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In the Midst of Zika Pregnancy Advisories, Termination of Pregnancy is the Elephant in the Room

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To date, the majority of research and reporting devoted to Zika virus has focused on its potential negative impact on fetal neurological development, in particular the risk of microcephaly. By contrast, relatively little attention has been paid to the impacts of Zika and its associated public health response on women, particularly regarding their ability to terminate pregnancies.

In response to the Zika outbreak in Latin America, government officials in Brazil, El Salvador, Dominican Republic, Ecuador, Colombia, and Jamaica issued unprecedented advisories to women, cautioning them avoid pregnancy until Zika no longer remains a risk. On June 7th, the World Health Organization (WHO) took a similar step and advised women in Zika-affected areas to delay pregnancy (1). WHO guidance on delaying pregnancy focuses on contraceptive use, abstinence, and increased access to emergency contraception and condoms (1). The Centers for Disease Control and Prevention (CDC), which has so far not issued any advisories against becoming pregnant, has recommended that women and men living in areas with active Zika transmission plan their pregnancies in consultation with their healthcare provider (2). Both organizations have also published guidelines on preventing Zika exposure in pregnancy. These guidelines offer advice on preventing sexual transmission of Zika through avoiding unprotected sex with potentially infected partners, and on preventing vector-borne transmission—though mosquito control, precautions to avoid mosquito bites, and avoiding travel to affected areas (1)(2).

Advice to carefully plan pregnancies, use contraception or abstinence, and guard against mosquito bites may help some women, for whom such things are achievable, to avoid a risky

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pregnancy. Yet current recommendations offer very little to women who are already pregnant, who may become unintentionally pregnant, or who lack the practical and financial means to follow the recommendations. Latest estimates of the percentages of pregnancies that were unintended in Latin America and in the United States, the two largest regions currently affected by Zika, are high at 56% and 45%, respectively (3)(4). In the United States, many women are unable to access a method of contraception they are able to use consistently and effectively. Some women struggle to find an acceptable method, while others lack the agency to negotiate contraceptive use or abstinence at all. Moreover, many women, particularly in Latin-American countries where Zika is already spreading, are unable to avoid contact with mosquitoes due to poor living conditions.

As a result, not all pregnancies among women at risk of Zika infection can or will be prevented and not all women who do become pregnant will be able to avoid Zika exposure. Yet astoundingly, no national or international health organization has issued any guidance on the reproductive options that should be available to women who are already pregnant, who become pregnant accidentally, or who cannot avoid becoming pregnant while Zika transmission remains a risk. For these women, the best evidence regarding their risk of experiencing fetal microcephaly suggests estimates of 1% to 13% depending on gestation (5).

New evidence, however, suggests that the Zika virus is highly neurotropic and may target the developing germinal matrix. Overt microcephaly is now thought to be the tip of the iceberg in terms of Zika-related risk to the developing brain. Moreover, most of the subtle fetal brain anomalies caused by Zika are not detectable on either ultrasound or MRI (6). Thus, serial scanning will not be sufficient for many women exposed to Zika during pregnancy. For those unwilling to take any risk of fetal anomaly, termination of pregnancy (TOP) must be an available option. However, since the proportion of Zika-exposed pregnancies that will result in fetal anomaly is unknown, and it will be impossible in most cases to detect anomalies before birth, numerous women may end up deciding to terminate an unaffected pregnancy.

The CDC and WHO have published guidelines on testing for possible Zika exposure among pregnant women (2)(7), as well as monitoring of those who test positive for Zika infection, but without any accompanying recommendations on subsequent interventions or choices, including the discussion and availability of TOP. Moreover, neither organization has included contingency plans for women who lack the ability to access or afford medical care in accordance with the testing protocols, which include laboratory tests and serial ultrasounds.

The decision about whether or not to end a pregnancy in light of confirmed or possible Zika infection is no doubt a very personal one. But personal choices become issues of public policy when the ability to choose a particular option is foreclosed, either through the lack of a legal right or the lack of ability to exercise that right. In most Latin-American countries, TOP is illegal or is available only under very highly restrictive circumstances (8). In the United States, while the right to choose TOP exists, the practice of that right depends on socioeconomic circumstances and geographical location. In many of the states expected to be hardest hit by Zika, including Alabama, Arizona, Florida, Louisiana, Mississippi, and

Texas, a surge of laws restricting access to TOP by forcing clinics to close and women to travel long distances and negotiate waiting periods mean that many women are effectively unable to choose TOP (9). Moreover, recent convergence of the politics of abortion and contraception has meant that contraceptive access in many of these states has also been devastated by budget cuts and diversion of funds away from dedicated family-planning providers (10). For many women living in Latin America and the Southern United States, the WHO guidance on delaying pregnancy is difficult to follow before conception and impossible once conception has occurred.

While Zika exposure is clearly not the only reason why women in Latin America and the United States require access to TOP, it brings the issue of reproductive rights in the midst of a public health crisis sharply into focus. Experiences in Latin-American countries have shown that there is both a need for clear information and a demand for TOP that is not currently met by healthcare systems. Our recent study indicates that requests for medical TOP through Women on Web, an online telemedicine service providing mifepristone and misoprostol to women in countries where safe, legal, TOP is not available, have increased by 36–108% since the Pan-American Health Organization (PAHO) issued an epidemiological alert regarding Zika virus (11). Many of the women seeking help were terrified of the risks Zika virus might pose, yet had no ability to pay for testing and no safe, legal option for ending their pregnancy through their own healthcare systems. The lesson from Latin America is clear: issuing to women advice that they cannot implement is not only unjust but also precipitates fear and anxiety.

Failure to include guidelines on the option of safe, legal TOP in Zika-response strategies is not only an issue of reproductive rights but also an issue of reproductive justice. The same women who are disproportionately affected by unintended pregnancy, including women living in financial hardship and women of color, are also the least able to choose TOP due to the cost of travel to a clinic and time away from work and childcare. They are also likely to be at highest risk of contracting Zika, since poor living conditions play an important role in the risk of exposure to mosquitos. Ironically, they are also the least able to access the recommended care pathways for testing and monitoring of possible infection during pregnancy due lack of health insurance coverage or ability to pay, or in the United States, lack of eligibility due to undocumented status.

WHO mathematical projections forecast a further 3–4 million Zika cases across the Americas in the next year, and there is also potential for the virus to spread to other regions where access to safe, legal, TOP is restricted, including Southeast Asia and Sub-Saharan Africa. The WHO Regional Office for Europe forecasts a high risk of Zika outbreak in Madeira, and a moderately high risk in Italy, Turkey, and Malta (12). In Madeira, Italy, and Turkey, TOP is legal but often very difficult to obtain due to high numbers of healthcare professionals who refuse to care for women requesting TOP. In Malta, TOP is illegal under all circumstances. With such high stakes, those with the power to make public health policy that places women in control of their own reproductive decisions must not ignore the elephant in the room any longer. Official Zika strategy must include safe, legal, accessible reproductive choices. To do otherwise is irresponsible public-health practice and unjust policy.

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