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REVISION

# PARTURITION AND BIRTH CARE PRACTICES DURING THE COVID-19 PANDEMIC: A SYSTEMATIC REVIEW OF THE LITERATURE

## PRÁTICAS DE ASSISTÊNCIA AO PARTO E NASCIMENTO DURANTE A PANDEMIA DE COVID-19: REVISÃO SISTEMÁTICA DA LITERATURA

## PRÁCTICAS DE ASISTENCIA AL PARTO Y NACIMIENTO DURANTE LA PANDEMIA DE COVID -19: REVISIÓN SISTEMÁTICA DE LA LITERATURA

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## ABSTRACT

**Objective**: to identify, in the literature, which obstetric practices were used during the COVID-19 pandemic period. **Method**: this is a systematic literature review, which was conducted by searching the PubMed (MEDLINE) and Embase databases covering the period from 2020 to 2024, following the PRISMA guidelines. A total of 2,505 references were found in the initial search, and after screening, 14 studies were included in the narrative synthesis, using the Synthesis Without Meta-Analysis (SWiM) methodology. **Results**: The studies indicated that, during the pandemic, there was an increase in the implementation of recommended practices in parturition, such as providing diet and non-pharmacological methods for pain relief. Non-recommended interventions, such as the use of episiotomy and oxytocin, decreased significantly. However, cesarean section rates remained stable in most studies, with the exception of some cases in which there was an increase, justified by the search for increased safety for the mother-baby dyad. **Conclusion**: The COVID-19 pandemic significantly impacted the organization of care for pregnant women, parturients, and newborns. In several international contexts, obstetric interventions considered unnecessary were adopted. This reinforces the need for continuous awareness among professionals involved in obstetric and perinatal care. Therefore, it is essential to strengthen strategies that favor women's autonomy and their active participation as central subjects in health care.

**Keywords**: COVID-19; Delivery Obstetric; Humanizing Delivery; Parturition; Obstetric Nursing; Infant, Newborn; Maternal-Child Nursing

## RESUMO

***Objetivo****: identificar, na literatura, quais foram as práticas obstétricas utilizadas durante o período da pandemia de COVID-19.* ***Método****: realizou-se uma revisão sistemática da literatura, por meio de busca nas bases de dados PubMed (MEDLINE) e Embase, no período de 2020 a 2024, seguindo as diretrizes PRISMA. Encontraram-se 2.505 referências na busca inicial e, após a triagem, 14 estudos foram incluídos na síntese narrativa, utilizando-se a metodologia Synthesis Without Meta-Analysis (SWiM).* ***Resultados****: os estudos indicaram que, durante a pandemia, houve um aumento na implementação de práticas recomendadas no parto, como oferta de dieta e métodos não farmacológicos para alívio da dor. As intervenções não recomendadas, como o uso de episiotomia e ocitocina, diminuíram significativamente. No entanto, as taxas de cesarianas permaneceram estáveis na maioria dos estudos, com exceção de alguns casos nos quais houve aumento, justificado pela busca de maior segurança para o binômio mãe-bebê.* ***Conclusão****: a pandemia de COVID-19 impactou significativamente a organização da assistência à gestante, parturiente e ao recém-nascido. Em diferentes contextos internacionais, constatou-se a adoção de intervenções obstétricas consideradas desnecessárias. Isso reforça a necessidade de sensibilização contínua dos profissionais envolvidos na atenção obstétrica e perinatal. Portanto, é essencial fortalecer estratégias que favoreçam a autonomia da mulher e sua participação ativa como sujeito central no cuidado em saúde.*

***Palavras-chave****: COVID-19; Parto Obstétrico; Parto Humanizado; Parto; Enfermagem Obstétrica; Recém-Nascido; Enfermagem Materno Infantil.*

