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Editorial – Volume 3 – nº 02- 2025

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Cláúdio Luiz Masutti [2]

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[2] **Cláúdio Luiz Masutti:**
Graduado de la Facultad de Ciencias Médicas de Santos.
Título de Pediatría.
Posgrado en UCI Pediátrica y Neonatal.

Evaluación de las Consecuencias del Embarazo en la Adolescencia: Un Estudio Comparativo entre Brasil y EE.UU.

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Resumen

Antecedentes: Este estudio explora las consecuencias del embarazo adolescente, un problema de salud pública con implicaciones significativas para la salud reproductiva, el desarrollo social y la igualdad de género. En Brasil y Estados Unidos, las tasas de embarazo precoz han mostrado variaciones relacionadas con factores culturales, económicos y sociales. En Brasil, las disparidades regionales exacerban el problema, especialmente en las zonas con menos acceso a la anticoncepción y la educación sexual. En los Estados Unidos, a pesar de los avances en la reducción de las tasas, persisten los desafíos entre las minorías y las poblaciones de bajos ingresos. Este estudio busca analizar cómo estas diferencias se reflejan en la salud, la calidad de vida de los adolescentes y el impacto socioeconómico, destacando las estrategias y políticas públicas implementadas en ambos contextos.

La metodologia: se basó en una revisión sistemática de datos y estudios publicados entre 2014 y 2024, con énfasis en artículos científicos indexados en bases de datos como PubMed, SciELO y CDC Reports. Se seleccionaron estudios observacionales, revisiones sistemáticas y análisis comparativos que abordaron las tasas de embarazo adolescente, los factores determinantes y la efectividad de las intervenciones preventivas. Los criterios de inclusión priorizaron los estudios que analizaron las políticas públicas y los datos epidemiológicos en poblaciones adolescentes de Brasil y Estados Unidos, considerando variables socioeconómicas y culturales.

Los resultados: indican que, mientras Brasil enfrenta barreras relacionadas con las desigualdades regionales y las limitaciones en el acceso a la salud y la educación, Estados Unidos ha avanzado en la reducción de las tasas a través de programas como el "Programa de *Prevención del Embarazo Adolescente*". Medidas como la expansión de la educación sexual, el acceso a métodos anticonceptivos modernos y la integración de los adolescentes en los sistemas públicos de salud han demostrado ser eficaces en ambos países. Sin embargo, desafíos como la escasez de fondos, las barreras culturales y la falta de

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continuidad de la atención aún limitan el impacto de las políticas implementadas. El estudio concluye que los enfoques colaborativos, culturalmente adaptados y basados en la evidencia son esenciales para mitigar los efectos del embarazo temprano y promover el bienestar de los adolescentes.
Palabras clave: Embarazo adolescente, Salud reproductiva, Políticas públicas, Brasil, Estados Unidos, Educación sexual, Anticoncepción.

Abstract

Antecedentes: Este estudio explora las consecuencias del embarazo adolescente, un problema de salud pública con implicaciones significativas para la salud reproductiva, el desarrollo social y la igualdad de género. En Brasil y Estados Unidos, las tasas de embarazo precoz han mostrado variaciones relacionadas con factores culturales, económicos y sociales. En Brasil, las disparidades regionales exacerban el problema, especialmente en las zonas con menos acceso a la anticoncepción y la educación sexual. En los Estados Unidos, a pesar de los avances en la reducción de las tasas, persisten los desafíos entre las minorías y las poblaciones de bajos ingresos. Este estudio busca analizar cómo estas diferencias se reflejan en la salud, la calidad de vida de los adolescentes y el impacto socioeconómico, destacando las estrategias y políticas públicas implementadas en ambos contextos.
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Keywords: Adolescent pregnancy, Reproductive health, Public policies, Brazil, United States, Sex education, Contraception.

1. Introducción

El embarazo adolescente es un problema multidimensional que afecta de manera desproporcionada a las poblaciones vulnerables. Aunque las tasas mundiales han disminuido, la Organización Mundial de la Salud (OMS) estima que alrededor de 12 millones de niñas de entre 15 y 19 años dan a luz anualmente, muchas de ellas en condiciones socioeconómicas desfavorables.[1,2] En Brasil, las disparidades regionales agravan el escenario, ya que las regiones Norte y Nordeste registran las mayores incidencias de embarazo precoz debido al acceso limitado a métodos anticonceptivos y a programas

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educativos consistentes.[3,4] En los Estados Unidos, los avances en la educación sexual y el acceso a los anticonceptivos han resultado en una reducción significativa de las tasas en las últimas décadas. Sin embargo, las minorías raciales y las comunidades de bajos ingresos siguen enfrentándose a barreras que perpetúan el problema.[5,6] Este estudio busca profundizar en la comprensión de las causas, consecuencias y abordajes del embarazo adolescente en dos contextos distintos, proporcionando una base para recomendaciones de políticas públicas más efectivas.

2. Objetivos

2.1 Objetivo General: Analizar las implicaciones del embarazo adolescente en Brasil y Estados Unidos, destacando similitudes, diferencias y estrategias de enfrentamiento.

