



**Organización  
Panamericana  
de la Salud**



**Organización  
Mundial de la Salud**

OFICINA REGIONAL PARA LAS **Américas**

# ZIKA y su impacto en la Salud Sexual y Reproductiva

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# IMAGENS AUTORIZADAS DE CRIANÇAS COM MICROCEFALIA. REGIÃO METROPOLITANA DE RECIFE, 01/08 A 31/10/2015.



Imagem autorizadas pelos responsáveis e estão resguardadas as identidades. Dados preliminares da Investigação epidemiológica de microcefalia em nascidos vivos na Região Metropolitana do Recife, Pernambuco, 2015

## Case definition of “Zika virus congenital syndrome”

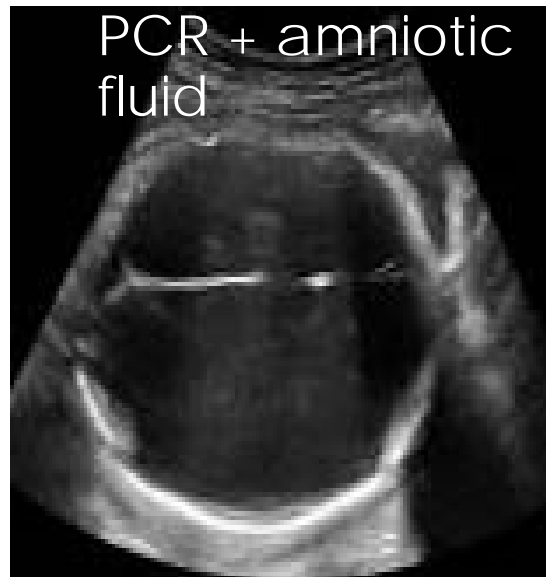
MICROCEPHALY IS  
NOT A DISEASE  
BUT A SIGN OF DISEASE



2



# Will probably remain undiagnosed



# Case definition “Zika virus congenital syndrome”

- ❖ Placental calcifications
- ❖ Oligo/anhydramnios
- ❖ Abnormal arterial cerebral flow
- ❖ Intrauterine growth restriction
- ❖ Arthrogryposis
- ❖ Redundant scalp skin
- ❖ Club foot
- ❖ Cataracts and ocular calcifications,
- ❖ Brain abnormalities with/out microcephaly
  - Cerebral volume reduction/atrophy
  - Abnormal cortical development
  - Ventriculomegaly
  - Callosal hypoplasia
  - Cerebral and cerebellar calcifications
  - Cerebellar hypoplasia
  - Subcortical calcification
- ❖ Fetal death

