



# UNHEARD VOICES

WOMEN'S EXPERIENCES WITH ZIKA

## COLOMBIA

CENTER  
FOR  
REPRODUCTIVE  
RIGHTS



HARVARD  
T.H. CHAN  
SCHOOL OF PUBLIC HEALTH

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INITIATIVE



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# COLOMBIA



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## Multimedia

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# Glossary

**Adolescents:** People between the ages of 10 and 19 as defined by the World Health Organization (WHO).

***Aedes Aegypti*:** A mosquito that can spread dengue, chikungunya, Zika and Mayaro viruses as well as yellow fever and other diseases.

**American Convention on Human Rights (ACHR):** A regional convention that promotes and protects human rights in the Americas, which was adopted in San Jose, Costa Rica on November 22, 1969 (also known as the Pact of San Jose).

**Centers for Disease Control and Prevention (CDC):** The leading national public health institute of the United States.

**Congenital Zika Syndrome (CZS):** A pattern of complications unique to fetuses and infants infected with the Zika virus before birth. It is defined by five features: (1) severe microcephaly in which the skull has partially collapsed, (2) decreased brain tissue with a specific pattern of brain damage, including subcortical calcifications, (3) damage to the back of the eye, including macular scarring and focal pigmentary retinal mottling, (4) congenital contractures, such as clubfoot, and (5) hypertonía restricting body movement soon after birth.

**Convention on the Elimination of All Forms of Discrimination against Women (CEDAW):** An international treaty upholding the human rights of women that was adopted in 1979 by the United Nations General Assembly (see definition below), which is often described as an international bill of rights for women.

**Convention on the Rights of People with Disabilities (CRPD):** A convention and optional protocol intended to protect the rights and dignity of people living with disabilities that was adopted on December 13, 2006 by the United Nations General Assembly (see definition below) and is ratified by 174 countries.

**Convention on the Rights of the Child (CRC):** An international treaty upholding the human rights of children that was adopted by the United Nations General Assembly (see definition below) on November 20, 1989. It is the most widely ratified treaty in the world (195 countries).

**Endemic:** A disease that exists permanently in a region or population.

**Epidemic:** An outbreak of a disease that attacks a large number of individuals within a population at the same time and has the potential to spread through one or several communities.

**General Comment/Recommendation:** A comprehensive interpretation of an article of a treaty issued by the respective U.N. Treaty Monitoring Body (see definition below).

**Guillain-Barré Syndrome (GBS):** A condition in which the immune system attacks a person's nerves.

**Human Development Index (HDI):** A composite statistic of life expectancy, education, and per capita income indicators that is used to rank countries into four tiers of human development.

**Inter-American Commission on Human Rights (IACHR):** An autonomous organ of the Organization of American States (OAS; see definition below), which was created to promote the observance and defense of human rights in the Americas. Its mandate is found in the charter of the OAS and the American Convention on Human Rights.

**Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (IACEDAPD):** A regional instrument committed to eliminating discrimination in all its forms and manifestations against persons with disabilities that was adopted on June 7, 1999.

**Inter-American Convention on the Prevention, Punishment, and Eradication of Violence against Women (IACPPEVAW):** A convention that was adopted in 1994, which codifies a state's duty to prevent, punish, and eliminate violence against women in the Americas (also known as the Convention of Belém do Pará).

**Inter-American Court on Human Rights (the Court):** An international court operating under the auspices of the Organization of American States, which derives its mandate from the American Convention on Human Rights. It began operating in 1979 and has seven independent judges. Among other things, the Court hears complaints against states and rules on specific cases of human rights violations.

**International Convention on Economic, Social, and Cultural Rights (ICESCR):** A multilateral treaty adopted by the United Nations General Assembly (see definition below) on December 16, 1966, which has been ratified by 165 countries.

**International Health Regulations (IHR):** An international legal instrument that is binding to 196 countries across the globe, including all the member states of the World Health Organization (see definition below).



**International Law:** The body of legal rules and norms that are decided and enforced by nation states at the international level based on treaties, customary law, and general principles of law.

**Microcephaly:** A congenital malformation resulting in a smaller than normal head size at birth or that develops within the first few years of life. This condition has also been associated with other birth defects and neurologic conditions, such as Congenital Zika Syndrome.

**Non-governmental Organization (NGO):** A nonprofit organization that is independent of governments and international governmental organizations.

**Office of the United Nations High Commissioner for Human Rights (OHCHR):** A U.N. agency that works to promote and protect human rights that are guaranteed under international law.

**Organization of American States (OAS):** An intergovernmental body composed of 35 countries in the western hemisphere. All members must ratify the Charter of the OAS, which is to strengthen cooperation and advance common interests, including democracy and human rights.

**Pan American Health Organization (PAHO):** An international public health agency working to improve the health and living standards of the people of the Americas.

**Pandemic:** An epidemic that spreads globally.

**Public Health Emergency of International Concern (PHEIC):** A formal declaration by the World Health Organization (see definition below) Emergency Committee operating under International Health Regulations, which designates a public health crisis of potential global reach (referred to as a “global health emergency” throughout this report).

**United Nations (U.N.):** An intergovernmental organization established to promote international cooperation and create and maintain international order.

**United Nations Children’s Fund (UNICEF):** A U.N. agency that works to protect and defend the rights of every child.

**United Nations Development Programme (UNDP):** A U.N. agency that works to eradicate poverty and reduce inequalities through sustainable development.

**United Nations General Assembly:** The General Assembly is one of the six main organs of the U.N., the only one in which all Member States have equal representation. All 193 Member States are represented in this unique forum to discuss and work together on a wide array of international issues covered by the U.N. Charter, such as development, peace and security, international law, etc.

**United Nations Human Rights Council:** An intergovernmental body within the United Nations that is made up of 47 states responsible for the promotion and protection of all human rights around the globe.

**United Nations Population Fund (UNFPA):** A U.N. agency dedicated to financing and supporting population and reproductive health programs in low- and middle-income countries.

**Universal Declaration of Human Rights (UDHR):** A declaration adopted by the United Nations General Assembly (see definition below) on December 10, 1948, consisting of 30 articles that define the meaning of fundamental human rights appearing in the United Nations Charter, which is binding for all member states.

**U.N. Special Rapporteur:** An independent expert appointed by the United Nations Human Rights Council (see definition above) to investigate, monitor, and recommend solutions to human rights problems. This person is not financially compensated.

**U.N. Treaty Monitoring Bodies (UNTMB or TMB):** U.N. committees that monitor governmental compliance with the major U.N. human rights treaties. While TMBs are not judicial bodies, they influence governments by issuing specific political observations about a state’s progress and compliance with human rights obligations. They also issue general recommendations, which are not specific to any one country but provide specific guidance on how states can better implement a provision or provisions of a treaty. In certain circumstances, some TMBs also have a mandate to decide state responsibility for individual complaints of violations.

**World Health Organization (WHO):** A U.N. agency devoted to researching and promoting public health worldwide.

**Vector:** An organism, typically a biting mosquito or tick, that transmits a disease or parasite from one animal or plant to another.

**Zika Virus:** An arbovirus that typically presents with mild symptoms such as fever, headache, rash, and muscle or joint pain typically lasting from two to seven days, however, it can also be asymptomatic. Zika is primarily transmitted through a daytime-active *Aedes aegypti* mosquito found in tropical regions. The virus can also be transmitted through sexual intercourse and during pregnancy from a woman to the fetus. To date, there is no specific treatment or vaccine currently available.











PUNTO DE  
HIDRATACIÓN

PULSFOG

# Foreword

The goal of this report series is threefold: firstly, it presents and evaluates the diverse impact that the Zika virus has had on the reproductive lives of women living in Brazil, Colombia, and El Salvador. Secondly, these reports analyze the global response to the Zika epidemic through both a public health and human rights lens, ultimately finding that there was a disconnect between the global, national, and local policies addressing the crisis and the realities faced by women, their children, families, and caregivers. Finally, through the personal stories of women affected by Zika, these reports underscore the gendered nature of the epidemic and the disproportionate effect the epidemic had on girls and women throughout Latin America and the Caribbean.

Nearly a year after public health experts first raised the alarm about the Zika outbreak, a multidisciplinary team of human rights and public health experts from the Center for Reproductive Rights (the Center), the Harvard T.H. Chan School of Public Health's Women and Health Initiative (W&HI), and Yale's Global Health Justice Partnership (GHJP) began using an interdisciplinary approach to research the epidemic.

We interviewed a diverse group of stakeholders, all of whom were familiar with or involved in the national, regional, and global response to the Zika epidemic. Our interviewees come from a diverse range of backgrounds in research and academia, the media, the health care sector, local and national governments, international organizations, and civil society.<sup>1</sup> Most critical to our research, however, were the interviews conducted with women who had been directly affected by the virus—those living with Zika, at-risk of contracting Zika, or who had decided to continue with a pregnancy after having been infected with Zika. This report series seeks to bring their voices to the forefront of the discussion on the Zika epidemic so that their experiences can inform future debates around global responses to public health crises.

This investigation is unique in that it integrates both a public health and human rights framework in the analysis of the Zika epidemic. This two-pronged approach provides a more holistic understanding of the Zika crisis and highlights the role that structural inequality has had on fueling the epidemic and amplifying its impact, particularly in regard to a woman's right to exercise informed and autonomous decision-making.







# Executive Summary

With over 108,537 confirmed or suspected cases of Zika as of November 2017, Colombia is second only to Brazil in terms of the number of reported cases.<sup>2</sup> The Zika outbreak in Colombia officially began in October 2015 when nine cases were confirmed by laboratory tests.<sup>3</sup> The number of newly reported cases peaked in February 2016, at which time the number of cases per week had reached more than 6,000.<sup>4</sup>

By January 2016, officials in Colombia had warned women to delay getting pregnant for up to two years.<sup>5</sup> In response to these warnings in both Colombia and Brazil, in February 2016, the World Health Organization (WHO) came out with a public statement declaring the Zika epidemic a Public Health Emergency of International Concern.<sup>6</sup> The WHO and U.S. Centers for Disease Control (CDC) followed this announcement by advising pregnant women against traveling to the more than 45 countries where Zika was present, getting tested if they had traveled to these regions, and refraining from having unprotected sex with partners who had visited these regions.<sup>7</sup> Despite these initial broad preventive measures, as of March 2017, over 70 countries and territories around the world have reported evidence of mosquito-borne Zika transmissions.<sup>8</sup>

In November 2016, as the number of Zika cases decreased, the WHO declared an end to the epidemic's international emergency status. However, some public health experts worried that losing this emergency status would deprioritize state efforts to effectively and efficiently respond to the epidemic.<sup>9</sup> In response to this concern, Dr. Peter Salama, executive director of the WHO Health Emergencies Programme, said, "We are not downgrading the importance of Zika. We are sending the message that Zika is here to stay and the WHO response is here to stay."<sup>10</sup> Nevertheless, despite the WHO's clarification, that was not how the message was interpreted by governments in Zika-affected countries. Despite the ongoing occurrence of new cases—more than 600 per week<sup>11</sup>—the Colombian government had declared the epidemic over by July 2016.

Evidence suggests that the WHO and the Colombian government's retraction of the epidemic might have been issued too soon. In fact, the number of infected people demonstrates an ever-growing epidemic. The long-term impact of the virus remains poorly understood, and the experiences of women and their families continue to be ignored by governments and health authorities.