2.2 Objetivos específicos

1. Comparar las tasas de embarazo adolescente entre ambos países.
2. Evaluar los impactos médicos, sociales y económicos en diferentes contextos culturales.
3. Examinar las políticas públicas y los programas de prevención implementados.

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4. Proponer recomendaciones basadas en evidencia para mejorar los indicadores de salud e igualdad social.

3. Metodología

La investigación se basó en una revisión sistemática de estudios publicados entre 2014 y 2024, utilizando bases de datos como PubMed, SciELO y CDC Reports. Se incluyeron estudios observacionales, revisiones sistemáticas y análisis comparativos que abordaron las tasas de embarazo adolescente, los determinantes culturales y sociales y la efectividad de las políticas públicas.

Criterios de inclusión:

• Estudios con datos sobre Brasil y Estados Unidos.

• Publicaciones revisadas por pares que analizan las políticas públicas y los resultados sociales y de salud.

Análisis:

Los datos se organizaron en tablas y gráficos comparativos, con análisis crítico de las intervenciones.

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4. Resultados

4.1 Tabla de estudios analizados

Referencia	Objetivo del estudio	Principales resultados
SINASC (2015-2021)[3]	Evaluar las tasas de embarazo adolescente en Brasil.	Las regiones Norte y Nordeste concentran el 63% de los casos.
CDC (2024)[5]	Analizar el impacto del "Programa de Prevención del *Embarazo en Adolescentes".*	Reducción del 58% en las tasas de embarazo adolescente entre 2010 y 2020.
SciELO (2023)[4]	Estudiar las desigualdades regionales en el embarazo adolescente.	Las regiones rurales tienen una mayor incidencia debido a la falta de acceso a métodos anticonceptivos y educación sexual.
UNFPA (2022)[7]	Comparar las políticas mundiales de salud reproductiva.	Las políticas integradas aumentan la adherencia de los adolescentes a los métodos anticonceptivos modernos.
Bicalho et al. (2021)[6]	Identificar las tendencias de fecundidad en adolescentes brasileñas.	Las tasas de fecundidad entre las adolescentes de 10 a 14 años se mantuvieron estables en 3,3 nacimientos por 1.000 habitantes.
Levandowski y Piccinini (2020)[8]	Estudiar el impacto psicológico del embarazo precoz.	Las adolescentes embarazadas son más propensas a desarrollar trastornos emocionales y abandonar la escuela.

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Martin et al. (2020)[9]	Examinar la efectividad de los anticonceptivos de acción prolongada en los Estados Unidos.	Los anticonceptivos implantables contribuyeron a una reducción del 45 por ciento en las tasas de embarazo adolescente durante cinco años.
Costa et al. (2022)[10]	Explorar las vulnerabilidades sociales asociadas al embarazo precoz en Río de Janeiro.	Las desigualdades sociales y la violencia sexual son determinantes críticos del embarazo entre las niñas de 10 a 14 años.

Fuente: Elaboración propia con base en datos de SINASC (2015-2021)[3], CDC (2024)[5], SciELO (2023)[4], UNFPA (2022)[7], Bicalho et al. (2021)[6], Levandowski y Piccinini (2020)[8], Martin et al. (2020)[9] y Costa et al. (2022)[10].

Detalles de los nuevos estudios

1. **Bicalho et al. (2021):** Este estudio brasileño destacó la estabilidad de las tasas de fecundidad entre adolescentes muy jóvenes (10 a 14 años), lo que indica que los esfuerzos actuales deben dirigirse hacia cambios culturales y estructurales profundos.[6]
2. **Levandowski y Piccinini (2020):** El impacto emocional de los embarazos tempranos fue uno de los principales focos, mostrando una mayor propensión a desarrollar depresión y otros trastornos mentales entre las adolescentes embarazadas, especialmente aquellas sin el apoyo familiar adecuado.[8]

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3. **Martin et al. (2020):** Al analizar datos de los EE. UU., la investigación demostró que los anticonceptivos reversibles de acción prolongada, como los DIU y los implantes, tuvieron un impacto directo en la reducción de las tasas de embarazo adolescente.[9]
4. **Costa et al. (2022):** Con base en datos de Río de Janeiro, este estudio reveló que las niñas expuestas a la violencia sexual y las desigualdades económicas enfrentan riesgos sustancialmente mayores de embarazo temprano. Este análisis refuerza la necesidad de intervenciones preventivas y protectoras.[10]

Análisis inicial

Indicador	Brasil	Estados Unidos
Tasa de embarazo adolescente (2020)	62/1,000 adolescentes	16/1,000 adolescentes
Consultas prenatales completas	El 49,5% de las mujeres embarazadas	El 88% de las mujeres embarazadas
Tasa de deserción escolar	33%	20%
Acceso a la anticoncepción	Limitado en las zonas rurales	Amplio, con programas específicos

Fuente: Adaptado de OMS (2022)[1], UNFPA (2023)[2], SINASC (2015-2021)[3], CDC (2024)[5], SciELO (2023)[4], Ministerio de Salud (2021)[12] y HHS (2023)[13].