## RESUMEN

***Objetivo****: identificar en la literatura cuáles fueron las prácticas obstétricas utilizadas durante el período de la pandemia de COVID-19.* ***Método****: se trata de una revisión sistemática de literatura. La búsqueda se realizó en las bases de datos Pubmed (MEDLINE) y Embase, con el período de 2020 a 2024, siguiendo las directrices PRISMA. Se encontraron 2,505 referencias en la búsqueda inicial y, tras revisar, se incluyeron 14 estudios en la síntesis narrativa usando la metodología Synthesis Without Meta-Analysis (SWiM).* ***Resultados****: los estudios indicaron que, durante la pandemia, hubo un aumento en la implementación de prácticas recomendadas en el parto, como oferta de dieta y métodos no farmacológicos para alivio del dolor. Las intervenciones no recomendadas, como el uso de episiotomía y oxitocina, disminuyeron significativamente. Sin embargo, las tasas de cesáreas permanecieron estables en la mayoría de los estudios, excepto en algunos casos donde hubo aumento, justificado por la búsqueda de mayor seguridad para la madre y el bebé.* ***Conclusión****: la pandemia de COVID-19 impactó significativamente la organización de la asistencia a la gestante, a la parturienta y al recién nacido. En varios contextos internacionales, se notó que se adoptaron intervenciones obstétricas que se consideran innecesarias. Esto resalta la importancia de seguir concienciando a los profesionales que trabajan en la atención obstétrica y perinatal. Se torna esencial fortalecer estrategias que favorezcan la autonomía de la mujer y su participación activa como sujeto central en el cuidado de la salud.*

*How to reference this article:*

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***Palabras clave:*** *COVID-19; Parto Obstétrico; Parto Humanizado; Parto; Enfermería Obstétrica; Recién Nacido; Enfermería Maternoinfantil.*

## INTRODUCTION

In recent decades, the care provided during labor has undergone significant changes worldwide, with the increased use of various practices aimed at regulating and monitoring the physiological birth process[1]. These practices are primarily aimed at improving perinatal outcomes, such as ensuring a companion during labor and delivery, non-pharmacological methods of pain relief, and free choice of birthing position. However, there are interventions that, when performed without clinical indications, negatively affect the pregnant woman's childbirth experience, such as the routine or liberal use of episiotomy, trichotomy, and enemas[1].

In 2018, the World Health Organization (WHO) published 56 guidelines on good care practices for labor, delivery, and birth, entitled "Intrapartum care for a positive childbirth experience", based on the Sustainable Development Goals from the perspective of women's health, especially regarding the reduction of maternal mortality. The document aims to promote respectful maternity care, not only to avoid complications during childbirth but also to ensure a positive birth experience, achieving better physical, mental, and psychological outcomes for the mother, newborn, and family[1].

In 2020, the COVID-19 pandemic spread worldwide, bringing new challenges to healthcare in general and, simultaneously, to the care of pregnant, parturient, and postpartum women[2]. With the rise of the pandemic, it became necessary to reorganize the global healthcare system so that care for pregnant, parturient, and postpartum women would not be negatively impacted. There was then a need to adapt hospital care, with the implementation of protocols and safety flowcharts for the care of pregnant women. For instance, specific care locations were implemented, visits were restricted, and changes were made to birth plans[3].

The challenges imposed on healthcare services during the pandemic highlighted the need to restructure work processes, considering the consequences caused by the new coronavirus and the specificities related to labor, delivery, and birth(4). Due to several physiological changes that occur during pregnancy, especially in the immune and respiratory systems, pregnant women were included, along with postpartum women, older people, and people with chronic diseases, in the COVID-19 risk group, given that these individuals were at higher risk if infected[3].

In light of the reorganization of the healthcare system for pregnant, parturient, and postpartum women, some changes in care were necessary, from prenatal care to labor, delivery, and postpartum care. Studies have demonstrated weaknesses in care for pregnant women, reporting a general reduction in the quality of maternal healthcare services compared to the pre-pandemic period. Pregnant women identified barriers and difficulties in accessing services such as prenatal care, postpartum appointments, and pregnancy monitoring, considering the reorganization of healthcare services during the pandemic to be unsatisfactory[5,6].

Therefore, it is vital that pregnant women have access to adequate facilities, with qualified staff and sufficient equipment, where they can give birth and care for their children[7]. Thus, the COVID-19 pandemic may have repercussions on the provision of maternal and neonatal healthcare services. Therefore, a better understanding of the models of care practices for labor and birth that occurred during this period is necessary to contribute to possible future pandemics.

