Narrative review article

Physical and psychological consequences of obstetric violence in Latin American countries

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Consecuencias físicas y psicológicas de la violencia obstétrica en países de Latinoamérica

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Abstract
The The term obstetric violence has its origins in Latin America, it is considered an expression of gender violence and institutional violence against women. It can be exercised in two ways, physical and psychological, therefore, the aim is to define obstetric violence, its origin, divisions, and relation with women's sexual and reproductive rights, as well as to identify its physical and psychological consequences. A bibliographic search was conducted in Medigraphic, SciELO, and Google Scholar, including only publications that were found in full text, in Spanish, English, and Portuguese during the years 2014 to 2022. Obstetric violence causes the violation of women's sexual and reproductive rights, which makes it essential for all those involved in health care to be aware of the related physical and psychological repercussions that contribute to maternal and newborn morbidity and mortality, such as vaginal tears, breastfeeding problems, post-traumatic stress syndrome, and postpartum depression.

Keywords
Gender violence, obstetric violence, Latin America, women's rights, sexual and reproductive rights.

Resumen
El término violencia obstétrica tiene sus orígenes en Latinoamérica, se considera una expresión de violencia de género y de violencia institucional contra la mujer. Puede ser ejercida de dos maneras, física y psicológica, por lo que se pretende definir la violencia obstétrica, su origen, divisiones, relación con los derechos sexuales y reproductivos de la mujer, así como identificar sus consecuencias físicas y psicológicas. Se realizó una búsqueda bibliográfica en Medigraphic, SciELO y Google Académico, fueron incluidas únicamente las publicaciones que se encontraron a texto completo, en español, inglés y portugués durante los años 2014 al 2022. La violencia obstétrica provoca que los derechos sexuales y reproductivos de las mujeres sean quebrantados, lo que hace imprescindible que todos los involucrados en la atención en salud conozcan las repercusiones físicas y psicológicas relacionadas que contribuyen a la morbimortalidad de la madre y el recién nacido, tales como: desgarros vaginales, problemas en la lactancia materna, síndrome de estrés postraumático y depresión posparto.

Palabras clave
Violencia de género, violencia obstétrica, América Latina, derechos de la mujer, derechos sexuales y reproductivos.

Introduction

Obstetric violence (OV) is an expression of gender violence and institutional violence against women, characterized by the dehumanization of treatment, medicalization and pathologization during pregnancy, childbirth and puerperium carried out by health personnel[1,2].

In Latin America and the Caribbean, "dehumanized care" or "discrimination" are terms used to refer to OV. References were also made to "institutional" and "structural" violence in health facilities to reflect the hegemonic model and gender inequity in health systems.

In the 2014 Geneva Declaration, "Prevention and Eradication of Disrespect and Abuse during Childbirth Care in Health Facilities," a definition of disrespectful and offensive treatment of women in childbirth had not been standardized, despite its prevalence[3,4].

The term "VO" has appeared in Latin America as result of the enactment of laws in countries such as Venezuela, Argentina, and Ecuador which have made it possible to define it. Since this is a multifactorial situation, not only does it consider inadequate procedures or practices that lead to the pathologization of pregnancy and childbirth, but also the patriarchal attitude exercised by health personnel during the care of pregnant women. This shows the inequality of power dynamics and which, in turn, is linked to gender-based violence in the context of gynecobstetrics, with both physical and psychological repercussions on pregnant women[3].

Women who suffer obstetric violence do not easily recognize it, since it is perceived as normal[2]. In Mexico, there is an underreporting of OV due to the naturalization of the phenomenon by medical and obstetric personnel and even by the women themselves at the time of delivery, who are often unaware of the mistreatment received[5]. Lack of knowledge of this type of violence in routine care in health centers prevents health personnel from identifying it and patients from taking action to defend their rights[6].

A bibliographic search was carried out in Medigraphic, SciELO, and Google Scholar, limited to full texts, published between 2014 and 2022 in Spanish, English, and Portuguese. Descriptors used were: women, violence, obstetric violence, gender violence, Latin America, origins, women's rights, reproductive rights, physical consequences, and psychological consequences.