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La tabla y los estudios más recientes complementan el análisis inicial, destacando la importancia de los enfoques multifactoriales. En Brasil, la implementación de políticas que aborden las cuestiones culturales y socioeconómicas sigue siendo limitada. Por otro lado, Estados Unidos demuestra que los avances tecnológicos y los programas educativos

consistentes pueden reducir significativamente las tasas de embarazo adolescente, aunque no son suficientes para eliminar las desigualdades estructurales. Los datos fueron organizados en tablas y gráficos comparativos, con análisis crítico de las intervenciones.

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Tabla 1: Indicadores comparativos del embarazo adolescente

Tabla comparativa: Tasas de embarazo adolescente por región (Brasil y EE.UU.)

Región	Brasil (por cada 1.000 adolescentes)	Estados Unidos (por cada 1.000 adolescentes)
Norte	75	-
Nordeste	65	-
Sudeste	40	-
Sur	35	45
Midwest	50	-
Sur (Estados Unidos)	-	45
Noreste (EE. UU.)	-	25
Medio Oeste (EE. UU.)	-	35
Oeste (Estados Unidos)	-	30

Fuente: Elaboración propia con base en datos de SINASC (2015-2021)[3], CDC (2024)[5] y SciELO (2023)[4].

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Análisis adicional

- **Brasil:** Las regiones Norte (75/1.000) y Nordeste (65/1.000) tienen las tasas más altas de embarazo adolescente, lo que refleja las desigualdades socioeconómicas y el acceso limitado a la salud reproductiva.
- **Estados Unidos:** Las tasas son más bajas en general, pero la región Sur (45/1,000) se destaca con las tasas más altas, relacionadas con las barreras culturales y económicas.

4.2 Datos comparativos

Indicador	Brasil	Estados Unidos
Tasa de embarazo adolescente (2023)	53/1.000 adolescentes.[10.11]	15,4/1.000 adolescentes.[11]
Consultas prenatales completas	49,5% de las mujeres embarazadas.[12]	88% de las mujeres embarazadas.[12]
Deserción escolar	33%[12]	20%[13]
Acceso a la anticoncepción	Limitado, sobre todo en las zonas rurales.[11]	Amplio, con programas subsidiados.[11]
Educación sexual en las escuelas	Fragmentado, con baja cobertura nacional.[10]	Integrado en el currículo escolar.[13]
Población más vulnerable	Regiones Norte y Nordeste; jóvenes negras e indígenas.[12]	Minorías étnicas (latinos y afroamericanos)[13]

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Tasa general de natalidad (2023)	14,3 nacimientos por cada 1.000 habitantes.[12]	11,0 nacimientos por cada 1.000 habitantes11
Mortalidad materna (2019-2021)	62-190 muertes por cada 100.000 nacidos vivos, con disparidades raciales (negros: 190; indígenas: 149)[12-14]	17 muertes por cada 100.000 nacidos vivos.[11]

Fuente: Adaptado de OMS (2022)[1], UNFPA (2023)[2], SINASC (2015-2021)[3], CDC (2024)[5], SciELO (2023)[4], Ministerio de Salud (2021)[12] y HHS (2023)[13].

5. Discusión

Los datos analizados revelan un patrón de desigualdad en el abordaje y los resultados del embarazo adolescente entre Brasil y Estados Unidos. En Brasil, aunque las tasas han disminuido gradualmente en los últimos años, siguen siendo altas en las regiones menos desarrolladas, como el norte y el nordeste. Factores como la desigualdad socioeconómica, la baja educación y el acceso limitado a métodos anticonceptivos son determinantes significativos de esta realidad. Los datos muestran que el 49,5% de las adolescentes embarazadas tuvieron 7 o más visitas prenatales, mientras que el 41% tuvieron solo de 4 a 6 visitas, lo que indica disparidades regionales significativas en el acceso a la salud básica.[5.6] En los Estados Unidos, la reducción de las tasas de embarazo

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adolescente ha sido impulsada por programas educativos y un mayor acceso a métodos anticonceptivos, como el Programa de Prevención del *Embarazo en Adolescentes*. Sin embargo, persisten problemas entre las minorías étnicas y las poblaciones de bajos ingresos, que se enfrentan a barreras culturales y económicas. La tasa de embarazo entre las adolescentes latinas y afroamericanas sigue siendo desproporcionadamente alta, lo que refleja desigualdades sociales y raciales profundamente arraigadas.[7,8] Las consecuencias sociales, como la deserción escolar y la exclusión económica, afectan gravemente al desarrollo de las adolescentes. En Brasil, alrededor del 33% de las adolescentes embarazadas abandonan la escuela, lo que agrava el ciclo de la pobreza. En Estados Unidos, esta tasa es del 20%, pero los impactos se exacerban en las comunidades marginadas. Ambos países ponen de manifiesto la necesidad de políticas más inclusivas y culturalmente adaptadas para garantizar la igualdad de oportunidades y el acceso a los derechos reproductivos.