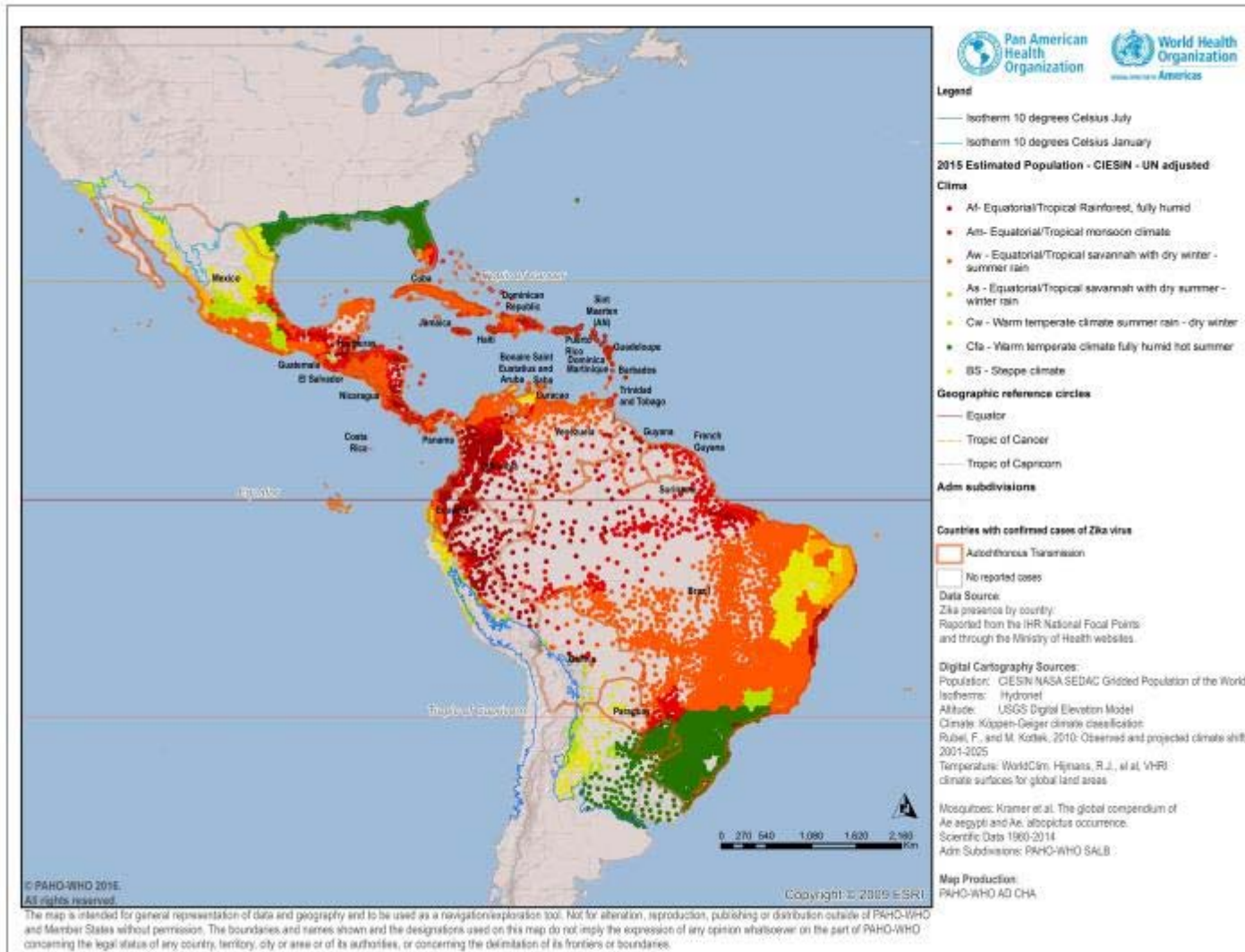
# Future of Zika virus in the region

- New arbovirus in the region with high risk for establishing an endemic transmission and co circulating with Dengue and Chikungunya
- **520 M.** of persons at risk to be infected by the Zika virus in the Americas:
  - Presence of *Aedes aegypti*
  - Altitude < 2,000 m
  - Including areas with permanent and seasonal risk of transmission
- Role of sexual transmission in the dynamics of the outbreak or maintaining the transmission is not known yet

# Future of Zika virus in the region

Total population in the Americas living in areas < 2000 m above sea level and within the 10° Celsius isotherms (North & South) delimiting survival of *Aedes aegypti* during winter in Tropical/Temperate climates

- **520 M** people  
(520,152,791)



# World Health Organization

## ZIKA SITUATION REPORT

### ZIKA AND POTENTIAL COMPLICATIONS

12 FEBRUARY 2016

- 1. HIGHLIGHTS**
- WHO has called for a coordinated and multisectoral response through an inter-agency Strategic Response Framework focusing on response, surveillance and research.
  - 39 countries have reported locally acquired circulation of the virus since January 2007. Geographical distribution of the virus has steadily expanded.
  - Six countries (Brazil, French Polynesia, El Salvador, Venezuela, Colombia and Suriname) have reported an increase in the incidence of cases of microcephaly and/or Guillain-Barré syndrome (GBS) in conjunction with an outbreak of the Zika virus. Puerto Rico and Martinique have reported cases of GBS associated with Zika virus infection without an increase of incidence. No scientific evidence to date confirms a link between Zika virus and microcephaly or GBS.
  - Women's reproductive health has been thrust into the limelight with the spread of the Zika virus. The latest evidence suggests that Zika virus infection during pregnancy may be linked to microcephaly in newborn babies.
  - WHO advice on travel to Zika-affected countries includes advice for pregnant women as well as women who are trying to become pregnant and their sexual partners.

