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Zika, Feminism, and the Failures of Health Policy

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Abstract

The Zika epidemic caused serious concerns about fetal health throughout Latin America and some southern states in the United States. The prevailing governmental response throughout the region continues to emphasize two disease control factors: pregnancy delay and mosquito abatement. This essay argues that the current health policy approach of the World Health Organization, the Centers for Disease Control, and various national governments fails in three primary ways. First, the approach does not adequately consider the intersection of gender and poverty; thus, the current policy fails to respond to the needs of women living in poverty. Second, the health policy response fails to consider the impact of gender-based violence in its efforts to control the epidemic. The recommendation to delay pregnancy, for example, fails to account for the widespread incidence of intimate partner violence in the region. A high rate of sexual violence in intimate partnerships makes the policy less effective, because some women will be impregnated as a direct result of intimate partner violence and others will be unable to negotiate for safe sex for the same reason. Third, the policy response fails to address the broader question of access to contraception and abortion in the region. Two decades of research concerning the connections between gender and HIV/AIDS transmission have taught policymakers a great deal about the need to carefully consider gender in the design and implementation of a public

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health response. Those lessons, however, have not translated to the Zika context and, unfortunately, the myopic public health response will leave women and their children increasingly vulnerable to Zika infection.

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I. Introduction

The Zika virus became a frightening public health crisis in 2016. Although the disease seemed to catch the public health world by surprise, the mosquito-borne virus has been around since 1942 when it was discovered in Uganda.[1] Scientists detected the first cases of Zika in humans in 1952, and outbreaks of Zika have occurred in Africa, Southeast Asia, and the Pacific Islands.[2]

1. *See* Dina Fine Maron, *How Zika Spiraled Out of Control*, SCI. AM. (May 24, 2016), http://www.scientificamerican.com/article/how-zika-spiraled-out-of-control1/ (last visited Apr. 4, 2017) (describing the origins of the virus) (on file with the Washington and Lee Law Review).

2. *Id.*; *The History of Zika Virus*, WORLD HEALTH ORG. (2016), http://www.who.int/emergencies/zika-virus/timeline/en/ (last visited Apr. 4, 2017) (on file with the Washington and Lee Law Review).

Previous outbreaks, however, have been small and have raised only mild concern.[3] Justin Lessler, Associate Professor of Epidemiology at the Bloomberg School, noted, "Despite knowing about this disease for nearly 70 years, we were completely surprised and rushing to discover the very basic things about it when it invaded the Americas . . . . We have been completely unable to stop its spread."[4] Since 2015, Zika has spread to more than forty countries, and scientists have linked it to severe birth defects in infants, including microcephaly.[5]

Microcephaly is a condition in which a baby's head is smaller than expected.[6] Severe microcephaly is characterized by an infant head size that is much smaller than average.[7] Usually, this much smaller head size is the result of the baby's brain not developing properly during pregnancy.[8] Severe microcephaly can be life-threatening, and microcephaly has been associated with other conditions including seizures, developmental delay, intellectual disability, and problems with movement and balance.[9] In addition to microcephaly, the Zika virus can cause neurological problems, mental health disabilities, vision loss, and hearing loss.[10]

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3. *See The History of Zika Virus*, *supra* note 2 (noting that scientists first found strains of Zika virus in monkeys in 1947).

4. *New Control Strategies Needed for Zika and Other Unexpected Mosquito-Borne Outbreaks*, JOHNS HOPKINS BLOOMBERG SCH. (July 14, 2016), http://www.jhsph.edu/news/news-releases/2016/new-control-strategies-needed-for-zika-and-other-unexpected-mosquito-borne-outbreaks.html (last visited Apr. 4, 2017) (on file with the Washington and Lee Law Review).

5. *See Zika Virus Causes Birth Defects, Health Officials Confirm*, N.Y. TIMES (April 14, 2016), http://www.nytimes.com/2016/04/14/health/zika-virus-causes-birth-defects-cdc.html?_r=0 (last visited Apr. 4, 2017) ("Officials at the Centers for Disease Control and Prevention said on Wednesday that there was now enough evidence to definitively say that the Zika virus could cause unusually small heads and brain damage in infants born to infected mothers.") (on file with the Washington and Lee Law Review).

6. *See Facts About Microcephaly*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/ncbddd/birthdefects/microcephaly.html (last updated July 25, 2016) (last visited Apr. 4, 2017) (on file with the Washington and Lee Law Review).

7. *See id.* (describing the symptoms of severe microcephaly).

8. *See id.* (observing the link between small head size and abnormal brain development).

9. *See id.* (listing the potential health problems associated with microcephaly).

10. *See* James G. Hodge, Jr. et al., *Zika Virus and Global Implications for*

Public health experts observe that the Zika virus has had a devastating impact on public health in large parts of Latin America.[11] Because of the virus's impact on infant morbidity rates, the World Health Organization (WHO) declared Zika to be an international public health emergency on February 1, 2016.[12] The WHO rescinded that designation on November 18, 2016, although officials indicated that the change did not reflect a diminution in the importance of the outbreak.[13] WHO estimates that "potentially 4 million people in the Americas may become infected in 2016."[14] The virus has already infected large numbers of people in Brazil, Colombia, French Guiana, Guatemala, Venezuela, and many other countries in the region.[15] Experts report that there have been over 1.5 million cases in Brazil alone.[16] Puerto Rico has also experienced an alarming number of reported cases.[17] The U.S.-based Centers for Disease Control (CDC) now estimates that the disease will also dramatically affect parts of the southern United States.[18] Some reports suggest

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Reproductive Reforms, DISASTER MED. & PUB. HEALTH 2 (2016) (noting these potential health impacts of the virus in light of its rapid spread in Latin America).

11. *See id.* (noting the current statistics regarding Zika infections and WHO's prediction about the spread of Zika in 2016).

12. *Id.*

13. Lena H. Sun, *WHO No Longer Considers Zika a Global Health Emergency*, WASH. POST (Nov. 18, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/11/18/who-no-longer-considers-zika-a-global-health-emergency-2/?utm_term=.228444b2bc21 (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

14. Hodge et al., *supra* note 10, at 1.

15. PAN AMERICAN HEALTH ORGANIZATION, ZIKA CASES AND CONGENITAL SYNDROME ASSOCIATED WITH ZIKA VIRUS REPORTED BY COUNTRIES AND TERRITORIES IN THE AMERICAS, 2015–2016: CUMULATIVE CASES (Sept. 1, 2016), http://www.paho.org/hq/index.php?option=com_docman&task=doc_view&Itemid=270&gid=36012&lang=en (summarizing suspected and confirmed cases of Zika virus and infants born with symptoms of microcephaly).

16. Hodge et al., *supra* note 10, at 1.

17. *See Nearly 20,000 Zika Cases Reported in Puerto Rico*, U.S. NEWS (Sept. 16, 2016, 2:45 PM), http://www.usnews.com/news/news/articles/2016-09-16/nearly-20-000-zika-cases-reported-in-puerto-rico (last visited Apr. 5, 2017) (observing an additional 2,000 reported cases of Zika virus infection in Puerto Rico, bringing the state's total to almost 20,000 cases) (on file with the Washington and Lee Law Review).

18. *See Potential Range in US*, CTRS. FOR DISEASE CONTROL & PREVENTION (2016), http://www.cdc.gov/zika/vector/range.html (last visited Apr. 5, 2017)

that the disease has reached its peak in a few of the most affected countries and new cases appear to be declining in those countries.[19]

Although the infection causes only mild, flu-like symptoms in most healthy adults, it has recently been proven to be the cause of significant birth defects when a pregnant woman becomes infected during pregnancy.[20] Infection during pregnancy can be caused by the bite of an infected mosquito or through sexual intercourse with an infected male partner.[21] Because many of the severe complications and related health problems are limited to pregnant women who transmit the virus to a fetus *in utero*,[22] recommendations from public health officials and state representatives have focused on advising women to delay pregnancy.[23]

In late 2015, health officials in Brazil warned women to delay pregnancy until the virus was contained.[24] In January 2016, the

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(illustrating on maps of the United States the possible reach of mosquitoes carrying Zika) (on file with the Washington and Lee Law Review).

19. Nick Miroff, *Spread of Zika Virus Appears to be Slowing in Parts of Latin America*, WASH. POST (Mar. 31, 2016), https://www.washingtonpost.com/world/the_americas/spread-of-zika-virus-appears-to-be-slowing-in-parts-of-latin-america/2016/03/31/9cbb4fc2-f5c2-11e5-958d-d038dac6e718_story.html (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

20. *CDC Concludes Zika Causes Microcephaly and Other Birth Defects*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 13, 2016), https://www.cdc.gov/media/releases/2016/s0413-zika-microcephaly.html (last visited Apr. 5, 2017) (noting with definitiveness the causal relationship between the virus and severe fetal brain defects) (on file with the Washington and Lee Law Review).

21. *Zika Virus: Transmission & Risks*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/zika/transmission/ (last updated Oct. 24, 2016) (last visited Apr. 5, 2017) (describing the possible methods of transmission, including mosquito bite, mother-to-child, sexual intercourse, and blood transfusion) (on file with the Washington and Lee Law Review).

22. Maggie Fox, *How Can Zika Kill You? Your Questions Answered*, NBC (Apr. 29, 2016 7:26 PM), http://www.nbcnews.com/storyline/zika-virus-outbreak/how-can-zika-kill-you-your-questions-answered-n565111 (last visited Apr. 5, 2017) (outlining the potential outcomes of Zika infection and stressing the seriousness of birth defects) (on file with the Washington and Lee Law Review).

23. *See infra* notes 24–26 and accompanying text (providing examples of countries recommending that women delay pregnancies).

24. *See* Shasta Darlington, *Brazil Warns Against Pregnancy Due to Spreading Virus*, CNN (Dec. 24, 2015 6:16 AM),

governments of Colombia and Ecuador followed suit and recommended that women in those countries delay pregnancy between six to eight months.[25] Government representatives in El Salvador have recommended that women avoid pregnancy until 2018.[26]

One medical official in the CDC's reproductive health division, Dr. Denise J. Jamieson, feels that the "delay pregnancy" advice is unnecessary because "most women will have healthy babies" even during an epidemic.[27] She argues that "highly motivated women can take measures to avoid mosquito bites."[28] But this advice, unfortunately, also fails to reflect reality for a large number of women in Zika-affected countries. Dr. Jamieson's observation is based on a hypothetical middle to upper-income woman who is not only "highly motivated" but who has the financial means to actualize that motivation. Women living in poor neighborhoods, who lack air conditioning, suffer from broken or no screens on their windows, and live in areas of abundant standing water,[29] may be highly motivated and yet unable to

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http://www.cnn.com/2015/12/23/health/brazil-zika-pregnancy-warning/ (last visited Apr. 5, 2017) (discussing Brazil's advice to delay pregnancy as suspected cases of microcephaly soared) (on file with the Washington and Lee Law Review).

25. *See* Hodge et al., *supra* note 10, at 1 (listing several countries affected by Zika Virus); AFP, *Zika Virus: Women in Colombia, Ecuador and El Salvador Advised to Postpone Pregnancy*, TELEGRAPH (Jan. 23, 2016 2:36 AM), http://www.telegraph.co.uk/news/health/news/12116858/Zika-virus-women-in-Colombia-Ecuador-and-El-Salvador-advised-to-postpone-pregnancy.html (last visited Apr. 5, 2017) (noting the countries of concern, including Ecuador, Colombia, and El Salvador) (on file with the Washington and Lee Law Review).