## What are the consequences of Zika?

Zika is primarily spread by an infected *Aedes* species mosquito, but can also be sexually transmitted or passed from a pregnant woman to her fetus.<sup>12</sup> A fetus infected with Zika can develop prenatal complications, such as microcephaly and/or Congenital Zika Syndrome.<sup>13</sup> To date, there is no vaccine or medicine available to prevent or treat Zika, and diagnostic testing tools remain inconsistently implemented across infected regions.<sup>14</sup>

The medical community continues to explore the repercussions of Zika around the world and have found that in addition to microcephaly, there have been other reported complications in Zika-affected children. For example, children may experience muscle and joint seizures, which prevents them from moving and maintaining balance, or they may experience developmental delays, vision and hearing alterations, or clubfeet.<sup>15</sup> These complications can range from mild to severe, and can even be life-threatening.<sup>16</sup> Because it is difficult to predict at birth what problems a baby may develop from microcephaly, it is important for these



children to be closely monitored by a trained health care professional during the first few years of their lives. Unfortunately, to date, there is no known cure or standard treatment for Zika-related complications.

The Colombian government's response to the epidemic showed a lack of consideration for the experiences of women with Zika and their children born with disabilities as a result of the virus. Although the government consistently advised women to delay pregnancy and worked to devise mosquito control strategies to mitigate the spread of Zika, this approach did not adequately integrate a human rights perspective and thus did little to ameliorate complications resulting from the epidemic.

Many public health experts interviewed for this report criticized Colombia's prioritization of vector control as a means of managing the spread of Zika as it suppressed other preventative strategies, such as comprehensive sexual and reproductive health services, social protections for children with disabilities, and improved water and sanitation infrastructure.

Recommendations for how to deal with Zika also varied depending on the audience. While tourists from Global North countries were advised not to travel to Latin American countries with reported Zika cases, impoverished women living in infected areas in Colombia were simply instructed to avoid getting pregnant.<sup>17</sup> These warnings however, were not accompanied by adequate health care information or services that would enable women to make informed choices about their reproductive health. Rather than receiving the tools necessary to navigate the epidemic, women in Colombia were frequently met with violence, stigma, or criminalization when seeking out reproductive health services, if they were available at all.<sup>18</sup>

## Our Findings

Our research found that women in Colombia encountered many barriers in exercising their sexual and reproductive rights and that crosscutting gender norms and inequities placed serious limitations on options for low-income women living in remote and rural areas. Despite that, shortly after the WHO declared a global health emergency, the importance of sexual and reproductive rights in the global response to Zika was affirmed by the United Nations Population Fund, the U.N. High Commissioner on Human Rights, and the Inter-American Commission on Human Rights.<sup>19</sup> However, our research indicated that language affirming a woman's sexual and reproductive rights was largely absent from Zika-related public health campaigns or government responses in Colombia, showing the disconnect between the global and national responses.



## Family Planning and Information Access

A woman's ability to control family planning was a critical challenge in responding to the threats posed by Zika. For example, cost was often flagged as a barrier to accessing contraception and lengthy travel distances to clinics were also highlighted as making access to sexual and reproductive health services difficult, if not impossible. Numerous women we interviewed indicated that there was ambiguity in government messaging, and that women were often unsure, or even unaware, of the risks associated with Zika.<sup>20</sup> In addition, we found that doctors were also struggling to give patients the required and religiously unbiased information that they needed as their understanding of Zika was, and remains, relatively limited.

We found that in Colombia there were also stark differences noted in contraception access between urban areas and rural areas. In rural areas, women faced many geographic barriers, such as long trips to quality clinics or clinics where they could access contraception anonymously, and variations in the quality of access, including incomplete or inaccurate information or lack of access to long-term forms of contraception.<sup>21</sup>

In our interviews, we asked four women at risk of contracting Zika if they faced barriers in accessing contraception; three reported that they did. One said she was unable to find injectable contraception from a public-sector provider; another said that the cost made access a challenge; and a third said that only some types were affordable with insurance whereas other types required large out-of-pocket costs. Several of the women we interviewed also said they had used contraception in the past for family planning, safer sex, or both, but had not used it to specifically avoid pregnancy during the Zika crisis.

## Abortion Access

Abortion is legal in Colombia under three circumstances: (1) when the continuation of a pregnancy poses a physical or mental risk to the life and/or health of the woman, (2) when the fetus has a fatal malformation making life unviable outside the uterus, or (3) when the pregnancy is the result of rape, incest, or insemination without consent.<sup>22</sup> However, it is not always easy for women to access abortion services. Health care professionals, insurance plans, and medical settings frequently refuse to give women care based on their own personal religious convictions in what is an improper use of conscientious objection laws. Another barrier women face is the lack of information available on the scope of legal abortion in Colombia. For example, the doctors we interviewed, both of whom provided abortions in public and private clinics, cited lack of adequate information as an important barrier to accessing the service.





Finding providers who were not only willing to provide accurate information, but able to provide an abortion was noted as another major barrier for women accessing abortions in Colombia. The abortion providers we interviewed said that there were very few doctors who would perform the procedure, and that women often ended up at their facilities after having unsuccessfully searched elsewhere.<sup>23</sup> Many health insurance plans also delay approving the procedure and try to make it more difficult for women to use their coverage to pay for it; as a result, we found that a woman's right to have an abortion covered by their insurance is more of a right in theory than in practice.<sup>24</sup>

## The Rights of Children with Disabilities

Social inclusion and access to support mechanisms were some of the largest concerns of families with children with disabilities. These families were typically among the most socioeconomically disadvantaged to begin with, making the added responsibility of taking care of a child with special needs even more difficult. In countries without universal health coverage and integrated social welfare support systems, we found that children with disabilities and their caretakers were particularly vulnerable. So far, no long-term programs have been announced in Colombia to specifically support children born with Zika-related health complications.

## The Economic and Social Rights of Women, Families, and Children

As with many other infectious diseases, the spread and impact of Zika is tied to social and economic inequalities in the Americas.<sup>25</sup> The WHO has noted that “the burden of Zika falls on the poor...in tropical cities throughout the developing world, the poor cannot afford air-conditioning, window screens, or even insect repellent.”<sup>26</sup> Additionally, accessing reproductive health services, such as contraception and abortion, is more difficult for those who face socioeconomic marginalization.

During on-site visits in the coastal department of Magdalena, in the northern part of Colombia, we saw untreated open sewage and storm drains that were creating unsanitary standing water conditions near the communities of the women we directly interviewed. These areas were said to have poor access to water and sanitation and were situated in a swamp, which made controlling mosquitos in the area even more difficult. Our research found that the lack of government investment in water and sanitation infrastructure contributed to conditions that increased the proliferation of mosquitos, which quickened the spread of Zika.

We also found that in almost all cases women were the main caregivers of children born with Zika-related disabilities, bearing more associated responsibilities compared to men. We documented the stories of women who had to quit their jobs or were no longer able to study because of how time consuming it was to take care of their children. Women also often reported needing to travel hours to take their children to therapies, and shared how they struggled to access medicines, treatment, and the medical equipment needed to take care of their children.



# Government's Human Rights Obligations

At the bare minimum, a human rights-based approach to the Zika virus requires:



access to quality and comprehensive information about the virus, its risks, and the options available regarding reproductive health to guarantee informed and autonomous decision-making



access to comprehensive reproductive health services, including contraception, quality maternal health, and abortion services



the provision of reasonable accommodations, including welfare plans, that guarantee the full inclusion and development of children with disabilities, which in turn will ease the burden placed on families and caregivers



the protection of the right to an adequate standard of living through the provision of access to sufficient, safe, acceptable, physically accessible, and affordable water for personal and domestic use



The Colombian government's advice instructing women not to get pregnant as a means of navigating the Zika epidemic was problematic and raised human rights concerns. Governments cannot advise women to avoid or delay a pregnancy without considering the availability and accessibility of reproductive health care services that would allow them to exercise this control over their lives and bodies. Furthermore, placing the burden of contraception on women alone perpetuates the stereotype that only they are responsible for planning or preventing a pregnancy.

In addition to contraception, governments must ensure that women, children with disabilities, and their caretakers have reasonable access to educational, health, financial, and other social accommodations. However, our research found that a disability rights perspective was rarely considered by governments in affected areas despite the spike in children born with Zika-related complications.

Colombia is a state party with a number of international human rights treaties that protect women's fundamental rights, the rights of people with disabilities, the right to water and sanitation, and the right to the highest attainable standard of health, among other socioeconomic rights. Under international human rights law, countries are required to prioritize women's autonomy and self-determination by ensuring their right to comprehensive reproductive health information and services.<sup>27</sup> Colombia also has a legal obligation to provide the support, training, and services necessary for raising a child with a disability.<sup>28</sup> As established in the Colombian Constitution, rights granted under international treaties to which Colombia is a state party form part of the country's constitutional law.<sup>29</sup> Therefore, as a signatory of these international and regional instruments, Colombia must work to respect, protect, and fulfill these human rights.<sup>30</sup>

## Conclusion

The Zika epidemic in Latin America exposed the stigmatization of reproductive rights within Colombia and highlighted the need for contraception and access to safe and legal abortion as a means of family planning. Zika not only exacerbated the need for these rights in the countries that it impacted, but also laid bare existing inadequacies and inequities in laws both as they were written and executed.

Unfortunately, our research found few signs that lasting changes were being made in Colombia to address the shortcomings of their health care systems to adequately protect women's reproductive health and the rights of people with disabilities. While the unmet needs of children with disabilities will surely be the longest lasting impact of Zika's many consequences, unfortunately this has not been a focus of the government's response to the epidemic.

Although there remains the possibility that positive law and policy changes could emerge as the government and their citizens reflect on the Zika epidemic and its impact, this seems increasingly unlikely given that the stories detailed in this report highlight the limited extent that women's perspectives were taken into consideration during the outbreak. Through their testimonies, it has become apparent that the Colombian government did not adequately ensure that women had the necessary tools to make informed decisions about their reproductive lives nor were they provided with the resources to take care of their children born with Zika-related complications, which further exacerbated existing inequalities.







# Methodology

In January 2017, we conducted interviews with nine women living on the Colombian Atlantic coast, a region with a high prevalence of Zika. Of the interview subjects, five were pregnant and at risk of contracting Zika given the region in which they lived. Of these women, three were from Maracaibo, a low-income area in the township of Ciénaga in the department of Magdalena, and two were from Tasajera, a remote area of Ciénaga. Prospective interviewees were identified through informal inquiries among local residents, looking specifically for women of reproductive age who were either pregnant or not and would be willing to speak without researchers. The eligibility of each interviewee was subsequently confirmed based on conversations with any initially identified women in their places of residence.

In addition to the five pregnant women we interviewed, we also spoke with two mothers who had been diagnosed with Zika, a married couple living in the town of Ciénaga whose child has been born with microcephaly, and a woman of reproductive age living in the city of Barranquilla whose child had not been diagnosed with any Zika-related complications thus far.

Researchers also interviewed 10 key stakeholders from the health care sector (3), government (2), media (1), academia (2), international organizations (1), and civil society groups (2). Interviewees included representatives from, among others, the National Institute of Health in Bogotá, the Secretary of Health of the City of Barranquilla, the Universidad del Norte of Barranquilla, the reproductive health clinic Oriéntame, the nonprofit organization Women's Link Worldwide, and the country office of the United Nations Population Fund.

Researchers complied with the Lund-London Guidelines on fact-finding reports by non-governmental organizations and completed the Protecting Human Research Participants training program offered by the U.S. National Institutes of Health's Office of Extramural Research. Informed consent was obtained from each interviewee and all data and information was securely recorded and stored. Any interview information collected by the Yale Global Health Justice Partnership for this report was gathered pursuant to IRB approval from Yale University.



