

Zika and reproductive justice

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The appearance of Zika in Latin America over the past six months has prompted a wide range of responses, from the creation of microcephaly clinics for newborns in affected areas to the rapid roll out of transnational scientific research to determine the molecular and epidemiological dimensions of this mosquito-borne disease. This crucial knowledge is needed to understand the scope and scale of this emerging disease – to establish baselines for further studies, to determine the extent of the problem, and make evidence-based plans for prevention and potential medical treatments for children with Zika-related conditions.

There also has been a flurry of articles about how Zika is challenging the strict abortion laws in place throughout most of Latin America, including Brazil, where Zika was declared a National Public Health Emergency on November 11, 2015, and abortion is prohibited except in cases of rape and endangerment to the mother (codified in the 1940 Constitution), and anencephaly, or absence of parts of the brain or skull (which became law in 2012). For the most part, these inquiries offer a welcome and needed perspective on the complex and fraught ways in which Zika, which can cause microcephaly and other neurological problems in the fetuses and children of infected pregnant women, intersects with reproductive health.

These accounts tend to focus on numbers produced by epidemiological surveillance, new discoveries about the structure and mutability of

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the virus, or Latin America's restrictive and uneven access both to contraception and abortion.

Often lost in this quickly emerging and crucial scholarship and reporting is the human dimension – the experiences and circumstances of women infected with Zika who are pregnant or have given birth to babies with microcephaly. Anthropologists and reproductive health advocates like Debora Diniz are capturing the real life struggles of women in places such as Bahia, Paraíba, Pernambuco, and Rio Grande do Norte, states in northeastern Brazil that are at the epicenter of the Zika virus, accounting for 72% of the babies born with Zika-related conditions¹.

Diniz's poignant commentary thoughtfully illuminates how motherhood, for overlapping cohorts of women of reproductive age, are now being redefined by new regimes of testing and imaging. Frequently results are uncertain and longer-term implications unclear. What is clear is that Zika reveals and underscores deep-seated structural inequalities that are resulting in an epidemic that overwhelmingly affects poor black and brown women in under-resourced parts of the country. Despite the existence of microcephaly clinics and well-trained and compassionate health care professionals, there is very little social support for families that now include a child with a significant developmental disability. Even though such support is guaranteed by Brazil's 1988 *Constitution*, and enshrined in international laws related to health and human rights,

it does not materialize. For many women, this means limited or no transportation for them and their child to travel from the outskirts of town or remote rural areas to medical clinics. In many instances, mothers have little choice but to give up their jobs and income because their newborns require specialized, constant care. This doesn't mean that they love them any less, but rather, that their lives have become harder and their futures more compromised.

What if we analyze Zika through the lens of reproductive justice? Reproductive justice is both a movement for reproductive rights, health, and equity, and a framework that leverages intersectionality and human rights. It has been popular among women of color in the United States, and was developed by African American feminists who sought to combine the insights of critical race theory with intersectional analysis of social oppressions, and situate women's rights and human rights. According to Loretta Ross, the co-founder of SisterSong, a collective of reproductive rights and justice organizations, reproductive justice encompasses equally "(1) *the right to have a child*; (2) *the right not to have a child*; and (3) *the right parent the children we have, as well as the right to control our birth options, such as midwifery*"².

A reproductive justice perspective compels us to consider Zika in the context of reproductive stratification, gender inequalities, and social justice, and can help navigate the social complexities of the virus and its human implications.

For example, some media stories about Zika utilize the specter of defective babies to underscore the need for expanded abortion laws and access in Latin America. However, there is a great deal of uncertainty about whether a pregnant woman infected with Zika will give birth to a child with microcephaly, about the likely range of developmental disabilities that might affect any child, and the longer-term affects of Zika-related conditions on maturing children. The decision to terminate a pregnancy should be in the hands of the pregnant woman and her partner in consultation with physicians and other health professionals who can provide the most accurate information. For many women, particularly those with strong religious values, the prospect of having a child with a mild to severe disability is not reason alone to terminate a pregnancy. Respecting decisions to give birth to children with detected or probable disabilities is one facet of reproductive justice can get lost in the laudable championing of expanded abortion and contraceptive care, particularly in Latin America. This does not mean that pregnant women carrying a child with detected disabilities should be compelled to have

a child, but rather they should be able to make the decision, to carry to term or abort, with the greatest degree of autonomy possible. When the tenets of reproductive justice were articulated, the "right to have a child" largely was a response to the histories of forced sterilization that women of color and poor women had endured in parts of the United States. This tenet is just as applicable in the Global South: in Peru, where thousands of indigenous women were sterilized during the administration of Fujimori, and India, where until recently sterilization quotas were nationally enforced in the name of family planning and population control.

Currently Brazil's law permits abort in cases of rape, endangerment to the women, and anencephaly (the absence of parts of the brain and skull in the fetus). To date, the law has not been modified to add an exception for microcephaly, a condition linguistically similar to but diagnostically distinct from anencephaly. Thus, women who might want to terminate a pregnancy due to detected fetal microcephaly or the fact they were infected with Zika while pregnant, face significant barriers to abortion. Indeed, women who undergo abortion can face up to one to three year's imprisonment, and the physician carrying out the procedure one to four year's imprisonment. Most strikingly, the appearance of Zika has not prompted Brazilian legislators to loosen exceptions for abortion, but to tighten the laws. For example, Anderson Ferreira, a conservative congressman from the Northeast, is seeking to lengthen the penalty for women to a maximum of 4.5 years and 6 years for the responsible physician³. The current political crisis in Brazil, in which an increasingly powerful evangelical bloc, appears to be successfully removing the elected albeit unpopular president, Dilma Rousseff, is likely to result in continued if not expanded restrictions on abortion for foreseeable future. Brazil's restrictions on abortions, which result in high numbers of unsafe procedures, contravene the second tenet of reproductive justice, and underscore the extent to which women's reproductive autonomy is subject to control and criminalization. Legal and accessible abortion would provide an important option to pregnant women infected with Zika or carrying fetuses with detected microcephaly. In many instances, women, their partners, existing children, and extended families, will carry the financial and care-taking burdens of adding a child with marked disabilities. The right to safe and legal abortion is a core principle of the United Nations' International Conference on Population and Development (ICPD), and was rearticulated in twenty-year anniversary report of the ICPD's 1994 Cairo (Egypt) meeting.

Specifically, the ICPD calls for “*revising policies and legislation to make abortion safe, accessible and legal to protect the human rights of women, to reduce maternal mortality and morbidity and to mitigate violence against women and its consequences*”⁴. Although Zika has the capacity to help to liberalize abortion in Brazil and Latin America, this path seems unlikely at this point.

Finally, Zika puts into stark relief the third tenet of reproductive justice, namely, the right of women to parent their children in an affirming and supportive environment. In her commentary, Debora Diniz¹ interviewed a woman who lives three hours away from the clinic in Campina Grande, and describes herself as “permanently troubled”, unable to sleep, and desperately trying to schedule intake appointments for her child with INSS (the social security office). This

scenario plays out over and over again, and reported cases of microcephaly are forgotten a few days after the headlines are published. As Diniz observes, her ethnographic research “*has shown me how the epidemic produces more precariousness in lives already made vulnerable by social inequality and sexual discrimination*”. Although equity is a core principle of the Brazilian Unified National Health System (SUS), qualitative and quantitative research demonstrates that while the country might have achieved a relatively high level of medical and technological development and competence, there are striking disparities when it comes to contraception, abortion, and childbirth⁵. Zika underscores the depth of inequalities related to race, poverty, and gender, and the need for comprehensive and holistic reproductive justice.

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