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## Commentary

## Zika: A Missed Opportunity to Protect Women's Health and Prevent Unwanted Pregnancies

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The Zika virus, related to dengue, yellow fever, and the West Nile and Japanese encephalitis viruses, has spread rapidly in the Americas (Derraik & Slaney, 2015; Lazear & Diamond, 2016; Petersen et al., 2016) and authorities have speculated that the U.S. health care system will see multiple patients with this infection (Gold & Josephson, 2016). Public health warnings about a Zika epidemic in this country have focused on repellent and insecticide use, avoidance of sexual transmission by using condoms, and what to do if a woman is pregnant and may become or is already infected. Unfortunately, there is limited information about options for pregnancy prevention or a frank discussion about the ongoing failure to prioritize women's health through policies, information, and resources aimed at protecting their right to decide if and when to become pregnant or carry a pregnancy to term. Within the context of Zika, these failures are exacerbated by the potentially severe consequences of Zika-infected pregnancies, leaving women, infants, and families vulnerable to long-term health, medical, and economic hardships.

### The Zika Potential

Since its most recent large outbreak in Latin America and the Caribbean, the Zika virus has been linked to pregnancy loss, intrauterine growth restriction, eye defects, congenital microcephaly, and brain abnormalities (Brasil et al., 2016; Meaney-Delman et al., 2016; Rasmussen, Jamieson, Honein, & Petersen, 2016) through congenital transmission in women who become infected while pregnant. The virus is spread through the bite of an *Aedes aegypti* or *Aedes albopictus* mosquito (Centers for Disease Control and Prevention, 2016a) and may also be spread through sexual contact (Brooks et al., 2016). As of late September

2016, more than 22,000 cases have been confirmed in Puerto Rico, with 1,490 reported pregnant cases. In the continental United States, more than 3,500 imported cases (those infected during travel outside of the country) have been confirmed, including 808 Zika-infected pregnant women, 21 live births with birth defects and 5 spontaneous abortions of fetuses' with birth defects (Centers for Disease Control and Prevention, 2016b). As the area of Zika transmission continues to expand throughout the country, an increasing number of women and their partners may be exposed.

The Centers for Disease Control and Prevention Zika prevention efforts include mosquito surveillance and control, promoting mosquito repellent use and extra clothing coverage, targeted education about Zika virus and condom use or abstinence for anyone who is not pregnant or trying to get pregnant to avoid sexually transmitted infection, and guidance for providers on contraceptive counseling to reduce unintended pregnancy (Centers for Disease Control and Prevention, 2016c). The latter would require providing information about effective contraception and removing the considerable barriers to access and contraceptive method availability that remain among women of reproductive age (Boulet et al., 2016).

Glaringly absent is a frank discussion about the ongoing failure to prioritize women's capacity to prevent Zika-affected pregnancies. The focus has been on pregnant women, neglecting policies, information, and resources aimed at protecting women's right to decide if and when to become pregnant or carry a pregnancy to term. Ensuring that women have the ability to prevent an unwanted pregnancy, obtain safe and legal abortion care, or deliver and raise a child is a matter of public health and human rights that is highlighted by the Zika threat (Dreweke, 2016).

### Reproductive Health in the Zika Context

Nearly one-half (45%) of all pregnancies in the United States are unintended (i.e., one in which the pregnancy was either

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mistimed or unwanted), with little change over the last 30 years (Finer & Zolna, 2016). Data suggest that low-income women and racial/ethnic minority women face disproportionate barriers in access to reproductive health care and have fewer contraceptive options (Hall, Moreau, & Trussell, 2012; Johnson, Call, & Blewett, 2010; Krieger et al., 2003). The consequences of constrained choices are reflected in stark and persistent disparities across a range of reproductive health outcomes. For example, women of color have higher rates of teen and unintended pregnancy compared with non-Hispanic Whites across all income levels (Finer & Zolna, 2016; Ngui, Greer, Bridgewater, Salm Ward, & Cisler, 2016). Further, non-Hispanic Black women have a persistent reproductive disadvantage relative to Whites across virtually every indicator: they experience a 1.5 times increased risk for preterm delivery; a two-fold increased risk for infant mortality, low birth weight, and small-for gestational age infants; and a maternal mortality ratio of more than three times that of Whites. These disparities are attenuated, but not explained entirely by socioeconomic factors (Creanga et al., 2015; Hamilton, Martin, Osterman, Curtin, & Matthews, 2015; Walker & Chesnut, 2010).