26. *See* Azam Ahmed, *El Salvador's Advice on Zika Virus: Don't Have Babies*, N.Y. TIMES (Jan. 25, 2016), http://www.nytimes.com/2016/01/26/world/americas/el-salvadors-advice-on-zika-dont-have-babies.html (last visited Apr. 5, 2017) (discussing El Salvador's advice that women stop having children for two years and noting the practical challenges associated with that recommendation) (on file with the Washington and Lee Law Review).

27. Donald G. McNeil, Jr., *Health Officials Split Over Advice on Pregnancy in Zika Areas,* N.Y. TIMES (April 14, 2016), http://www.nytimes.com/2016/04/15/health/zika-virus-pregnancy-delay-birth-defects-cdc.html (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

28. *Id.*

29. *See* Lulu Garcia-Navarro, *Is the Risk of Catching Zika Greater in Poor Neighborhoods?*, NPR (June 16, 2016),

escape infection. The observation fails to consider how the intersection of gender and poverty may constrain women's agency in the prevention of infection, even among "highly motivated" women.

A group of public health experts surveyed by the New York Times reported that the Zika response's "greatest failure was that while tourists were warned away from epidemic areas, tens of millions of women living in them—many of them poor slum dwellers—were left unprotected."[30] In addition, the group of public health experts lamented the overwhelming focus on transmission of Zika through mosquito bites, often to the exclusion of sexual transmission.[31] The New York Times reports:

> Most countries did not focus enough on preventing sexual transmission, experts said. Even New York City, which has a respected health department, filled its subways with posters showing big mosquitos. Yet not one of the nearly 1000 cases diagnosed there by year's end was transmitted by a local mosquito; all were either picked up elsewhere or transmitted sexually.[32]

Although the recommendation to delay pregnancy may, in fact, be sound medical advice for individual women, the strategy is likely to be ineffective as a large-scale public health strategy. There are many reasons that the strategy of delaying pregnancy will not likely succeed on a large scale. The strategy assumes that women are in a position to negotiate the timing and spacing of their pregnancies. Some women certainly can control the timing of pregnancy, but many others face significant power disparities in their intimate relationships. The imbalance of power often means that women lack the negotiating power and relational autonomy to determine how, when, and whether to have sex. As a result, a public health strategy that is premised on women's

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http://www.npr.org/sections/goatsandsoda/2016/06/16/482345540/is-the-risk-of-catching-zika-greater-in-poor-neighborhoods (last visited Apr. 5, 2017) (describing the connections between poverty and higher risks of Zika infection) (on file with the Washington and Lee Law Review).

30. Donald G. McNeil, Jr., *How the Zika Response Failed Millions,* N.Y. TIMES (January 16, 2017), https://www.nytimes.com/2017/01/16/health/zika-virus-response.html (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

31. *Id.*

32. *Id.*

unhindered exercise of control and discretion in planning pregnancies will likely be ineffective and detrimental to women.

Dr. Peter J. Hotez, the Dean of the National School of Tropical Medicine at Baylor College of Medicine, describes the advice to delay pregnancy: "It's a no-brainer. . . . They should say, 'Don't get pregnant—watch TV for six months and you won't have a badly hurt baby.'"[33] This observation ignores the reality that many women are unable to simply avoid sexual intercourse or otherwise control whether or when to have a child. Unequal power disparities in many intimate partnerships render this advice meaningless for these women. Even women highly motivated—and able—to avoid mosquito bites in countries with high rates of Zika may not be able to avoid pregnancy or exposure to the virus.[34]

For those women who become infected by the Zika virus while pregnant, many will decide to carry their fetuses to term, particularly in predominantly Catholic countries in which there is widespread opposition to abortion. Some women, however, will elect to terminate those pregnancies, whether or not they live in countries that allow for abortion under these circumstances. For women in countries that prohibit abortion even in cases involving severe health complications of the fetus, some women have already turned—and will continue to turn—to unsafe, illegal abortions.[35] Unsafe abortion has a significant effect on maternal mortality rates. For example, in 2014, unsafe abortions resulted in 10% of all maternal deaths throughout the Latin American and Caribbean region.[36] Unsafe abortion and its associated health

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33. McNeil, Jr., *supra* note 27.

34. *See* Ann Neumann, *WHO Advice that Woman at Zika Risk Delay Pregnancy Isn't an Abortion Debate*, GUARDIAN (June 14, 2016 7:00 AM), https://www.theguardian.com/commentisfree/2016/jun/14/who-advisory-women-zika-virus-risk-delay-pregnancy (last visited Apr. 5, 2017) ("More than half of all global pregnancies are unintended . . . .") (on file with the Washington and Lee Law Review).

35. *See generally* John M. Paxman, Alberto Rizo, Laura Brown, & Janie Benson, *The Clandestine Epidemic: The Practice of Unsafe Abortion in Latin America*, 24 STUD. FAM. PLANNING 205 (1993).

36. *See* Hodge et al., *supra* note 10, at 2 (noting the statistical significance of the spreading Zika virus).

risks primarily affect poor women, indigenous women, and women of color.[37]

The public health advisory to delay pregnancy will also stigmatize poor women who deliver sick babies. The reproductive lives of poor women and women of color have always been the subject of moral judgment and directed decision-making by the medical profession.[38] In cases of poor and otherwise marginalized women, doctors have historically justified substituting their own judgment for that of the patient.[39] In the context of Zika, the likely social narrative will applaud privileged women who decide to undertake the difficult task of raising a child with severe disabilities, ignore the privileged women who access expensive, illegal abortion, and stigmatize poor women who either choose to deliver potentially microcephalic infants or who were unable to access safe abortion after a diagnosis. In the context of limited use and availability of contraceptives, high rates of intimate partner violence, and limited access to abortion, the public health advisory to delay pregnancy sets marginalized women up for public judgment and stigmatization.

This essay argues for an appropriate state response to the Zika crisis, one that reflects the reality of women's intimate partner relationships and the gendered power imbalance that is often reflected in those relationships. The essay also calls on states to re-evaluate restrictive abortion policies and to increase access to contraceptives as part of the public health response to the Zika crisis. In Part Two, intersectionality theory provides a framework for analyzing the ways in which the state response has been limited to date. This section explores the ways in which

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37. *See generally* Christine Dehlendorf, Lisa H. Harris & Tracy A. Weitz, *Disparities in Abortion Rates: A Public Health Approach*, 103 AM. J. PUB. HEALTH 1772 (2013) (providing an overview of the inequalities that exist among women seeking abortions).

38. *See generally* RICKIE SOLINGER, PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA (2005) (discussing the role of race and poverty in policies governing reproductive rights throughout U.S. history).

39. Lisa Ko, *Unwanted Sterilization and Eugenics Programs in the United States*, PBS (Jan. 29, 2016), http://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/ (last visited Apr. 5, 2017) (describing how forced sterilization was used to limit pregnancies in low income, disabled, mentally ill, and criminal populations, as well as people of color) (on file with the Washington and Lee Law Review).

gender and poverty intersect to increase the vulnerability of some women and privilege others in the transmission and treatment of disease. Part Three of the essay discusses the effects of gender power disparities and intimate partner violence on Zika transmission, surveying the landscape of reproductive rights in regions that were hit hardest by Zika. It suggests that public health organizations should apply lessons taken from HIV infection and prevention to the Zika epidemic. In Part Four, the essay explores the limited reproductive choices available to women in countries significantly affected by Zika. Part Five examines international human rights law as a vehicle for the promotion of women's reproductive rights in the context of the global fight against the Zika virus. It discusses women's rights to health, to abortion access, and to freedom from gender-based violence.

II. Zika at the Intersection of Gender and Poverty

The expert institutional advice to delay pregnancy to avoid the risks of fetal Zika infection and microcephaly does not account for intersectionality. This section considers the approach taken by the WHO and CDC. It reflects upon poor women's lack of access to health care or access to low quality health care, then examines several examples of intersectional issues related to women's reproductive rights and health in Latin America and the southern United States. It concludes that economics, in addition to the myriad other factors affecting individual women, plays a significant role in the Zika infection and treatment for pregnant woman.

To date, the WHO and CDC messages have had a decidedly essentialist tone.[40] In other words, "women" are reduced to a monolithic category of human beings with reproductive capacity. The WHO/CDC message, which implies that "if you have a uterus, you should heed the Zika warning to avoid pregnancy,"

40. *See, e.g.*, *Women Trying to Become Pregnant*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/zika/pregnancy/women-and-their-partners.html (last updated Oct. 3, 2016) (last visited Apr. 5, 2017) (providing general suggested guidelines for delaying pregnancy after exposure to the Zika virus) (on file with the Washington and Lee Law Review).

reduces women to the essential characteristics of reproductive capacity. It fails to consider the ways in which multiple systems of oppression intersect and affect different groups of women differently. In the case of Zika, multiple factors such as age, level of poverty, race, existence of intimate partner violence, and sexual orientation intersect to determine whether and how the Zika epidemic affects different groups of women.[41]

According to the UN Development Programme (UNDP), reproductive health care systems are one of the primary factors in sustaining gender inequality across the globe.[42] Unequal access to health care undermines not only gender equality but also equality based on race, ethnicity, and class.[43] These forms of structural inequality are often built into the design of health care systems and serve as systemic impediments to universal access to health care.[44] Although there has been an increasing global focus on universal access, inequalities persist and wealth continues to be a major determinant of access to health care.[45] The context of reproductive health care represents just one example of an intersection between poverty and gender inequality.

An intersectional approach to reproductive justice within the Latin American region is necessary to capture the ways in which sexism, racism, classism, and heterosexism—among others—work together to limit the enjoyment of sexual and reproductive rights to those who enjoy social privilege. Anthropology scholars

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41. *See infra* notes 42–45 and accompanying text (identifying the aspects of structural inequality that impact women and pregnancy).

42. *See* Jasmine Gideon, Marianna Leite & Gabriela Alvarez Minte, *What is Hindering Progress? The Marginalization of Women's Sexual and Reproductive Health and Rights in Brazil and Chile,* 31 J. INT'L & COMP. SOC. POL'Y 255, 255 (2015) (explaining how broad-based and historically constructed gender policy functions to limit positive outcomes in women's sexual and reproductive health in Brazil and Chile).

43. Ruqaiijah Yearby, *Breaking the Cycle of 'Unequal Treatment' with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1284 (2012) (highlighting the effects of continuing inequalities—particularly in relation to race—in health care policy).

44. *See generally* GITA SEN, PIROSKA OSTLIN & ASHA GEORGE, UNEQUAL, UNFAIR, INEFFECTIVE AND INEFFICIENT GENDER INEQUALITY IN HEALTH: WHY IT EXISTS AND HOW WE CAN CHANGE IT (2007), http://www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf.