This review aims to describe the main physical and psychological consequences of obstetric violence, as well as identifying the social repercussions in the Latin American context.

Discussion

Obstetric violence, origin y types

OV is not a recent phenomenon, and according to Ramírez *et al.*, it arises as a result of power disparities in gender relations, which undermine women's actions and worth[7]. According to the Costa Rican Association of Legal Medicine and Related Disciplines, pro-humanized childbirth organizations attribute the inequities to the patriarchal and authoritarian model that predominates in the doctor-patient relationship in the gynecobstetric area[8]. Since ancient times, women have suffered unequal treatment concerning men in all aspects of life.

Under the influence of Greek and Roman philosophy, the superiority of men over women was reinforced in rules and laws, and they were treated as the property of men. Since then, there has been inequality between men and women, favoring the former over the latter, since prejudices transferred through legal discrimination[9]. In 1960, a feminist social movement emerged to advocate for respectful childbirth and rights in perinatal care to expose OV[9].

In 1979, the "Convention on the Elimination of All Forms of Discrimination against Women" recognized the disadvantaged conditions of women and their right to access family planning services. In 1985, the recommendations of the World Health Organization (WHO) and the Pan American Health Organization (PAHO) emerged through an interdisciplinary conference on appropriate technology for childbirth, focused on modifying the structure of health services and the attitudes of personnel who provide care to patients during childbirth[10]. In 2007, Venezuela was the first country worldwide to incorporate the term "obstetric violence" in its legal framework, followed by Argentina in 2009 and Mexico in 2014, with the approval of amendments to several laws that considered OV as a reprehensible practicee[11].

OV refers to violent or perceived violent practices, behaviors, and abuses by action or omission, carried out by physicians, nurses, social workers, among other health system professionals, towards women during pregnancy, childbirth, or puerperium. This occurs in the different areas of healthcare, both in public and private services, and may result in various physical, psychological, patrimonial, economic, and sexual consequences or even lead to death[12,13].

For a better understanding of its consequences, OV divides into two main sections, the Physical and the Psychological[13].

Physical obstetric violence

Physical OV is defined as any action or procedure that is not essential to care, is not clinically justified, or is performed without the consent of the pregnant woman. In addition, it includes neglecting the needs and pain of pregnant women, denial of treatment, repeated or multiple vaginal exams by more than one individual, and the execution of abrupt maneuvers, including restriction of movements and remaining in bed during labor[14,15].

Sometimes unnecessary procedures such as episiotomy and cesarean section are performed, without taking into account that episiotomy should only be performed in specific cases since it has been shown that the resulting wound takes longer to heal

in natural childbirth than the wound from vaginal tearing[16]; in addition, the cesarean section should only be performed to reduce morbidity and mortality in at-risk pregnancies[17]. To determine the criteria for its implementation, the ten-group or Robson's classification is recommended, which allows for the identification, analysis, and planning of the intervention.

The rise in unjustified cesarean sections is worrying because it leads to greater maternal morbimortality and increases the risk of complications such as placenta previa, placental accreta, and obstetric hemorrhage[18]. For instance, Latin America was the region with the highest number of cesarean births in 2018 with 44,3 %[17].

Interventions not recommended by WHO, which continue to be performed without regard to specific indications, include the use of oxytocin to induce labor, enemas, and the Kristeller maneuver[19].

Labor stimulation has traditionally been performed by administering intravenous oxytocin[19]. The application of this drug requires caution, due to its serious adverse effects. The errors related to its use are common and are related to high doses, which can cause excessive uterine activity[20]. Furthermore, enemas are used during the dilation period, which is an uncomfortable procedure; there is no evidence of effects on the sanitary conditions of labor or on the decrease in the risk of infection for both the mother and the newborn[21].