## OBJECTIVE

To identify in the literature which obstetric practices were used during the COVID-19 pandemic period.

## METHODS

This is a systematic review based on the guidelines of the Cochrane Handbook for Systematic Reviews of Interventions[8] and reported according to the steps recommended by PRISMA[9]. The study protocol was registered on the PROSPERO Platform under registration number CRD42024509029.

The research question for this review was: "What models of labor, delivery, and birth care practices were used in different countries during the COVID-19 pandemic?".

In addition, the question was devised based on the PECO strategy, which is an acronym: P - Population of interest (pregnant women/postpartum women), E - Exposure (childbirth intervention models), C - Control (not applicable), O - Outcome (childbirth care models, COVID-19).

### Search strategy

The search strategy was performed using PECO terms adapted to the different Pubmed (MEDLINE)

and Embase databases. PECO terms, when available as indexers (MeSH and Emtree), were used alongside textual terms. Searches were performed in January 2024, without language restrictions, and updated in July 2024. The synonymous search terms included were separated by Boolean operators "OR," and each group of synonymous PECO terms was grouped by "AND." The reference lists of the included publications were also examined.

The following search keys were used:

a) Pubmed Key (MEDLINE)

("delivery, obstetric"[MeSH Terms] OR "deliveries obstetric"[All Fields] OR "Obstetric Deliveries"[All Fields] OR "Obstetric Delivery"[All Fields]) AND ("Episiotomy-"[MeSH Terms] OR "Amniotomy"[MeSH Terms] OR "Artificial Rupture of Membranes"[All Fields] OR "Fundal pressure"[All Fields] OR "Kristeller maneuvers"[All Fields] OR (("offer"[All Fields] OR "offered"[All Fields] OR "offering"[All Fields] OR "offerings"[All Fields] OR "offers"[All Fields]) AND ("diet"[MeSH Terms] OR "diet"[All Fields])) OR "freedom of movement"[All Fields] OR "partogram"[All Fields] OR ("non pharmacological"[All Fields] AND ("method s"[All Fields] OR "methods"[MeSH Terms] OR "methods"[All Fields] OR "method"[All Fields] OR "methods"[MeSH Subheading]) AND ("pain"[MeSH Terms] OR "pain"[All Fields]) AND ("relief"[All Fields] OR "reliefs"[All Fields])) OR "enema"[All Fields] OR "trichotomy"[All Fields] OR (("supine position"[MeSH Terms] OR ("supine"[All Fields] AND "position"[All Fields]) OR "supine position"[All Fields] OR "lying"[All Fields] OR "deception"[MeSH Terms] OR "deception"[All Fields]) AND "down"[All Fields] AND ("deliveries"[All Fields] OR "delivery, obstetric"[MeSH Terms] OR ("delivery"[All Fields] AND "obstetric"[All Fields]) OR "Obstetric Delivery"[All Fields] OR "delivery"[All Fields])) OR "oxytocin infusion"[All Fields] OR "analgesia"[All Fields].

b) EMBASE Key

'obstetric delivery'/syn AND 'coronavirus disease 2019'/syn OR 'Severe acute respiratory syndrome coronavirus 2'/syn AND 'episiotomy'/syn OR 'amniotomy'/syn.

## Selection criteria

The inclusion criteria consisted of studies conducted from March 2020 onwards, due to the COVID-19 pandemic, and which answered the guiding question. Systematic reviews, meta-analyses, and letters to the editor were excluded.revisões sistemáticas, metanálises e cartas ao editor.

## Study selection and extraction

Two independent reviewers selected the studies by analyzing the titles and abstracts of all articles identified via the Rayyan® platform. Next, the studies that met the inclusion criteria were submitted for full-text reading. Disagreements were settled by consensus among the reviewers. If doubts persisted, a third and fourth reviewer were consulted. Articles that met the eligibility criteria were included in the review. These same two reviewers performed data extraction using the Synthesis Without Meta-Analysis (SWiM) methodology.