45. Gideon et al., *supra* note 42, at 255.

Lynn Morgan and Elizabeth Roberts recognize, for example, the interplay between gender and poverty in the context of Brazilian adoption.[46] They suggest, "When Brazilian poverty is discursively associated with criminality, for example, moral regimes may be more supportive of the notion that children of poor families be sent abroad for adoption."[47]

Nationalism and sexism can also intersect in ways that affect women's fertility in the region. For example,

> Nicaraguan migrants who give birth in Costa Rican hospitals may be more likely than their Costa Rican counterparts to become candidates for tubal ligation, because of their perceived irrational reproduction, at a time when Costa Rican pundits inflame nationalist and pronatalist sentiments by making dire predictions about the consequences of Costa Rican fertility decline and the coming "demographic winter."[48]

When nationalism and paternalism intersect in the context of women's reproduction in this way, the result is powerful enough to overcome the general skepticism toward tubal ligation in a largely Catholic country such as Costa Rica.[49]

An intersectional approach to reproductive justice also sheds light on the circumstances surrounding the coerced sterilization of hundreds of thousands of indigenous women in Peru in the 1990s.[50] In this instance, discrimination based on indigeneity and gender combined, resulting in a targeted, secret campaign to prevent reproduction among indigenous Peruvian women.[51] Alberto Fujimori was the leader of Peru from 1990–2000, when the mass sterilizations occurred.[52] Interestingly, when Alejandro

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46. *See* Lynn M. Morgan & Elizabeth F.S. Roberts, *Reproductive Governance in Latin America,* 19 ANTHROPOLOGY & MED. 241, 242 (2012) (considering "shifting political rationalities" related to populations and reproduction through the lens of government actions).

47. *Id.*

48. *Id.*

49. *See id.* (suggesting that countries may "recast as defensible and even rational" certain policies given a sufficient moral basis).

50. *See id.* at 246 (providing a summary of the events sanctioned by the Peruvian government).

51. *Id.*

52. *See generally* Jo-Marie Burt, *Guilty as Charged: The Trial of Former Peruvian President Alberto Fujimori for Human Rights Violations*, 3 INT'L J. TRANSITIONAL JUST. 384 (describing the crimes committed under the former

Toledo was elected in 2001, after domestic and international outrage over the sterilizations had surfaced, Toledo's new administration worked to recognize and bolster collective rights claims based on indigeneity.[53] Toledo's administration, however, simultaneously worked to circumvent women's rights claims for reproductive justice outside the context of coerced sterilization.[54] Toledo's administration backed conservative efforts to limit access to contraception and post-abortion hospital care as well as to surveil all women's reproduction by requiring registration of pregnancies at conception.[55] Although he responded to public outrage concerning the coerced sterilization by recognizing indigenous sovereignty claims, he failed to sufficiently consider the broader gender implications of his reproductive policy-making.

In the fight against Zika within the southern United States, poor women and women of color will disproportionately feel the effects of the disease. Texas and Florida are particularly at risk; while the national rate of unintended pregnancy is 49%,[56] the percentage of unintended pregnancies in Florida is nearly 60%.[57] In Texas, women relying on community health centers for

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president's power).

53. *See* Morgan & Roberts, *supra* note 46, at 246 (noting Toledo's efforts to encourage state institutions to recognize rights claims based on "collective sovereignty" rather than individual citizenship).

54. *See* Anna-Britt Coe, *From Anti-Natalist to Ultra-Conservative: Restricting Reproductive Choice in Peru*, 12 HEALTH MATTERS 56, 66 (2004), http://hrlibrary.umn.edu/research/Peru-COE%20Antinatalist%20to%20ultraconservative%20restrictin%20reproductive%20choice.Coe.pdf (observing Toledo's delayed declaration regarding his government's position on reproductive rights and noting the limitations on those rights in Peru during Toledo's presidency).

55. *See* Morgan & Roberts, *supra* note 46, at 246 (drawing a connection between Toledo's policies of recognizing indigenous rights and requiring pregnancy-registration as indications of his advocacy for the "sanctity of life").

56. *Unintended Pregnancy Prevention*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/reproductivehealth/unintendedpregnancy/ (last updated Jan. 22, 2015) (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

57. Mike Stobbe, *When Zika Hits, a Push for Birth Control and Abortion?*, AP (May 11, 2016, 11:55 AM), http://bigstory.ap.org/article/67e2a68be7784e9d97f53c78990f003c/when-zika-hits-push-birth-control-and-abortion (last visited Apr. 5, 2017) (noting that nearly 60% of pregnancies in Florida are unintended) (on file with the Washington and Lee Law Review).

prenatal care often live in housing that lacks air conditioning or is otherwise easy for mosquitos to enter.[58] Poor women also have little money to spend on insect repellent or protective clothing.[59] Both Texas and Florida declined to expand Medicaid, a decision that some experts say will make it difficult to educate the public about Zika and its possible effects in pregnancy.[60] While Texas has dedicated two million dollars to a Zika awareness campaign,[61] Florida had not authorized specific funding for public education campaigns related to Zika as of mid-June 2016.[62] Neither state has addressed the problem of contraceptive access among poor women in the state.[63] Although the federal government has authorized the use of Medicaid dollars to fight Zika, Texas is still exploring the use of Medicaid in Zika prevention.[64] The CDC reports that, as of December 14, 2016, there were 4617 cases of Zika reported in the continental United States.[65]

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58. *See, e.g.*, Shefali Luthra, *Gaps in Women's Health Care May Derail Zika Prevention in Texas, Florida*, KAISER HEALTH NEWS (June 14, 2016), http://khn.org/news/gaps-in-womens-health-care-may-derail-zika-prevention-in-texas-florida/ (last visited Apr. 5, 2017) ("We're extremely concerned that health centers, because of the housing and conditions around the housing that our patients live in, are going to start seeing quite a few of the Zika patients . . . .") (on file with the Washington and Lee Law Review).

59. *Id.*

60. *See id.* (noting that many poor pregnant women fall into the "coverage gap," being "too poor for subsidies to buy insurance on the exchange but too wealthy for the low-income health insurance program").

61. *See* Rosie Newberry, *Texas Launches $2 Million Zika Awareness Campaign*, KXAN.COM, http://kxan.com/2016/06/22/texas-launches-2-million-zika-awareness-campaign/ (last updated June 22, 2016) (last visited Jan. 7, 2017) (discussing the awareness program and Zika's potential threat in Texas) (on file with the Washington and Lee Law Review).

62. *See* Luthra, *supra* note 58 (observing that Texas and Florida had launched some public health campaigns but highlighting the limited funding thus far dedicated to those campaigns).

63. *See id.* (identifying this issue in the context of the limited education and prevention efforts underway).

64. *See id.* ("The federal government has said states can use Medicaid dollars to help with Zika prevention, covering services from purchasing mosquito repellent to family planning.").

65. Lena H. Sun, *CDC Sends $184 Million in Zika Funding to States as Texas Reports New Case*, WASH. POST (Dec. 22, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/12/22/cdc-sends-nearly-200-million-in-zika-funding-to-states/?utm_term=.d79e3f8ffcda (last

An intersectional lens sheds light on the economic factors that increase certain women's susceptibility to infection. Economic insecurity affects potential Zika exposure in multiple ways. Poverty and potential infection intersect most directly in terms of quality of health care and housing, neighborhood susceptibility (including existence of standing water and other mosquito breeding grounds), and the ability to purchase repellants and protective clothing.[66] There are, however, indirect effects of poverty and economic insecurity on potential Zika infection. For example, poor women may increase the possibility of Zika transmission through commercial sex work.[67] Poor women who experience intimate partner violence may stay in violent relationships due to economic dependence, increasing the chances of transmission through sexual violence.[68] The next section will explore the effects of intimate partner power disparities and sexual transmission on the spread of Zika in Latin American countries.

III. Zika, Intimate Partner Violence, and Lessons from HIV Transmission

Latin American governments have primarily responded to the Zika crisis by advising women to delay pregnancy. The government of El Salvador, for example, has advised women to delay pregnancy until 2018.[69] Other well-meaning governments in the region have offered women of child-bearing age similar

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visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

66. *See supra* notes 58–59 and accompanying text (describing the conditions that exacerbate Zika).

67. *See* Jaime Lopez, *The Zika Virus and Sexual Tourism in San Jan, Costa Rica*, COSTA RICA STAR (Feb. 7, 2016), http://news.co.cr/the-zika-virus-and-sexual-tourism-in-san-jose-costa-rica/44515/ (last visited Apr. 5, 2017) (discussing the precautions being taken to prevent transmission of Zika in regions that experience significant sexual tourism) (on file with the Washington and Lee Law Review).

68. *See infra* Part III (exploring the cultural and economic factors that drive intimate partner violence).

69. Hodge et al., *supra* note 10, at 1.

guidance.[70] The WHO recently joined the chorus of advisors promoting the notion that women should delay pregnancy.[71]

The problem with this policy is that it assumes that women have decision-making authority about whether to have sexual intercourse in the first place and whether to use birth control to protect against unwanted pregnancy or transmission of disease. This public health strategy fails to adequately consider the power disparities between men and women that often exist in opposite-sex intimate partnerships. Power disparities within intimate partnerships often leave women unable to negotiate contraceptive use.[72] In cases of intimate partner violence, sex is often forced or coercive, leaving women with no ability to insist on safe sexual practices or contraceptive use.[73] The official guidance to delay pregnancy is, at best, ineffectual in the context of widespread violence against women.

Within the region, and throughout the world, large numbers of women suffer from gender-based violence. According to the Economic Commission for Latin America and the Caribbean (ECLAC), up to 40% of women in the region have been victims of violence.[74] Guatemala ranks third in the world for the murder of

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70. *See id.* (noting that the governments of Brazil, Colombia, and Ecuador had issued recommendations).

71. *See* Amanda Holpuch, *WHO Advises Women to Delay Pregnancy over Zika Virus Threat*, GUARDIAN (June 9, 2016, 4:55 PM), https://www.theguardian.com/world/2016/jun/09/zika-virus-pregnancy-world-health-organisation (last visited Apr. 5, 2017) ("The World Health Organisation has advised people living in regions where the Zika virus has spread to consider delaying pregnancy because of the severe birth defects that have been tied to the disease.") (on file with the Washington and Lee Law Review).

72. *See* N.M. Naylor, *"Cry the Beloved Continent . . ." Exploring the Impact of HIV/AIDS and Violence on Women's Reproductive and Sexual Rights in Southern Africa*, *in* THE REPRODUCTIVE RIGHTS READER: LAW, MEDICINE, AND THE CONSTRUCTION OF MOTHERHOOD 22 (Nancy Ehrenreich ed., 2008) ("The impact of violences on women's personal, sexual, social and reproductive life reduces their autonomy and destroys their sense of personal safety and quality of life.").

73. *See* Greta Friedemann-Sánchez & Rodrigo Lovatón, *Intimate Partner Violence in Colombia: Who Is at Risk?*, 91 SOC. FORCES 663, 664 (2012) (discussing the gender- and role-based power differentials that contribute to intimate partner violence).

74. Nadine Gasman & Gabriela Alvarez, *Gender: Violence Against Women*, AMS. Q., http://www.americasquarterly.org/node/1930 (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

women and girls.[75] Findings from the Demographic and Health Surveys Project in 2004 put the rate of spousal abuse in Colombia at 44% and the rate of physical violence against women in Peru at 47%.[76] The Pan American Health Organization (PAHO) reported a high rate of intimate partner violence within the region.[77] The rates of women who reported ever experiencing physical or sexual violence by an intimate partner ranged from a low of 17% in Haiti to a high of 53.3% in Bolivia.[78]

Most significantly, PAHO's 2013 study linked intimate partner violence with "significantly" higher rates of unintended and unwanted pregnancy.[79] According to PAHO, "In some countries, levels of unwanted pregnancy were two to three times higher among women who reported partner violence *ever* compared with women who did not."[80] The PAHO data also establish that large proportions of women who reported experiencing physical or sexual violence "lived in fear of additional violence, ranging from nearly one-third (32.5%) of women in Paraguay [in] 2008 to three-fourths (75.5%) of women in Bolivia [in] 2008."[81] Violence within intimate heterosexual partnerships often operates to secure unfettered sexual access to the female partner or spouse.[82] Violence and the corresponding fear virtually guarantee that there can be no meaningful negotiation over sex.[83] The dynamics of intimate partner violence

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75. Johanna Mendelson Forman & Carl Meacham, *In Latin America, Women Still Confront Violence*, CTR. FOR STRATEGIC & INT'L STUD. (Mar. 8, 2013), https://www.csis.org/analysis/latin-america-women-still-confront-violence (last visited Apr., 2017) (on file with the Washington and Lee Law Review).