The Kristeller maneuver is usually indicated when there is suspicion of fetal distress, dystocia, or maternal exhaustion and consists of pressing with the hands on the uterine fundus to avoid prolonging the second stage of labor or resorting to surgery[22].

Some procedures performed without prior consent include induction of labor, removal or rupture of membranes, vacuum or forceps-assisted delivery, or manual removal of the placenta[23]. A study in Mexico by B. Muñoz on the medical complaints file of the National Commission for Medical Arbitration (Comisión Nacional de Arbitraje Médico) found cases in which women suffered physical OV by health personnel. In this study, it was described that, during delivery, health personnel used obstetric instruments such as forceps to extract the child, which resulted in hemorrhages and even hysterectomies caused by the maneuvers performed[24].

Psychological violence

On the other hand, psychological violence is a type of abuse against women, composed of different behaviors or subtle attitudes of aggression, which makes it hard to identify and demonstrate. It can be linked to physical violence, be a warning sign of it, or occur independently[25].

According to Jojoa-Tobar *et al.*, psychological OV has two subcategories; "1) verbal violence and the obstruction of pregnant women to express themselves freely; and 2) the omission of the right to information and autonomy in decision making of both the pregnant woman and her family in the process of childbirth"[2]. Verbal aggression consists of mockery, humiliation, insults, dehumanizing treatment, undermining her needs, and ignoring the patient's fears or concerns[26].

In a study conducted in Venezuela, Araujo-Cuauro reported that, of 180 patients surveyed, 55 % responded that they had suffered some type of abuse before, during, or after delivery by health personnel, and 44,4 % perceived verbal abuse or aggression[27].

Verbal violence also encompasses a relationship of inequality in the framework of medical care between the patient and the health professional, called by Foucault "the power/knowledge"[28]. It could be understood as the lack of effective communication with patients because they are considered inferior due to their lack of knowledge in the obstetric area[2].

Psychological OV by omission is based on the prohibition of an accompanying person in the health facility during the delivery, failure to give informed consent to the patient, or failure to report on the evolution of the delivery process and the state of health of the newborn[26]. This type of violence includes the lack of information or the unjustified rejection of women's opinions; actions that can lead a woman to feel obliged to accept procedures and interventions that respond to the prevailing hegemonic models in some health services, in which the medical personnel holds the authority and the woman is deprived of the right to decide about her body[29,30].

Another occurrence is when the woman is not allowed company during the labor process. According to Andrade *et al.*, the presence of a person the patient trusts is crucial, as it helps to reduce the patient's fear, provides emotional support such as security and confidence, and reduces the risk of complications during labor[31].

Obstetric violence and sexual and reproductive rights in Latin American countries

OV is a form of gender-based violence that violates women's human rights (WHR),

specifically sexual and reproductive rights[6]. It is a multifactorial phenomenon that also involves institutional violence, considering that these human rights are breached in the context of pregnancy, childbirth, and postpartum in both, public and private health centers[32].

According to the General Law on women's access to a life free of violence, in Mexico, women's human rights are an inalienable, fundamental and inseparable part of the Universal Human Rights included in the Convention on all Forms of Discrimination against Women (CEDAW), and other international tools that seek to guarantee a dignified treatment of women at all times, including pregnancy, childbirth, and postpartum[33].

The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[34]. In this sense, the right to health is the first right violated by the implementation of OV, due to the physical and psychological effects it produces. In this sense, the right to health is the first right violated by the practice of OV, due to the physical and psychological effects that are produced. This same right enclose reproductive health, appending to the above definition "in all aspects related to the reproductive system, its functions and processes"[35].

The right to health is not respected whether the autonomy of individuals is completly ignored[36]. OV violates the right to personal integrity in its physical, psychological and moral dimensions; specifically, reproductive freedom and autonomy, i.e., the right to make decisions related to procreation, such as the number of children, the time interval between pregnancies, and the interventions to be performed at the time of delivery[7,35]. According to Soto-Toussaint, some patients are forced to wear an intrauterine device as a requirement before they discharge from hospitals, hear taunting comments, or experience delays in care because of their requirement to comply with their reproductive rights to the point of risking a perinatal death[37].