RIA 1<sup>a</sup>

DROGUERIA 1<sup>a</sup>



DROGAS

COSMETICOS

FOTOCOPIAS

RECARGAS  
TODO OPERADOR





# Background

Colombia currently ranks “high” in the Human Development Index (HDI) after a 29% increase over the last three decades.<sup>31</sup> Despite this ranking, gains across Colombian society have not been equal. In fact, Colombia’s human development ranking is marked by greater inequality than the average country in Latin America and the Caribbean, and has significantly more inequality than the average country with a “high” HDI ranking, particularly in regard to income inequality.<sup>32</sup>

Gender inequality is also prevalent in Colombian society. There is low female political representation and only 56% of women are in the workforce compared to 80% of men.<sup>33</sup> In the context of Zika, this means that low-income women face intersecting forms of marginalization despite the benefits gained from improved national development.

With over 108,537 confirmed or suspected cases of Zika as of November 2017, Colombia is second only to Brazil in terms of the number of reported cases.<sup>34</sup> Additionally, the incidence rate of Zika—the number of new cases reported over a given period of time—in Colombia is the highest in all of South America. At 221.55 per 100,000 people, this incidence rate is also higher than most countries in Central America, yet lower than much of the Caribbean.<sup>35</sup>

As late as October 2016, there were reports suggesting that the number of babies born with microcephaly was surprisingly low in Colombia given the similarity of their Zika incidence rate to Brazil—47 in Colombia versus more than 2,000 in Brazil.<sup>36</sup> Less than two months later, additional reports suggested that the number in Colombia was approaching 500, and at its peak in July the rate of microcephaly births represented a nine fold increase over the pre-Zika rate in 2015.<sup>37</sup> Given that Brazil has reported three times as many cases of Zika as Colombia, the country has also reported nearly 18 times as many cases of confirmed Congenital Zika Syndrome associated with Zika. According to some studies, a small mutation in Zika’s genetic makeup has made the virus much more dangerous in Brazil than in other neighbor countries.<sup>38</sup>

The Zika outbreak in Colombia officially began in October 2015 when nine cases were confirmed by laboratory tests.<sup>39</sup> The number of newly reported cases peaked in February 2016, at which time the number of cases per week had reached 6,000.<sup>40</sup> Despite the ongoing occurrence of new cases, the Colombian government declared that the epidemic was over in July 2016, at a time when there were still more than 600 new cases per week.<sup>41</sup>

In declaring an end to the epidemic, the country’s Vice-Minister of Health said, “Colombia is the first country in the world to declare an end to the Zika epidemic,” determining that the virus had reached an endemic phase and was no longer rapidly spreading.<sup>42</sup> While the virus continued to decline, it had still produced over 1,200 new infections between January 1 and May 20, 2017.<sup>43</sup> While local transmission was suspected in every department of Colombia, except in the area surrounding the capital city of Bogotá, the highest rates of incidence were in several of the country’s interior departments. The densely populated Caribbean coast was particularly affected; this was especially true in the departments of Córdoba, Sucre, Atlántico, and Magdalena, the latter two of which comprised the locations of the fieldwork for this report.<sup>44</sup>

In early 2016, Colombia adopted the regional practice of recommending women avoid getting pregnant as a means of navigating the Zika outbreak. Specifically, the Ministry of Health recommended an eight-



month abstention from becoming pregnant.<sup>45</sup> The government's official advice to health care providers in light of the Zika outbreak was that pregnant women infected by Zika "should be informed of the existence of an association between the infection and congenital anomalies...but that the diagnosis of the infection in the mother does not necessarily implicate alterations in her child."<sup>46</sup> They also stated that "all women should be fully aware of the grounds for the voluntary interruption of a pregnancy in Colombia including the health clause in its physical, mental, and social dimensions." Thus, the government's guidance made clear that the potential mental health consequences caused by the risk of contracting Zika was sufficient to permit abortion.

Abortion is legal in Colombia when the continuation of a pregnancy poses a physical or mental risk to the life and/or health of a woman.<sup>47</sup> However, despite the government's recommendation and legality of abortion in the country, press reports indicated that providers were divided as to whether a Zika infection (or fear thereof) was cause enough on its own to provide an abortion.<sup>48</sup>

Like abortion, contraception is legal in Colombia and several forms are covered by the country's national health plan since it was expanded and upgraded in 2008 (although there are cost-sharing requirements depending on the insurance policy).<sup>49</sup> Emergency contraception, sometimes known as the "morning after pill," is also legal and covered by the national health plan. Women who decided to take active measures to prevent pregnancy in light of the Zika virus, and who had the means to access the health care system, theoretically enjoyed the right to access various forms of contraception. Other socioeconomically disadvantaged and rural women, however, faced many barriers.

## Testing and Surveillance

The experts we spoke with said that on the Colombian coast Zika was diagnosed almost exclusively through clinical diagnosis—that is, by a doctor examining a patient, discussing their symptoms, and deciding whether the infection was likely—rather than by a blood test. An expert from Universidad del Norte, which had been working with the government to implement Zika surveillance programs, said that there was no testing center on the coast, and that samples had to be sent Bogotá, the capital.<sup>50</sup> Daniela and Teresa, the two pregnant women interviewed for this report, said that their doctors clinically diagnosed them.

Confirming a Zika diagnosis has been difficult in Colombia due to the medical and scientific infrastructure in the most affected areas of the country. The National Institute of Health has only confirmed three Zika cases nationwide out of the 1,211 suspected infections between January 1 and May 20, 2017, the equivalent of only 0.2% of all cases.<sup>51</sup> Comparatively, at the end of 2016, 9.19% of cases had been confirmed nationwide,<sup>52</sup> indicating that even as the epidemic subsided and surveillance became more manageable, the government continued to fall behind in its monitoring rather than improving its vigilance to identify a potential resurgence early.

Several experts have said that a major part of the government's response to the Zika epidemic has been providing access to information and educating people on the symptoms of the virus so that they could identify a potential infection and seek medical attention. In the city of Barranquilla, one awareness campaign on Zika, chikungunya, and dengue took place in shopping malls—popular destinations for escaping the heat, particularly on the weekends.<sup>53</sup> In Barranquilla, researchers also saw government-sponsored, publicly posted information about Zika in the waiting room of a major clinic. However, at-risk women interviewed in Tasajera and Maracaibo—cities an hour outside of Barranquilla in a different jurisdiction—all reported that they had never seen a public campaign about Zika or received any printed materials about the risks either in their neighborhoods or in the clinics they visited. Instead, their information

about the virus came from news coverage at the height of the epidemic. Given that the government used television and radio to provide messaging about the virus, it is possible that interviewees heard official government information, but were unable to distinguish it from the news.

In Barranquilla, the city's department of health sought out and reported cases soon after the virus emerged in the region, according to the head of the public health office.<sup>54</sup> The city also developed a *caminante* (brigades) program, which assigned health workers to individual neighborhoods where they walked door-to-door delivering information and making referrals for those who needed them. The *caminantes* shared general information about arboviruses as well as information about reproductive health and were well equipped to inform people on issues related to reproductive health complications associated with Zika.<sup>55</sup> The city also collected some blood samples for future research purposes.<sup>56</sup>

Barranquilla was also the site of the pilot program Proyecto VEZ, a medical surveillance program for pregnant women with Zika.<sup>57</sup> Interviewees who assisted in the implementation of the program explained that while it did not change the care women with Zika received, it ensured that detailed medical histories were kept for both women and their newborn children and that monitoring for their babies during the first year of their lives occurred.<sup>58</sup> The organizations participating in the program included the Centers for Disease and Prevention and Colombia's National Institute of Health (Instituto Nacional de Salud, INS). A Zika specialist at INS confirmed that monitoring occurs in several of Colombia's major cities.<sup>59</sup> She also described another research initiative, which tracked at-risk women with infections to learn more about the spread of the virus beyond the current diagnostic and monitoring tools employed by the national government. This study also tracked the sexual transmission of the virus, and as of early 2017, researchers were preparing to introduce condoms as a preventive intervention method with the intention of tracking their effectiveness at preventing the spread of Zika.

## The Right to Access Accurate and Comprehensive Information

U.N. Treaty Monitoring Bodies have recognized that the right to accurate and comprehensive information includes seeking, receiving, and imparting information and education on reproductive health.<sup>60</sup> In order for women to be able to make the best and most informed decisions about their reproductive lives, states must ensure that they have access to both comprehensive sexual and reproductive health services and adequate health information.<sup>61</sup> The disseminated information must be accurate, unbiased, and evidence-based so women can make informed decisions about things like pregnancy and parenting.

Information must also be disseminated in a timely and inclusive manner.<sup>62</sup> This means that states must ensure that information reaches the poorest and most marginalized populations to dispel any rumors and misconceptions that may exist about Zika and its prenatal complications. States must also work to ensure that women and their communities are aware of how Zika is transmitted as well as the preventative measures available to mitigate the spread of the virus.





## Zika Prevention

The official clinical guidelines issued by the Colombian government in response to the Zika outbreak aligned with those issued by the World Health Organization.<sup>63</sup> The guidelines advised wearing long clothing, using insect repellent containing an effective active ingredient, and sleeping with mosquito nets at night.<sup>64</sup> They also instructed health care providers to advise people on the sexual transmission of Zika and to explain to pregnant women the importance of using condoms for the duration of their pregnancies to avoid contracting Zika from a sexual partner. Despite living in a high-risk coastal zone, none of the pregnant women we interviewed had been counseled in this manner; additionally, none were following the government's recommended guidelines with respect to wearing insect repellent.

The cost of insect repellent was a barrier faced by many Colombian women. In one coastal town, a bottle of insect repellent cost between USD 2.70 (COP 8,000) and USD 4.75 (COP 14,000),<sup>65</sup> which was a costly item for someone earning Colombia's minimum wage of USD 61.47 (COP 184,000) per week.<sup>66</sup> Indeed, several of the pregnant women we interviewed reported that insect repellent was too expensive for them to purchase. Despite the financial constrain, the head of the Barranquilla public health office said that no effort had been made to distribute free or reduced-cost repellent to low-income individuals. Instead, the government's free distribution program had focused on tourists visiting the city's famed carnival festival in February 2016 during the height of epidemic.<sup>67</sup> Researchers at the nonprofit organization Women's Link Worldwide (WLW) also reported that there had been no effort on the national level to distribute insect repellent for free to low-income women,<sup>68</sup> as had been planned (although long delayed) in Brazil. However, WLW did say that some cities have offered insect repellent programs, including the large city of Cali in the southwest of the country, a location where they have conducted Zika-related fieldwork.<sup>69</sup> Once again, the integration of insect repellent as part of the country's response to the virus proved to be uneven and uncoordinated.



## States' Prevention and Treatment Obligations

According to article 12(c) of the International Covenant on Economic, Social, and Cultural Rights, state parties have an obligation to take every measure required for the prevention, treatment, and control of epidemics.<sup>70</sup> Furthermore, General Comment N°1 of the U.N. Committee on Economic, Social, and Cultural Rights mandates that the government of Colombia is obligated to establish “prevention and education programs for behavior-related health concerns,” particularly those that adversely impact an individual’s sexual and reproductive health.<sup>71</sup> Mitigating the spread of sexually transmitted infections like Zika, which adversely affects the sexual and reproductive lives of both women and men, requires such behavior-related prevention health programming.

States are also required to put systems in place for urgent medical care in cases of epidemics or health hazards.<sup>72</sup> This could be achieved through national governmental efforts or collaboration between governments and private entities. Ultimately, the goal is to ensure epidemiological surveillance and data is used and improved, all relevant technologies are made available, and other strategies of disease control are implemented or enhanced.<sup>73</sup> This report has illustrated that there is a need for greater epidemiological surveillance of Zika, particularly in marginalized and remote communities. Additionally, given that there is currently no vaccine available to prevent the transmission of Zika, relying on other preventative strategies, such as the enhancement of vector control management, the use of insect repellent, and improvements to water and sanitation infrastructure, has become even more important.