76. Gasman & Alvarez, *supra* note 74.

77. SARAH BOTT ET AL., VIOLENCE AGAINST WOMEN IN LATIN AMERICA AND THE CARIBBEAN, A COMPARATIVE ANALYSIS OF POPULATION-BASED DATA FROM 12 COUNTRIES 6 (2013), http://apps.who.int/iris/bitstream/10665/173293/1/Violence%20Against%20Women.pdf.

78. *Id.*

79. *Id.* at xvii.

80. *Id.* at 45.

81. *Id.* at 56.

82. *See generally* Jamila K. Stockman, Marguerite B. Lucea & Jacquelyn C. Campbell, *Forced Sexual Initiation, Sexual Intimate Partner Violence, and HIV Risk in Women: A Global Review of the Literature*, 17 AIDS BEHAV. 832 (2013).

83. *See* Elizbeth Miller, Beth Jordan, Rebecca Levenson & Jay G. Silverman, *Reproductive Coercion: Connecting the Dots Between Partner*

and the operation of fear as a vehicle to secure male sexual access explain the correlation between intimate partner violence and high rates of unintended or unwanted pregnancies.[84]

Even when intimate partner violence is reported, it is often not prosecuted to the same extent as other crimes. For example, in Bolivia, which had the highest rate of domestic violence in South America as of 2011, there were 442,000 reports of gender-based violence between 2007–2011.[85] Of those reported cases, prosecutors have prosecuted only ninety-six.[86]

Many governments and international organizations have failed to craft a Zika response that reflects even a basic understanding of women's frequent disempowerment within domestic relationships. The proposed policies, largely involving safe sex and pregnancy avoidance,[87] do not reflect the lessons learned over a decade ago concerning the relationship between gender inequality and HIV/AIDS.[88] In 2004, UNAIDS launched the Global Coalition on Women and AIDS, which prompted greater awareness of the impact of HIV/AIDS on women.[89] This

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Violence and Unintended Pregnancy, ASSOC. OF REPROD. HEALTH PROFS. (June 2010), http://www.arhp.org/publications-and-resources/contraception-journal/june-2010 (last visited Apr. 5, 2017) (discussing the destructive affects of intimate partner violence in sexual relationships) (on file with the Washington and Lee Law Review).

84. *Id.*

85. Forman & Meacham, *supra* note 75.

86. *Id.*

87. *See supra* notes 24–26 and accompanying text (observing the recommendations of several Latin American countries to delay pregnancy for a period of months or years to avoid possible microcephaly).

88. *See* Naylor, *supra* note 72, at 22 (discussing the importance of recognizing the impacts of violence against women "in order to hold States accountable under relevant treaties and to ensure full enjoyment and protection of freedom, security and reproductive rights for women"). Naylor continues, "in the context of HIV/AIDS, the issue of sexual violence takes on even more alarming proportions since violations of women's rights and sexual violence against women fuel the epidemic." *Id.*; *see also* Geeta Rao Gupta, *How Men's Power over Women Fuels the HIV Epidemic: It Limits Women's Ability to Control Sexual Interactions*, 324 BRIT. MED. J. 183, 183 (2002) (summarizing the factors leading to the spread of HIV infection and concluding that "[t]o protect women from HIV infection we must find ways to empower them").

89. *See e.g.*, *About GWCA*, THE GLOBAL COALITION ON WOMEN AND AIDS, *available at* https://gcwa.unaids.org/about-gcwa (last visited May 21, 2017) (on file with the Washington and Lee Law Review).

and other research led to a better understanding of the ways in which intimate partner violence within heterosexual relationships creates a power dynamic in which the victim, most often a woman, cannot effectively negotiate for safe sex.[90] In other cases, intimate partner violence involves sexual violence, including rape, in which women cannot control contraceptive use.[91]

In coming to terms with the relationship between gender inequality and HIV infection, the WHO in 2004 recognized "[t]here is a growing recognition that women and girls' risk of and vulnerability to HIV infection is shaped by deep-rooted and pervasive gender inequalities—violence against them in particular."[92] The realization that there is a relationship between gender-based violence and HIV grew, in part, from disproportionate infection rates among girls and younger women. For example, in 2004, the WHO reported that in sub-Saharan Africa, young women between 15 and 24 years old "account[ed] for 75% of HIV infections and are approximately three times more likely to be infected than young men of the same age."[93] When this infection disparity surfaced, researchers began to investigate why women seemed to be more vulnerable to HIV infection, which ultimately led to the conclusion that gender inequality and gender-based violence played an important role in women's vulnerability to infection.[94]

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90. *See* Julie Pulerwitz, Annie Michaelis, Ravi Verma & Ellen Weiss, *Addressing Gender Dynamics and Engaging Men in HIV Programs: Lessons Learned from Horizons Research*, 125 PUB. H. REPS. 282, 283 (2010) ("Gender norms that put men in a position of sexual dominance also limit women's ability to control their own reproductive and sexual health.").

91. *See* Stockman et al., *supra* note 82 ("Violence and the threat of violence can impede women's ability to adequately protect themselves from HIV infection or assert healthy sexual decision-making.").

92. WORLD HEALTH ORGANIZATION & GLOBAL COALITION ON WOMEN & AIDS, VIOLENCE AGAINST WOMEN AND HIV/AIDS: CRITICAL INTERSECTIONS: INTIMATE PARTNER VIOLENCE AND HIV/AIDS 2 (2004) [hereinafter WHO, INTIMATE PARTNER VIOLENCE AND HIV/AIDS], http://www.who.int/hac/techguidance/pht/InfoBulletinIntimatePartnerViolenceFinal.pdf; *see also* Naylor, *supra* note 72, at 28–29 (noting that a 2001 UN Declaration of Commitment on HIV/AIDS stated that women and young girls were particularly vulnerable).

93. WHO, INTIMATE PARTNER VIOLENCE AND HIV/AIDS, *supra* note 92, at 1.

94. *See* Gupta, *supra* note 88, at 183 ("The most extreme manifestation of the unequal power balance between women and men is violence against

Researchers in Brazil and Colombia have recently reported similar disproportionate infection rates in Zika cases.[95] In Colombia, researchers have found far greater numbers of Zika cases among women than men, "with young women accounting for two-thirds of the 65,726 cases diagnosed by mid-April 2016."[96] These disproportionate infection rates contributed to the conclusion that Zika is, like HIV, sexually transmitted.[97] The CDC acknowledges that a number of cases of Zika infection in the United States occurred through sexual transmission.[98] On July 29, 2016, the CDC published interim guidelines on the prevention of Zika through sexual transmission.[99] The guidelines offer a clinical picture of transmission but fail to address, or even mention, women's vulnerability to sexual transmission as a result of gender-based violence.[100] Similarly, the WHO published an

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women.").

95. Laurie Garrett, *Could Zika Be the Next HIV?*, CNN (July 15, 2016), http://www.cnn.com/2016/07/15/opinions/zika-becoming-an-std-laurie-garrett/ (last visited Apr. 5, 2017) (on file with the Washington and Lee Law Review).

96. *See id.*

> Critics charge that both the Brazilian and Colombian studies may simply reflect the greater fear women have about exposure to Zika during pregnancy, prompting more of them to seek medical care. The researchers disagree, insisting that the higher rates of diagnosed Zika are seen in young women, whether or not they are pregnant or are trying to conceive.

97. Lisa Schnirring, *Zika Data Point to Sexual Transmission in Women*, CTR. FOR INFECTIOUS DISEASE RES. & POL. (May 27, 2016), http://www.cidrap.umn.edu/news-perspective/2016/05/zika-data-point-sexual-transmission-women (last visited Apr. 5, 2017) ("Women in the sexually active age-group are overwhelmingly whom likely than men to be infected with Zika virus, with sexual transmission the most likely cause . . . .") (on file with the Washington and Lee Law Review).

98. According to the CDC, as of July 20, 2016, fifteen of the Zika cases in the United States occurred through sexual transmission. John T. Brooks, Allison Friedman, Rachel E. Kachur, Michael LaFlam, Philip J. Peters & Denis J. Jamison, *Update: Interim Guidance for Prevention of Sexual Transmission of Zika Virus—United States, July 2016*, 65 MORBIDITY & MORTALITY WKLY. REP. 745, 745–47 (2016).

99. Brooks et al., *supra* note 98.

100. *Id.* The CDC's Interim Guidance, excerpted below, contains no reference to or acknowledgement of gender-based violence as a contributing factor to women's vulnerability to infection. The guidance states, in part:

> Men and women who want to reduce the risk for sexual transmission of Zika virus should use barrier methods against infection consistently and correctly during sex or abstain from sex when one

Interim Guidance on the sexual transmission of the Zika virus on June 7, 2016.[101] As is the case with the CDC Guidance, the WHO Guidance wholly fails to mention gender-based violence as a contributing or exacerbating factor in sexual transmission.[102] The

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> sex partner has traveled to or lives in an area with active Zika virus transmission. Based on expert opinion and on limited but evolving information about the sexual transmission of Zika virus, the recommended duration of consistent use of a barrier method against infection or abstinence from sex depends on whether the sex partner has confirmed infection or clinical illness consistent with Zika virus disease and whether the sex partner is male or female. The rationale for these time frames has been published previously.
>
> Couples who do not desire pregnancy should use available strategies to prevent unintended pregnancy and might consider multiple options, including (in addition to condoms, the only method that protects against both pregnancy and sexual transmission of Zika virus) use of the most effective contraceptive methods that can be used correctly and consistently. In addition, couples should be advised that correct and consistent use of barrier methods against infection, such as condoms, reduces the risk for other sexually transmitted infections.

Id.

101. WORLD HEALTH ORGANIZATION, PREVENTION OF SEXUAL TRANSMISSION OF ZIKA VIRUS: INTERIM GUIDANCE UPDATE 2 (June 7, 2016) [hereinafter WHO, PREVENTION OF SEXUAL TRANSMISSION], http://www.szu.cz/uploads/Epidemiologie/ZIKA_virus/2016_06_07_WHO_Prevention_of_sexual_transmission_of_Zika_virus.pdf.

102. The WHO Interim Guidance states:

> Based on growing evidence that Zika virus can be sexually transmitted, WHO recommends:
>
> 1. Country health programmes should ensure that:
>
> a. All people (male and female) with Zika virus infection and their sexual partners (particularly pregnant women) receive information about the risks of sexual transmission of Zika virus, contraceptive measures and safer sexual practicesa practices, and are provided with condoms.
>
> b. Women who have had unprotected sex and do not wish to become pregnant due to concerns about Zika virus infection have ready access to emergency contraceptive services and counselling.
>
> c. In order to prevent adverse pregnancy and fetal outcomes, men and women of reproductive age, living in areas where local transmission of Zika virus is known to occur, be correctly informed and oriented to consider delaying pregnancy; and follow recommendations (including the consistent use of condoms) to prevent human immunodeficiency virus (HIV), other sexually transmitted infections, and unwanted pregnancies.

