



**Using Science and Medicine to  
Stop Human Rights Violations**

## **Priority Actions in the Zika Virus Response**

The emergence of the Zika virus, with its suspected risk of causing microcephaly in infants, is highlighting how public health policies related to sexual and reproductive rights are being hijacked by politicians who ignore well-established public health principles and human rights norms.

Even as scientists race to understand the link between the Zika virus and microcephaly, some governments are calling on women at risk to delay pregnancy. However, these calls are problematic in countries where – as a matter of government policy – women are denied access to the information and means to make informed decisions about their reproductive choices. Too often, governments adopt policies and practices that limit access to contraception and disempower women and girls, or that conversely compel women with HIV to undergo sterilization procedures or terminate healthy pregnancies. And these violations of women’s sexual and reproductive rights are exacerbated by the failure of governments to address sexual and gender-based violence – a practice which also strips women and girls of control over their sexual and reproductive choices.

It is imperative that governments dealing with the Zika virus provide the public with the best possible information on the nature of the threat, the prevalence of the disease, the risk to pregnant women, and the options available to women who are pregnant or are planning a pregnancy. Consistent with fulfilling the right to health, governments must both ensure that women can make informed decisions about their sexual and reproductive choices and that they have the means to do so – specifically, that they have meaningful and timely access to comprehensive reproductive services, including abortion.

The crisis sparked by the Zika virus has created an opportunity for states to review and reform governmental laws and policies that undermine women’s sexual and reproductive rights and their and their children’s right to health.

### **Background**

The mosquito-borne Zika virus is spreading across the Americas, with reported cases from the Southern Cone through the Andes and Central America to the United States. The U.S. Centers for Disease Control and Prevention reported confirmed cases in 24 countries as of

January 26, 2016.<sup>1</sup> With no commercially available test to confirm infections, many countries are unable to assess the real reach of the virus within their territories.

Zika virus disease has been described as being similar to dengue fever and “usually relatively mild,”<sup>2</sup> though – as with other viral infections – people with weakened immune systems may suffer disproportionately. The World Health Organization (WHO) has noted an increasing body of evidence pointing to a link between the Zika virus and microcephaly<sup>3</sup> in infants.<sup>4</sup> As of late October 2015, Brazil has reported 270 confirmed cases of microcephaly as well as 4,180 suspected cases.

### **Government Responses to Zika**

Fears related to the Zika virus and the links to microcephaly have led authorities in Colombia,<sup>5</sup> El Salvador,<sup>6</sup> and Jamaica<sup>7</sup> to issue official warnings for women of reproductive age to avoid or delay pregnancy, some specifying a period of between six months and two years.<sup>8</sup>

In Colombia, the government has recommended that pregnant women living in high altitude areas not travel to lower altitude areas, where the virus-carrying mosquitoes are more prevalent.<sup>9</sup> Such travel advisories are wise, as long as they are not mandatory. In Panama, the government has specifically said that indigenous women should avoid pregnancy due to the prevalence of the virus in areas with larger indigenous populations.<sup>10</sup> In Brazil, where the incidence of both confirmed cases of Zika infections and of microcephaly is the highest, authorities have not, as of yet, issued an official warning against pregnancy, though health workers have commented unofficially.<sup>11</sup>

While it is important that people living in affected areas have the best possible information regarding the Zika virus and the risks so that they can make informed choices, governments would be ill-advised to rely on women delaying pregnancy or to restrict women’s freedom of movement as the key means to address the issue. In short, states must affirmatively tackle the problem by attacking the sources of the virus, namely fumigating or otherwise eliminating mosquito breeding grounds.

### **Limitations of Pregnancy Warnings**

Many governments in the Americas have for decades curtailed the ability of women and girls to make independent decisions about their reproductive lives.<sup>12</sup> Despite increased access to contraceptive methods throughout the Americas, the WHO still reports significant unmet needs.<sup>13</sup> Abortion, where not completely illegal, is often subject to judicial authorization, and guidelines for women who would like to terminate unhealthy pregnancies are unclear or nonexistent.<sup>14</sup>