The mistreatment of pregnant women also occurs when the mother is labeled as ignorant, due to attitudes of superiority adopted by medical personnel[38].

Another of the fundamental rights violated by OV is the right to life since it represents a potential danger of death for the mother, the child, or both. This right states that everyone should enjoy their existential cycle without interruption by extrinsic agents, with the State guaranteeing protection and respect for the lives of those under its jurisdiction[39].

Some countries in Latin America incorporated the defense of pregnant women in their laws. For instance, Venezuela introduced VO into the regulation of punishable conduct in 2007 in the The Organic Law on the right of women to a life free of violence. Afterwards, in 2009 Argentina published the Comprehensive Protection Law to prevent, punish and eradicate violence against women in interpersonal relationships, in which dehumanizing treatment is defined, in the context of OV, as cruel or humiliating treatment by health care personnel[26].

In Ecuador, article four in the Law to prevent and eradicate violence against women, published in 2018, includes the gynecosbtetric harm or suffering in the concept of gender violence. In article ten of the same law, different actions considered OV are highlighted; for instance, considering pregnancy, childbirth and postpartum as diseases. It also emphasizes that such actions negatively impact women's sexual and reproductive health, as included in the above-mentioned laws[40].

El Salvador also has a legal base since 2021, mainly directed to the National Integrated Health System and aims to guarantee the right to be respected during childbirth and provide caring attention to the NB[41].

Despite the existence of legislations with their respective sanctions for the different forms adopted by OV, Latin America continues reporting transgressions of rights in the gynecobstetrics context. According to the "National Survey on the Dynamics of Household Relationships" conducted in Mexico, from October 2011 to October 2015, 8,7 million births were delivered, and 33,4 % of the assisted women suffered some kind of mistreatment by health care personnel[42].

Physical and Psychological Consequences of Obstetric Violence in Latin America

OV can present both, physical and psychological consequences. Hernández defines it as: "the product of an experience that has caused a rupture or interruption in a person's life and their immediate context, which includes their relationships with their partner, family or community. It may be visible or invisible changes, injuries or traces at the physical, emotional, psychological or health level." The damage caused by OV in women after childbirth could be perceived in the short or long term, with varying degrees of severity, which in some cases may become irreversible[29].

Physical consequences

Breastfeeding

The evolution of childbirth is a determinant of breastfeeding, and the problems presented in breastfeeding may be related to the interventions performed on the patient. Among the most frequent are: the use of antibiotics that could alter the microbiota and cause obstruction in the mammary duct and even mastitis; the pain caused by cesarean section could be an inconvenience for the mother when breastfeeding; an induced premature delivery may cause the newborn not to have enough suction strength; in addition, some mothers may develop post-traumatic stress syndrome and find it difficult or impossible to breastfeed[43].

Episiotomy

The WHO considers episiotomy a practice wrongly performed due to the complications it causes. It has been proven for 30 years that this procedure is not beneficial because it does not help expel the child or prevent vaginal tears in women but is associated with more severe tears[44,45]. The former director of the WHO Maternal and Child Health Department, Mardsen Wagner, stated in 2000 that "performing too many episiotomies is been correctly labeled as a form of female genital mutilation."

In a study conducted in Peru by Mendoza *et al.*, it was observed that the most frequent complications in patients who had episiotomies were: hemorrhage (47.1 %), dehiscence, and grade I tear, which involves the compromise of the skin and/or vaginal mucosa (32.9 %), edema (31.8 %), grade II tear, which involved the skin, mucosa and superficial perineal muscles without the involvement of the external sphincter (29.4 %), infection (18.8 %), hematoma (17.6 %) and perineal pain (2.4 %)[46].

Incontinence

It can occur in different degrees and is caused by various reasons, among them: directed pushes, episiotomy, or the use of instrumentation. In 10 % of the cases, it is severe, and if there is no adequate treatment, the risk of complications increases. In addition, incontinence can be fecal, reducing the quality of life[43].