Id.

critical public health insights concerning the links between gender-based violence and HIV transmission have disappeared from sight within the context of the public health response to the Zika crisis.

The WHO and the Global Coalition on Women and AIDS identify five ways in which intimate partner violence and HIV/AIDS intersect.[103] Because scientists have recently established that Zika can be sexually transmitted, three of the five critical HIV/AIDS intersections apply in the context of the Zika epidemic.[104] First, there is the potential for direct transmission of both HIV and Zika as a result of rape and sexual violence.[105] In the case of sexual violence, women are often unable to protect themselves against infection of sexually transmitted diseases, including HIV and Zika.[106] Second, women victims of gender-based violence may be more susceptible to infection due to an increase in risk-taking behavior that results from violence.[107] Those risk-taking behaviors include having multiple sexual partners, having sexual partners outside of marriage, or engaging in transactional sex.[108] The same risk-taking behavior that is linked to increased vulnerability to HIV infection would presumably increase the risk of Zika infection in pregnancy. Third, many women are exposed to HIV, and presumably Zika,

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103. *See* WHO, INTIMATE PARTNER VIOLENCE AND HIV/AIDS, *supra* note 92, at 2–4 (discussing five ways that intimate partner violence and HIV/AIDS intersect).

104. *See infra* notes 105–103, *supra* notes 105–111 and accompanying text (reviewing the intersections relevant to the transmission of Zika virus). The WHO's fourth and fifth critical intersections between intimate partner violence and HIV infection appear to have less relevance in the Zika context, although there have been few, if any, relevant studies concerning Zika and sexual behavior. *See* WHO, INTIMATE PARTNER VIOLENCE AND HIV/AIDS, *supra* note 92, at 2–4. The WHO identifies as its fourth critical intersection "Indirect transmission by partnering with riskier/older men." *Id.* at 3. Studies from sub-Saharan Africa demonstrate that many young women become sexually involved with older men and that girls and young women in relationships with a significant age disparity face higher risks of both HIV infection and intimate partner violence. *Id.* The WHO's fifth critical intersection links violence that stems from HIV infection and disclosure. *Id.*

105. *Id.* at 2.

106. *Id.*

107. *See id.* (describing the risk-taking behaviors associated with women who experience violence).

108. *Id.*

due to their inability to negotiate safe sex.[109] Studies suggest that intimate partner violence limits women's ability to negotiate condom use.[110] According to one study in South Africa, "women who experienced forced sex were found to be nearly six times more likely to use condoms *inconsistently* than those who did not experience coercion," increasing the statistical likelihood that they would be infected with HIV.[111]

The dynamics of intimate partner violence that increase women's risk of HIV infection also apply to other sexually transmitted diseases.[112] This essay argues that the Zika virus is no exception. Because the discovery of the sexual transmission of the Zika virus is so recent, there is insufficient data to definitively conclude that the same intersections exist between intimate partner violence and potential Zika infection. I argue, however, that the risk factors are sufficiently similar such that researchers and policy makers should explore the issues as interrelated. The failure to do so, despite decades of similar findings concerning the links between intimate partner violence and HIV infection, is surprising.

IV. Zika and Restricted Reproductive Choice

Throughout Latin America, women have enjoyed greater levels of gender equality within the last several decades.[113]

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109. *See id.* at 2–3 ("[R]esearch suggests that violence limits women's ability to negotiate condom use.").

110. *See id.* (observing the results of a study in which women with physically abusive partners were more likely to be verbally abused or physically threatened if they asked their primary partner to use condoms).

111. *Id.* at 3.

112. *See* INTERSECTION OF INTIMATE PARTNER VIOLENCE AND HIV IN WOMEN, CTRS. FOR DISEASE CONTROL & PREVENTION 2 (2014) ("Women in relationships with violence have four times the risk for contracting STIs, including HIV, than women in relationships without violence.").

113. These strides take economic, political, and social forms. *See* Elizabeth Tinoco, *100 Million Women in Latin America's Labour Force*, INT'L LABOR ORG. (Mar. 8, 2014), http://www.ilo.org/global/about-the-ilo/newsroom/comment-analysis/WCMS_237488/lang--en/index.htm (last visited Apr. 5, 2017) ("For the first time in history more than half the women of working age in Latin America are in the labour force.") (on file with the Washington and Lee Law Review); Luisita Lopez Torregrosa, *Latin America Opens Up to Equality*, N.Y. TIMES (May 1, 2012), http://www.nytimes.com/2012/05/02/world/americas/02iht-

Despite these gains, however, reproductive rights remain limited. The region, for example, has experienced high levels of teen pregnancy, with only a 10% decline in the 1990s.[114] Sex education and contraception use are limited in the region.[115] In Chile, only 20% of women of reproductive age visiting public health care centers have access to contraception.[116] Legal, social, and religious constraints on reproductive choices intersect in the region, dramatically limiting reproductive options for women. These restrictions, in turn, have significant ramifications for Zika virus transmission and infection that may affect pregnancy.

Access to abortion is generally limited throughout Latin America, although the extent of the limitations varies significantly by country. In Chile, for example, abortion is not permitted for any reason.[117] Despite this comprehensive ban, however, the Chilean Institute of Reproductive Medicine estimates that between 60,000 and 70,000 abortions are performed every year in Chile.[118]

Chile is not alone in its severe restrictions on abortion within the region. Argentina, Ecuador, El Salvador, and Peru have reformed their laws or constitutions to embrace conception as the legally cognizable point at which the right to life attaches.[119] El Salvador and Nicaragua have complete prohibitions on

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letter02.html (last visited Apr. 5, 2017) ("Quietly and against the odds, women are stepping up the political ladder in Latin America, moving ahead of the United States when it comes to political empowerment and closely matching much of Western Europe.") (on file with the Washington and Lee Law Review); Johannes P. Jütting, Christian Morrisson, Jeff Dayton-Johnson & Denis Drechsler, *Measuring Gender (In)Equality: Introducing the Gender, Institutions and Development Data Base* (GID) 19–20 (OECD Dev. Centre, Working Paper No. 247, 2006) (reflecting findings that women in Latin America suffer less gender discrimination in terms of their physical integrity, family code, ownership rights, and civil liberties than all other country blocks except the advanced capitalist democracies).

114. Gideon et al., *supra* note 42, at 256.

115. *See id.* (noting that unwanted teen pregnancies are a result of this limited sex education).

116. *Id.* at 258.

117. *See generally* Lidia Casas & Lieta Vivaldi, *Abortion in Chile: The Practice Under a Restrictive Regime*, 22 REPROD. HEALTH MATTERS 70 (2014).

118. Gideon et al., *supra* note 42, at 259.

119. *See* Morgan & Roberts, *supra* note 46, at 247 (noting the Catholic Church's promotion of these conservative policies).

abortion.[120] Nicaragua enacted the total ban on abortion in 2006, causing global health experts to worry about the country's already high rate of maternal mortality from complications related to unsafe abortions.[121] Haiti, the Dominican Republic, Honduras, and Suriname also ban abortion and make no explicit exceptions, although abortion may be permitted under the general criminal defense of "necessity" if a woman's life is in danger.[122]

A number of countries in the region stop short of a total ban on abortion.[123] Many impose a ban subject to a narrow exception only available under certain circumstances; in some countries, the exception is rape, in others, the health of the mother or fetus.[124] Guatemala, Paraguay, and Venezuela ban abortions with one exception: to save a woman's life.[125] Peru permits abortion to save the life of a woman or to prevent grave and permanent damage to her health.[126] Belize recognizes one exception to its ban in cases of fetal impairment.[127] Argentina limits its exceptions only to cases of rape.[128] Ecuador includes a more limited exception for cases involving rape of a woman with a

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120. *See id.* (observing that these bans were implemented after the international conferences of the 1990s).

121. *See id.* ("The situation in Nicaragua . . . has become a flashpoint for global attention to this issue, as several European Union countries threatened to withhold development assistance while global anti-abortion organisations rallied to defend and emulate the measure as upholding the rights of the unborn.").

122. *See The World's Abortion Laws 2017*, CTR. FOR REPROD. RTS., http://worldabortionlaws.com/map/ (last visited May 21, 2017) [hereinafter *World's Abortion Laws*] (providing an interactive map with descriptions of each country's laws) (on file with the Washington and Lee Law Review).

123. *See id.* (indicating that Uruguay allows abortions but requires parental notification and authorization).

124. *Id.*

125. *See id.* (describing this exception as the "explicit life exception").

126. *See* Sarah A. Huff, *Abortion Crisis in Peru: Finding a Woman's Right to Obtain Safe and Legal Abortions in the Convention on the Elimination of All Forms of Discrimination Against Women*, 30 B.C. INT'L & COMP. L. REV. 237, 239 (2007) ("Abortion is illegal in Peru, except in extreme circumstances when it is the only way to save a woman's life or avoid serious and permanent damage to a woman's health.").

127. *World's Abortion Laws*, *supra* note 122.

128. *Id.*

mental disability.[129] Bolivia's exceptions include only incest and rape.[130]

A number of countries, taking a less restrictive view, allow for several exceptions to their abortion bans. Mexico is a federal system with abortion policy set at the state level.[131] In 2007, Mexico decriminalized abortion in the first trimester in Mexico City, but elsewhere it remains illegal except in circumstances such as rape and, in some regions, to save the woman's life or in cases of fetal impairment.[132] Similarly, Panama bans abortion but allows for several exceptions to the ban: to save a woman's life, in cases of fetal impairment, and in cases of rape.[133] The law in Panama requires parental notification in situations in which the woman seeking an abortion under one of the exceptions is a minor.[134] Brazil's law includes the common exceptions to save the life of the woman and in cases of rape, as well as a list of enumerated grounds under which abortion is permitted.[135] In 2012, the Brazilian Supreme Court legalized abortion in cases of

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129. *Id.*

130. *Id.*

131. *See* SARAH FAITHFUL, MEXICO'S CHOICE: ABORTION LAWS AND THEIR EFFECTS THROUGHOUT LATIN AMERICA 1 (2016), http://www.coha.org/wp-content/uploads/2016/09/Mexico-Abortion-Laws-ACTUAL.pdf (observing that states within Mexico have the power to "restrict or liberalize" abortion as long as state laws do not violate the Mexican Constitution).

132. *World's Abortion Laws*, *supra* note 123; *see also* FATIMA JUÁREZ, SUSHEELA SINGH, ISAAC MADDOW-ZIMET & DEIRDRE WULF, UNINTENDED PREGNANCY AND INDUCED ABORTION IN MEXICO: CAUSES AND CONSEQUENCES, GUTTMACHER INSTITUTE (Nov. 2013), https://www.guttmacher.org/sites/default/files/report_pdf/unintended-pregnancy-mexico.pdf; Mary Cuddehe, *Mexico's Abortion Wars*, ATLANTIC (Oct. 2009), https://www.theatlantic.com/magazine/archive/2009/10/mexicos-abortion-wars/307768/ (last visited May 15, 2017) ("Until two years ago, abortion at any stage was considered a crime throughout the country, with exemptions in all states for rape and in some for fetal defects or endangerment to the mother.") (on file with the Washington and Lee Law Review).

133. *World's Abortion Laws*, *supra* note 122.