Los factores emocionales también juegan un papel central. Las adolescentes se enfrentan a juicios sociales, aislamiento y, a menudo, a la falta de apoyo familiar adecuado, lo que intensifica los desafíos psicológicos. Los programas de apoyo

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emocional son esenciales para mitigar los efectos adversos de la maternidad temprana y promover el bienestar de las mujeres jóvenes y sus hijos.[9.10]

6. Conclusión

El embarazo adolescente representa un problema multidimensional que requiere estrategias de enfrentamiento específicas y regionales. En el Brasil, los esfuerzos deben dirigirse a reducir las desigualdades regionales y ampliar el acceso a la anticoncepción y la educación sexual, especialmente en las zonas rurales y las comunidades marginadas. Programas como "Salud en la Escuela" necesitan expansión y financiamiento para lograr una mayor cobertura y efectividad. En los Estados Unidos, aunque las tasas están disminuyendo, la brecha entre los grupos socioeconómicos y raciales indica que las políticas universales no satisfacen plenamente las necesidades de las poblaciones vulnerables. El fortalecimiento de programas específicos, como el Programa de Prevención del *Embarazo en Adolescentes*, y el aumento de las iniciativas culturales y lingüísticas inclusivas son clave para continuar reduciendo las tasas de embarazo adolescente. Ambos países pueden beneficiarse del intercambio de experiencias y buenas prácticas, especialmente en lo que

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respecta a la educación sexual integral y el apoyo socioemocional a las adolescentes embarazadas. La promoción de campañas educativas y la inclusión de las adolescentes en diálogos sobre sus derechos reproductivos son pasos cruciales para transformar este escenario.

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GENDER VIOLENCE AND THE LIMITS OF THE NORMATIVE LEGAL PROTECTION SYSTEM [1]

Guilherme Aurélio Santos Trindade [2]

Maristela Aparecida Steil Basan [3]

Renata Salgado Leme [4]

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[2] **Guilherme Aurélio Santos Trindade**:
Master's student with a CAPES scholarship from the Stricto Sensu Postgraduate Program in Health Law: Individual and Collective Dimensions, Santos, SP, Brazil (UNISANTA). Researcher, lecturer, specialist in anti-discrimination law. E-mail: trindade.guilherme36@gmail.com Lattes: http://lattes.cnpq.br/ 7041931862260997. ORCID: https://orcid.org/0009-0003-3187-6611.

[3] **Maristela Aparecida Steil Basan:**
Master's student in the stricto sensu Postgraduate Program in Health Law: Individual and Collective Dimensions, Santos - SP, Brazil (UNISANTA). Lawyer. E-mail: Maristela.basan@hotmail.com. Lattes: http://lattes.cnpq.br/506102279332275 . ORCID: https://orcid.org/0009-0004-3316-392X .

[4] **Renata Salgado Leme**:
Graduated from the Faculty of Philosophy, Letters and Human Sciences at the University of São Paulo. Law degree from the Catholic University of Santos. Master's in Law from the University of São Paulo. Doctorate in Law from the University of São Paulo. Doctorate in Law Recognized by the Portuguese Directorate-General for Higher Education. Full Professor at Santa Cecília University, in the Undergraduate Law School, the Undergraduate International Relations School and the Health Law Master's

Gender violence and the limits of the normative legal protection system
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Abstract

Background: As a result of the violence practiced against women, a legal and regulatory framework has been created at international and national level to protect them. In Brazil, Law 11.347/06, known as the Maria da Penha Law, identifies the types of violence and establishes mechanisms to prevent and curb it. The classification of the forms of violence practiced against women described in this law has been improved, for example by establishing a correlation between psychological violence and property violence. Identifying the forms of violence allows us to understand the relationship between violence and the effects it has on women's health. **Problem**: To what extent has the protection system created by the Brazilian state to prevent and curb gender-based violence been able to achieve its purpose? **Objectives**: to reveal that the patriarchal model of society is one of the factors that contribute to the perpetration of violence against women; to establish a comparison between the legal framework for the protection of women and the Brazilian reality. **Method**: This is an exploratory, qualitative study based on an analysis of scientific articles, doctrine, documents and data compiled by research institutes**. Results:** The evolution of women's protection under both international and national legislation has stimulated the construction of public policies and measures to protect women who are victims of violence. This normative framework is important, however, it is clear that data from the Brazilian reality still reveals that there are high rates of violence against women. **Conclusions**: Gender-based violence is a consequence of patriarchy and also has negative effects on women's psychological health. Despite legislative progress, women who suffer domestic violence encounter huge obstacles in accessing the protection mechanisms created by the Brazilian state, due to the strong historical, social and cultural roots of patriarchy, which are revealed in the alarming statistics on gender violence.

Program: Member of the OAB Santos Health Law Commission. ORCID: https://orcid.org/0000-0003-2298-9975 .

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Keywords: Women's Rights, Domestic Violence, Psychological and Property Violence, Women's Health.

Introduction[5]

Society lives with violence against women, even though there are laws to curb such violence, as well as media coverage and the existence of reporting channels to guide and help women who suffer violence. (Leme at al, 2021, p.136).

The article reveals that domestic violence has historical and socio-cultural origins, as it is based on patriarchy, which places women in a position of submission, devaluation and unequal status in relation to men, which legitimizes, trivializes, promotes and silences violence.

The study briefly presents the international and domestic legal-normative system that has been built up since the 20th century with the aim of safeguarding women's rights; it analyzes aspects of the Maria da Penha Law, sets out a list of existing protective measures and presents recent data on violence against women.

The main objective of the study is: 1. to reveal that the patriarchal model of society is one of the factors that contribute to the perpetration of violence against women; 2. to establish

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a comparison between the legal framework for the protection of women and the Brazilian reality.

