cuff at home, so there wasn't really an option for me to check my blood pressure myself.*
>
> 40 years old, Urban, Delivered in 2021, Interview (P107)

3.7.1.3. Dissatisfaction with virtual prenatal classes

3.7.1.3.1. Limited confidence and knowledge acquisition

Most mothers attended online prenatal classes, which were the only format available during that time. However, some mothers felt that virtual classes were too basic and left them unprepared, making them less confident, particularly when they lacked prior experience with pregnancy. A first-time mother expressed,

> *Okay, I'm going to say that it was a very negative experience. It wasn't like doing modules or attending in-person classes. I think, as a new mom with no prior experience, that situation was detrimental to my confidence, going into motherhood. My husband and I just read through some very basic information, which wasn't enough. It didn't provide the support I needed.*
>
> 38 years old, Southern, Delivered in 2021, Interview (P103)

3.7.1.3.2. Desire for real time virtual interaction

The virtual prenatal classes, conducted through online distance courses, lacked opportunities for real-time interaction. While this is not a universal concern, it was raised by multiple participants, suggesting a potential area for improvement in how virtual prenatal education is delivered. They emphasized having opportunities to ask questions and interact with others in the class in real-time.

> *It would have been better if there had been a facilitator available in real time to answer questions from new moms. In-person is always better than virtual prenatal courses. You know, going to a location and sitting together in person—obviously, that's the best scenario. The second best would be real-time virtual sessions, where everyone is still participating via a video call.*
>
> 38 years old, Southern, Delivered in 2021, Interview (P103)

The lack of opportunities to interact with instructors and connect with peers left many women feeling unsupported and overwhelmed.

> *It's basically online distance courses. Yeah, I feel like they just guided me through the process. It's stressful doing it all by myself.*
>
> 32 years old, Northern, Delivered in 2020, Interview (P123)

4.0

Concluding thoughts

The lived experiences of women who gave birth during the COVID-19 pandemic in Saskatchewan reveal a complex landscape of challenges and adaptations that significantly impacted maternal healthcare. This qualitative study underscores the profound effects of the pandemic on perinatal care, highlighting both negative experiences, such as increased anxiety, disrupted access to care, and feelings of isolation, as well as positive outcomes, including enhanced family bonding and supportive healthcare provider relationship.

The findings indicate that while some mothers appreciated the flexibility and accessibility of virtual care, significant concerns remained regarding the quality of care, the lack of personal connection, and the absence of physical examinations essential for monitoring maternal and fetal health. The emotional toll of the pandemic, exacerbated by uncertainty and health risks, has underscored the importance of comprehensive support systems for expectant mothers, particularly in times of public health crises.

Recommendations

1. Formal recognition of pregnant women and children as priority groups during health emergencies

☑ Emergency response plans must explicitly identify pregnant women and young children as priority populations with unique clinical and psychosocial needs. This includes ensuring continuity of perinatal care, access to in-person assessments, screening and diagnostic testing, and dedicated mental health resources.

2. Clarify communication protocols for public health emergencies

☑ Provide expectant mothers with timely, consistent updates on changing hospital policies (e.g., visitation rules, mask mandates) and care options. Use multiple channels (e.g., SMS, prenatal apps) to relay information, addressing confusion and anxiety caused by evolving guidelines during public health emergencies.

3. Revisit pandemic response plans

☑ Periodic review of Saskatchewan's emergency response plans will allow for the incorporation of lessons learned from past and recent crises, such as the COVID-19 pandemic and forest fire events. This type of review will identify practical steps to strengthen coordination of maternal and child health services during times of crisis. The SHA pandemic plan lacks an Annex that is specific to maternal-child health care delivery but has developed supplemental documents.

4. Scale and expand hybrid care models

☑ Build on the current hybrid model by broadening access to video-based consultations that foster richer patient-provider interaction, while ensuring in-person visits are prioritized when needed. Expand digital integration through prenatal app enhancements (e.g., symptom trackers) and extend hybrid postpartum support to include virtual lactation specialists and mental health check-ins, particularly for rural mothers who reported unmet needs.

5. Combat isolation arising from emergency countermeasures through structured peer and community support

☑ Develop virtual peer mentorship programs and online prenatal classes with real-time facilitator interaction to replicate in-person social connections. Create safe, localized events (e.g., outdoor prenatal groups) to address canceled baby showers and community activities, which exacerbated feelings of loneliness.

6. Continue to strengthen accessible care models for rural and northern communities

☑ Address geographic barriers by enhancing virtual care options paired with transportation support (e.g., subsidized travel for appointments) and ensuring consistent provider availability. During emergencies, prioritize in-person visits for critical assessments, such as ultrasounds and high-risk consultations, to mitigate delays reported by rural participants.

5.0

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