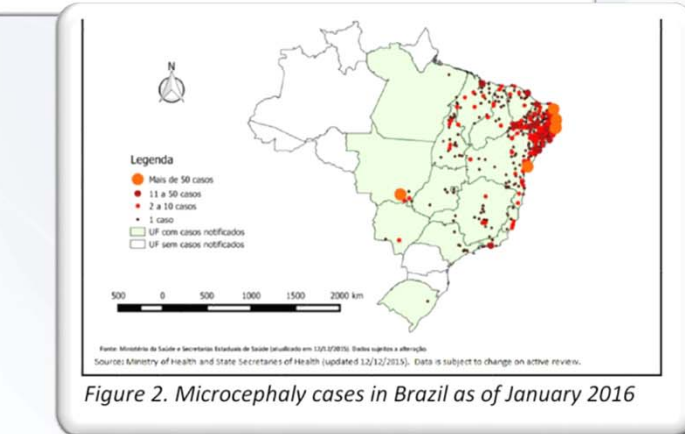
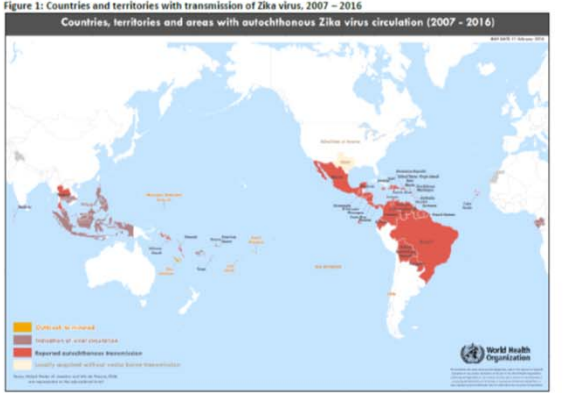


Figure 2. Microcephaly cases in Brazil as of January 2016

# Pregnancy management in the context of Zika virus

Interim guidance  
2 March 2016  
WHO/ZKVV/MOC/14.2

**1. Introduction**

**1.1 Background**

Zika virus is a flavivirus that is primarily transmitted by *Aedes* mosquitoes. This vector is found in tropical and subtropical environments in the Americas, Asia and the Pacific. Although first identified in humans in 1952, it was not documented prior to 2015. Human infection is typically asymptomatic, and symptoms are self-limiting. While the usual characteristics of the virus have not changed, the recent association with congenital Zika syndrome (CZS) and Guillain-Barré Syndrome (GBS) in some affected individuals has raised a Public Health International Concern.<sup>1,2</sup>

**1.2 Rationale and objectives**

The mosquito vector that causes the warm climate and particularly in wet conditions. Pregnant women living in areas at equal risk as the rest of the infected by viruses borne by this vector with Zika virus may go unnoticed as develop symptoms. Although Zika virus infection is typically a mild disease, cases of congenital microcephaly, GBS and other neurological complications outbreaks have occurred,<sup>1,2</sup> has significant implications for pregnant women and their families, providers and policy-makers.<sup>4</sup>

While the association between Zika virus infection and microcephaly is still being investigated, transmission throughout pregnancy has been documented.<sup>6,8</sup> Laboratory isolation of neurologic tissues of infants with microcephaly has added to the suspicion of causality.<sup>9</sup> Whether Zika virus infection causes congenital Zika syndrome, stillbirths, although has been detected in products of conception and in amniotic fluid of fetuses with microcephaly by affected women.

The aim of this document is to provide guidance for interventions to reduce the risk of infection and to manage potential complications. This guidance is based on

# Lactancia materna en el contexto del brote de virus de Zika

Orientación provisional  
25 de febrero de 2016  
WHO/ZKVV/MOC/14.5

**1. Introducción**

**1.1 Información general**

El principal modo de transmisión del virus de Zika es a través de mosquitos infectados del género *Aedes*. Sin embargo, la amplia transmisión actual del virus ha llevado a preocuparse si también puede transmitirse por la lactancia materna, una práctica esencial para la supervivencia y el desarrollo del lactante y el niño pequeño.

La finalidad del presente documento consiste en hacer recomendaciones provisionales que orienten las prácticas relativas a la lactancia materna en el contexto del actual brote de virus de Zika. En marzo de 2016 se realizará una revisión sistemática de la literatura que se actualizarán estas recomendaciones.

**1.2 Público destinatario**

El presente documento va dirigido a los gobiernos, ministerios de salud, planificadores de políticas y profesionales sanitarios, proporcionándoles orientación sobre la lactancia materna en el contexto del actual brote de virus de Zika. Asimismo, puede utilizarse en la comunicación con la población en general.

