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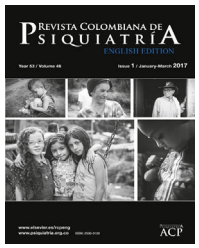

Editorial

Voluntary interruption of pregnancy in Colombia: Contributions to the debate from public mental health☆

Interrupción voluntaria del embarazo en Colombia: aportes al debate desde la salud mental pública

Adalberto Campo-Arias[a,*], *Edwin Herazo*[b]

[a] *Programa de Medicina, Facultad de Ciencias de la Salud, Universidad del Magdalena, Santa Marta, Colombia*
[b] *Instituto de Investigación del Comportamiento Humano, Bogotá, Colombia*

The population's mental health problems will not go away if we simply avoid them or fail to address them. Historically, the prohibition and recommendation of behaviours, mostly related to the mental hygiene perspective, have dominated Colombian psychiatry.

In recent decades, a broader and more extensive participation in the search for solutions to public mental health problems and in debates of national importance has overcome an unjustifiable absence that left notorious loopholes in how the country dealt with socio-political violence, social inequity and inequality, the impoverishment of the population, the use of legal and illegal substances, the exclusion, stigmatisation and discrimination of entire groups (Afro-Colombians, native peoples, LGBTTTIIQAH, etc.) and, even more regrettably, most of the Colombian population: women.

Throughout history, women have been denied or prevented from exercising their right to self-determination, the vote, to elect and be elected, to family planning, to access advances in contraception and to making free, autonomous and informed decisions about their bodies and pregnancies, with the latter being an issue for which women are still fighting despite the ruling passed by the Constitutional Court of Colombia in 2006 on the voluntary interruption of pregnancy (VIP), which defined health reasons – including mental health – as one of the grounds for its decriminalisation.[1] It was hoped that said ruling would be the light to guide the proceedings of the healthcare and judicial systems, as well as other State authorities. This was not the case. The same Constitutional Court also passed subsequent rulings to safeguard the rights of Colombian women against infringing actions by agents of the healthcare system and judicial branch.[2,3]

The debate, controversy and disagreements surrounding VIP are far from over, since they include ethical and philosophical questions to which humanity has not yet found an unequivocal answer.[4] Nonetheless, it is necessary to focus on the facts. VIP has existed since ancient times, even among human groups who followed a reproductive model or childbearing pattern which anthropologists refer to as the hunter-gatherer mode of reproduction.[5] However, with the transition to the industrial-digital mode of reproduction and the dawn of biotechnological advances, simple, safe and effective methods have been discovered which allow women to decide how many children they would like and to have or choose the length of an interpregnancy interval without resorting to VIP.[5,6]

VIP should be considered an exceptional measure in situations where other steps or actions (health-related, cultural, social or political) have failed.[7] Nevertheless, some authors

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* *Corresponding author*.
E-mail address: acampoa@unimagdalena.edu.co (A. Campo-Arias).
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consider the criminalisation of VIP to be a violation of women's human rights,[8,9] while denying this right reinforces the stigma–discrimination complex towards women, traceable to the beginning of time, and corroborates the institutionalisation of misogyny in the present day.[8,10]

In Colombia, the bureaucratic itinerary to enjoy the right to health is full of obstacles.[11] These barriers tend to be even greater in controversial cases such as VIP.[12,13] Following the Constitutional Court's C-355 ruling in 2006, which specifies that VIP is a legal matter and the woman's choice,[1] additional rulings were required in order to overcome institutional barriers to VIP and the violation of Colombian women's right to health and a dignified life.[2,3]

Currently, certain VIP opponents are wielding new arguments and expressing concern about the negative effects of VIP on women's mental health. However, it is necessary to analyse the available evidence in order to understand the effects of VIP in psychiatric clinical practice. It is important to remember that the best evidence is obtained through the analysis of collective or group data and that it is never able to predict the potential findings or results of a particular case.[14]

Generally speaking, the reporting and clinical confirmation of anxious and depressive symptoms is common in response to pregnancy loss. However, these symptoms are usually temporary.[15] In countries like Colombia, the decision regarding VIP is permeated by religion, even in cases where said decision is based on medical conditions that seriously compromise the life of the foetus or mother.[8,9,16] For a woman, VIP will always be a complex and difficult choice that may be accompanied by emotional manifestations, according to the particular context of the decision.[17–21] Sereno et al. indicate that, although VIP is a situation that causes transitory and tolerable conflict for most women,[17] some temporary depressive symptoms are also observed, with no significant decline in overall performance.[18–21] The best levels of evidence and grades of recommendation can be found in the works published by Charles et al. (2008)[22] and Steinberg (2011),[23] along with precautions to be taken in individual cases. The authors conclude that VIP, even after the first trimester, does not affect the woman's mental health in a statistically significant manner. Similarly, Herd et al., [24] in a longitudinal study that assessed older adult women, observed that women who carried unwanted pregnancies to term had poorer mental health outcomes than women with wanted pregnancies, not only in measures of neuroticism, extroversion and agreeableness, but also a greater risk of depression (odds ratio [OR] = 1.42; 95% confidence interval [95% CI], 1.07–1.88). Moreover, Foster et al.[25] observed that women who were refused a VIP reported greater financial difficulties and required more medical social services than those in whom the procedure was authorised.

It should be considered that meeting mental disorder criteria – at any time in life – is the result of a complex and interwoven interaction of proximal, medial and distal determinants, both in women and in men.[26–28] For example, the diagnosis of a mental disorder following an abortion is associated with the pre-existence of the former, a history of sexual abuse, intimate partner violence, barriers accessing sexual and reproductive health, mental health and the stigma–discrimination complex related to VIP.[29–31] In keeping with the guidelines of the Colombian Ministry of Health and Social Protection,[32] psychiatry professionals are called upon to protect the sexual and reproductive rights of women, both those who, exercising their autonomy, opt for a VIP on the grounds identified by the Constitutional Court,[1] and those who wish to continue the pregnancy.[4] Regarding the former group, streamlining the VIP process is recommended, for the purpose of reducing any unfavourable impact on the pregnant woman's mental health. Moreover, in both cases, psychiatry professionals must be willing to help in light of emotional reactions or emerging mental disorders.[26–28] In Colombia, there is undoubtedly a need for further research into the impact of VIP on individual and collective mental health across different social and cultural settings. Generally speaking, this may help to reduce inequities in healthcare.

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Universidad del Magdalena, Santa Marta, and the *Instituto de Investigación del Comportamiento Humano* [Human Behavioural Research Institute], Bogotá, Colombia.

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