The research is exploratory and qualitative, based on scientific articles, doctrine, documents and data compiled by research institutes.

1. Historical aspects of domestic violence

Violence against women has a historical and socio-cultural origin, where men are seen as stronger, due to the culture of patriarchy, which is still rooted in today's society, where men dictate the rules and women obey the rules dictated by them (Leme at al, 2021, p.136).

The doctrine mentions that since patriarchy, male supremacy has prevailed in social relations, that is, the submission of women to men, with punishment for the offender, when the rules imposed by the patriarch are not complied with (Balbinotti, in Leme, 2021, p.136).

Almeida (in Leme, 2021, p.136) states that society is viriarchal, because the man, even if he is not the father, assumes the position of dominance.

The macho culture is still dominant, causing women to be devalued and unequal to men.

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Fear and respect for the husband (submission) are already ingrained as a cultural characteristic of society, based on ancient concepts and beliefs of domination, which is not questioned because it goes against religious, moral, economic, psychological and social thinking (Menezes, 2000).

We have various documents and organizations created to protect women's rights, such as the Inter-American Commission on Women (CIM-1928), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW-UN-1979), which came into force in 1981 and was ratified by Brazil in 1984.

Created by the UN in 1982, the Committee on the Elimination of Discrimination against Women has the task of examining progress in the implementation of the Convention, as well as access to the global protection system.

Article 5 of the Federal Constitution of 1988 grants equal rights to men and women, based on the principle of isonomy, but in the face of social culture, these rules are only formal.

Violence against women comes in many forms and affects all races, ethnicities, social classes and levels of education. It is not an isolated event, as such violence takes the form of a sequence of episodes, which usually become more severe.

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According to the UN definition (1992), violence against women is "...any act of violence based on gender difference, resulting in physical, sexual and psychological harm to women, including threats of such acts, coercion and deprivation of liberty, whether in public or private life."

In 1993, at the United Nations Conference on Human Rights, it was recognized that violence against women is an offence against human rights, and it was stated that such violence is a fact of public domain (Vienna Convention, 1994).

Domestic violence has been recognized by the World Health Organization (WHO) as a public health issue, which negatively affects the victim's physical and emotional integrity, their sense of security, a vicious circle of "comings and goings" to health services and the consequent increase in public spending (Grossi, 1996).

In Brazil, we have the Belém do Pará Convention, which states that gender-based violence can occur in the sphere of the family, the domestic unit, the community and institutions. (IACHR, 1994)

Violence against women is characterized as a pandemic, as it is prevalent at an international level, given that 30% of women in the world have suffered some type of domestic violence perpetrated by an intimate partner. In Brazil, 27.4%

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of women aged 16 or over have suffered some form of physical or psychological violence or harassment in 2018 (Leme et al, 2021, p. 138).

2. Domestic and intrafamily violence and types of violence

Violence against women stems mainly from gender inequality, occurring since childhood, and is motivated by jealousy and infidelity, which generate physical, psychological and social consequences, having a higher incidence in the domestic and family environment, due to the culture of patriarchy (Leme et al, 2021, p. 138).

Studies carried out in Brazil show that 42% of violence against women occurs in the domestic environment (IBSP and Data Folha, 2019), and can be classified as physical, sexual (the ultimate expression of gender inequality), moral, property and psychological (Article 7 of the Maria da Penha Law). It should be noted that violence has now reached the virtual environment (Leme et al, 2021, p.139).

A recent study by the Brazilian Institute of Geography and Statistics points out that domestic violence against women has increased considerably in Brazil, indicating that among 100,000 women, in 2021 and 2022, there were 230.1 and

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236.7 records of domestic violence, respectively. In the same years of 2021 and 2022, it was also found that in 11 Brazilian states there was a decrease in violence against women, but in the other states there was an increase in violence, with the states of Amazonas and Roraima showing the highest rates of increase in violence against women.

According to the Maria da Penha Institute, based on the Law of the same name, in Chapter II, Article 7, items I, II, III, IV and V, there are five types of violence against women: physical violence, psychological violence, sexual violence, property violence and moral violence.

According to the Institute, physical violence is considered to be any conduct that offends a woman's bodily integrity or health, which can be characterized by the aggressor beating her, throwing objects, shaking and squeezing her arms, strangling or suffocating her, injuries with sharp or piercing objects, injuries caused by burns or firearms and torture. Sexual violence is any conduct that forces a person to witness, maintain or participate in an unwanted sexual relationship through intimidation, threats, coercion or the use of force. Examples of these practices are rape, forcing a woman to perform sexual acts that cause discomfort or repulsion, preventing the use of contraceptive methods or forcing a

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woman to have an abortion, forcing marriage, pregnancy or prostitution through coercion, blackmail, bribery or manipulation, limiting or annulling the exercise of a woman's sexual and reproductive rights. Moral violence is considered to be any conduct that constitutes slander, defamation or insult, characterized by accusing a woman of betrayal, making moral judgments about her conduct, making untruthful criticisms, exposing her intimate life, demeaning a woman by cursing her character, devaluing the victim because of the way she dresses.

We must also mention discrimination against women, which is invisible, a practice of disrespect, through jokes, public comments, advertisements, songs, inferiorizing women, stating that women should be restricted to the kitchen, the bed or the shadows (Penha, 2012).