**2. Recomendaciones provisionales**

**2.1 Recomendaciones provisionales**

La Organización Mundial de la Salud (OMS) recomienda comenzar la lactancia materna en la primera hora de vida, utilizando de forma exclusiva durante los primeros 6 meses e introducir posteriormente alimentos complementarios, mientras se mantiene la lactancia materna hasta los 2 años más [1].

a. Estas recomendaciones de la OMS siguen siendo válidas en el contexto del brote de virus de Zika.

b. Como cualquier otra madre, aquella con infección preñata, probable o confirmada por este virus durante el embarazo o después del parto debe recibir apoyo cualificado de los profesionales sanitarios para que inicie y mantenga la lactancia materna. Lo mismo se aplica a las madres y las familias de lactantes con infección preñata, probable o confirmada.

c. Las madres y las familias de lactantes con malformaciones congénitas (microcefalia, por ejemplo

# Prevention of potential sexual transmission of Zika virus

Interim guidance  
18 February 2016  
WHO/ZKVV/MOC/14.1

**1. Introduction**

**1.1 Background**

This guidance has been developed to provide advice on the prevention of potential sexual transmission of Zika virus. The primary transmission route of Zika virus is via the *Aedes* mosquito. However, sexual transmission of Zika virus may also be possible, with limited evidence recorded in a few cases. This is of concern due to an association between Zika virus infection and potential complications, including microcephaly and Guillain-Barré syndrome.

The current evidence base on Zika virus remains extremely limited. This document is intended to inform the general public, and to be used by health care workers and policy makers to provide guidance on appropriate sexual practices in the context of Zika virus.

**1.2 Target audience**

This document is intended to inform the general public, and to be used by health care workers and policy makers to provide guidance on appropriate sexual practices in the context of Zika virus.

**2. Potential sexual transmission of Zika virus**

**2.1 Current evidence**

Sexual transmission of Zika virus has been described in two cases, and the presence of the Zika virus in semen in one additional case.

Zika virus transmission by sexual intercourse has been suggested by Foy et al. [1], who described a male patient infected with Zika virus in south-eastern Senegal in 2008. Four days after the patient returned home to the United States of America, his wife began to display symptoms of Zika virus infection. Because she had not travelled out of the United States during the previous year, and had sexual intercourse with the patient one day after he returned, transmission by semen was suggested. In another case on 2 February 2016, the United States Centers for Disease Control and Prevention announced that a patient with Zika virus infection in Texas had acquired the virus through sexual contact, rather than via a mosquito vector – the primary route [2].

Zika virus has been isolated in semen in one documented case of a man in Tahiti who sought treatment for

hematospermia during a Zika virus outbreak in French Polynesia in December 2013 [3]. He had previously experienced symptoms of Zika virus infection twice two weeks and ten weeks before presentation with hematospermia. Zika virus was isolated from semen samples taken at presentation and also three days later. The observation of Zika virus in semen supports the possibility that the virus could be sexually transmitted.

**2.2 Interim recommendations**

Based on precautionary principles, WHO recommends that

- All patients (male and female) with Zika virus infection and their sexual partners (particularly pregnant women) should receive information about the potential risks of sexual transmission of Zika virus, contraceptive measures and safer sexual practices<sup>1</sup>, and should be provided with condoms when feasible. Women who have had unprotected sex and do not wish to become pregnant because of concern with infection with Zika virus should also have easy access to emergency contraceptive services and counselling [4].
- Sexual partners of pregnant women, living in or returning from areas where local transmission of Zika virus is known to occur, should use safe sexual practices or abstinence from sexual activity for the duration of the pregnancy.
- As most Zika virus infections are asymptomatic<sup>2</sup>:
  - Men and women living in areas where local transmission of Zika virus is known to occur should consider adopting safer sexual practices or abstinence from sexual activity.
  - Men and women returning from where local transmission of Zika virus is known to occur should adopt safer sexual practices or consider abstinence for at least four weeks<sup>3</sup> after return.

<sup>1</sup> Safer sexual practices include: postponing sexual debut, non-penetrative sex, correct and consistent use of male or female condoms, and reducing the number of sexual partners.