Unwarranted cesarean sections

Sadler, in his study, determined that "cesarean deliveries are associated with a two-fold increase in the risk of severe maternal morbidity compared to vaginal deliveries." Cesarean section is associated with reproductive complications, including increased risk of newborn morbidity and mortality, preterm delivery, and increased risk of hospitalizations in the Neonatal Intensive Care Unit (NICU).

Psychological consequences

Postpartum depression (PPD)

Its worldwide incidence is 15 % and in middle-developed countries, one in five women suffers from PPD[46]. During the puerperium, the risk of mood disorders increases due to the physiological changes and stress levels experienced. Women with a previous history of PPD have a risk of recurrence in the next delivery. One of the main complications of untreated or late diagnosis is suicide and filicide, the former being a significant cause of maternal mortality in the perinatal period[47].

Having experienced OV in health care services increases the probability of developing PPD by up to six times. Some risk factors consist of feelings of abandonment during labor, poor pain control, and the patient's frustration at being subjected to a cesarean section when it was not required. In the study of 432 women, de Souza *et al.* in Brazil found that physical violence by health care personnel is a crucial component of PPD, with a statistically significant association ($p < 0,01$ by Wald test)[47]. On the other hand, the WHO has described that women who suffer obstetric violence have a 16 % increase in the risk of presenting alterations in the weight of the child; more than 50 % present the risk of miscarriage and traumatic disorders related to childbirth[48].

Post-traumatic stress syndrome (PTSD)

One of the trigger factors for the development of PTSD is inadequate obstetric management and the perception of inappropriate care in pregnancy, childbirth, or postpartum[49]. According to Vergara Arango, patients who have undergone a traumatic birth process due to a high level of stress have lower concentrations of oxytocin in their bodies and increased secretion of adrenaline, which interferes with the innate mechanisms of mother-child bonding and breastfeeding. Failure to achieve this bonding between mother and newborn can lead to the development of negative behaviors such as not knowing how to hold, breastfeed, or even rejecting the child[49].

Anxiety

It is characterized by negative thoughts, recklessness, and excitement due to constant feelings of worryness. Women in the postpartum period, due to the effect of hormonal changes, are more vulnerable to the presentation or exacerbation of anxiety disorders. Silva *et al.* interviewed 209 pregnant women, 42.9 % of them presented anxiety during the third trimester of gestation; this period of time is associated with moments of vulnerability since the patient is close to her due date, which is conducive to the development of emotional disorders[50].

The consequences identified in the research reveal a clear problem in gynecobstetric services in some Latin American countries, whereas other regions have been investing years in trying to make visible the impact of this phenomenon that has affected women's maternity and lives.

A limitation of this study is that efforts to identify and eradicate OV in several Latin American countries are not evident due to the lack of publications.

Conclusions

OV is a result of gender violence in which sexual and reproductive rights are violated. The introduction of laws in several Latin American countries has contributed to preventing or reducing the number of cases of OV in different health facilities; however, despite these laws, violations of these rights continue to be reported. OV causes both, physical and psychological consequences, including difficulty in breastfeeding, urinary or fecal incontinence, tearing, hemorrhage, PPD, PTSD, and anxiety, which represent a high risk of morbidity and mortality for the mother and newborn.