In addition, Latin American and the Caribbean countries have very high levels of gender-based violence, including sexual violence in intimate partnerships.<sup>15</sup> Male control of family planning is often a key element of intimate partner abuse. Not surprisingly, studies show that intimate partner violence in Latin America and the Caribbean is significantly associated with

unintended pregnancies.<sup>16</sup> Government inaction to prevent gender-based violence thus contributes to further reducing the autonomy of women's and girls' reproductive decision-making. Studies show uneven knowledge of and access to emergency contraception<sup>17</sup> in the region: poor women and women with less than primary education are the least likely to have heard of this method.<sup>18</sup>

Between restrictions on access to family planning methods, high levels of intimate partner violence, and cultural expectations that women and girls be sexually inexperienced and passive, 58 percent of all pregnancies in Latin America and the Caribbean are unintended.<sup>19</sup> Furthermore, many states in the Americas must understand that their calls – official and otherwise – to delay pregnancy may be heard by women in indigenous communities as yet another tactic to promote anti-natalist policies among them. Many states in the region have a long history of forced sterilization and other reproductive rights violations against indigenous women; they must therefore be particularly sensitive to this history, and ensure that they are transparent and consult in a meaningful manner with indigenous communities, generally, and women, in particular.

Moreover, the Zika virus will not long be confined to the Americas. Indeed, the WHO notes that the spread of the Zika virus could be explosive and potentially have global reach, at least in countries where mosquitoes live and breed easily.

This situation demands a concerted, coordinated, and urgent response that builds on public health expertise from analogous situations and fully respects human rights guaranteeing the highest attainable standard of health for everyone. Such a response must not impose travel or pregnancy bans, which at best provide inadequate containment of the virus – if any containment at all – and would constitute disproportionate limitations on personal autonomy and human rights.<sup>20</sup>

To be compliant with human rights obligations, an appropriate response to the spread of the Zika virus must include, at a minimum:

1. **Global support for coordinated assessment, surveillance, and identification of risk factors:** Current ability to detect and surveil the spread of the virus consistently is limited in many countries, severely hampered by the lack of a commercially available test and – in some countries – by weak health system infrastructure. The international community, led by the WHO, should immediately design and implement a plan for consistent detection and surveillance of the virus, as well as identification of the immediate and long-term effects of infection.
2. **Coordination of appropriate strategies for containing the spread of Zika:** Experience from the containment of other mosquito-borne diseases, such as malaria, has shown that the success of containment strategies strongly depends on the involvement of the affected people and communities in the implementation of such strategies. Education, at the most local level, is critical in explaining to members of high-incidence or at-risk communities how the virus is spread and what actions they can take to protect

themselves. In the case of mosquito-borne diseases, experience shows that the most successful interventions include a mixture of barrier strategies such as the use of mosquito nets and insect repellent, behavioral strategies such as covering open water containers, and community-based strategies such as the draining of ponds and other mosquito breeding grounds and the use of insecticides in larger areas. In each case, communities must be involved in evaluating the most appropriate mixture of these strategies.

3. **Ensuring a coordinated strategy for dissemination of information:** It is crucial that everyone understand what Zika is, the means of its transmission, how to prevent transmission, and how to mitigate symptoms for a person who has been infected. Given the likely link between the Zika virus and birth defects, it is imperative to empower women to make informed choices about pregnancy and birth. This includes ensuring access to family planning methods, addressing intimate partner violence, and developing easily comprehensible information about the actual risks and prevention factors for Zika infection.
4. **Avoiding blanket testing:**<sup>21</sup> Further research is required to determine the specific risk factors for microcephaly after Zika exposure. The use of amniocentesis is not without risk to the pregnancy;<sup>22</sup> strategies for detection must therefore avoid blanket amniocentesis testing of pregnant women even if they are asymptomatic and other diagnostics have not revealed fetal microcephaly or intracranial calcifications indicating infection. Any testing must be based on informed consent. Pregnant women and girls must have the opportunity to obtain all medically relevant information about the prognosis of their pregnancy in order for them to make informed decisions about their health and that of their family. No one should be compelled to obtain an abortion or to carry a pregnancy to term.<sup>23</sup>
5. **Review and approval of treatment and vaccine:** Experts have noted that while the development of a Zika treatment and potential vaccine may only be a few years off, the approval of their use may take disproportionately longer. All safeguards must be taken to ensure that any drug approved for human use has passed through the appropriate clinical studies and review process. International investment and support should ensure that this process is as short as possible.