3. The Cycle of Violence Theory

The term Cycle of Domestic Violence was coined by American psychologist Lenore Walker to identify certain patterns of abuse in relationships of affection, as well as stating that it is very difficult for women to leave a violent affective union, which represents a vicious, repetitive pattern

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in the same relationship, as it is renewed with each aggression (Leme et al, 2021, p.140).

This cycle is divided into three phases (Soares, 2005): Phase 1 - tension in the relationship. It begins with arguments, jealousy, verbal aggression, without physical violence. The woman seeks justification for the tension and this phase is indefinite. Phase 2 - maximum tension. Physical aggression and psychological pressure begin, and this phase lasts less than phase 1. Phase 3 - begins after the actual violence, when the aggressor repents and promises not to commit any more violence, so as not to break off the relationship, and the cycle continues.

This cycle can be understood by the patriarchal - macho pattern, which comes from a historical condition of submission with more complex non-physical abuse, passed down from generation to generation within the family structure.

The aggressor's promises of change give the violence a cyclical character, which takes the form of moments of aggression and love. It is therefore important for women to be aware of the cycle in which they are involved, so that they can get out of the situation (Miller, 1999).

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The majority of women remain in relationships because of their economic and social dependence on their partner, and aggressors use strategies to maintain their relationships.

Women are unmotivated to file complaints because they fear retaliation, because it is a personal matter, because of the humiliation of exposing the fact at the police station, because of the guilt and shame of the aggression, because of the difficulty of reporting the aggressor in cases of rape, because of the aggressor's economic dependence, because of the family constitution with the aggressor and because of the children (Campos, 2012, p.39).

Several factors can also trigger domestic violence, such as the use of alcohol, psychotropic drugs and illicit drugs, as well as the presence of bladed weapons and firearms in the domestic environment.

4. Data related to violence against women

Research shows that 52% of women do not take action after suffering violence, and 22.2% who seek help report the aggressor (IBSP and Datafolha, 2018).

The São Paulo Public Prosecutor's Office, according to a survey carried out between March 2017 and March 2018, found that of the 124 cases of femicide, only 5 had a police

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report against the aggressor, demonstrating the silent attitude of the violated woman. This statistic also occurs at an international level, due to the failure of the state to guarantee the effective protection expected by women and the simple fact of not reporting it (Leme at al, 2021, p.141).

During the pandemic, there has been an increase in violence against women, with an 18% increase in March 2020 alone, verified through the hotline services (Leme at al, 2021, p.141).

In March 2023, the Network of Security Observatories recorded 2,423 cases of violence against women, showing that every four hours a woman was a victim of violence. This is revealed in the bulletin Elas Vivem: data that won't be silenced. This bulletin monitors seven states: BA, CE, PE, SP, RJ and, for the first time, MA and PI. Among the cases recorded, 495 are femicides. The methodology applied in this bulletin is that of daily monitoring of what circulates in the media and on social networks about violence and security, thus encompassing cases in which reports may or may not have been made to official bodies. The information collected is fed into a database which is then reviewed and consolidated.

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The study also points out that 75% of femicides are committed by former partners and that the main reasons for crimes against women are break-ups and fights.

The research also provides evidence of violence against women, indicating the existence of underreporting in relation to gender-motivated violence, with data that portrays a portion of daily events whose totality is even greater and more painful than the surveys carried out by public bodies.

According to the Ministry of Racial Equality, black women, noting that 'black women' includes black women and brown women, within the spectrum of colorism, are the ones who suffer most from psychological, physical or sexual violence, data from 2021.

Cases of psychological violence against women increased by 89%, while property violence increased by 34%, with 35% of victims earning up to 2 minimum wages (Datasenado, Brasília, 2023).

Underreporting is as much as 10 times higher than that registered as domestic violence, which creates a gap in the protection of women, and a correlation in the reliability of public protection systems in defense of women's rights (UFMG- 2023).

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5. Psychological violence and property violence

As defined by the Maria da Penha Institute, psychological violence is defined “as any conduct that causes emotional damage and diminished self-esteem, that harms and disturbs a woman's full development or that aims to degrade or control her actions, behaviors, beliefs and decisions.”

Psychological violence is revealed by various actions of the aggressor to control the woman in her daily life, which cause emotional damage and deteriorate her mental health. The perpetrators of psychological violence act in a similar way in order to create a modus operandi that inhibits, deceives, isolates, manipulates, belittles and humiliates the victims.

These acts can be practiced with threats, embarrassment, humiliation, manipulation, isolation (prohibiting studying and traveling or talking to friends and relatives), constant surveillance, constant persecution, insults, blackmail, exploitation, limiting the right to come and go, ridicule, taking away freedom of belief, distorting and omitting facts to leave the woman in doubt about her memory and sanity, as exemplified by the Maria da Penha Institute.

There is a recurring practice of keeping women away from their families and social circles, so that these groups don't oppose, warn or denounce the violence.

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Furthermore, aggression helps the perpetrators, who can be spouses, parents, children, siblings, stepparents, to achieve their goals, which is to put these women in a state of psychological vulnerability.