In the context of Zika, this primarily takes the form of better access to virus testing, medical abortion pills, and ultrasounds. To ensure that these things are readily available, governments can remove barriers by changing medical protocols or facilitating the approval of new testing technologies.





## Family Planning and Contraception

Access to contraception is a key component of women's experiences with Zika, and while it is legally covered under Colombia's national health plan, many barriers still exist. According to an expert in the Bogotá office of the United Nations Population Fund (UNFPA), "It's not easy to educate the public about the use of contraception in light of Zika."<sup>74</sup> A major challenge is that the need for contraception in response to Zika is twofold: preventing the sexual transmission of the disease, which can only be done with condoms, and preventing pregnancy for those who wish to avoid Zika-related risks, which can be done more effectively with other forms of birth control, such as oral pills or intrauterine devices (IUDs). Therefore, people who wish to both avoid a Zika infection and pregnancy should use both condoms and an additional, more effective form of birth control. This, however, has complicated messaging efforts and doubled the burden for individuals who need to acquire, pay for, and utilize multiple forms of contraception. Among young people, a UNFPA representative said, "The first worry—or the only worry—is pregnancy." For this reason, UNFPA has recommended using a more efficacious form of birth control than condoms.<sup>75</sup> At the same time, it has recommended complementing these prevention efforts with condoms to prevent sexually transmitted infections (STIs), including Zika.

Despite contraception's success in preventing pregnancy, access to the most effective forms of birth control, such as IUDs, is complicated for two reasons.<sup>76</sup> First, while theoretically covered under the national health care plan, IUDs are expensive and thus in short supply; many clinics only have a few available per month and offer them to women on a first-come, first-served basis. This means that what should be a right under the national health care plan is instead really a privilege for patients who visit high quality facilities. Second, provider knowledge on long-term forms of contraception is low, and many providers fail to offer women complete and accurate information on the full range of contraceptive methods available.<sup>77</sup>

Unfortunately, the Ministry of Health's Zika awareness campaign did little to provide a more clear and comprehensive overview of available and effective contraception methods. About the campaign, the UNFPA expert we spoke with said, "They stated the problem, but without a solution," adding that the Ministry of



Health failed to recognize that women who wanted to get pregnant had the right to do so and should have access to information on minimizing their risks.<sup>78</sup> Issuing a blanket statement instructing all women to avoid pregnancy was not “practical advice for the population.”<sup>79</sup> A researcher at Universidad del Norte working on Zika surveillance agreed that accurate information on contraception was vital in improving access to birth control across Colombia; furthermore, he believed that many women lacked even the basic knowledge of who to go to for more information.<sup>80</sup>

As with seemingly all aspects of Zika’s impact, there were also stark differences noted in contraception access in cities versus rural areas. “There are two different dimensions,” said a policy expert with the U.N. Development Programme’s Colombia office.<sup>81</sup> “One dimension is in the big cities and capitals, and the other is in the rest of the country.” In the latter, she said, women faced many geographic barriers (e.g. long trips to quality clinics or clinics where they could access contraception anonymously) and variations in the quality of access (e.g. incomplete or inaccurate information or lack of access to long-term forms of contraception). One doctor we spoke with noted that, in his experience, there was little stigma surrounding contraception usage in Bogotá, but that things were different for women living in less urban areas.

Another challenge was the fact that the more successful a form of contraception, the costlier it tended to be. This meant that some women were not able to afford the form that would best help them prevent pregnancy. A journalist who had been covering the Zika crisis for the coast’s largest newspaper, *El Heraldo*, said that cost was in fact the main obstacle low-income women in highly at-risk regions faced when trying to access contraception.<sup>82</sup>

In our interviews, we asked four at-risk women if they faced barriers in accessing contraception. Three answered affirmatively; one said she was unable to find injectable contraception from a public-sector provider; another said that the cost in general made access a challenge; and a third said that only some types were affordable with insurance whereas other types required large out-of-pocket costs. Several said they had used contraception in the past—for family planning, safer sex, or both—but had not used them to specifically avoid pregnancy during the Zika crisis.





# DANIELA'S STORY: PREGNANT AND IN THE DARK

Daniela, a 27-year-old woman living in the city of Barranquilla, was infected with Zika by sexual transmission from her husband who had recently visited a coastal region with a high prevalence of the virus. When he presented symptoms, he chose not to seek medical care because he had heard that clinicians were only giving patients over-the-counter remedies like acetaminophen, which he could purchase for himself from a drug store. A short time after his illness, Daniela also became sick with what appeared to be Zika, although she too did not seek out medical care.

*Image is not of Daniela and is solely representational.*

## A month after she had begun to feel ill, Daniela learned that she was pregnant.

She had private insurance so she made an appointment to see a doctor within her network for her first prenatal care visit. At this point she was concerned for the health and well-being of her child given her suspicion that she had recently contracted Zika. At the appointment, her provider asked her if she had the Zika virus, and she stated that she believed she had contracted it through sexual transmission from her husband. Unfortunately, her provider never tested her to confirm her self-diagnosis—an omission her doctor later admitted was “an error” as Daniela should have been tested during that first visit. “When I started my prenatal care,”<sup>83</sup> she said, “they could have done tests on me to see if I had Zika. But they didn’t confirm if I had Zika or not,” said Daniela.<sup>84</sup>

Based on the description of her and her husband’s symptoms, Daniela’s doctor believed that she had, in fact, been infected with Zika, and deemed her pregnancy to be high risk as a result. In the immediate weeks following, Daniela received enhanced testing and was sent for more detailed imaging of her fetus’s development. However, in a deviation from recommended practices by the Colombian government,<sup>85</sup> no one ever spoke to her about the potential risks posed to her pregnancy by Zika. Noting that her doctors never spoke to her about termination she said, “The doctors that I was seeing at that time didn’t even give me any options<sup>86</sup> nor did they draw blood.”<sup>87</sup> At home, she reported feeling disoriented after hearing on the news the potentially grave consequences for pregnant women infected with Zika. She told her obstetrician that she was experiencing a great deal of distress from the situation, but her doctor never offered her any information about the risks nor did he refer her to psychological services. Instead, all her providers merely said, “Your baby is okay,” leaving Daniela to deal with her anxiety and uncertainty alone.

“More than anything, my [medical] attention was physical,”<sup>88</sup> Daniela explained, and never, “emotional, psychological, nor educational.” This left a significant gap in the care that she desired during her pregnancy and what she received. A Zika diagnosis, she said, “affects you psychologically and emotionally. It debilitates you mentally because you are concerned over something you can’t see or observe.”<sup>89</sup> By failing to provide her with sufficient information and support during her pregnancy, her doctor exacerbated these problems rather than addressing them head on. In the end, her physician’s knowledge of her Zika diagnosis only meant that Daniela received some limited additional testing and a little more monitoring and reporting to the government—actions that helped in the collection of data, but nothing that ultimately helped Daniela.

Although her distress and anxiety persisted throughout her pregnancy, Daniela said that because she was never presented with proof of a malformation in her fetus, she never really considered the option of terminating her pregnancy. However, while she said the option was “always in my thoughts,” she had very little information about it. All of her providers omitted any discussion regarding the risks involved in her pregnancy, her medical and legal options given those risks, or what additional steps she could take to come to a decision.

In the end, Daniela gave birth to a baby with no apparent complications from her supposed Zika infection or otherwise. However, a specialist never examined her baby and no ongoing tests have been provided despite the possibility of Zika-related complications developing as the infant ages. For example, research has found that babies born to mothers with Zika may develop problems with their eyesight long after having been deemed clear of Zika-related complications, and many experts believe children may experience other unknown complications as they age.<sup>90</sup>

After giving birth, Daniela was not given any information on family planning, a critical service for all postpartum mothers, and something that was especially desired by Daniela due to her lingering concerns about what a Zika infection could mean for a future pregnancy. Her providers never offered her any advice following the birth of her child on how she might postpone an additional pregnancy should she still be concerned about Zika. Nonetheless, Daniela decided to focus on her first child and avoid becoming pregnant again soon. “It was a decision I made with my husband to wait for some time before having another baby.”





## The Right to the Highest Attainable Standard of Health

The right to health is a fundamental right that is indispensable for the enjoyment of other rights and is enshrined in many international human rights instruments.<sup>91</sup> Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The human right to health is recognized in numerous treaties. Article 25.1 of the Universal Declaration of Human Rights states: “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, medical care, and necessary social services.” The International Covenant on Economic, Social, and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, states parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

The U.N. Committee on Economic, Social, and Cultural Rights developed the content of the right to the highest attainable standard of health in its General Comment No. 14,<sup>92</sup> explicitly stating that it included a right to reproductive health, defined as “the freedom to decide if, and when, to reproduce and the right to be informed, and to have access to safe, effective, affordable, and acceptable methods of family planning.”<sup>93</sup>

Solo Personal  
Autorizado

QUIROFANO



## Recolección de muestras de participantes del proyecto Vigilancia de Embarazadas con Zika (VEZ)

**Es posible que reciba en su sala de parto a una participante de VEZ.**

Se deben tomar a todo producto de la gestación de las participantes de VEZ, muestras de tejido con las siguientes especificaciones.

PASO 1

Identificar a una mujer embarazada como participante de VEZ.



### ¿QUÉ RECOLECTAR?

Placenta: Tomar 1cm cúbico de la cara fetal y 1cm cúbico de la cara materna almacenar en un frasco estéril con SSN mantener refrigerado (4°C), tomar 1cm cúbico de la cara fetal y 1cm cúbico de la cara materna almacenar en un frasco estéril con formol tamponado neutro que cubra el tejido.



### ¿A DÓNDE ENVIARLAS?

Al laboratorio de su hospital.

### ¿QUÉ RECOLECTAR?

Recoger muestra de sangre del cordón del lado placentario conservar a 2-8°C.



### ¿A DÓNDE ENVIARLAS?

Al laboratorio de su hospital.

PASO 2

### ¿QUÉ RECOLECTAR?

Cordón: tomar 1 cm cúbico del eje proximal y 1cm cúbico del eje distal almacenar en un frasco estéril con SSN mantener refrigerado (4°C), tomar 1 cm cúbico del eje proximal y 1cm cúbico del eje distal almacenar en un frasco estéril con formol tamponado neutro que cubra el tejido.



### ¿A DÓNDE ENVIARLAS?

Al laboratorio de su hospital.

### Pérdidas fetales, muerte fetal

#### ¿QUÉ RECOLECTAR?

Enviar el producto de la gestación en su totalidad a laboratorio de patología. Tomar todo lo anteriormente mencionado, mas muestra de membranas, almacenar en un frasco estéril con SSN mantener refrigerado (4°C), y otro con formol tamponado neutro.



### ¿A DÓNDE ENVIARLAS?

Al laboratorio de patología

Si tiene alguna duda acerca de VEZ, escriba a [vez@ins.gov.co](mailto:vez@ins.gov.co)  
También puede llamar a los siguientes números de teléfono:

En Barranquilla: 301-406-6776 | En Neiva: 302-266-2928 | En Cúcuta: 304-662-1669

Comuníquese con el personal de VEZ e infórmele acerca de cualquier muestra que haya tomado de una participante de VEZ.



CO-000000-00 May 11, 2014



A woman with dark hair tied back, wearing a purple tank top and a necklace, sits against a wall. The wall is red on the bottom half and blue on the top half. To her left is a wooden door. The background shows some foliage. A dark red horizontal band is overlaid across the middle of the image, containing the title text.