<sup>2</sup> All individuals should receive appropriate counselling to make informed choices on the usually transmitted infection prevention method(s) they wish to use.

<sup>3</sup> Based on estimates of one week for virus incubation, one week of clinical symptoms (if any), and two weeks for Zika virus to remain in semen after a clinical episode (based on evidence from Mexico et al.)





FEBRERO, MES DEL AMOR





























¡Y DEL  
ZIKA!



Alecw

**Table 2 Deaths in women aged 15–44 years attributable to six leading risk factors, 2004 (percentage)**

<b>Risk</b>	<b>World</b>	<b>Low-income countries</b>	<b>Middle-income countries</b>	<b>High-income countries</b>
<b>Percentage of deaths</b>				
Unsafe sex	20 	23 	16 	5 
Unmet contraceptive need	5 	6 	2 	0
Iron deficiency	4 	5 	2 	0
Alcohol use	3 	1 	5 	9 
High blood pressure, cholesterol and glucose	2 	2 	3 	4 
Tobacco use	2 	1 	3 	5 
Overweight and obesity	1 	1 	2 	4 

Source: World Health Organization.<sup>2</sup>

FEBRERO

¡ME SIENTO FELIZ...  
CREO QUE ME PICO  
CUPIDO!



DEFINITIVAMENTE  
NO ERA CUPIDO...  
ERA ZIKA

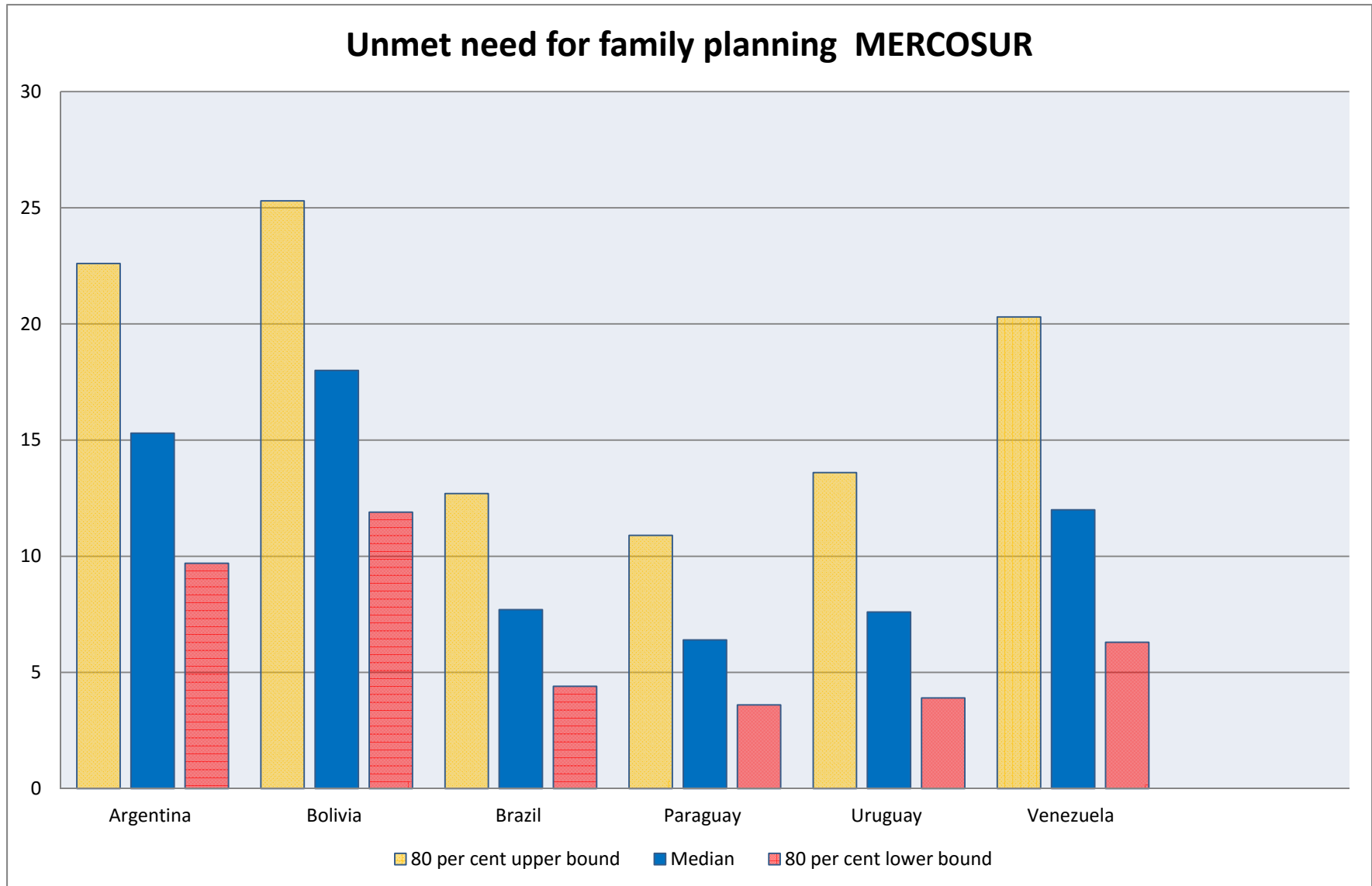


## Estimates of contraceptive prevalence (any method and modern methods), unmet need for family planning and percentage of demand that is satisfied with modern methods among married or in-union women aged 15 to 49, 2015

	Contraceptive prevalence (all methods)			Contraceptive prevalence (modern methods)			Unmet need for family planning			Demand for family planning satisfied with modern methods		