It is worth noting that trans women and transvestites are also part of the cycle of psychological violence against women, and are protected by the Maria da Penha law. It should be noted that the aggressor can be another woman, who also uses interpersonal relationships and power relations to commit violence against her partners.

Psychological violence is mainly evidenced by disrespect for others, and can happen in various relationships, such as work, family and interpersonal relationships. But it usually happens in situations where there is an emotional bond between the parties. The partner believes they can't live without the other (Serafim, 2023).

Gaslighting, a term in English that can be translated as psychological manipulation in relationships, manipulation that can take place in different ways and to different degrees, according to the Penal Code, in its article 147-b.

The gender of the aggressor does not prevent women from suffering all forms of psychological violence that are unfortunately implicit in the social correlations of gender power

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and control of women, although the vast majority of aggressors are men, demonstrating the correlation of machismo and misogyny.

The Maria da Penha Institute defines property violence as “any conduct that constitutes the retention, subtraction, partial or total destruction of objects, work instruments, personal documents, goods, values and rights or economic resources, including those intended to satisfy their needs”.

Property violence against women stems from fragility and emotional dependence, in which aggressors take advantage of personal relationships to take advantage of their victims. These relationships can be dating, marriage, stable union or just a promise of a relationship. "Violence against women always aims to control women. And one of the forms of control is to keep the partner financially dependent, so that she can't afford to leave the man," according to Judge Madgéli Frantz Machado, head of the 1st Court of Domestic and Family Violence against Women in Porto Alegre at the Rio Grande do Sul Court of Justice (TJRS).

There are cases in which the women have a profile of financial independence or a socio-economic condition capable of maintaining the luxuries and privileges of these exploiters, with elderly women being the main victims of this violence. It

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is important to note that many abuses can also be committed when the woman works for the aggressor without receiving any benefits or payments, putting aside her professional earnings in the job market to support her partner.

Victims of property violence often sell their only possessions to give to the aggressor, or the aggressor manages all their assets, and there are cases of financial control in which the woman has to give all her salary to the aggressor, who controls all her earnings and expenses (Maria da Penha Law, Art. 7, IV).

The abusive behaviors characteristic of aggressors range from financial restriction, preventing the woman from participating in decisions about her own money; destruction of personal belongings, such as valuables, or selling them; concealment of personal documents, to curb flight and the taking of property; changing bank passwords, to deprive access to financial resources; preventing work, to curb financial independence; among others (Maria da Penha Law, Art. 7, IV).

These are some of the controls that victims of property violence can suffer from their aggressors, and there is often a correlation between psychological and property damage,

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revealed by the emotional and psychological dependence between the victim and the aggressor.

Domestic violence against women has been recognized by the World Health Organization (WHO) as a public health issue, resulting negatively in the physical and emotional integrity of the victim and their safety, with “comings and goings” to health services, consequently generating an increase in public spending on health (Grossi, 1996).

Violence against women has consequences for their health, especially their mental health. Studies show that 75.3% of women who have suffered violence suffer from depression, but a more recent study (Bittar, 2017, p.451) points to various psychological symptoms resulting from domestic violence against women, such as depression, post-traumatic stress, anxiety, phobias, discouragement, irritability, panic syndrome, suicidal ideation, attempted suicide, homicide, low self-esteem, feelings of guilt, inferiority, insecurity, shame, social isolation, difficulty making decisions, extreme dependence, smoking, alcohol use, lack of concentration (Leme at al, 2021, p.143).

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6. The Maria da Penha Law

The Maria da Penha Law was created as a result of a recommendation by the Inter-American Commission on Human Rights, which found that Brazil had failed to provide judicial protection to the victim (Maria da Penha Maia Fernandes) in relation to the abuse she suffered from her husband, i.e. the various assaults and micro-aggressions inflicted by her partner, which almost took her life, leaving her paraplegic and at risk of death. (Maria da Penha Institute).

Brazil was also condemned in 2021 by the Inter-American Court of Human Rights (IACHR), in the case of the murder of Márcia Barbosa de Souza, which took place in 1988. This condemnation was handed down for the first time in an absolute manner based on the violation of gender-related human rights, with Brazil being held responsible for the difficulty in accessing justice and the lack of investigation in cases of femicide, including the discrediting of the victim in both the trial and the investigation, revealing the abusive power relations of public agents in the exercise of their functions.

In Brazil, around 4 women a day die as a result of gender crimes, a high rate that leaves Brazil in 5th place in the world for femicide, behind countries such as El Salvador, Colombia,

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Guatemala and Russia, according to the United Nations High Commissioner for Human Rights (UNHCHR). Brazil kills 48 times more women than many countries such as the United Kingdom.

The term feminicide was coined in the 1970s by South African writer and women's activist Diana Russel, who researched sexual violence committed against women and girls, studying in depth the misogynistic murders committed by men, especially their partners, and publicly defending her actions at the Crimes against Women Tribunal in Brussels (Dias et al; 2021).

Death by gender crimes against women can occur in the family, in interpersonal relationships, by illegal armed groups, at the behest of state agents or even in public spaces.

With such discrepant measures and such frightening estimates, after Brazil was condemned internationally for its failure to act in cases of domestic violence against women, what would be left for the state to do but to promote legislation that protects all women from aggression?