# TERESA'S STORY: PARENTHOOD WITHOUT SUPPORT

Teresa is a 31-year-old woman living in the small town of Ciénaga located about 40 miles to the east of Barranquilla in the department of Magdalena. The town was identified as a high-risk area for Zika by experts interviewed for this report. This was supported by epidemiological evidence indicating that the northern departments of Magdalena and Atlántico (where Barranquilla is located) have had some of the highest cumulative incidences of Zika—both generally and among pregnant women—in the whole country next to the department of Santander.<sup>94</sup>

*Image is not of Teresa and is solely representational.*

### Teresa was infected with Zika when she was almost three months pregnant.

Shortly after contracting the virus, Teresa sought the advice of her health care providers who told her that there was no evidence of any complication to her pregnancy; however, detecting Congenital Zika Syndrome (CZS) would not be possible so early in a pregnancy. Two months later, when Teresa was five months pregnant, her doctors discovered that her fetus had developed microcephaly. As was true in Daniela's story, Teresa did not feel that she had been given adequate information about her options when the abnormality was found. "The only thing they told me was to terminate [the pregnancy],"<sup>95</sup>she said. Beyond termination, she was not given adequate information about what to expect in continuing her pregnancy and what the quality of life might be for her and her child. Teresa felt heartbroken by the news, and for a time wished her life was over. Despite her clear distress at the news and concerns for the health of her fetus, at no point was she offered psychological or emotional support.

Despite the potential risks, Teresa decided to ignore her doctor's instruction that she had no choice but to end the pregnancy. For Teresa, continuing the pregnancy was important given that she previously believed she could not get pregnant despite her desire to do so. This, combined with her religious values, led her to believe her pregnancy was a "miracle." Suffice to say, she was firmly against her doctor's unequivocal recommendation that her only option was to terminate her pregnancy.

A few months later, Teresa gave birth to a son with microcephaly. At the time of this interview, Teresa's son was seven months old, and it was too early to tell exactly how extensive the impact of microcephaly would be on his life. Teresa and her husband reported that their son was unable to move well or support his own weight, but that they have taken solace in the positive signs they see in his development and are hopeful for his future. Their views have largely been informed by their own observations, as they have received little to no information from medical professionals. While several people have come to the house to gather information for public health records, no one from the government or health care system has come to ensure that their son receive specialized follow-up care or monitor his microcephaly and overall health and development.

Teresa also reported that she is worried about how her son will overcome the barriers she knows he will face due to CZS. Teresa and her husband feel that the responsibility of their child's well-being is squarely on their shoulders, and that any support they receive from the government or health care system will be limited. Neither Teresa nor her husband have confidence that the local, regional, or national governments have the capacity or political will to ensure that their child will enjoy special protections or rights as a person living with a disability.

Teresa believes more needs to be done to alert women about the risks associated with Zika. She feels that the government should do more to prevent transmission by fumigating high-risk areas such as her town and believes that insect repellent is too expensive for low-income women to use regularly and should be available for free or at a lower cost. For families such as hers that have already been permanently impacted by the virus and have children with special needs, more needs to be done by the government to ensure that adequate social protections are available.





## Respect for Women's Decision-Making and Privacy

The U.N. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) explicitly recognizes a woman's right to decision-making, which includes the right to determine the number, spacing, and timing of her children, and to have access to the contraceptive information and services necessary to exercise this right.<sup>96</sup> The right to privacy protects the right of all people to make decisions about their private lives, and decisions about whether and when to start a family falls within this protected definition of privacy.<sup>97</sup>

Safeguarding women's autonomy and decision-making regarding their sexual and reproductive lives should be central to national, global, and regional responses to Zika.<sup>98</sup> In order to do this effectively, states must be attuned to the social, economic, and political realities that women face each day when trying to exercise their sexual and reproductive rights.

## Contraception Access

Both the U.N. Committee on Economic, Social, and Cultural Rights and CEDAW explicitly recognize that the right to reproductive health must include the availability of contraceptive information and services.<sup>99</sup> For women seeking to delay or avoid pregnancy, states must ensure that they have affordable access to a full range of contraception options. Access to safe, effective, affordable, and acceptable family planning methods of your choice is integral to the freedom to decide, if and when, to reproduce.<sup>100</sup> Requirements of third-party consent for access to contraception must be removed as international human rights bodies have consistently considered such requirements contrary to women's rights.<sup>101</sup>







## Abortion Access

The widely divergent experiences of Daniela and Teresa—one who was never told the risks of continuing her pregnancy despite a Zika infection and the other who was told that ending her pregnancy was the only option—show how the health care system failed to provide women with the necessary information to make informed reproductive health decisions. In addition to this failure, several experts explained that the government did not collect national level data regarding the number of abortions that occurred during the epidemic, and that there was no data to reflect the many clandestine abortions that took place. Furthermore, it was never required for patients to state the reason that an abortion was requested so it has been difficult to ascertain the number of terminations that were Zika-related. Given these factors, it has also been difficult to determine whether or not there was an increase in the demand for abortions at a national level or even at individual clinics. Without this information, it has also been hard to ascertain the impact Zika has had on women's health care decision-making.

A doctor we interviewed who was providing abortions at a public hospital and has had several patients with Zika, noted that there were many barriers and stigma around women who chose to get therapeutic abortions.<sup>102</sup> The barriers encountered included access to accurate information, providers willing to perform the procedure, associated costs of termination, and religious and cultural biases, which were complicated further by the difficulty in detecting Congenital Zika Syndrome until late in a pregnancy when abortion generally becomes a much more difficult procedure to obtain.

Several interviewees mentioned that women had limited information on their right to abortion, even less than the limited information they had in regard to accessing and using contraception. The executive director of the reproductive health clinic Oriéntame noted that women received a lot of misinformation regarding the legality of abortion and the supposed medical risks associated with the procedure.<sup>103</sup>

The two doctors we interviewed, both of whom provided abortions in public and private clinics, cited that lack of adequate information regarding abortion as a leading, if not the principle, barrier to abortion access. They noted that many health care providers did not mention it as an option and in some cases provided misinformation because many believed that their personal stance against abortion justified sharing limited information with patients.<sup>104</sup> “There are many women—or people, men included—who do not know the law, who do not know what rights they have after ten years with this law,” said one doctor.

Finding providers both willing to provide accurate information and able to provide the service was noted as another major barrier women faced. Abortion was only partially legalized in Colombia in 2006, meaning that the vast majority of doctors in the country were educated before this legal change occurred. As a result, many doctors were never trained on how to provide the procedure or accurately advise patients, said the executive director of Oriéntame.<sup>105</sup> Both she and the United Nations Population Fund (UNFPA) expert we interviewed also noted refusals of care under the guise of conscientious objection by doctors who did not want to perform the procedure as a problem for accessing abortions.<sup>106</sup> In theory, these doctors are required to refer women to someone who will do the procedure, but this is more difficult in remote areas. This is very easy to say when we're in Bogotá (the capital),” said the UNFPA expert. “In remote zones of the country, where there are three gynecologists and five doctors in town...it's a critical barrier.”

The abortion providers we interviewed reported that another critical barrier to care was the lack of doctors in the country who would perform abortions. As a result, they found that women often ended up at their facilities after having unsuccessfully searched elsewhere.<sup>107</sup> Both doctors believed the problem was not merely a matter of doctors lacking the knowledge to perform the procedure, one noting that doctors have had ten years

since abortion became legal to get training, but rather that their attitudes prevented them from performing therapeutic abortions.<sup>108</sup>

If women were able to find someone to perform a legal abortion, many were unable to afford the cost. One study found that financial barriers were the most prevalent problem for women seeking to end a pregnancy, helping to explain why low-income individuals had more than double the odds of encountering difficulties in accessing services.<sup>109</sup> Many health plans also delayed approving the procedure as a mean of making it more difficult for women to use their coverage to pay for the procedure. As a result, we found that a woman's right to have an abortion covered by their health plan was more of a right in theory than one in practice.<sup>110</sup>

In addition to financial barriers, many women did not understand the steps required to legally terminate a pregnancy. Without this information, many women were forced to get a clandestine abortion instead after being turned away by their provider. While these procedures can be less expensive, they are also incredibly dangerous.

Removing barriers to abortion access would not only help the Colombian Constitutional Court fulfill its mandate of providing real and meaningful access to abortion, but it would also lower costs for the health care system. For example, one study found that the cost of an abortion at a specialized facility following best practices was a fraction of the price of providing follow-up care in a hospital to an individual who began the process elsewhere, such as at home with a medical abortion or with a clandestine provider.<sup>111</sup> This research also indicated that minimizing the time individuals spend acquiring an abortion, and maximizing the efficiency by which they can exercise their right to do so, would decrease the burden on Colombia's health care system.

## The Right to Abortion

Under international human rights law, women have the right to “the highest attainable standard of physical and mental health.”<sup>112</sup> The U.N. Committee on Economic, Social, and Cultural Rights recognizes that the right to health includes “the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference.”<sup>113</sup> Restricting women's access to safe and legal abortion, especially for those whose physical and/or mental health is at risk, jeopardizes many of their internationally protected human rights. In fact, U.N. human rights bodies have recognized the negative consequences of restrictive abortion laws on women's health<sup>114</sup> and have consistently raised concerns about the inaccessibility of safe abortion services.<sup>115</sup> As recognized by the Office of the U.N. High Commissioner for Human Rights: “[e]nsuring access to these services in accordance with human rights standards is part of state obligations to eliminate discrimination against women and to ensure women's right to health as well as other fundamental human rights.”<sup>116</sup>





## Caregiving and Children with Disabilities

While some women with Zika or those at risk of contracting the virus have chosen to avoid getting pregnant or voluntarily terminated a pregnancy, others have chosen (or were compelled through lack of other options) to get pregnant and give birth. In regions with a high prevalence of Zika, even children who were not born with any complications, like Daniela's child described earlier, will need to be monitored and tested. Ideally, such monitoring should continue for the first year of a child's life, as it is known that children with laboratory evidence of Zika can develop complications after being born free of any abnormalities consistent with Congenital Zika Syndrome.<sup>117</sup> A member of the Zika Universidad del Norte research team said that little is known about the long-term impact of the virus and that children born to mothers with Zika should be monitored indefinitely.<sup>118</sup>

"The state needs to come out strongly offering reproductive health services," said a lawyer at Women's Link Worldwide,<sup>119</sup> who believes that this obligation has been heightened by the fact that babies affected by Zika will have significant long-term needs that require a strong system of support from the government to such families and caretakers. "The reality is that that's not how the system works [at least not yet]," she said. The journalist for the newspaper in Barranquilla, *El Heraldo*, said that families of children born with microcephaly shouldn't bear the substantial costs associated with raising a child with high medical needs, and that these women need more economic support from the government.<sup>120</sup>

So far, no new programs have been announced that specifically support children born with Zika-related health complications. Without significant aid from the state, managing the health of a child born with Zika-related complications can present a major burden for parents—primarily for women who generally assume the caregiving role in Colombian society. "We have women who cannot work for the rest of their lives because they need to care for their babies [with microcephaly and other complications]," said a Zika expert at Colombia's National Institute of Health (Instituto Nacional de Salud). When you look at it this way, Zika has the potential to have a long-term impact on women's equality, and threatens to further marginalize women and limit their financial opportunities and ability to freely make choices with respect to planning and caring for their families.





## The Rights of Children with Disabilities

Protecting the rights of children with disabilities must be at the forefront of every state's response to Zika. The rights of people with disabilities are protected under the Convention on the Rights of People with Disabilities (CRPD).<sup>121</sup> CRPD states that people with disabilities are entitled to the full and equal enjoyment of all human rights and fundamental freedoms.<sup>122</sup> States must ensure that all the necessary support mechanisms and appropriate modifications are available and in place so that children with disabilities—and their caretakers—can enjoy and exercise all of their guaranteed human rights on an equal basis with others.<sup>123</sup>

The U.N. Committee on the Rights of the Child (CRC) recognizes the need to provide “material support in the form of special allowances as well as consumable supplies and necessary equipment, such as special furniture and mobility devices, that are deemed necessary for the child with a disability to live a dignified, self-reliant lifestyle, and be fully included in the family and community.”<sup>124</sup> In accordance with the CRC, “[s]upport services should also include different forms of respite care, such as care assistance in the home and day care facilities directly accessible at the community level. Such services enable parents to work, as well as relieve stress and maintain healthy family environments.”