134. *Id.*

135. *Id.* (providing examples of the additional enumerated grounds, including the woman's age or her capacity to care for a child); *see also* Matt Sandy, *Brazilian Legislators Look to Increase Abortion Penalties in the Wake of Zika Outbreak*, TIME (Feb. 22, 2016), http://time.com/4230975/brazil-abortion-laws-zika-outbreak/ (last visited Apr. 5, 2017) (examining Brazil's limitations on abortion and criminal penalties for women who undergo and doctors who perform abortions) (on file with the Washington and Lee Law Review).

fetal anencephaly, which is a genetic condition that affects the development of a baby's brain and skull.[136] Trinidad and Tobago recognizes the potentially broad exception to preserve a woman's mental health.[137] Colombia's law includes a number of exceptions to the general ban on abortion: fetal impairment, incest, rape, and to preserve a woman's mental health.[138]

Several countries in the region provide more liberal access to abortion. Cuba and Uruguay, for example, require only parental notification in cases of a minor seeking an abortion.[139] Guyana allows abortion up to the gestational limit of eight weeks.[140]

In addition to legal restrictions on abortion, access to contraception is limited in many countries in the region. Although most forms of contraception are legal in the region, with the exception of the "morning after" pill in certain countries, access to and use of contraception are not universal.[141] Studies indicate that prevalence rates for contemporary forms of contraception, including condoms, birth control pills, IUDs, and the like, in the region range from 64% in El Salvador to 75% in Brazil.[142]

Legal regimes are not the only factors limiting women's reproductive health in Latin America. Poor women of color in the region experience even greater hurdles in accessing quality

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136. Gideon et al., *supra* note 42, at 259; *see also* Press Release, Center for Reproductive Rights, Brazil Supreme Court Allows Abortion in Cases of a Severe Fetal Condition (Apr. 13, 2012), https://www.reproductiverights.org/press-room/brazil-supreme-court-allows-abortion-in-cases-of-a-severe-fetal-condition

> Brazilian women now have a right to access abortion if they are carrying pregnancies suffering from anencephaly—a severe fetal anomaly causing the fetus to lack parts of the brain and to have no chance of survival after birth—and the state is obligated to provide them with medical care, according to a ruling handed down today by the Brazilian Supreme Court.

137. *World's Abortion Laws*, *supra* note 122.

138. *Id.*

139. *Id.*

140. *Id.*

141. *See* Hodge et al., *supra* note 10, at 1 (observing that Honduras does not allow emergency contraception, which is known commonly as the "morning after" pill, and recognizing that "legality does not imply widespread access or use").

142. *Id.*

sexual and reproductive health care, demonstrating again the intersectionality of poverty and gender. In Brazil, for example, poor black women have a significantly higher maternal mortality rate than their wealthier, white counterparts.[143]

Religion, particularly the Catholic Church, has also had a profound effect on law and policy related to sexual and reproductive health in the region.[144] Each country's history of engagement with the Catholic Church has influenced current policy debates in particularized ways. In some countries, the Catholic Church's conservative views towards abortion are readily apparent in the approaches taken by state governments. In Chile, for example, the military regime in power from 1973–1990 embraced Catholic notions of gender roles and sexual and reproductive rights despite the fact that the Catholic Church challenged the regime regarding its human rights record.[145] Chile's military regime embraced an essentialist and stereotypical view of women's roles as mothers in an effort to preserve the traditional family "for the good of the nation."[146] Although the country became a democracy again in 1990, these highly gendered and traditional religious values have continued to influence Chilean policy.[147] The strong influence of conservative elites on policy has affected Chile's ability to ensure meaningful access to sex education, emergency contraception, and abortion.[148]

The laws governing reproductive rights in Latin American countries, socio-economic power of women, and political the

143. *Id.* at 258 (noting that "regional and socio-economic inequalities in health" contribute to maternal mortality).

144. *See* CTR. FOR REPROD. RTS., ABORTION AND REPRODUCTIVE RIGHTS IN LATIN AMERICA: IMPLICATIONS FOR DEMOCRACY 3 (2015), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/IAD9794%20Repro%20Rights_web.pdf (describing abortion policies in Chile during the Pinochet regime and observing that the Catholic Church "clearly influenced provisions of the new constitution").

145. *See* Gideon et al., *supra* note 42, at 262 (observing the paradox of the government being influenced by the Church in one area while being challenged in another).

146. *See id.* (citing Chile's 1979 National Development Plan).

147. *See id.* ("Since the return to democracy in 1990, a powerful and religious elite has been able to influence policy implementation on sexual education in schools, access to emergency contraception, and abortion.").

148. *Id.*

influence of the Catholic Church significantly affect women's power of choice in the context of the officially sanctioned mandates to delay pregnancy in light of Zika outbreaks. Writing for the New York Times, Donald G. McNeil, Jr. observed that health authorities in the region, "fearful of offending religious conservatives, never seriously discussed abortion as an alternative to having permanently deformed babies—even in countries where abortion is legal."[149] In relationships where women do not control sex, pregnancy is an expected outcome. In countries with rigid restrictions on terminating unwanted pregnancies, women will be forced to choose between illegal methods for terminating the pregnancy or carrying it to term. These realities are clearly at odds with the recommendations of Latin American governments to simply delay or avoid pregnancy.

V. International Human Rights as a Framework for Zika Policy

International human rights obligations provide further support for addressing the spread of Zika by means of implementing policies that take into consideration poverty, sexism, intimate partner violence, the legality of contraception and abortion, and access to health care.[150] These obligations comprise internationally recognized reproductive rights for women.[151] An excessive focus on delaying pregnancy without a broader campaign to ensure women's *ability* to delay pregnancy is unreasonable given the legal and relational realities for women in Latin American countries already discussed in this essay. The reproductive rights obligations Latin American countries have committed to fulfilling support a more expansive approach to combating the Zika epidemic.

Reproductive rights became fully integrated into the global international human rights framework in 1994 through the International Conference on Population and Development (ICPD)

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149. McNeil, Jr., *supra* note 30.

150. *See infra* Part V.A–E (discussing several significant rights recognized by international law that create reproductive rights obligations for Latin American countries).

151. *See, e.g.*, *infra* Part V.A (explaining how the internationally recognized right to health impacts women's reproductive rights).

in Cairo.[152] At the Cairo Conference, reproductive rights dominated the global human rights agenda for the first time.[153] Rights identified by the Cairo Conference include the right of couples and individuals to have the information and means to decide freely the number, spacing, and timing of their children, the right to attain "the highest standard of sexual and reproductive health," and the right to make reproductive decisions free of discrimination, coercion, and violence.[154] Arguably, these rights are not protected in countries where women do not have legal access to contraception or abortion or where they face intimate partner violence and gender discrimination, particularly, as is the case with the response to the spread of Zika, when these same countries encourage women to delay pregnancy without providing any resources or legal means for doing so.

In addition to the development of these international human rights standards, regional human rights treaties also protect women's physical and reproductive rights. For example, in the same year as the Cairo Conference, the Belém Convention[155]

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152. *See* BREAKING THROUGH: A GUIDE TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, SWEDISH ASSOC. FOR SEXUALITY EDUC. 6 (2004) [hereinafter BREAKING THROUGH] (noting that the ICPD was the first international conference to recognize reproductive rights as human rights).

153. *See id.* at 8 (relating the history of the International Conference on Population and Development).

154. Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, U.N. Doc. A/CONF.171/13/Rev.1, at para. 7.3 (1995), *available at* http://www.un.org/popin/icpd/conference/offeng/poa.html [hereinafter ICPD Programme of Action].

155. The Belém Convention, also known as the Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women or Convention Belém do Pará, is a part of the broader Inter-American System intended to protect human rights in the thirty-five independent member states of the Organization of American States (OAS). *Inter-American Human Rights System*, INT'L JUST. RESOURCE CTR., http://www.ijrcenter.org/regional/inter-american-system/ (last visited Apr. 6, 2017) (on file with the Washington and Lee Law Review). The Inter-American System, which includes the American Declaration on the Rights and Duties of Man, American Convention on Human Rights, the Additional Protocol to the American Convention on Economic, Social and Cultural Rights (Protocol of San Salvador), the Belém Convention, and the Inter-American Commission and Court of Human Rights, "expressly enshrines the duty of states to adequately protect women and to guarantee women access to health services free from discrimination." CTR. FOR REPROD. RTS., VIOLENCE

called for groundbreaking mechanisms to protect and defend women's rights as essential to combatting the impacts of physical, sexual, and psychological violence against women.[156] The Belém Convention entered into force in 1994 and has been ratified or acceded to by all American states except for Canada and the United States.[157] Calling for the eradication of discrimination and violence against women, it acknowledges the necessity of addressing the violence against women that exists in American countries.[158]

One year after the ICPD and Belém Convention, in 1995, the U.N. held the Fourth World Conference on Women in Beijing, and again, countries around the world articulated a consensus that reproductive rights were essential to the achievement of women's equality more broadly.[159] The Platform for Action, which is the consensus document that came out of the Beijing Conference, concluded that women's autonomy in the area of their health was affected by gender stereotypes present in government health policies [160] The international and intergovernmental response to the Zika crisis has failed to fully consider that women may lack autonomy regarding their health, in spite of the two decades of public health experience between the 1995 Beijing Conference and the 2015 Zika outbreak in Latin America.

AGAINST WOMEN AND REPRODUCTIVE RIGHTS IN THE AMERICAS 2–3 (2015), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/(EN)%20Advocacy%20Doc%20for%20OAS%20Convening.pdf.

156. *See About the Belém do Pará Convention*, ORG. OF AM. STATES, http://www.oas.org/en/mesecvi/convention.asp (last visited Apr. 6, 2017) (providing an overview of the Convention's outcomes) (on file with the Washington and Lee Law Review).

157. *A-61: Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women*, OAS DEP'T OF INT'L LAW, http://www.oas.org/juridico/english/sigs/a-61.html (last visited Apr. 6, 2017) (on file with the Washington and Lee Law Review).

158. *See generally* Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará), June 9, 1994.

159. *See generally* United Nations Fourth World Conference on Women, United Nations, U.N. Doc. A/CONF.177/20 (1995).

160. *See id.* at para. 90 (noting that "[h]ealth policies and programmes often perpetuate gender stereotypes . . . and may not fully take account of the lack of autonomy of women regarding their health").

Over the past twenty years, various U.N. Conventions and Committees have considered reproductive rights within the context of the rights to health, life, non-discrimination, autonomy, privacy, and freedom from torture and cruel, inhuman and degrading treatment.[161] States have an obligation to respect, protect, and fulfill human rights, meaning that states must refrain from violating rights, take steps to prevent violations of rights, and take positive measures to ensure that all people are able to exercise their rights.[162] This section explores several of the internationally recognized reproductive rights and their sources in international law, underscoring the positive obligations of states to support and protect the reproductive rights and choices of women. As this essay demonstrates, many of the Latin American countries confronted with the spread of the Zika virus are failing to fulfill their obligations to protect these internationally recognized rights.

A. The Right to Health

The right to health is widely understood to encompass the enjoyment of the "highest attainable standard of physical and mental health."[163] Generally, states are expected to ensure that health facilities, good, services, and information are available, accessible, acceptable, and of sufficient quality.[164] Non-discrimination is critical to achieving health goals.[165] States are not fulfilling their obligations when they recommend that women

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161. *See infra* Parts V.A–E (describing rights enumerated in international treaties that protect women's reproductive choices and health).