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References

1. Lafaurie Villami MM, Rubio León DC, Perdomo Rubio A, Cañón Crespo AF. La violencia obstétrica en la literatura de las ciencias sociales en América Latina. 2019;18(36). Available in: https://revistas.javeriana.edu.co/files-articulos/RGPS/18-36%20(2019-I)/54559086009/
2. Jojoa Tobar E, Cuchumbe Sánchez YD, Ledesma-Rengifo JB, Muñoz Mosquera MC, Paja Campo AM, Suarez Bravo JP. Violencia obstétrica: haciendo visible lo invisible. Rev Univ Ind Santander Salud. 2019;51(2):136-147. DOI: 10.18273/revsal.v51n2-2019006
3. Goberna Tricas, Josefina. Nascere e mettere al mondo. Sguardi sociali e filosofico politici - 2020. 1ra edición. Lecce. Università del Salento; 2020. Capítulo 8, 67-74.
4. Organización Mundial de la Salud. Prevención y erradicación de la falta de respeto y el maltrato durante la atención del parto en centros de salud. Declaración de la OMS. Ginebra. 2014. 4 p. Available in: https://apps.who.int/iris/rest/bitstreams/599813/retrieve
5. Andión X, Beltrán AL, León FD de, Escudero M, García I, García M, *et al.* Omisión e indiferencia derechos reproductivos en méxico. 1ra edición. Ciudad de México, Grupo de Información en Reproducción Elegida, GIRE; 2013. Capítulo 4, Violencia Obstetrica. 119-143.
6. Salgado F, Díaz M. Naturalización de la violencia obstétrica mediante el discurso médico y sus prácticas. Revista Venezolana de Estudios de la Mujer. 2017;22(49):153-176. Available in: https://dialnet.unirioja.es/servlet/articulo?codigo=6786993
7. Ramírez Saucedo MD, Hernández Mier C, Ceballos García GY. La violencia obstétrica en la vulneración de los derechos humanos de las mujeres. Revista CONAMED. 2021;26(3):149-155. DOI: 10.35366/101680
8. Al Adib Mendiri M, Ibáñez Bernáldez M, Casado Blanco M, Santos Redondo P, Al Adib Mendiri M, Ibáñez Bernáldez M, *et al.* La violencia obstétrica: un fenómeno vinculado a la violación de los derechos elementales de la mujer. Medicina Legal de Costa Rica. 2017;34(1):104-111.
9. Morales EJP. Violencia Obstétrica: una condensación histórica de violencias y violaciones a los derechos humanos. 2021;1(1):84-97.
10. Appropriate technology for birth. The Lancet. 1985;326(8452):436-437. DOI: 10.1016/S0140-6736(85)92750-3
11. Sánchez SB. La violencia obstétrica desde los aportes de la crítica feminista y la biopolítica. Dilemata. 2015;7(18):93-111. Available in: https://www.dilemata.net/revista/index.php/dilemata/article/view/374
12. Assembly, Parliamentary. Obstetrical and gynaecological violence. Strasbourg Cedex. European Council. 3 de octubre de 2019. 2 p. Available in: http://www.europeanrights.eu/public/atti/Resolution_2306_(2019)_ENG.pdf