In addition, General Comment No. 5 of the U.N. Committee on Economic, Social, and Cultural Rights (ESCR) recommends that states ensure the provision of social security and adequate income support to people with disabilities and their caretakers.<sup>125</sup> ESCR has recognized that “as far as possible, the support provided should also cover individuals (who are overwhelmingly female) who undertake the care of a person with disabilities.”



## Socioeconomic Inequality and Zika

Researchers visited the township of Tasajera and the Maracaibo neighborhood in the town of Ciénaga to interview women deemed at high risk for contracting Zika. Both areas are in the coastal department of Magdalena, a part of the country with a high prevalence of Zika.<sup>126</sup> These areas were said to have poor access to water and sanitation and are situated in a swamp that makes control of mosquitos particularly difficult.

The township of Tasajera is located on the main road between the cities of Barranquilla and Santa Marta, but its dirt roads and open houses bear little resemblance to the urban center an hour away. Moreover, the women who were interviewed there had seen little sign of intervention by the government or health care system to address the Zika epidemic and its aftermath; no interviewees had seen public or private health workers in the area during the Zika epidemic nor had they seen any information on the virus. The area we visited also had many stagnant bodies of water—often below houses built on wooden stilts—a perfect environment for mosquitos to thrive. Flor, one of the two women interviewed, said she had seen someone come to spray for mosquitos once at the height of the epidemic. “They only came that one time. Since then, they haven’t come back for Zika,” Flor said. “It seems they’ve already forgotten that disease.”

Maracaibo is a low-income neighborhood in the nearby town of Ciénaga where the roads are unpaved and the houses are simple structures of cement. There are no screens to keep mosquitos out and doors sit open all day to provide air in the intense heat. None of the women we talked to in this area had seen any evidence of government intervention related to the Zika crisis in their community. No government representative had provided information, testing, or insect repellent, although one woman had heard about fumigation in the area. None of the women thought that they had received enough information from the government about the virus, how to protect themselves, or the potential risks associated with Zika.

“If I was more informed, it’d be better,” said Ana, a woman in Maracaibo. “Because knowing even more, one can take better care of oneself...for pregnant women, there’s little help or information.”<sup>127</sup> Ana shared that at one time, when stories about Zika were appearing regularly in the news, women were concerned about getting pregnant and being infected, “but not anymore.” Now she does not hear about her neighbors taking precautions to avoid becoming infected or postponing pregnancy. “Up here, no. No one mentions anything,” she said. “Here, people stay misinformed.”

While most the five women we spoke to saw a public-sector health care provider regularly to monitor the status of their pregnancy, none had been told anything about Zika. The majority reported getting their information from the television or radio, which raised questions about how individuals without regular access to these devices stayed informed.

None of the women interviewed were using insect repellent to prevent transmission. Ana, for example, knew that insect repellent could help prevent infection, but said it was too expensive for her to buy. Researchers conducted a visit to the local pharmacy in Maracaibo a few blocks from Ana’s home and found that prices ranged from approximately USD 2.70 (COP 8,000) for a bottle designed for children to USD 4.75 (COP 14,000) for the most expensive bottle for adults. Given that the minimum wage in Colombia at the time of the interviews was approximately USD 61.47 (COP 184,000) per week,<sup>128</sup> a bottle of this insect repellent per week would equal approximately 8% of an individual’s monthly income, and would be even more for someone who was informally employed and not covered by minimum wage laws.

In the village of Tasajera, one woman told us that insect repellent was not even available for purchase in her local store. Although one interviewee, the head of the Barranquilla office of public health, mentioned a government program to distribute insect repellent in her city, the program was aimed at reaching tourists arriving for the city's annual carnival celebration, not at helping local, at-risk women. That same official, however, noted that she believed that even if the government provided free insect repellent to the population, it would not solve the problem anyway as there was not a culture of using insect repellent to protect against mosquitos in the first place.

## The Right to an Adequate Standard of Living

In accordance with the International Covenant on Economic, Social and Cultural Rights, state are mandated to recognize the right to an adequate standard of living for everyone.<sup>129</sup> This includes the right to adequate food, clothing, housing, and the continuous improvement of living conditions. The right to adequate housing applies to everyone, and includes the right to legal security of tenure, the availability of services and facilities, affordability of housing, habitability, accessibility of housing, suitability of location, and cultural adequacy.<sup>130</sup> In the context of Zika, states are obligated to “give due priority to those social groups living in unfavorable conditions by giving them particular consideration.”<sup>131</sup>

## The Right to Water and Sanitation

Longstanding infrastructure problems have been found to have exacerbated the Zika outbreak in Latin America and the Caribbean.<sup>132</sup> This was particularly true in the poorest areas of the countries that were hit hardest by Zika. In 2015, the U.N. General Assembly adopted resolution 70/169, which recognized the human right to safe drinking water and sanitation. The United Nations called upon all member states “to ensure the progressive realization of the right to safe drinking water and sanitation for all in a non-discriminatory manner while eliminating inequalities in access, including for individuals belonging to groups at risk and to marginalized groups, on the grounds of race, gender, age, disability, ethnicity, culture, religion, and national or social origin or on any other grounds, with a view to progressively eliminate inequalities based on factors such as rural-urban disparities, residence in a slum, income levels, and other relevant considerations.”<sup>133</sup> States are required to ensure that the right to water and sanitation is enjoyed by their population, a guarantee which could effectively mitigate Zika and future outbreaks of the virus.<sup>134</sup>





## Conclusion

Our research found that women exposed to Zika encountered many barriers in exercising their sexual and reproductive rights, particularly low-income women living in remote and rural areas. For example, language affirming the sexual and reproductive rights of women was largely absent from Zika-related public health campaigns or government responses in Colombia. Cost was often flagged as a barrier in accessing contraception and lengthy travel distances to clinics were also highlighted as making access to sexual and reproductive health services difficult. We also found that there were stark differences noted in contraception access between urban areas and rural areas.

Although abortion is legal in Colombia under three circumstances, including to protect a woman's physical and mental health, we found that it was not easy for women to access these services. Health care professionals and even health care insurance plans, and medical settings frequently refuse care based on personal religious convictions in what is an improper use of conscientious objection laws. Lack of adequate information was also identified as an important barrier to accessing abortion. The abortion providers interviewed for this report said that there were very few doctors who would perform the procedure, and that women often ended up at their facilities after being denied elsewhere.<sup>135</sup> Many health insurance plans also delay approving the procedure and try to make it more difficult for women to use their coverage to pay for the procedure.<sup>136</sup>

While many cases of babies with microcephaly were reported, we found that policies related to social inclusion and access to support mechanisms were some of the largest concerns of families with children with disabilities. These families were typically among the most socioeconomically vulnerable, making the added responsibility of taking care of a child with a disability even more challenging. However, what was even more worrying was that the government has announced no long-term programs to specifically support children born with Zika-related health complications.



During on-site visits in the coastal department of Magdalena in the northern part of the country, we walked through a great number of untreated open sewage and storm drains near the towns and cities where we conducted interviews, creating unsanitary standing water conditions near the homes of people we directly interviewed. While poverty and development conditions will continue to impact the most vulnerable people living in tropical cities who cannot afford window screens or insect repellent, governments must prioritize and invest in increasing access to water and sanitation by improving the infrastructure of towns with large unsanitary water conditions.

The Barranquilla department of health said one of their initial priorities was to prevent a public panic in regard to the Zika epidemic, which is why they did not declare a public health emergency.<sup>137</sup> But, as of early 2017, after the worst of the epidemic had passed, the head of that office said she was worried that the public might let down its guard, potentially leading to a resurgence of the virus.

It was a mistake for the Colombian government to declare the epidemic over in July 2016 as it suggested to the public that they no longer needed to take precautions to prevent transmission or consider family planning options. By declaring the epidemic over without explaining the implications for women who were already exposed or who may become infected in the future, the government has seemed to have confused the population. Every expert interviewed on the subject agreed that the crisis was not over—and that the repercussions of the virus were here to stay and could get worse, perhaps even in the shape of another infectious disease. Unfortunately, that was not the message the public received from the government.

A Zika researcher at Universidad del Norte said, “fear is the first word” that came to mind when thinking about the early days of the epidemic, but now the problem has reversed itself. Rather than the government continuing to respond to inform the public and ease their fears, there needs to be even more effort made to keep people vigilant in preventing Zika and considering its impact on their family planning.<sup>138</sup> An abortion provider agreed that early on the outbreak was actually an opportunity to educate women and bring reproductive health issues into public discussion.<sup>139</sup> “Right now,” he said, “the alertness and fear have gone down,” even though the risk of contracting Zika persists. The underlying needs of the population to have access to reproductive health services, as well as to have protection from diseases spread by mosquitos, remains even as the Zika crisis has faded.



# Recommendations



## Government Recommendations

- Guarantee that all pregnant women have comprehensive information and access to reproductive health services, including abortion, that reflect all available options and not the personal biases or preferences of providers.
- Enact legislation that supports legalizing abortion in all cases and regulates conscientious objection by health providers and institutions.
- Ensure that public education campaigns provide accurate, complete, and easily comprehensible information about the transmission of the Zika virus, including sexual transmission and its consequences.
- Guarantee that people have information about their fundamental rights and any policies related to protecting themselves against Zika and its consequences, including the right to free contraceptive methods and various social assistance programs.
- Provide access to free or affordable insect repellent for all women of reproductive age, particularly during peak mosquito seasons and in areas with a high risk of Zika and other arboviral diseases.
- Guarantee all families and children affected by Congenital Zika Syndrome (CZS), particularly low-income families, access to social assistance programs necessary for their children's development and families' livelihoods.
- Ensure the implementation of policies to proactively counter disability discrimination or stigmatization and guarantee the inclusion of children affected by CZS in the school system and other social spaces.
- Intensify efforts to eliminate mosquito-breeding sites and ensure long-lasting control of *Aedes aegypti*, including investing in water and sanitation infrastructure for communities that have been most susceptible to the spread of Zika and other arboviruses.



## Health Care System Recommendations

- Increase the availability of a full range of contraception options and information for women wishing to avoid pregnancy, including long-term and permanent contraception in the public and private health care systems.
- Increase the capacity of health care professionals to detect and diagnose Zika and consistently provide demographic data, including race/ethnicity, for reported cases as a means of better documenting the social inequities of the epidemic
- Ensure that surveillance systems to monitor Zika in rural and peri-urban areas are on par with those in urban areas.
- Guarantee that all individuals, particularly adolescent and young women, have access to accurate information about the prevention of pregnancy and sexually transmitted infections, including the sexual transmission of Zika.
- Ensure that all pregnant women are able to access prenatal care early in their pregnancies and receive counseling on the prevention of Zika.
- Provide access to psychosocial care for all pregnant women living in areas affected by Zika, particularly those who have been diagnosed with an infection during their pregnancy.
- Guarantee the availability of a second ultrasound to all pregnant women living in areas affected by the virus in order to facilitate early diagnosis of microcephaly.
- Train health care professionals to properly diagnose and provide or refer care for infants with CZS.
- Conduct medical re-evaluations of all reported cases of CZS that were discarded for microcephaly during the early months of the epidemic to identify cases that may now fit the broader criteria.
- Ensure that all health care professionals have knowledge about abortion access, including how women can legally access the procedure and what options they have to receive care.
- Ensure that women who wish to terminate a pregnancy receive accurate information about their legal options, including harm reduction where the procedure is not legally available.