	Median	80 per cent lower bound	80 per cent upper bound	Median	80 per cent lower bound	80 per cent upper bound	Median	80 per cent lower bound	80 per cent upper bound	Median	80 per cent lower bound	80 per cent upper bound
<b>Mercosur Countries</b>												
<b>Argentina</b>	<b>61.6</b>	51.8	70.4	<b>57.9</b>	48.4	66.7	<b>15.3</b>	9.7	22.6	<b>75.2</b>	65.3	83.3
<b>Bolivia</b>	<b>62.5</b>	51.9	71.9	<b>40.4</b>	29.6	51.2	<b>18</b>	11.9	25.3	<b>50.4</b>	37.6	62.3
<b>Brazil</b>	<b>79</b>	70.4	85.6	<b>75.2</b>	66.6	82.1	<b>7.7</b>	4.4	12.7	<b>86.8</b>	79.9	91.7
<b>Paraguay</b>	<b>77.4</b>	68.5	84.3	<b>68</b>	58	76.2	<b>6.4</b>	3.6	10.9	<b>81.4</b>	72	88.1
<b>Uruguay</b>	<b>77</b>	66.5	84.6	<b>73.8</b>	63.2	81.9	<b>7.6</b>	3.9	13.6	<b>87.3</b>	78.9	92.7
<b>Venezuela</b>	<b>70</b>	57.3	80.3	<b>63.8</b>	51.3	74.9	<b>12</b>	6.3	20.3	<b>77.8</b>	65.7	87.1
<b>Out of Mercosur Countries</b>												
<b>Belize</b>	<b>58.1</b>	48.3	67.4	<b>53.5</b>	43.8	62.7	<b>16.8</b>	11.2	23.7	<b>71.2</b>	61.1	79.8
<b>Chile</b>	<b>65.1</b>	52.5	75.8	<b>61.6</b>	49.3	72.4	<b>13.4</b>	7.5	21.6	<b>78.4</b>	66.4	87.2
<b>Colombia</b>	<b>78.2</b>	70.8	84.3	<b>71.7</b>	63.5	78.3	<b>8.2</b>	5.1	12.6	<b>83</b>	75.7	88.2
<b>Ecuador</b>	<b>72.6</b>	61.6	81.5	<b>61.2</b>	49.4	71.5	<b>9.1</b>	5	15.4	<b>75.1</b>	62.9	84.1
<b>Peru</b>	<b>73.5</b>	68.1	78.3	<b>52.4</b>	45.5	59	<b>9.1</b>	6.8	12	<b>63.5</b>	55.5	70.6
<b>Suriname</b>	<b>51.8</b>	42.4	61.2	<b>50.8</b>	41.5	60	<b>19.4</b>	13.4	26.6	<b>71.1</b>	61.1	80
<b>Mexico</b>	<b>72.6</b>	63.4	80.4	<b>67.4</b>	58	75.5	<b>10.5</b>	6.3	16.4	<b>81</b>	72.4	87.5
<b>Dominican Republic</b>	<b>71.8</b>	66.3	76.7	<b>68.6</b>	63.3	73.5	<b>10.7</b>	8.1	13.9	<b>83.1</b>	78.8	86.7