13. Esperanza Tuñón P, Mena Farrera RA. Género y TIC. 1ra Ed. Chiapas. El Colegio de la Frontera Sur; 2018. 546 p.
14. Ribeiro D de O, Gomes GC, de Oliveira AMN, Alvarez SQ, Gonçalves BG, Acosta DF. Obstetric violence in the perception of multiparous women. Rev. Gaúcha Enferm. 2020;41(1):e20190419. DOI: 10.1590/1983-1447.2020.20190419
15. Vallana Sala, VV. "Es rico hacerlos, pero no tenerlos": análisis de la violencia obstétrica durante la atención del parto en Colombia. Rev. Cienc. salud. 2019;17(especial):128-144. DOI: 10.12804/revistas.urosario.edu.co/revsalud/a.8125
16. Berzaín Rodríguez MC, Camacho Terceros LA. Episiotomía: Procedimiento a elección y no de rutina. Revista Científica Ciencia Médica. 2014;17(2):53-57. Available in: http://www.scielo.org.bo/pdf/rccm/v17n2/v17n2_a11.pdf
17. Hernández-Espinosa CJ. La epidemia de cesáreas como limitante del parto humanizado. Medicas UIS. 2019;32(1):9-12. DOI: 10.18273/revmed.v32n1-2019001
18. Martínez Rodríguez DL. Utilidad y eficacia de la clasificación de Robson para disminuir la tasa de cesáreas. Ginecol Obstet Mex. 2018;86(10)627-633. DOI: 10.24245/gom.v86i10.1462
19. World Health Organization. WHO recommendations for augmentation of labour. 1ra Ed. Ginebra. World Health Organization; 2014. 64 p.
20. Hidalgo-Lopezosa P, Hidalgo-Maestre M, Rodríguez-Borrego MA. Labor stimulation with oxytocin: effects on obstetrical and neonatal outcomes. Rev Lat Am Enfermagem. 2016;24(1):e2744. DOI: 10.1590/1518-8345.0765.2744
21. Vacaflor CH. Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina. Reprod Health Matters. 2016;24(47):65-73. DOI: 10.1016/j.rhm.2016.05.001
22. Youssef A, Salsi G, Cataneo I, Pacella G, Azzarone C, Paganotto MC, *et al.* Fundal pressure in second stage of labor (Kristeller maneuver) is associated with increased risk of levator ani muscle avulsion. Ultrasound Obstet Gynecol. 2019;53(1):95-100. DOI: 10.1002/uog.19085
23. Zazzaron L. Obstetric Violence as Violence Against Women: A Focus on South America. Tesis de maestría. Venecia. Università Ca' Foscari Venezia; 2018. 145 p.
24. Quattrocchi P, Magnone N, Ramírez GA, Palomo LRB, Castro R, Diniz CSG, *et al.* Violencia obstétrica en América Latina: conceptualización, experiencias, medición y estrategia. 1ra Ed. Buenos Aires. EDUNLa Cooperativa; 2020. 231 p.
25. Torres Cabrera JJ. Análisis del Artículo 157 del Código Orgánico Integral Penal en Relación a la Violencia Psicológica y su Derecho Comparado. Tesis de maestría. Samborondón. Universidad Espiritu Santo; 2018. 45 p.
26. Díaz García LI, Fernández MY Situación legislativa de la Violencia obstétrica en América latina: el caso de Venezuela, Argentina, México y Chile. Revista de Derecho de la Pontificia Universidad Católica de Valparaíso. 2018;15:123-143. DOI: 10.4067/S0718-68512018005000301
27. Araujo Cuauro JC. Obstetric violence: a hidden dehumanizing practice, exercised by medical care personnel: Is it a public health and human rights problem?. Rev Mex Med Forense. 2019;4(2):1-11. Available in: https://www.medigraphic.com/pdfs/forense/mmf-2019/mmfi192a.pdf
28. Palazio Galo E. Michel Foucault y el saber poder. Revista Humanismo y Cambio Social. 2014;2(1):95-100. DOI: 10.5377/hcs.v0i3.4906
29. Vargas MH. Pasar por la carnicería: relatos de mujeres costarricenses sobre violencia obstétrica. Wimb Lu. 2021;16(2):93-118. DOI: 10.15517/wl.v16i2.48101
30. Quattrocchi P. Violencia obstétrica: Aportes desde América Latina. Revista Gênero & Direito. 2018;7(1):20-46. Available in: https://periodicos.ufpb.br/index.php/ged/article/view/38974
31. Matos MG de, Magalhães AS, Féres Carneiro T. Violencia obstétrica y trauma en el parto: relatos de madres. Psicol. cienc. prof. 2021;41(1):e219616. DOI: 10.1590/1982-3703003219616
32. Pineda Guerrero, C del C, Valdez Ureña AJ. Violencia obstétrica. Tesis de grado. Santo Domingo. Universidad Nacional Pedro Henríquez Ureña; 2020. 56 p.
33. Ley general de acceso de las mujeres a una vida libre de violencia. México. 6 de septiembre de 2022.
34. Herrero Jaén S. Formalización del concepto de salud a través de la lógica: impacto del lenguaje formal en las ciencias de la salud. Ene. 2016;10(2). Available in: https://scielo.isciii.es/scielo.php?script=sci_arttext&pid=S1988-348X2016000200006
35. Ramos R, Luna K. Violencia obstétrica. Un enfoque de derechos humanos. Ciudad de México. GIRE. 2015. 104 p. Available in: https://docplayer.es/7414686-Violencia-obstetrica-un-enfoque-de-derechos-humanos.html
36. Egan LAV, Gutierrez MA, Valdez Santiago R, Lezana Fernández MA. De qué hablamos cuando hablamos de violencia obstétrica? 2016;21(1):1-19. Available in: https://www.medigraphic.com/pdfs/conamed/con-2016/cons161b.pdf