## Private Sector Recommendations

- Partner with the government to reduce the price and extend the distribution of quality diagnostic tests, safe insect repellent, necessary medications, and medical devices for the treatment of CZS, and, when available, vaccines.



## Civil Society Recommendations

- Support the advancement of human rights by recognizing the impact Zika and other infectious diseases has on a person's socioeconomic status, gender, and race.
- Support ongoing public information campaigns about Zika with an emphasis on mobilizing the community and educating individuals about their health-related rights and social assistance programs or policies available to them.
- Monitor the creation and implementation of long-term policies and programs related to sexual and reproductive health and social assistance for families and caregivers of children with disabilities, particularly in the context of infectious diseases.
- Engage in interdisciplinary, qualitative, and quantitative research efforts on the impact of Zika and other infectious diseases to develop evidence-based recommendations and best practices for laws and policymakers.
- Foster research on the long-term impact of Zika on women's and children's rights, facilitate community-led dialogue and networks among women affected by the virus, and promote knowledge sharing, particularly in areas with low surveillance, detection, and prevention public health systems.

# Endnotes

- <sup>1</sup> These included formal interviews with five experts as well as informal discussions with three additional experts for the purpose of background information and snowball sampling. Interviewees included experts currently or formerly with the WHO, UNDP, OHCHR, and IACHR. Additionally, in completing the analysis herein, transcripts were reviewed from interviews with experts working for U.N. agencies and entities in the countries studied for this report, including UNFPA and UNICEF in Brazil, UNFPA and UNDP in Colombia, and UNFPA and UNICEF in Brazil.
- <sup>2</sup> PAHO/WHO, *Zika Cases and Congenital Syndrome Associated with Zika Virus Reported by Countries and Territories in the Americas, 2015 – 2017: Cumulative Cases*, November 20, 2017.
- <sup>3</sup> Oscar Pacheco et al., *Zika Virus Disease in Colombia - Preliminary Report*, N. Engl. J. Med. at 2, 15 Jun. 2016.
- <sup>4</sup> Instituto Nacional de Salud (Colombia), *Semana Epidemiológica* No. 1, Jan. 2017, at 88.
- <sup>5</sup> “Colombia Advises Women to Delay Pregnancy During Zika Outbreak,” Reuters, Jan. 21, 2016; Shasta Darlington, “Delay Pregnancy in Areas with Zika, W.H.O. Suggests,” *New York Times*, June 9, 2016.
- <sup>6</sup> “WHO Director-General Summarizes the Outcome of the Emergency Committee Regarding Clusters of Microcephaly and Guillain-Barre syndrome,” WHO Media Centre, Feb. 1, 2016; Donald G. McNeil Jr., “How the Response to Zika Failed Millions,” *New York Times*, Jan. 16, 2017; interview by authors with Joana (Mar. 2017).
- <sup>7</sup> Donald G. McNeil Jr., “To Protect Against Zika Virus, Pregnant Women Are Warned About Latin American Trips,” *New York Times*, Jan. 15, 2016.
- <sup>8</sup> WHO, *Zika Situation Report*, Aug. 18, 2016, available at <http://www.who.int/emergencies/zika-virus/situation-report/18-august-2016/en/>.
- <sup>9</sup> Stephanie Nebehay and Julie Steenhuisen, “WHO Declares End of Zika Emergency But Says Virus Remains a Threat,” Reuters, Nov. 18, 2016; Donald G. McNeil Jr., “Zika Is No Longer a Global Emergency, W.H.O. Says,” *New York Times*, Nov. 18, 2016.
- <sup>10</sup> McNeil Jr., *supra* note 9.
- <sup>11</sup> Nick Miroff, “Colombia Declares its Zika Epidemic Over,” *Washington Post*, July 25, 2016.
- <sup>12</sup> CDC, *Zika: Symptoms, Testing, & Treatment*, available at <https://www.cdc.gov/zika/symptoms/index.html>.
- <sup>13</sup> *Id.*
- <sup>14</sup> *Id.*
- <sup>15</sup> Pam Belluck and Tania Franco, “For Brazil’s Zika Families, a Life of Struggle and Scares,” *New York Times*, Mar. 11, 2017; *see also* CDC, *Birth Defects: Facts About Microcephaly*, Dec. 2016.
- <sup>16</sup> CDC, *supra* note 15.
- <sup>17</sup> *Id.*
- <sup>18</sup> *Id.*
- <sup>19</sup> *See, e.g.*, WHO, *Information for Travellers Visiting Zika Affected Countries Fact Sheet*, Apr. 17, 2017; Amy S. Patterson, “Here’s Why the WHO Responded So Differently to Zika and Ebola,” *The Washington Post*, Apr. 4, 2016; Government of the U.K., *Zika Virus: Travel Advice*, July 25, 2016, available at <https://www.gov.uk/guidance/zika-virus-travel-advice>; Judy Koutsky and Meredith Carey, “12 Zika-Free Destinations to Travel to This Year,” *Condé Nast Traveller*, Apr. 5, 2017.
- <sup>20</sup> McNeil Jr., *supra* note 6.
- <sup>21</sup> CFR Press Statement, UNFPA, *UNFPA Closely Monitors Zika Outbreak, Urges Access to Sexual and Reproductive Health Care and Information*, (Feb. 4, 2016); UNFPA Press Statement, *Voluntary Family Planning, Including Condoms, Essential to Prevent Spread of Zika Virus*, Mar. 10, 2016; Office of the United Nations High Commissioner for Human Rights, *Upholding women’s human rights essential to Zika response – Zeid*, Feb. 5, 2016; David H. O’Connoer et al., *Forging Collaborative Relationships in Brazil: From AIDS to ZIKA*, 166 CELL 2 (2016) which speaks to how we can build better relationships to combat the Zika epidemic by learning from how Brazil stimulated collaborations during the HIV epidemic. These collaborations could create a more effective international infectious disease research response; *see also* IACHR *Welcomes Progress and Urges States to Ensure Favorable Conditions for the Exercise of Women’s Rights*, IACHR, Mar. 8, 2016.
- <sup>22</sup> Interview by authors with faculty researchers in Zika surveillance at a university in Barranquilla, Jan. 2017.
- <sup>23</sup> Interview by authors with Carolina Melo, Gender Officer at UNDP, Jan. 2017.
- <sup>24</sup> Corte Constitucional [C. C.] [Constitutional Court], Mayo 10, 2006, Sentencia C-355/06, (Colomb.).
- <sup>25</sup> Interviews by authors with two physicians who provide abortions at public and private hospitals in Bogotá, Jan. 2017.
- <sup>26</sup> Interview by authors with Cristina Villarreal, Director, Oriéntame Foundation, Jan. 2017.
- <sup>27</sup> *See, e.g.*, Paul Farmer, *Infections and Inequalities: The Modern Plagues* (2001); Michael J. Selgelid, *Justice, Infectious Diseases and Globalization*, in 7 *Global Health and Global Health Ethics* 89, 89 (Solomon Benatar and Gillian Brock eds., 2011); Lara Stemple et al., *Human Rights, Gender, and Infectious Disease: From HIV/AIDS to Ebola*, 38 *Human Rights Quarterly* 993 (2016).
- <sup>28</sup> WHO, *One Year into the Zika Outbreak: How An Obscure Disease Became a Global Health Emergency* (accessed June 30, 2017).
- <sup>29</sup> *See* the definition of reproductive health provided by the Office of the High Commissioner for Human Rights in *Article 12.2(a): The Right to maternal, child and reproductive health* in footnote 12 of the ESCR *Gen. Comment No. 14*.
- <sup>30</sup> *See* Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, art. 1, G.A. Res. A/RES/61/106. U.N. GAOR, 61<sup>st</sup> Sess., U.N. Doc. A/61/611 (1980) (*entered into force* May 3, 2008) [hereinafter CRPD]; *See also* Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, *adopted* Jun 7, 1999, art. II, G.A. 29<sup>th</sup> Sess.
- <sup>31</sup> Constitución Política de Colombia [Constitution] art. 93 (Col.).
- <sup>32</sup> *See* Office of the United Nations High Commissioner for Human Rights, *supra* note 21.
- <sup>33</sup> United Nations Development Program, *Colombia: HDI Values and Rank Changes in the 2013 Human Development Report*, at 1-2 (2013).
- <sup>34</sup> *Id.*, at 4.
- <sup>35</sup> *Id.*, at 5.
- <sup>36</sup> PAHO/WHO, *Zika Cases and Congenital Syndrome Associated with Zika Virus Reported by Countries and Territories in the Americas, 2015 – 2017: Cumulative Cases*, June 8, 2017.
- <sup>37</sup> *Id.*
- <sup>38</sup> Donald G. McNeil Jr. and Julia Symmes Cobb, “Colombia Is Hit Hard by Zika, But Not By Microcephaly,” *New York Times*, Oct. 31, 2016.
- <sup>39</sup> “Microcephaly Quadrupled in Colombia This Year Due to Zika – Report,” *Reuters*, Dec. 9, 2016.
- <sup>40</sup> William Wan, “Zika was a mild bug. A new discovery shows how it turned monstrous,” *The Washington Post*, Sept. 28, 2017; PAHO/WHO, *supra* note 36; *see also* Declan Butler, *Brazil Asks Whether Zika Acts Alone to Cause Birth Defects*, *Nature*, July 25, 2016 and Jing-Wen Ai et al., *Zika Virus Outbreak: ‘A Perfect Storm’*, 5 *Emerging Microbes Infect* e21 (2016) to explain why Brazil’s incidence of microcephaly and other Zika-related complications might be unique to the area.
- <sup>41</sup> Pacheco et al., *supra* note 3.
- <sup>42</sup> Instituto Nacional de Salud (Colombia), *supra* note 4.
- <sup>43</sup> Miroff, *supra* note 11.
- <sup>44</sup> *Id.*
- <sup>45</sup> Instituto Nacional de Salud (Colombia), *supra* note 4.
- <sup>46</sup> Pacheco et al., *supra* note 3, at 5.
- <sup>47</sup> Associated Press, “Zika Virus Triggers Pregnancy Delay Calls,” *BBC News*, Jan. 23, 2016.
- <sup>48</sup> Ministerio de Salud y Protección Social (Colombia), *Lineamientos Provisionales Para el Abordaje Clínico de Gestantes Expuestas al Virus Zika en Colombia*, Feb. 2016, at 22.
- <sup>49</sup> *Id.*
- <sup>50</sup> Constitutional Court, *supra* note 24.
- <sup>51</sup> Nicholas Casey, “Zika Virus in Colombia Presents Complicated Choice about Abortion,” *New York Times*, Feb. 15, 2016.
- <sup>52</sup> Health editor, *Cinco Anticonceptivos Entrarán al POS*, *El Tiempo*, Dec. 15, 2007.
- <sup>53</sup> *Id.*
- <sup>54</sup> Interview with faculty researchers in Zika surveillance, *supra* note 22.
- <sup>55</sup> Instituto Nacional de Salud (Colombia), *Semana Epidemiológica* No. 20, May. 2017, at 95.
- <sup>56</sup> Instituto Nacional de Salud (Colombia), *Semana Epidemiológica* No. 52, Dec. 2017, at 114.
- <sup>57</sup> Interview with faculty researchers in Zika surveillance, *supra* note 22.
- <sup>58</sup> Interview by authors with Eloena Guenago, Header of Public Health Office, City of Barranquilla, Colombia, Jan. 2017.
- <sup>59</sup> *Id.*
- <sup>60</sup> *See* Press Release, Barranquilla Ministry of Health, *Suroccidente se Prepara para Enfrentar el Aedes Aegypti en Invierno*, Apr. 11, 2017.
- <sup>61</sup> Interview with Eloena Guenago, *supra* note 58.
- <sup>62</sup> CDC Press Release, *CDC and the Instituto Nacional de Salud of Colombia Collaborate to Understand Long-Term Effects of Zika Virus Infection During Pregnancy*, Sep. 2, 2016; Press Release, *Colombia Ministry of Health, Colombia y EE.UU. Investigarán Efectos a Largo Plazo del Zika*, Feb. 3, 2017.
- <sup>63</sup> Interview with faculty researchers in Zika surveillance, *supra* note 22.
- <sup>64</sup> Interview by authors with Marcela Mercado, Investigator at the National Institute of Health, Colombia, Jan. 2017.
- <sup>65</sup> CRC, *Gen. Comment No 4*, para. 28; ESCR Committee, *Gen. Comment No 14*, para. 34; CEDAW Committee, *Gen. Recommendation 21*, para. 22.
- <sup>66</sup> CRR, *CENTERING HUMAN RIGHTS IN THE RESPONSE TO ZIKA* at 2.
- <sup>67</sup> *Id.*
- <sup>68</sup> *Id.*, at 1-4.
- <sup>69</sup> *Id.*
- <sup>70</sup> WHO, *Emergencies Preparedness, Response: Publications, Technical Guidance on Zika Virus*, 2017.
- <sup>71</sup> Ministry of Health, *Zika Clinical Guidelines*, at 11-12.
- <sup>72</sup> *Id.*
- <sup>73</sup> These prices are based on those at a drugstore in Maracaibo, Magdalena visited by researchers in January 2017.
- <sup>74</sup> Salario Mínimo en Colombia 2017, *Portafolio*, Aug. 17, 2017.
- <sup>75</sup> Interview with Eloena Guenago, *supra* note 58.
- <sup>76</sup> Interviews by authors with María Alejandra Cárdenas Cerón, former Regional Legal Director, and Carmen Martínez López, Senior Attorney, at Women’s Link Worldwide, Jan. 2017.
- <sup>77</sup> *Id.*