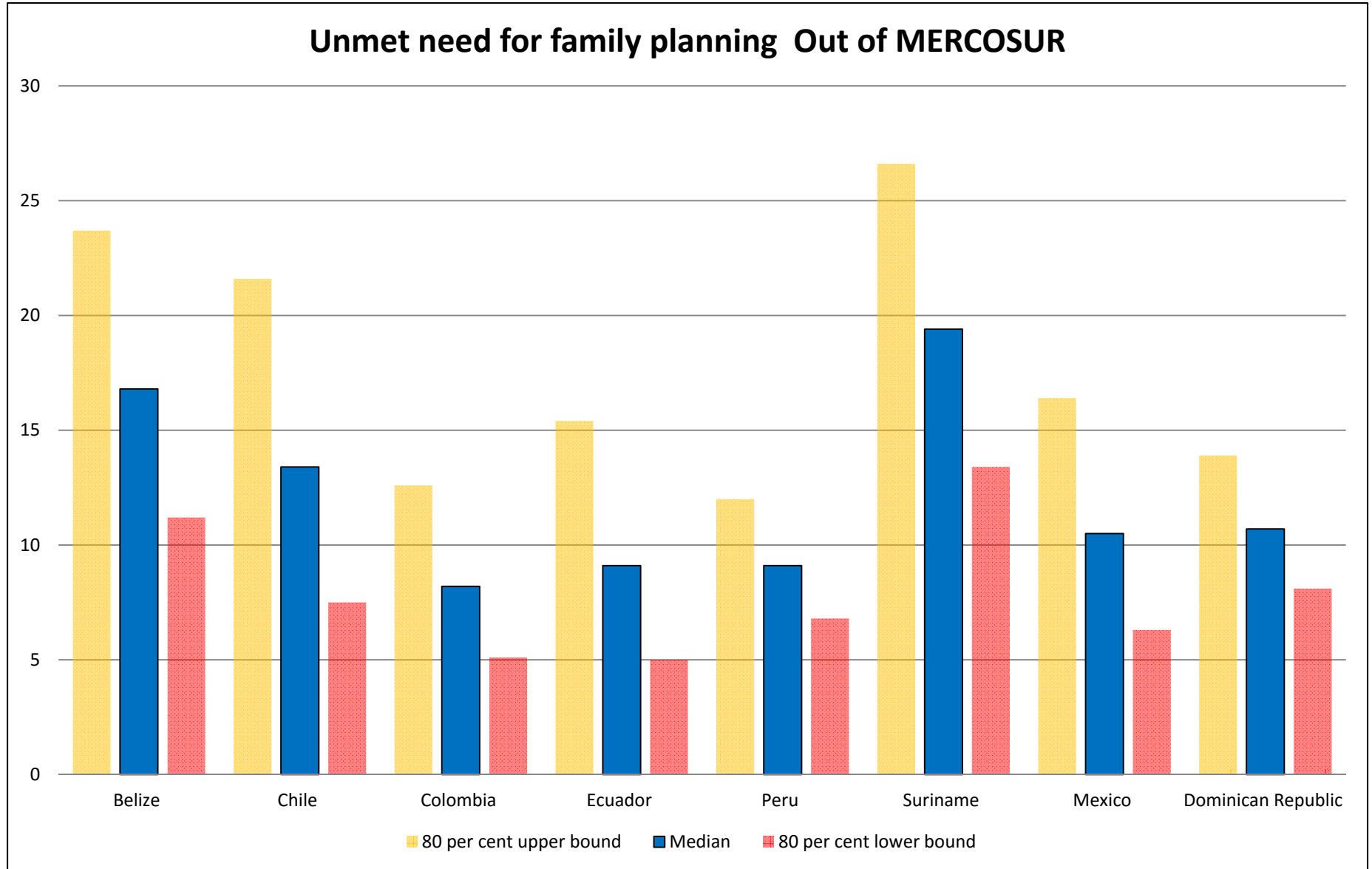
Fuente: United Nations, Department of Economic and Social Affairs, Population Division (2015). Trends in Contraceptive Use Worldwide 2015