States most likely to experience the largest impact of Zika are southern and gulf coast states where mosquitos that can carry the virus are common (Centers for Disease Control and Prevention, 2016c) and 59 cases of Zika have already been identified. Concurrently, these states are home to large populations of women living in poverty, women of color, and some of the worst reproductive health rankings in the country. Florida, Georgia, Mississippi, Louisiana, and Texas have some of the highest rates of unintended pregnancy and lack of health insurance among women of reproductive age (Guttmacher Institute, 2016), as well as some of the most restrictive abortion climates in the country (Hess et al., 2015). Furthermore, there are a large number of women who travel to the Caribbean and other Zika-infested areas. With so many women vulnerable to Zika infection, the serious adverse health and economic consequences of exposure during pregnancy are, therefore, likely to be greatest among women who lack the resources and/or access to obtain effective contraception, safe and legal abortion, regular medical care, or the resources and support necessary to raise an infant with microcephaly (Dreweke, 2016). As a result, already vast reproductive health disparities within the region will only intensify, as evidenced by the Zika crisis unfolding in Latin America and the Caribbean (Roa, 2016).

The context of Zika preparedness exposes these challenges as an unacceptable failure to prioritize women's health and bring to light the potentially severe consequences borne by women and communities across the country. With the removal of financial and eligibility barriers with passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and coverage of all Food and Drug Administration-approved contraceptive methods at zero cost (Bearak, Finer, Jerman, & Kavanaugh, 2016; Sonfield, 2013), increased access to highly effective, long-acting reversible contraception (LARC) should afford all women a more equitable range of contraceptive choice. LARCs—namely intrauterine devices and implants—are more effective than non-LARCs, such as the pill, patch, ring, diaphragm, and condoms, in reducing the risk of unintended pregnancies. Less than 1% of LARC users per year will experience an unintended pregnancy, compared with 6% to 28% of non-LARC users (American College of Obstetricians Gynecologists, 2015; Centers for Disease Control and Prevention, 2011; Guttmacher Institute, 2015; Trussell, 2011). Yet widespread messaging, education, and adoption of approved LARCs has been minimal.

Although LARCs are highly efficacious and are highly tolerable by women (low discontinuation rates and high satisfaction rates), they are used by less than 12% of contraceptive users nationwide (Daniels, Daugherty, Jones, & Mosher, 2015; Guttmacher Institute, 2015). Moreover, despite the ACA's provisions to ensure all contraceptive methods—including LARCs—be covered by private health plans, subsequent Supreme Court rulings allowed for religious exemptions by closely held corporations, and nationwide 13% of women continue to cost share (Bearak et al., 2016). Recommendations to improve access and availability to LARCs among all women include state- and jurisdictional-level strategies, such as provider reimbursement for the full range of contraceptive services, removal of logistic and administrative barriers for contraceptive services and supplies, training of providers on LARC insertion and removal techniques, and supporting youth-friendly reproductive services (Auerbach, 2016; Boulet et al., 2016; Gavin et al., 2014; Hathaway, Torres, Vollett-Krech, & Wohltjen, 2014).

Expansion of state Medicaid eligibility for family planning services to individuals who would otherwise not be eligible is also paramount and is shown to be effective. Nationally, the \$1.6 billion in public funds from Medicaid spent on contraceptive services in 2010 saved Medicaid \$9.2 billion public dollars that would have been spent on the cost of unintended births—a net savings of \$7.6 billion (Frost, 2013). Publicly funded family planning services helped women in the United States avoid 1.5 million unintended pregnancies in 2012, preventing 741,000 unintended births and 510,000 abortions (Frost, 2014).

### The Zika Opportunity

Long-standing and ongoing politically and ideologically driven legislation and judicial actions in states across the country have resulted in increased restrictions on reproductive rights in recent years (NARAL - Pro-Choice America Foundation, 2015). These include regulations dictating the circumstances under which women may obtain effective contraception, safe and legal abortion, infertility treatment, and the comprehensive sexual education necessary to make informed decisions about their own bodies (Hess et al., 2015; Wright, Bird, & Frost, 2015). The months-long delay in appropriating more than \$1 billion to fight Zika by a Congress embattled over provisions to defund Planned Parenthood highlights the nation's ongoing hostility around issues of women's reproductive health and rights (Dreweke, 2016). The needs of women of reproductive age present unique public health and medical challenges during an emergency (Zotti, Ellington, & Perez, 2016). But the Zika virus outbreak—declared a Public Health Emergency of International Concern (Fauci & Morens, 2016)—need not be a crisis. It presents an unprecedented opportunity to shift public health policy, legislation, and programming to bolster and support the rights of all women to achieve the highest attainable standard of health and well-being now and for the future.

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