162. *See* CTR FOR REPROD. RTS., SUBSTANTIVE EQUALITY AND REPRODUCTIVE RIGHTS: A BRIEFING PAPER ON ALIGNING DEVELOPMENT GOALS WITH HUMAN RIGHTS OBLIGATIONS 20 (2014) [hereinafter SUBSTANTIVE EQUALITY], https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Equality_Guide_Reduced_size.pdf (elaborating on the obligations of countries that are parties to these international human rights treaties).

163. International Covenant on Economic, Social, and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

164. SUBSTANTIVE EQUALITY, *supra* note 162, at 8.

165. *See id.* (calling for the "availability, accessibility, acceptability, and quality (AAAQs) of health facilities, goods, services, and information on a basis of non-discrimination").

delay pregnancy without providing appropriate health care support or other assistance.

Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) obligates States Parties to eliminate discrimination against women in the field of health care and to ensure women access to appropriate services in connection with pregnancy.[166] In addition to access to health care, CEDAW establishes the expectation that, in conjunction with providing women with appropriate services in connection with pregnancy and post-natal care, States Parties will grant "free services where necessary."[167] All thirty-three Latin American countries have ratified CEDAW.[168] If Latin American governments continue to recommend that women in Zika-prone areas delay pregnancy without ensuring that women have the means to prevent pregnancy, these countries should be financially responsible for providing free services to women who give birth to microcephalic infants in those areas.

U.N. human rights committees frequently adopt General Comments or General Recommendations, which are intended to guide States parties in their interpretation of the obligations contained in the treaty.[169] The CEDAW Committee has issued a General Recommendation concerning the obligations of states to protect gender and health under Article 12 of the CEDAW Convention.[170] In its commentary on Article 12, the Committee

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166. *See* Convention on the Elimination of all Forms of Discrimination Against Women art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter CEDAW]. CEDAW requires States Parties to ensure women "access to health care services, including those related to family planning." *Id.* at art. 12 para. 1.

167. *Id.* at art. 12 para. 2.

168. *See* RATIFICATION MAP FOR CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, UNHR OFFICE OF THE HIGH COMMISSIONER, http://www.ohchr.org/Documents/HRBodies/CEDAW/OHCHR_Map_CEDAW.pdf (providing a visual summary of ratification to the treaty).

169. *See Human Rights Treaty Bodies—General Comments*, UNHR OFFICE OF THE HIGH COMMISSIONER, http://www.ohchr.org/EN/HRBodies/Pages/TBGeneralComments.aspx (last visited Apr. 6, 2017) (explaining the role of committee recommendations in relation to treaty agreements) (on file with the Washington and Lee Law Review).

170. CEDAW General Recommendation No. 24 (2009), *available at* http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24.

specifically states that the "duty of States [P]arties to ensure . . . access to health care services, information and education implies an obligation to respect, protect and fulfill women's rights to health care."[171]

The General Recommendation further discusses the requirements associated with each of these obligations. The Committee found that the obligation to protect women's rights to health care, for example, prohibits States Parties from preventing the actions of women taken to achieve their health goals.[172] Many of the Latin American countries involved in the Zika crisis, as discussed *supra*, have granted women very limited control over their health goals by maintaining restrictive laws and reinforcing existing societal norms in clear contravention of the CEDAW Committee's General Recommendation.

Another treaty, the International Covenant on Economic, Social and Cultural Rights (ICESCR) provides guidance for countries that dates back to its entry into force in 1976.[173] Every Latin American country has ratified the treaty.[174] The ICESCR was the first human rights treaty to recognize that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.[175] Significantly, the ICESCR "emphasized governmental responsibility to ensure that all

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171. *Id.* at para. 13.

172. *Id.* at para. 14. The commentary recognizes that "barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures." *Id.*

173. International Covenant on Economic, Social and Cultural Rights, *supra* note 163.

174. *Id.*

175. *See* AVANI MEHTA SOOD, LITIGATING REPRODUCTIVE RIGHTS: USING PUBLIC INTEREST LITIGATION AND INTERNATIONAL LAW TO PROMOTE GENDER JUSTICE IN INDIA 34 (2006) [hereinafter LITIGATING REPRODUCTIVE RIGHTS] (recommending that States Parties "refrain from obstructing action taken by women in pursuit of their health goals"). The International Covenant on Economic, Social and Cultural Rights defines the right to health as

> encompassing entitlements, such as "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health," as well as freedoms, such as "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from torture, nonconsensual medical treatment and experimentation."

Id.

women have access to affordable and comprehensive reproductive healthcare, especially contraception and family planning services and information."[176] Latin American countries, having ratified this treaty, have an obligation to protect, respect, and fulfill these health standards.

The Committee on Economic, Social and Cultural Rights has issued several relevant General Comments regarding the ICESCR, including one that articulates state obligations as including identifying how gender roles affect health and removing legal restrictions on reproductive health, among other things.[177] These obligations to remove legal restrictions on reproductive health decision-making are especially critical in light of the spread of the Zika virus by sexual transmission.

Finally, the Convention on the Rights of the Child (CRC) provides some important rights in the context of Zika infection during pregnancy, which might result in microcephaly. The CRC "requires governments to protect children's right to the highest attainable standard of health, and to 'ensure appropriate pre-natal and post-natal health care for mothers'—thereby reinforcing women's right to maternal health."[178] Children born with microcephaly suffer from a number of developmental issues. The governments of Brazil and other Latin American countries facing Zika-affected pregnancies have a duty not only to the mothers, but also to the children.

B. The Right to Access Abortion and Contraception

In Zika-exposed areas where pregnant women may be at risk of having microcephalic infants, the right to access abortion and contraception is essential. The right to access abortion and contraception is, in many ways, critical to the right to health and physical autonomy. For women who are victims of intimate

176. *See* BREAKING THROUGH, *supra* note 152, at 50 (addressing governmental obligations, including educational initiatives concerning sexual and reproductive health in school curricula).

177. ICESCR General Comment 16, The Equal Right of Men and Women to the Enjoyment of all Economic, Social and Cultural Rights (Art. 3 of the International Covenant on Economic, Social and Cultural Rights), E/2006/22 (2005) at para. 29.

178. LITIGATING REPRODUCTIVE RIGHTS, *supra* note 175, at 35.

partner violence or who lack the power in their sexual relationships, contraception and abortion may be the only means by which they can prevent pregnancies.

CEDAW, which aims to eliminate discrimination against women generally, does not address abortion or contraception directly in its text, but requires States Parties to respect, protect, and fulfill women's right to access appropriate health care and to have the highest attainable standard of health.[179] For its part, despite the absence of express treaty language, the CEDAW Committee has repeatedly emphasized the obligations of States parties to amend abortion restrictions and to ensure access where abortion is legal.[180] These recommendations are especially critical in light of the policies adopted by several Latin American countries that women simply wait to have children for as long as two years in order to avoid complications associated with the Zika virus.

The ICESCR, like CEDAW does not expressly mention abortion. As discussed *infra*, Article 12 of ICESCR calls for States parties to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[181] States Parties are responsible for creating provisions for the "healthy development of the child," for the "prevention, treatment, or control" of diseases, and for assuring medical services and attention in the event of sickness.[182]Arguably, the limited public health response to the Zika crisis by Latin American government authorities violates these obligations.

The Convention on the Rights of the Child (CRC) provides another source of international law obligations. It requires states Parties to respect and protect the right of the child to the "highest attainable standard of health."[183] States Parties should ensure

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179. *See supra* Part V.A (providing an overview of CEDAW).

180. CEDAW General Recommendation No. 24 (1999) and Concluding Observations, *available at* http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm. In its General Recommendation about women's health, the Committee stated that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women." *Id.*

181. International Convention on Economic, Social, and Cultural Rights, *supra* note 163, at art. 12(1).

182. *Id.* at art. 12(2).

183. Convention on the Rights of the Child art. 24(1), Nov. 20, 1989, 1577

appropriate pre- and post-natal care for mothers and take appropriate measures to reduce infant mortality.[184] The CRC, like CEDAW and ICESCR, does not contain a provision specifically including abortion; it is focused on the wellbeing of the child.

Human rights committees within the U.N., which monitor states' implementation of the primary U.N. human rights treaties, have at times considered reproductive rights in their communications with states.[185] In assessing the progress of individual states in fulfilling the treaty obligations, committees issue "Concluding Observations" which highlight the ways in which the particular state is, or is not, fulfilling its obligations under the treaty.[186] In its Concluding Observations on Peru, the CEDAW Committee urged Peru to "remove punitive measures for women who undergo abortion."[187] The Committee has distinguished removing punitive measures from the legalization of abortion in certain cases.[188] The CEDAW Committee's Concluding Observations on the Dominican Republic recommended that the country provide free or affordable family planning services and contraceptives.[189] The Committee also

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U.N.T.S. 3.

184. *Id.* at art. 24(2).

185. *UN Concluding Observations*, CTR. FOR REPROD. RTS., https://www.reproductiverights.org/resources/publications/un-concluding-observations (last visited May 22, 2017) (detailing numerous concluding observations issued by UN treaty-monitoring bodies) (on file with the Washington and Lee Law Review).

186. See *Glossary of Treaty Body Terminology*, OFFICE OF THE UNITED NATIONS HIGH COMM'R FOR HUM. RTS., http://www2.ohchr.org/english/bodies/treaty/glossary.htm#CO (last visited May 15, 2017) (on file with the Washington and Lee Law Review).

187. Concluding Observations on Peru, CEDAW/C/PER/CO/7-8 (2014), at para. 36.

188. CEDAW Committee Statement on the ICPD Beyond 2014 Process (Feb. 2014)

> States parties should legalize abortion at least in cases of rape, incest, threats to the life and/or health of the mother, or severe foetal impairment, as well as provide women with access to quality postabortion care, especially in cases of complications resulting from unsafe abortions. States parties should also remove punitive measures for women who undergo abortion.

189. Committee on the Elimination of Discrimination Against Women, Concluding Observations on Dominican Republic, CEDAW/C/DOM/CO/6-7 (2013), at para. 37(b).

expressed its support for an amendment to the country's Criminal Code decriminalizing abortion in cases where the mother's life is threatened.[190]

Other human rights committees also make recommendations related to abortion and contraception. The Committee on Economic, Social, and Cultural Rights, in its Concluding Observations on Great Britain and Northern Ireland, voiced concerns that the United Kingdom's 1967 Abortion Act was not applicable in Northern Ireland.[191] The Committee on the Rights of the Child has also included commentary about access to abortion in some of its Concluding Observations.[192] In its Concluding Observations on Costa Rica, the Committee recommended that the country clarify that the exceptions to illegal abortion include pregnancies resulting from sexual violence and pregnancies involving a severely malformed fetus.[193] While each Concluding Observation is uniquely tailored to the state Party being assessed, the recommendations and observations expressed in Concluding Observations also demonstrate the respective human rights committee's interpretation of international reproductive rights.

The WHO has stated unequivocally that "restricting legal access to abortion does not decrease the need for abortion. Rather, it likely increases the number of women seeking illegal and unsafe abortions, leading to higher rates of morbidity and mortality."[194] In countries throughout Latin America that have experienced Zika outbreaks and that have significant restrictions on access to abortion, as described in Part IV above, women will undoubtedly seek illegal abortions based on concerns surrounding

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190. *Id.* at para. 37(c).

191. Committee on Economic, Social and Cultural Rights, Concluding Observations on United Kingdom of Great Britain and Northern Ireland, E/C.12/GBR/CO/5 (2009), at para. 25 ("The Committee calls upon the State party to amend the abortion law of Northern Ireland to bring it in line with the 1967 Abortion Act with a view to preventing clandestine and unsafe abortions in cases of rape, incest or foetal abnormality.").