The SWiM guideline contains a nine-item checklist to promote transparent reporting:[1] Study grouping for synthesis;[2] Description of standardized metrics and transformation methods used;[3] Description of synthesis methods;[4] Criteria used to prioritize results for summary and synthesis;[5] Examination of heterogeneity in reported effects;[6] Certainty of evidence;[7] Methods of data presentation;[8] Results reporting; and[9] Synthesis limitations[10].

## Methodological quality

All included studies were independently assessed by the authors for methodological quality and risk of bias using the Newcastle-Ottawa scale, adapted for observational studies[10]. The studies were then assessed based on the following domains: (i) sample size and representativeness (0–4 points); (ii) comparability between study sites (0–2 points); and (iii) description of obstetric practices (0–3 points). A study was considered low quality if it received less than five stars, medium quality if it received five to six stars, and high quality if it received seven stars or more.

## Data analysis

The data were grouped by narrative synthesis and the results were formatted in descriptive tables using the SWiM methodology.

## RESULTS

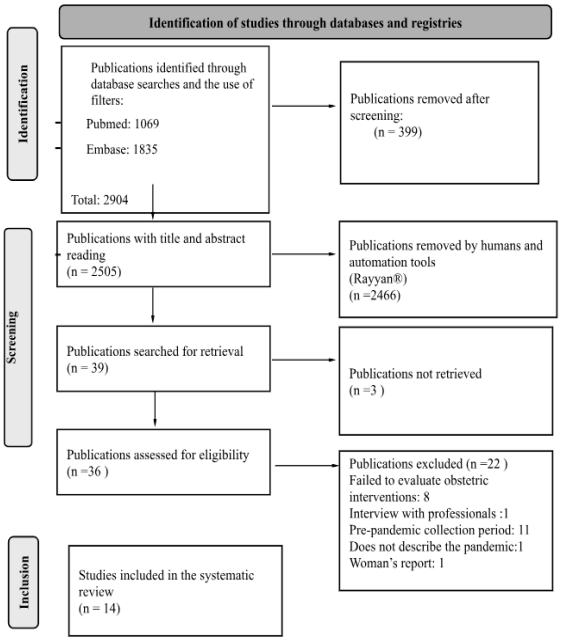
AThe search strategy retrieved 2,904 citations, of which 399 were excluded due to duplication. Thus, 2,505 titles and abstracts were assessed using the Rayyan® automation tool. After this step, 36 studies were included

and submitted for full-text reading. Subsequently, after this step, 14 studies that met the inclusion criteria were included in this systematic review (Figures 1 and 2).

It should be noted that the studies stemmed from the following locations: Portugal[6]; Slovenia[11]; Spain[12]; Europe[13]; Norway[14]; Czech Republic[15]; Lithuania[16]; The Netherlands[17]; Austria[18]; China[19]; Iran[20]; Guinea[7]; Ecuador[21]; and Brazil[22].

In terms of study sites, Europe concentrated most studies (64%), followed by Asia (14%), America (14%), and Africa (7%). It was found that in 50% of articles, data collection was performed using online questionnaires; in 42%, data collection was performed using medical

Figure 1 – Identification of studies through databases and registries




Source: Prepared for the purposes of this study, based on PAGE et al. (2021). Adapted from: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71[9]

records; and in 8%, interviews were conducted with the women.

Most studies in the sample are cohort or cross-sectional studies, whose objectives were mainly to analyze the impact of the COVID-19 pandemic on childbirth care, parturition and birth outcomes, and neonatal outcomes.

The main obstetric practices were analyzed and classified as either recommended or not recommended during labor, delivery, and birth. Among the recommended practices, the presence of a companion was mentioned in 60% of the articles, which addressed whether or not a companion was allowed during the pandemic. The choice of position during delivery was mentioned in 20% of the studies, the provision of a diet in 6% of the studies, non-pharmacological methods for pain relief were documented in 26.6% of the studies, the use of analgesia in 46% of the studies, and freedom of movement in 13.3% of the studies.