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<sup>1</sup> Centers for Disease Control, “Zika-affected areas,” updated January 26, 2016 at <http://www.cdc.gov/zika/geo/index.html> (accessed on January 29, 2016).

<sup>2</sup> World Health Organization, “Zika virus, fact sheet,” January 2016, at <http://www.who.int/mediacentre/factsheets/zika/en/> (accessed on January 28, 2016).

<sup>3</sup> “Microcephaly is a medical condition in which the circumference of the head is smaller than normal because the brain has not developed properly or has stopped growing. Microcephaly can be present at birth or it may develop in the first few years of life.” National Institute of Neurological Disorder and

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Stroke, “NINDS Microcephaly Information Page,” as modified on June 30, 2015, at <http://www.ninds.nih.gov/disorders/microcephaly/microcephaly.htm> (accessed on January 28, 2016).

<sup>4</sup> World Health Organization, “Zika virus, fact sheet,” January 2016, at <http://www.who.int/mediacentre/factsheets/zika/en/> (accessed on January 28, 2016).

<sup>5</sup> “Ante epidemia de zika, Gobierno recomienda evitar los embarazos en zonas afectadas,” Noticias Colombianas (online), January 19, 2016 at <http://www.noticiascolombianas.com.co/index.php/226371/ante-epidemia-de-zika-gobierno-recomienda-evitar-los-embarazos-en-zonas-afectadas/> (accessed on January 28, 2016).

<sup>6</sup> Gillian Mohney, “El Salvador Advises Women to Avoid Pregnancy for 2 Years Due to Zika Outbreak,” ABC News, January 26, 2016, at <http://abcnews.go.com/Health/el-salvador-advises-women-avoid-pregnancy-years-due/story?id=36524952> (accessed on January 29, 2016).

<sup>7</sup> “Jamaica advises women to delay pregnancy due to Zika virus,” Associated Press, January 18, 2016 at <http://bigstory.ap.org/article/6bdff0c8fe734934b57418ald8d7d7d2/jamaica-advises-women-delay-pregnancy-due-zika-virus> (accessed on January 29, 2016).

<sup>8</sup> As of February 1, 2016, there were no public records of confirmed cases of infants born with microcephaly due to the Zika virus in Colombia, El Salvador, or Jamaica.

<sup>9</sup> “Ante epidemia de zika, Gobierno recomienda evitar los embarazos en zonas afectadas,” Noticias Colombianas (online), January 19, 2016 at <http://www.noticiascolombianas.com.co/index.php/226371/ante-epidemia-de-zika-gobierno-recomienda-evitar-los-embarazos-en-zonas-afectadas/> (accessed on January 28, 2016), figures from 2008.

<sup>10</sup> “Panamá: piden aplazar embarazos en comarca indígena por zika,” Terra Noticias (online), January 26, 2016 at <http://noticias.terra.com/mundo/latinoamerica/panama-piden-aplazar-embarazos-en-comarca-indigena-por-zika.5b14d2a7a6f1572732c9277e9bd7e5c516vap4qb.html> (accessed on January 29, 2016).

<sup>11</sup> “Brazil warns women not to get pregnant as Zika virus is linked to rare birth defect,” The Guardian, December 4, 2015 at <http://www.theguardian.com/global-development/2015/dec/04/brazil-zika-virus-pregnancy-microcephaly-mosquito-rare-birth-defect> (accessed on January 29, 2016).

<sup>12</sup> Guttmacher Institute, “Investing in Sexual and Reproductive Health in Latin America and the Caribbean,” December 2014 at <http://www.guttmacher.org/pubs/FB-AddingItUp2014-LA.html> (accessed on January 29, 2016).

<sup>13</sup> World Health Organization, “Family Planning/Contraception, Fact sheet no. 351,” updated May 2015 at <http://www.who.int/mediacentre/factsheets/fs351/en/> (accessed on January 29, 2016).

<sup>14</sup> Guttmacher Institute, “Facts on Abortion in Latin America and the Caribbean,” November 2015 at [http://www.guttmacher.org/pubs/IB\\_AWW-Latin-America.html](http://www.guttmacher.org/pubs/IB_AWW-Latin-America.html) (accessed on January 29, 2016).