- 78 International Covenant on Economic, Social, and Cultural Rights, *adopted* Dec. 16, 1966, art. 12(c), G.A. Res. 2200A (XXI), U.N. GAOR, 21<sup>st</sup> Sess., Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976).
- 79 ESCR Committee, *supra* note 65, at para. 16.
- 80 *Id.*
- 81 *Id.*
- 82 Interview by authors with Martha Lucia Rubio Mendoza, advisor of sexual and reproductive health and youth, UNFPA Colombia, Jan. 2017.
- 83 *Id.*
- 84 *Id.*
- 85 *Id.*
- 86 *Id.*
- 87 *Id.*
- 88 Interview with faculty researchers in Zika surveillance, *supra* note 22.
- 89 Interview with Carolina Melo, *supra* note 23.
- 90 Interview by authors with Alison Nikol Guerrero Rodriguez, Journalist with *El Heraldo* Newspaper, Jan. 2017.
- 91 Interview by authors with Daniela, a pseudonym was used to protect the identity of the interviewee, Jan. 2017.
- 92 *Id.*
- 93 Ministerio de Salud y Protección Social (Colombia), *supra* note 48, at 18 and 22.
- 94 Interview with Daniela, *supra* note 91.
- 95 *Id.*
- 96 *Id.*
- 97 *Id.*
- 98 See, Vanessa van der Linden et al., *Description Of 13 Infants Born during October 2015 – January 2016 with Congenital Zika Virus Infection without Microcephaly at Birth – Brazil*, 65(47) *Morb. Mortal Wkly Rep.* 1343, 1344, Dec. 2, 2016.
- 99 The right to the highest attainable standard of health is recognized in numerous international instruments, including the *Universal Declaration of Human Rights* and the *International Covenant on Economic, Social and Cultural Rights*. This right is also recognized in the *International Convention on the Elimination of All Forms of Racial Discrimination*, the *Convention on the Elimination of All Forms of Discrimination against Women*, the *Convention on the Rights of the Child*, and the *Convention on the Rights of Persons with Disabilities*. In the regional context, the right to health is also protected under the *Additional Protocol to American Convention on Human Rights in the Area of Economic, Social and Cultural Rights*.
- 100 Committee on Economic, Social and Cultural Rights (ESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12), (22<sup>nd</sup> Sess., 2000), U.N. Doc HRI/GEN/1/Rev.9 (vol. I) (2008).
- 101 See the definition of reproductive health, *supra* note 29.
- 102 Pacheco et al., *supra* note 3, at 5-6. The departments of Magdalena and Atlántico had a cumulative incidence of Zika ranging from 81.4 and 333.4 per 100,000 among Zika in pregnant women, whereas Santander had a range of 333.5 and 621.4 per 100,000. The cumulative incidence of Zika among the general population in Magdalena and Atlántico was 283.3 655.7 per 100,000, whereas it was 655.8 1342.2 per 100,000 in Santander, Casanare, and Tolima.
- 103 Interview by authors with Teresa, a pseudonym was used to protect the identity of the interviewee, Jan. 2017.
- 104 Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 16(1)(e), G.A. res. 34/180, U.N. GAOR, 34<sup>th</sup> Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1980), U.N.T.S. 13 (*entered into force* Sept. 3, 1981); see also CRPD, *supra* note 30, at art. 23(1)(b).
- 105 International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 17, paras. 1–2, G.A. Res. 2200A (XXI), U.N. GAOR, 21<sup>st</sup> Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976); see also Convention on the Rights of the Child, *adopted* Nov. 20, 1989, arts. 16(1–2), 22(1), G.A. Res. 44/25, annex, U.N. GAOR, 44<sup>th</sup> Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC]; American Convention on Human Rights, *adopted* Nov. 22, 1969, art. 11, para. 2, O.A.S.T.S. No. 36, O.A.S. Off. Rec. OEA/Ser.L/V/II.23, doc. 21, rev. 6 (*entered into force* July 18, 1978), available at <http://www.cidh.oas.org/Basico/English/Basic3.American%20Convention.htm>.
- 106 CEDAW Committee, *Gen. Recommendation No. 25*, para. 9.
- 107 ESCR Committee, *supra* note 65, at para. 34; CEDAW Committee, *Gen. Recommendation No. 24*, para. 17; CEDAW Committee, *supra* note 65.
- 108 See the definition of reproductive health, *supra* note 29.
- 109 CEDAW, *Gen. Recommendation 24*, para. 14; CEDAW, Concluding Observations on Indonesia, CEDAW/C/IDN/CO/5 (2007), para. 16; Committee on the Rights of the Child, General Comment 15, para. 31.
- 110 Interview by authors with a physician who provides abortion services at a public hospital in Bogotá, Jan. 2017.
- 111 Interview with Cristina Villarreal, *supra* note 26.
- 112 Interviews with two physicians, *supra* note 25.
- 113 *Id.*
- 114 Interview with Cristina Villarreal, *supra* note 26.
- 115 Interview with Martha Lucia Rubio Mendoza, *supra* note 82.
- 116 Interviews with two physicians, *supra* note 25.
- 117 *Id.*
- 118 Sarah Baum et al., *Delays and Barriers to Care in Colombia Among Women Obtaining Legal First- and Second-Trimester Abortion*, 131 *Int J Gynaecol Obstet* 285, 287, 2015.
- 119 Interview with Cristina Villarreal, *supra* note 26.
- 120 Elena Prada, Isaac Maddow-Zimet, and Fatima Juarez, “The cost of post abortion care and legal abortion in Colombia,” *International Perspectives on Sexual and Reproductive Health*, 39:3, 114-23, at 119 (2013).
- 121 *Id.*
- 122 International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 12 G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976), [hereinafter ICESCR].
- 123 ESCR Committee, *supra* note 65, at para. 80.
- 124 See, e.g., Human Rights Committee, Concluding Observations: Argentina, para. 14, U.N. Doc. CCPR/CO/70/ARG (2000); CEDAW 1999 pt. 2, ch. IV, Chile, para. 228; CEDAW 1999, pt. 1, ch. IV, Colombia, para. 393.
- 125 See, e.g., Human Rights Committee, Concluding Observations: Mali, para. 14., U.N. Doc. CCPR/CO/77/MLI (2003); Human Rights Committee, Concluding Observations: Poland, para. 11, U.N. Doc. CCPR/C/79/Add.110 (1999); CAT Committee, Concluding Observations: Chile, para. 7(m), U.N. Doc. CAT/CR/32/5 (2004).
- 126 OHCHR, *Information Series on Sexual and Reproductive Health and Rights: Abortion* at 1, [http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO\\_Abortion\\_WEB.pdf](http://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Abortion_WEB.pdf)
- 127 CDC, Follow-up Care: Long-Term Follow-Up Care for Infants with Congenital Zika Virus Infection, 2017). The prognosis for infants with CZS is currently unknown. The CDC released guidelines specific to infants, which includes recommendations for testing for CZS as well as clinical management recommendations for infants with evidence of a Zika virus infection, both with and without apparent complications. This is to ensure careful screening and monitoring of fetal development. Routine care for infants with laboratory evidence of Zika virus infection but without abnormalities consistent with CZS should include monitoring of head (occipitofrontal) circumference, length and weight. Developmental monitoring should also occur at every visit, and age-appropriate standardized validated developmental screening should occur at 9 months. According to the CDC, “vision screening, including visual regard, should [also] be performed at each well child visit, and referral to an ophthalmologist should be made for any caregiver or provider concerns. Infants who passed an initial ABR should be referred for behavioral audiological diagnostic testing at age 9 months, or sooner for any hearing concerns. Overall, families and caregivers of infants with congenital Zika virus infection will require ongoing psychosocial assessment and support. As a critical component of patient care and to facilitate early identification of developmental delays, families should be empowered to be active participants in their child’s monitoring and care.”
- 128 Interview with faculty researchers in Zika surveillance, *supra* note 22.
- 129 Interview by authors with María Alejandra Cárdenas Cerón, former Regional Legal Director, Women’s Link Worldwide, Jan. 2017.
- 130 Interview by authors with Alison Nikol Guerrero Rodriguez, *supra* note 90.
- 131 See CRPD, *supra* note 30.
- 132 *Id.*, at art. 1; See also Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities, *supra* note 30.
- 133 CRPD, *supra* note 30, at art. 2, para. 5.
- 134 CRC, *Gen. Comment No. 9*, para. 41.
- 135 *Id.*
- 136 ESCR Committee, *Gen. Comment No. 5*, para. 28.
- 137 *Id.*
- 138 Interviews with faculty researchers in Zika surveillance, *supra* note 22.
- 139 Interview by authors with Ana, a pseudonym was used to protect the identity of the interviewee, Jan. 2017.
- 140 *Id.*
- 141 Salario Mínimo en Colombia 2017, *supra* note 74.
- 142 ICESCR, *supra* note 120, at art. 11, para. 1.
- 143 *Id.*
- 144 ESCR Committee, *General Comment No. 4: The Right to Adequate Housing (Art.11 (1) of the Covenant)*, (6<sup>th</sup> Sess., 1991), at para. 8, U.N. Document E/1992/23.
- 145 *Id.*, at para. 11.
- 146 Margaret Wurth, *Brazil’s Zika Threat Remains: Water, Sanitation Problems That Intensified Zika Outbreak Persist*, HRW, May 12, 2017.
- 147 G.A. Res. 70/169, The human rights to safe drinking water and sanitation, at 4 (Feb. 22, 2016).
- 148 Wurth, *supra* note 146.
- 149 Interviews with two physicians, *supra* note 25.
- 150 Interview with Cristina Villarreal, *supra* note 26.
- 151 Interview with Eloena Guenago, *supra* note 58.
- 152 Interviews with faculty researchers in Zika surveillance, *supra* note 22.
- 153 Interviews with two physicians, *supra* note 25.













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