It should be noted that a study[22] compared the period before and during the pandemic, noting an increase in the implementation of recommended practices, which included an increase in the provision of dietary care from 48% to 98%, non-pharmacological methods for pain relief from 43% to 67%, and administration of analgesia from 14% to 29%.

Regarding non-recommended practices, episiotomy was mentioned in 80% of the studies, the Kristeller maneuver in 26.6%, the use of enema in one study (i.e., 6.6%), instrumental delivery in 66.6%, trichotomy in 13.3%, and the use of amniotomy in 33.3% of the studies.

In addition, there was a reduction in non-recommended interventions, such as the inadequate use of oxytocin infusion from 45% to 28%, amniotomy from 30% to 15%, Kristeller maneuver from 15% to 0.94%, the lithotomy position during delivery from 71.23% to 6.54%, and routine use of episiotomy from 15% to 2% [22]. In the study by Fors et al.[21], conducted in Ecuador in 2023, no significant differences were found in the frequency of the Kristeller maneuver (before COVID-19: 27.8%; during COVID-19: 22.4%) and membrane rupture (before COVID: 28.7%; during COVID-19: 29.3%). Vaginal exams, enemas, and trichotomy decreased significantly during the pandemic by more than 10%, 20%, and 25%, respectively[21].

Regarding cesarean sections, 73.3% of studies mentioned their use, while labor induction was described in 33.3% of studies. Several studies in this systematic review found that the impacts of the pandemic on the healthcare system did not alter cesarean section rates[2,17,23,24,25].

Conversely, another study analyzed in this review reported that the cesarean section rate was significantly higher during the pandemic period, which also coincided with an increase in the use of intrapartum oxytocin. Among the possible causes of this phenomenon, the authors cited the fact that cesarean section was considered a safer and faster alternative to protect the mother and child from the possible effects of infection[12].

Regarding the methodological quality assessment of the studies, only three were classified as high quality, representing 21.4% of the total. Seven studies received a medium classification, corresponding to 50%, and four

Figura 2 - Study characterization in terms of authorship, location, sample size, and data collection instrument.

| | Author | Year | Location | Methodological design | Sample size | Collection instrument |
|---|---|---|---|---|---|---|
| **Europe** | | | | | | |
| | Costa et al. | 2022 | Portugal | Cross-sectional study | 1.845 women | Semi-structured online questionnaires |
| | Drandic et al. | 2022 | Slovenia; Croatia; Bosnia; Serbia | Cross-sectional study | 4.817 women | Online questionnaire |
| | Hidalgo et al. | 2022 | Spain | Cohort study | 276 women | Medical records |
| | Miani et al. | 2022 | Europe (Bosnia, Croatia, France, Italy, Luxembourg, Romania, Serbia, Slovenia, Spain, Switzerland, Sweden, Portugal, Norway, Germany, Latvia) | Cross-sectional study | 27.173 women | Online questionnaire |
| | Nedberg et al. | 2022 | Norway | Cross-sectional study | 3.326 women | Online questionnaire |
| | Pavlista | 2022 | Czech Republic | Retrospective cohort | 872 chil--birth | Electronic medical records |
| | Poskiene et al. | 2023 | Lithuania | Retrospective cohort | 1.185 | Medical records |
| | Verhoeven et al. | 2022 | The Netherlands | Descriptive study | 5.913 women | Electronic records |
| | Wagner | 2021 | Austria | Cohort study | 423.320 | Medical records |
| **Asia** | | | | | | |
| | Chen et al. | 2024 | China | Cohort study | 360 women | Electronic records |
| | Mortazavi F. | 2022 | Iran | Cross-sectional study | 601 women | Interview with women in the immediate postpartum period |
| **África** | | | | | | |
| | Millimonou et al. | 2023 | Guinea | Observational study | 1.298 women | Electronic records |
| | Fors et al. | 2023 | Ecuador | Cross-sectional study | 1598 women | Online questionnaire |
| **America** | | | | | | |
| | Menezes et al. | 2023 | Brazil | Cross-sectional study | 1532 women | Hospital records |

studies were classified as low quality, corresponding to 28.5%.