<sup>15</sup> World Health Organization, Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence, (WHO: Geneva, 2013).

<sup>16</sup> A Han, D.E. Stewart, “Maternal and fetal outcomes of intimate partner violence associated with pregnancy in the Latin American and Caribbean region,” *Int J Gynaecol Obstet*, 2014, Jan; 124(1):6-11.

<sup>17</sup> “Emergency contraception, or emergency birth control, is used to help keep a woman from getting pregnant after she has had sex [including forced sex] without using birth control or if the birth control method failed.” See “Emergency contraception (emergency birth control) fact sheet,” Office of Women’s Health, U.S. Department of Health and Human Services at <http://www.womenshealth.gov/publications/our-publications/fact-sheet/emergency-contraception.html#a> (accessed on January 29, 2016).

<sup>18</sup> Tia Palermo, Jennifer Bleck, and Elizabeth Westly, “Knowledge and Use of Emergency Contraception: A Multicountry Analysis,” *International Perspectives on Sexual and Reproductive Health*, 2014, 40(2):79–86.

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<sup>19</sup> Susheela Singh, Gilda Sedgh, and Rubina Hussain, “Unintended Pregnancy: Worldwide Levels, Trends, and Outcomes,” *Studies in Family Planning* 2010; 41[4]: pp. 241–250. The number for North America and Europe is 48 percent.

<sup>20</sup> On February 1, 2016, Margaret Chan, WHO director-general, declared the Zika virus “a public health emergency of international concern,” but noted that there was no need for travel or trade restrictions “at this time.” Ariana Eunjung Cha, Lena H. Sun, and Brady Dennis, “Zika virus: WHO declares global public health emergency, says causal link to brain defects ‘strongly suspected,’” *Washington Post*, February 1, 2016 at <https://www.washingtonpost.com/news/to-your-health/wp/2016/02/01/zika-virus-who-declares-global-public-health-emergency-given-rapid-spread-in-americas/> (accessed on February 1, 2016).

<sup>21</sup> “Amniocentesis is a procedure used to take out a small sample of the amniotic fluid for testing.” John Hopkins University online Health Library at [http://www.hopkinsmedicine.org/healthlibrary/test\\_procedures/gynecology/amniocentesis\\_procedure\\_92.P07762/](http://www.hopkinsmedicine.org/healthlibrary/test_procedures/gynecology/amniocentesis_procedure_92.P07762/) (accessed on January 29, 2016).

<sup>22</sup> Amniocentesis is associated with an overall 0.1 percent risk of pregnancy loss when performed at less than 24 weeks of gestation. Amniocentesis performed at  $\geq 15$  weeks of gestation is associated with lower rates of complications than those performed at earlier gestational ages, and early amniocentesis ( $\leq 14$  weeks of gestation) is not recommended. See Centers for Disease Control and Prevention, “Chorionic Villus Sampling and Amniocentesis: Recommendation for Prenatal Counselling,” publication date July 21, 1995, at <http://wonder.cdc.gov/wonder/prevguid/m0038393/M0038393.asp> (accessed on January 29, 2016).

<sup>23</sup> While there is no current information about women being compelled to obtain an abortion or to carry a pregnancy to term in the context of the spread of the Zika virus, neither scenario is improbable given the history in the region. Studies have confirmed numerous cases throughout the region and beyond in which health professionals pressured women with HIV to terminate their pregnancies or go through tubal ligation. Limitations to abortion across the Latin American continent are mentioned above in this briefing. See, e.g., Regina Barbosa, Adriana Pinho, Naila Santos, and Wilza Villela, “Exploring the relationship between induced abortion and HIV infection in Brazil,” *Reproductive Health Matters*, Vol 20, Issue 39, Supplement, 2012, pp. 80-89; Ann Strode, Sethembiso Mthembo, and Zaynab Essack, “‘She made up a choice for me’: 22 HIV-positive women’s experiences of involuntary sterilization in two South African provinces,” *Reproductive Health Matters*, Vol 20, Issue 39, December 2012; Sarah MacCarthy, Jennifer Rasanathan, Laura Ferguson, and Sofia Gruskin, “The pregnancy decisions of HIV-positive women: the state of knowledge and way forward,” *Reproductive Health Matters*, Vol 20, Issue 39, Supplement, December 2012, pp. 119-140.