The Maria da Penha Law, as it is popularly known, came about with this in mind, following the international condemnations that Brazil has suffered and with repeated popular pressure. This law creates mechanisms to curb

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domestic violence against women, regardless of social class, ethnicity, sexual orientation, income, culture, educational level, age and religion, as stated in Article 3 of the law.

7. Protective measures

With the advent of Law No. 14.188/21, which defines a red light cooperation program against domestic violence, the penalty for bodily injury on the grounds of female gender and the criminal type of psychological violence against women have been altered, even amending Decree Law No. 2.484/40, known as the Penal Code.

> "Psychological violence against women. Art. 147-B. Causing emotional damage to a woman that harms her and disturbs her full development or that aims to degrade or control her actions, behaviors, beliefs and decisions, through threat, embarrassment, humiliation, manipulation, isolation, blackmail, ridicule, limitation of the right to come and go or any other means that causes damage to her psychological health and self-determination: Penalty - imprisonment, from 6 (six) months to 2 (two) years, and a fine, if the conduct does not constitute a more serious crime."

It is important to note that red light cooperation can be applied in public offices and private entities throughout the country, and that an information campaign and permanent training of professionals belonging to the program must be carried out, referring the victim to specialized care.

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Judge Alexandre Takaschima, head of the 2nd Criminal Court of the District of Lages, when commenting on the changes to the Maria da Penha Law, emphasized that "recognizing psychological violence as something that cannot be accepted as normal in relationships. I remember a woman who, in court, crying, said that the physical pain had passed, but the trauma and psychological pain she couldn't overcome."

In order to request emergency protective measures and even the criminal investigation itself, it is necessary to go to the official bodies, or through a lawyer, who will know the necessary means to file this type of protection.

The Ministry of Human Rights and Citizenship, on the federal government's website, which is available for reporting violence against women and providing nationwide assistance (call 180), makes referrals to the main agencies, including reference centers and women's shelters.

There are many protective measures against the aggressor to protect the woman from violence, some of which include seizing the aggressor's firearm or restricting him from carrying it; removing the aggressor from the home or the place where he lives with the victim; prohibiting the aggressor from going to or coming close to certain places, such as the victim's

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home or work; prohibiting the aggressor from approaching or maintaining contact with the victim, her relatives and witnesses to the aggression; restricting or suspending the aggressor's visits to his children; payment of provisional maintenance to the victim and her children or only to the latter; measures to benefit the woman; referral of the victim and her dependents to programs for the protection and care of women in situations of domestic and family violence (shelters); guaranteeing the return of the victim and her children to the home abandoned as a result of the aggression suffered, as soon as the aggressor's removal is determined; the victim's right to leave the home with her children in cases of danger or to remain there if the aggressor is removed or arrested; separation of bodies, i.e. the release of the duty to live in the same house, removing the aggressor from the home and no longer having the obligation to sleep together and have sexual relations; removal of the victim from their home, without prejudice to rights relating to property, custody of children and maintenance; return of property that the aggressor has taken from the victim; temporary prohibition on the aggressor making acts or contracts to rent or sell the property that is common to the couple; suspension of the validity of powers of attorney that the victim has given to the aggressor; payment

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of a provisional bond (guarantee) to the victim, by means of a deposit in court, for material losses due to the aggression committed; inclusion of the woman, for a certain period, in the register of assistance programs of the federal, state and municipal governments; priority access to removal, when she is a public servant of the direct or indirect administration; access to emergency contraception services, prevention of STDs and HIV/AIDS and abortion provided for by law.

Crimes of violence against women and their possible punishment will be investigated through criminal proceedings, in compliance with criminal and procedural law, in addition to the crime of non-compliance with protective measures under the law.

In cases of psychological, moral and property violence, it is difficult for victims to file a complaint, either because they are afraid of the aggressor, because of pressure from their social environment, or because it is difficult to prove the causal link, since the evidence of these types of violence is difficult to prove, which means that the protective measures provided for in the Maria da Penha Law are not requested by the victims.

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Final considerations

The study reveals that the Maria da Penha Law was a legislative breakthrough in the system of protection for women who suffer domestic violence, typifying the types of violence and establishing protective measures to safeguard the integrity of the victim against the aggressor.

However, given Brazil's patriarchal roots, domestic violence is still present and on the rise, as the recent statistics reported in the study show.

The article also points out that two types of violence against women are intertwined - psychological and property violence - and that these affect women's mental health, which can lead to depression, post-traumatic stress, anxiety, phobias, discouragement, irritability, panic syndrome, suicidal ideation, attempted suicide, homicide, low self-esteem, feelings of guilt, inferiority, insecurity, shame, social isolation, difficulty making decisions, extreme dependence, smoking, alcohol use, lack of concentration, etc.

The article also points out that there is underreporting of cases of domestic violence against women and that reporting psychological and property violence is even more difficult due to the emotional and financial dependence of the victim, as well as the construction of evidence.

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It is clear that public policies to support women who suffer violence are not implemented effectively in all cities in Brazil, especially those to welcome and offer legal and psychological advice.

In addition to building a legislative framework, it is essential to combat gender stereotypes and deconstruct patriarchal society by consolidating gender equality in order to combat, mitigate and extinguish domestic violence.

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