## DISCUSSION

According to this study, during the COVID-19 pandemic, there was an increase in recommended obstetric practices, such as the provision of a diet, non-pharmacological methods for pain relief, and the use of analgesia. In contrast, non-recommended practices, such as episiotomy, the Kristeller maneuver, and instrumental delivery, were highlighted in some studies. Non-recommended interventions decreased during the pandemic, such as the use of oxytocin and episiotomy. However, the cesarean section rate did not change significantly.

The WHO states that any medical or surgical procedure performed during pregnancy, childbirth, or the

Figure 3 - Author/Obstetric practice described.

| | Episiotomy | Kristeller maneuver | Enema | Instrumental Delivery | Cesarean section | Presence of a companion | Position during child-birth | Provision of a diet | Methods for pain relief | Trichotomy | Use of anal-gesia | Amniotomy | Freedom of movement | Induction of labor with medication |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Chen et al., 2024** | * | | | * | | | | | | | | | | * |
| Costa et al., 2022 | * | * | | * | * | * | * | | | | | | | |
| Drandic et al., 2022, | * | | | | * | * | * | | * | | | | * | |
| **Fors et al., 2023** | | * | * | | | * | | | | * | | * | | |
| Hidalgo et al., 2022 | * | | | * | * | | | | * | | * | * | | * |
| Menezes et al., 2023 | * | * | | | | * | * | * | * | * | * | * | * | * |
| Miani et al., 2022, | * | | | * | * | * | | | | | | * | | |
| **Millimonou et al., 2023** | * | | | * | * | | | | | | | | | * |
| Mortazavi F, 2022 | * | | | * | * | * | | | | | * | | | |
| Nedberg et al., 2022 | * | * | | * | * | * | | | * | | | * | | |

postpartum period may be considered a violation of obstetric rights. These interventions include induction of labor, episiotomy, cesarean section, instrumental delivery with forceps, analgesia, and anesthesia[1].

In addition, the presence of a companion was a widely discussed aspect in the studies analyzed. Due to the restrictive measures adopted during the pandemic period, the presence of a companion during labor and delivery was often denied to pregnant women. In approximately 60% of the reports, restrictions on the presence of companions were noted, as evidenced in the studies by Fors et al.[21], in 2023; Costa et al.[6], Drandic et al.[11], Miani et al.[13], and Mortazavi and Mehrabadi[20], in 2022.

A study analyzed[15] showed that the absence of a companion during childbirth did not affect the variables associated with labor, stating that the absence of the father or a companion at birth did not interfere with the main perinatal outcomes. This conclusion is considered a setback in the practices recommended by the WHO, since the presence of a companion is a right of the woman in labor, granted by Law No. 11,108, dated April 7, 2005[26].

The continuous support provided by the companion during labor/delivery acts as a protective factor for the physiology of childbirth, as it favors the reduction of interventions as well as harmful and aggressive practices at a time when women and newborns are vulnerable to obstetric interventions[27].

Furthermore, freedom of movement was mentioned in only two of the studies[11,22], which demonstrates a weakness, since the pandemic altered the flow of care and patient movement. Therefore, the restriction on movement may have been imposed during this period and was not adequately analyzed.

The practice of induced labor increased significantly during the COVID-19 pandemic period[7]. This practice may have been intentional to hasten labor, reduce the time women spent in the facility, decrease fear of infection, avoid crowding, and maintain social distancing in a context of lack of space in crowded maternity wards[7]. The use of oxytocin during labor was also significantly higher during the pandemic period compared to the pre-pandemic period[12].

Regarding the use of instrumental delivery during the COVID-19 pandemic, the main reason was due to the risk of fetal compromise[12]. However, in the study by Wagner et al.[18] (2021), a higher rate of instrumental deliveries was found among women who gave birth during the COVID-19 pandemic. The reason for performing such deliveries was not described in the studies.