192. *See, e.g.*, Committee on the Rights of the Child, Concluding Observations on Costa Rica, CRC /C/CRI/CO/4 (2011), at para. 64(c).

193. *Id.*

194. WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 90 (2003), http://whqlibdoc.who.int/publications/2003/9241590343.pdf.

Zika. As is often true where abortion access is limited, women with economic resources can find and pay for abortion services.[195] Poor women, however, will either carry the pregnancy to term or seek an illegal, often unsafe, abortion. As this essay previously discussed, unsafe abortion is one of the most significant contributors to mortality among women of childbearing age.[196]

International human rights law provides a tool to hold states accountable for increasing access to safe abortion under all circumstances and, at a minimum, when there are serious health concerns for the mother or the fetus or when the pregnancy results from gender-based violence.

C. The Right to Be Free from Gender-Based Violence

The right to be free from gender-based violence is well-established in international human rights law. Although gender-based violence is not explicitly addressed in the text of the CEDAW Convention, the CEDAW Committee has unequivocally stated that systemic gender-based violence is a form of discrimination against women. In its General Recommendation 19, the CEDAW Committee stated, "[g]ender-based violence is a form of discrimination that seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men."[197] The U.N. General Assembly has also noted the connection between violence and reproductive health, observing that "[a]ll forms of violence against women seriously violate and impair or nullify the enjoyment by women of all human rights and fundamental freedoms and have serious immediate and long term implications for health, including sexual and reproductive health."[198]

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195. *See supra* note 143 and accompanying text (discussing the intersection of poverty and access to abortion).

196. *See supra* Parts II & IV (noting that illegal abortion continues to be a source of serious health risk for women).

197. CEDAW General Recommendation No. 19 (1992).

198. G.A. Res. 65/228, Strengthening Crime Prevention and Criminal Justice Responses to Violence Against Women, Addendum, [Strategies and Updated Model of Practical Measures for the Elimination of Violence Against Women in the Area of Crime Prevention and Criminal Justice], UN Doc. A/RES/65228, at para. 2 (2011).

In the Americas, the Belém Convention offers clear protection against gender-based violence, including intimate partner violence.[199] The Convention defines violence against women to include "any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere."[200] The Convention unambiguously includes gender-based violence perpetrated by non-state actors in the private sphere, which would include intimate partner violence.

As this article argues above, unintended or unwanted pregnancy is sometimes a direct or indirect consequence of intimate partner violence. Pregnancy sometimes results directly from sexual violence. The power dynamics in a violent intimate partnership often make it difficult or impossible for the victim of violence, most often the female partner in a heterosexual relationship, to negotiate safe sex. Intimate partner violence in parts of the world that have experienced significant Zika outbreaks makes it difficult to adhere to the CDC and WHO advisory to avoid pregnancy.

In addition to unintended or unwanted pregnancies, intimate partner violence may result in the transmission of sexually transmitted diseases. The linkages between intimate partner violence and the sexual transmission of HIV/AIDS also exist between intimate partner violence and sexual transmission of other diseases, including Zika. The United Nations General Assembly held a Special Session on HIV/AIDS in 2001 in which the General Assembly adopted a Declaration of Commitment calling on states to

> ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV and AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other

199. *See generally* Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará), *supra* note 158.

200. *Id.* at art. 1

> forms of sexual violence, battering and trafficking in women and girls.[201]

Through this and a number of subsequent declarations, the U.N. has acknowledged as critically important the linkages between sexual transmission of HIV/AIDS and the existence of intimate partner violence and other forms of gender-based violence.[202] In the context of the Zika epidemic, however, the official response from the WHO and CDC to date has consistently failed to consider how power imbalances within intimate relationships and, in some cases, violence in these relationships may impact a woman's ability to adhere to the recommendation to "avoid pregnancy."

The International Covenant on Civil and Political Rights (ICCPR) expressly recognizes the equal rights of both men and women to "life, liberty, and security of person."[203] Under this treaty, the Human Rights Committee has found that forcing a woman to carry an anencephalic fetus to term "constituted cruel, inhuman, and degrading treatment."[204] A violation of the treaty also exists "when women have difficulty accessing contraceptive methods to prevent unwanted pregnancies."[205] These are exactly

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201. Special Session of the U.N. General Assembly, *Declaration of Commitment on HIV/AIDS*, A/Res/S-26/1, at para. 61 (Aug. 2, 2001), *available at* www.un.org/ga/aids/coverage/FinalDeclarationHIVAIDS.html.

202. *See generally* GLOBAL COALITION ON WOMEN AND AIDS, UNAIDS, ISSUE BRIEF: STOPPING VIOLENCE AGAINST WOMEN AND GIRLS FOR EFFECTIVE HIV RESPONSES (2011), https://gcwa.unaids.org/sites/womenandaids.net/files/Issue%20Brief%20-%20Stopping%20violence%20against%20women%20and%20girls%20for%20effective%20HIV%20responses.pdf.

203. LITIGATING REPRODUCTIVE RIGHTS, *supra* note 175, at 33.

204. *See id.* at 34. Under the ICCPR, in 2005, the Human Rights Committee issued a landmark ruling in *K.L. v. Peru*, a case brought against the Peruvian government under the Optional Protocol to the Civil and Political Rights Covenant. The case involved a woman who was forced by state hospital authorities to carry a pregnancy to term, even though she carried an anencephalic fetus (characterized by severe anomaly in brain formation) that threatened her health and had no chance of survival. The Human Rights Committee ruled in favor of the woman, recognizing that denying her an abortion in a circumstance where it was legal violated her right to privacy, and that forcing her to carry the pregnancy to term constituted cruel, inhuman, and degrading treatment.

Id.

205. BREAKING THROUGH, *supra* note 152, at 51.

the cases facing many women in Latin American countries plagued by the Zika virus. Under the current WHO and CDC recommendations, and the recommendations of governments, women who have difficulty legally accessing contraceptive methods and abortions in these countries and who become pregnant may be forced to carry their unwanted pregnancies to term.

D. Protection from Discrimination

Where the equality of men and women is not realized, women's reproductive rights are often disregarded.[206] This is apparent in several of the Latin American countries facing the spread of Zika virus, where women still lack equal status in contravention of international law, which recognizes that the right to protection from discrimination intersects with every other reproductive right.

International sources of law governing reproductive rights address discrimination universally. CEDAW specifically aims to eliminate all forms of discrimination against women and it includes gender-based violence as a form of discrimination.[207] The Belém Convention also recognizes that the right of women to be free from violence includes the right of women to be free from all forms of discrimination.[208] The ICCPR provides fundamental protection against all discrimination,[209] while the ICESCR

206. *See* SUBSTANTIVE EQUALITY, *supra* note 162, at 4 ("Where women's rights to equality and non-discrimination are not fulfilled, women's ability to access reproductive health services and make meaningful choices about their reproductive lives is limited.").

207. *See* AMNESTY INT'L, THE STATE AS A CATALYST FOR VIOLENCE AGAINST WOMEN 62 (2016) ("[D]iscrimination under CEDAW 'includes gender-based violence' which is defined as 'violence that is directed against a woman because she is a woman or that affects women disproportionately.'").

208. Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women (Convention of Belém do Pará), *supra* note 158, at art. 6.

209. *See* OHCHR, HUMAN RIGHTS IN THE ADMINISTRATION OF JUSTICE: A MANUAL ON HUMAN RIGHTS FOR JUDGES, PROSECUTORS AND LAWYERS 638 (2003), http://www.ohchr.org/Documents/Publications/training9chapter13en.pdf (describing Article 26 of the ICCPR as the "cornerstone of protection against discrimination under the Covenant).

obligates States parties "to ensure the equal right of men and women" to enjoy all of the rights enumerated in the ICESCR.[210] The CEDAW Committee has additionally issued recommendations specifically addressing various aspects of gender discrimination.[211] The recommendations have included language advocating for non-discrimination in situations of violence against women, equality in marriage and family relations, and women's health.[212]

E. The Right to Not Live in Poverty

Poverty creates limitations and barriers for women seeking health services and equal treatment. As this essay discusses, in countries where abortion and contraceptives are illegal or extremely difficult to access, women with resources can afford to pay for unsanctioned services while women living in poverty cannot. Poverty, though not addressed in many international treaties, is included in the Universal Declaration of Human Rights (UDHR) and the ICESCR.[213] The UDHR provides for broad human rights protections, among them the right to be free from poverty.[214] This right to be free from poverty is closely linked with the right of human dignity. The UDHR states that everyone is entitled to realize the economic, social, and cultural rights indispensable for dignity.[215] These are the fundamental rights that provide the foundation for the ICESCR.

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210. *Id.* at 639.

211. *Id.* at 641 n.14.

212. *Id.*

213. The U.N.'s Universal Declaration on Human Rights is "considered legally binding as customary international law, because of its wide acceptance and implementation." BREAKING THROUGH, *supra* note 152, at 47. The U.N. General Assembly adopted the UDHR in 1948. *Id.*

214. "The UDHR protects the right to equality, the right to life, liberty and security, the right to be free from torture and other forms of cruel, inhumane or degrading treatment, the right to privacy, the right to marry and found a family, the right to health and well-being, and the right to education." *Id.* at 47–48.

215. *Freedom from Poverty: A Fundamental Right*, ASIAN-PACIFIC HUM. RTS. INFO. CTR., http://www.h urights.or.jp/archives/focus/section2/1998/06/freedom-from-poverty-a-fundamental-human-right.html (last visited Apr. 6, 2017) (on file with the Washington and Lee Law Review).

The reproductive rights recognized by international law do not currently align with many of the practices of Latin American countries and the United States. These treaties create obligations and States Parties that do not fulfill their treaty obligations are in violation of the treaty. In the current Zika crisis, as countries recommend that women delay their pregnancies without taking responsibility for the lack of health care, contraceptives, equal treatment, protection from violence, and efforts to eradicate poverty, these violations are readily apparent.

VI. Conclusion

Latin America "holds one of the most rapidly evolving women's rights movements that is now focused in advancing reproductive rights."[216] It is possible that the Zika crisis will provide openings for strategic conversations concerning limits on contraceptive and abortion access. The vocal, strategic, and active feminist advocacy community will continue to pressure governments to take seriously the health and reproductive rights of all women, not only women who are privileged along the axes of race and class. Zika may prove to be a catalyst for those conversations. In the meantime, national governments and international and regional human rights organizations must act immediately to ensure that all women have options to prevent, safely continue, or discontinue a pregnancy in which the fetus suffers from microcephaly or other Zika-related complications.

The CDC, WHO, and governmental representatives throughout the Latin American region must apply the lessons learned from more than two decades of research and advocacy concerning the connections between HIV/AIDS transmission and intimate partner violence. In the case of sexually transmitted diseases such as HIV and Zika, that research strongly suggests that an effective public health intervention must take into consideration the dynamics of intimate partner violence. The widespread failure to consider gender and gender-based violence in efforts to remediate the Zika epidemic is both surprising and

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216. Fabiola Carrión, *How Women's Organizations Are Changing the Legal Landscape of Reproductive Rights in Latin American*, 19 CUNY L. REV. 37, 38 (2015).

short-sighted. The women in the region who will most acutely feel the effects of this failure of health policy will be those who are already vulnerable due to violence and poverty. An international human rights framework that specifically incorporates gender analysis and intersectionality theory holds the greatest promise for reframing the health policy interventions around Zika.