37. Soto-Toussaint LH. Violencia obstétrica. 2016;39(1):6. Available in: https://www.medigraphic.com/pdfs/rma/cma-2016/cmas161s.pdf
38. Castañeda Aponte W, Vargas Daza Y. La Violencia Obstétrica, una mirada desde la experiencia de parto de mujeres rurales pertenecientes al programa de desarrollo infantil en medio familiar de Une Cundinamarca. Tesis de grado. Bogotá. Universidad Colegio Mayor de Cundinamarca; 2018. 142 p.
39. Comisión Nacional de los Derechos Humanos. Recomendación General No. 31/2017 sobre la violencia obstétrica en el Sistema Nacional de Salud. Ciudad de México. CNDH México. 2017. 83 p.
40. Ley para prevenir y erradicar la violencia contra las mujeres. Ecuador. 5 de febrero de 2018.
41. Ley nacer con cariño para un parto respetado y un cuidado cariñoso y sensible para el recién nacido. El Salvador. 17 de agosto de 2021.
42. Instituto Nacional de Estadística y Geografía. Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH) 2016. Ciudad de México. INEGI. 2017. 20 p. Available in: https://vicerrectoriaurc.unison.mx/wp-content/uploads/2018/08/endireh2017_08.pdf
43. Pupiales ALM. Violencia obstétrica y cuidado de enfermería durante el proceso de parto en pacientes atendidas en el hospital San Luis de Otavalo - 2021. Ecuador: Universidad técnica del norte; 2021.
44. Fernández Guillén F. ¿Qué es la violencia obstétrica? Algunos aspectos sociales, éticos y jurídicos. Dilemata. 2015;10(18):113-128. Available in: https://www.dilemata.net/revista/index.php/dilemata/article/view/375/380
45. Camacaro M, Ramírez M, Lanza L, Herrera M. Conductas de rutina en la atención al parto constitutivas de violencia obstétrica. Utopía y Praxis Latinoamericana. 2015;20(68):113-120. Available in: https://www.redalyc.org/pdf/279/27937090009.pdf
46. Mendoza Vilcahuaman J, De la Cruz KN, Muñoz De La Torre RJ. Complicaciones en nulíparas con episiotomía y sin episiotomía en el hospital Zacarias Correa Valdivia, Huancavelica. Llamkasun. 2021;2(1):21-28. Available in: https://llamkasun.unat.edu.pe/index.php/revista/article/view/28
47. Souza KJ de, Rattner D, Gubert MB. Institutional violence and quality of service in obstetrics are associated with postpartum depression. Rev. Saúde Pública. 2017;51(0):159-162. DOI: 10.1590/s1518-8787.2017051006549
48. Ucañay Dávila LE, Contreras Rivera RJ. Violencia obstétrica y síndrome de depresión post parto en centros maternos públicos. Ciencia Latina. 2022;6(6):6639-6653. DOI: 10.37811/cl_rcm.v6i6.3911
49. Lemus Díaz LF, Cabrera Ramírez KMM. Percepción de mujeres acerca de la violencia obstétrica. Tesis de grado. Guatemala. Universidad de San Carlos de Guatemala; 2017. 89 p.
50. Silva MM de J, Nogueira DA, Clapis MJ, Leite EPRC. Anxiety in pregnancy: prevalence and associated factors. Rev. esc. enferm. USP. 2017;51(0). DOI: 10.1590/S1980-220X2016048003253