The pandemic period led to several changes in healthcare, with new measures to protect against the spread of the virus, which may have affected care and effective communication between healthcare professionals and women. In studies conducted during this period, women

Figure 4 -Newcastle-Ottawa Scale for the assessment of study quality.

| Author and year | Selection (maximum 4 stars) | Comparability (maximum 2 stars) | Assessment of results (maximum 3 stars) | Quality |
|---|---|---|---|---|
| Chen et al., 2024 | ** | * | ** | Low |
| Costa et al., 2022 | ** | * | *** | Medium |
| Drandic et al., 2022, | *** | * | *** | High |
| Fors et al., 2023 | ** | * | ** | Medium |
| Hidalgo et al., 2022 | ** | * | ** | Medium |
| Menezes et al., 2023 | *** | * | *** | High |
| Miani et al., 2022, | **** | * | *** | High |
| Millimonou et al., 2023 | ** | * | ** | Low |
| Mortazavi F.,Mehrabadi, 2022 | ** | * | * | Low |
| Nedberg et al., 2022 | *** | * | ** | Medium |
| Pavlista, 2022 | *** | * | ** | Medium |
| Poskiene et al., 2023. | *** | * | ** | Medium |
| Verhoeven et al., 2022 | *** | * | ** | Medium |
| Wagner et al., 2021 | *** | * | ** | Low |

Source: Prepared by the author, 2025.

reported that communication from healthcare professionals was biased or ineffective, that they were not always involved in medical decisions, and that they were not always treated with dignity[6,11,13].

These changes in the care process may have led to obstetric violence, which, although not yet well described in the literature, has been characterized as any physical, verbal, or psychological aggression or harm during pregnancy and the postpartum period[28]. Research on the prevalence of obstetric violence can have profound implications for public health initiatives and policies[21].

In this context, it is worth noting that the WHO defines any medical or surgical procedure performed during pregnancy, childbirth, or postpartum as a violation of obstetric rights. These interventions include induction of labor, episiotomy, cesarean section, instrumental delivery with forceps, analgesia, and anesthesia[1].

It is also worth noting that the pandemic has had a significant impact on healthcare systems worldwide. These factors highlight the need for strategies to address fear of infection in future pandemics and ensure the provision of high-quality, safe, and compassionate care to pregnant women, promoting their physical and mental well-being during this critical period[21].

Finally, the analysis performed highlights the need to question the criteria considered in the organization and planning of a care protocol for labor, birth, and hospitalization in pandemic settings, given that contradictions were found between standard care protocols and those adopted during the COVID-19 pandemic[21].

Public health strategies can focus on improving the training of care providers to promote respectful and empathetic practices, ensuring informed consent, and implementing robust reporting mechanisms to readily address cases of obstetric violence. Discussing this issue not only improves the quality of care provided to pregnant women, but also promotes a healthier social perspective on childbirth, increasing trust in healthcare systems. Ultimately, the practical implications of this research can contribute to the creation of safer and more compassionate childbirth experiences, positively impacting public health outcomes for mothers and babies[21].

## LIMITATIONS

The limitations of this study include the fact that it encompasses different sample sizes, with studies conducted in different locations, which hinders comparison.

Another limitation refers to the use of two databases; however, it should be noted that these are widely recognized databases in the health field (PubMed and Embase). Furthermore, despite these potential limitations, this study employed a rigorous methodology, achieving highly relevant results in the field of maternal and child health.

## CONCLUDING REMARKS

The COVID-19 pandemic has imposed significant challenges on obstetric and perinatal care, requiring swift adaptations to care protocols. Although some recommended practices were intensified during this period, such as the use of non-pharmacological methods for pain relief and the provision of analgesia, there was also a persistence and, in some cases, an increase in non-recommended interventions, such as labor induction and the use of instrumental delivery, often without explicit clinical justification.

The practices identified reveal contradictions between the protocols adopted in pandemic contexts and the principles of woman-centered obstetric care, highlighting weaknesses in the protection of reproductive rights and in addressing obstetric violence. These issues highlight the importance of clear, evidence-based guidelines aimed at humanizing childbirth, even in public health emergency settings.

Although several advancements toward adherence to an evidence-based model are highlighted in the results, there is still a need for improvements in the care provided to these women and their families. It is therefore clear that the strategies identified need to be improved, with continuous monitoring of evidence-based care practices.

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