## Unmet need for family planning MERCOSUR



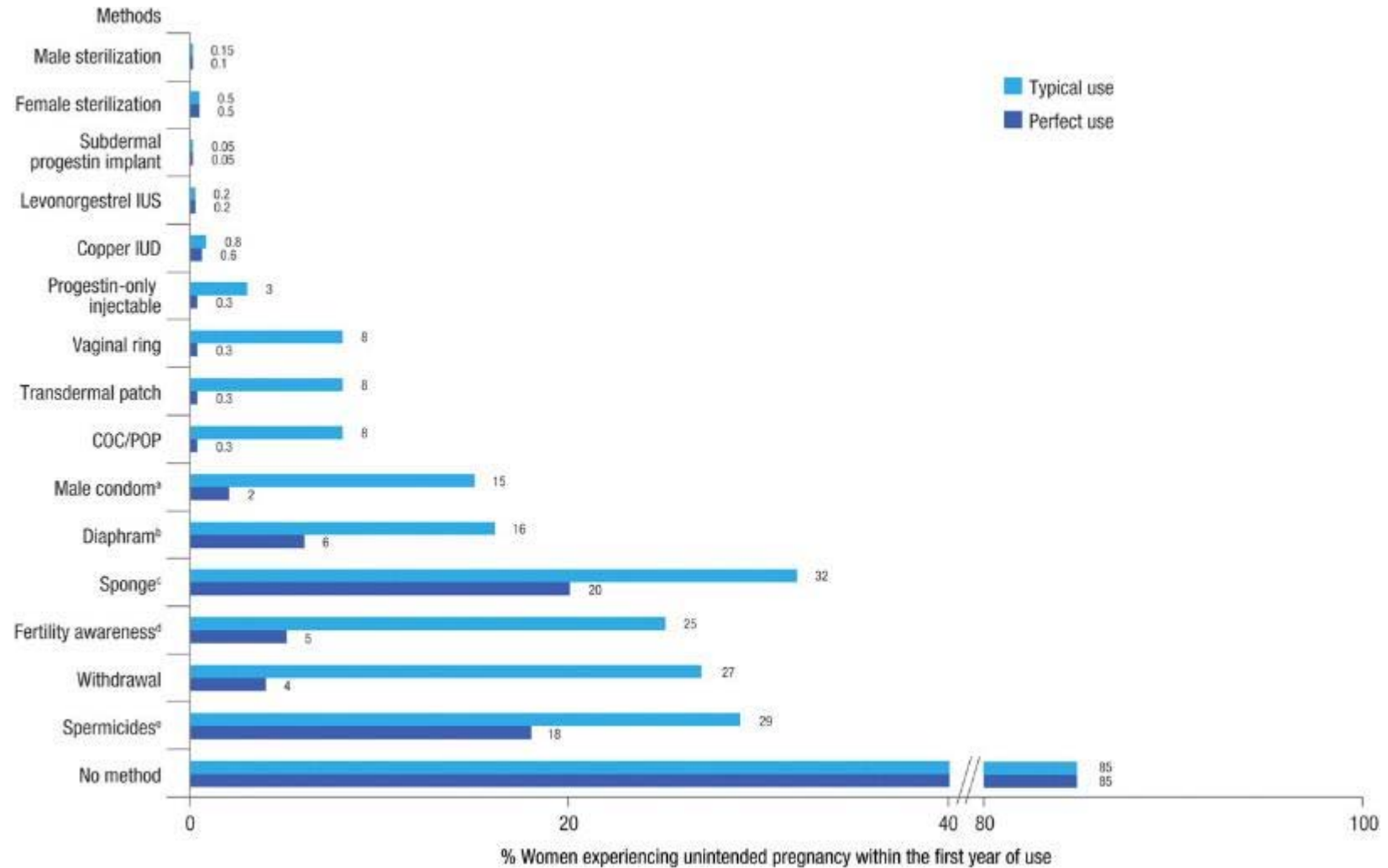
Fuente: United Nations, Department of Economic and Social Affairs, Population Division (2015). Trends in Contraceptive Use Worldwide 2015

## Unmet need for family planning Out of MERCOSUR



Fuente: United Nations, Department of Economic and Social Affairs, Population Division (2015). Trends in Contraceptive Use Worldwide 2015

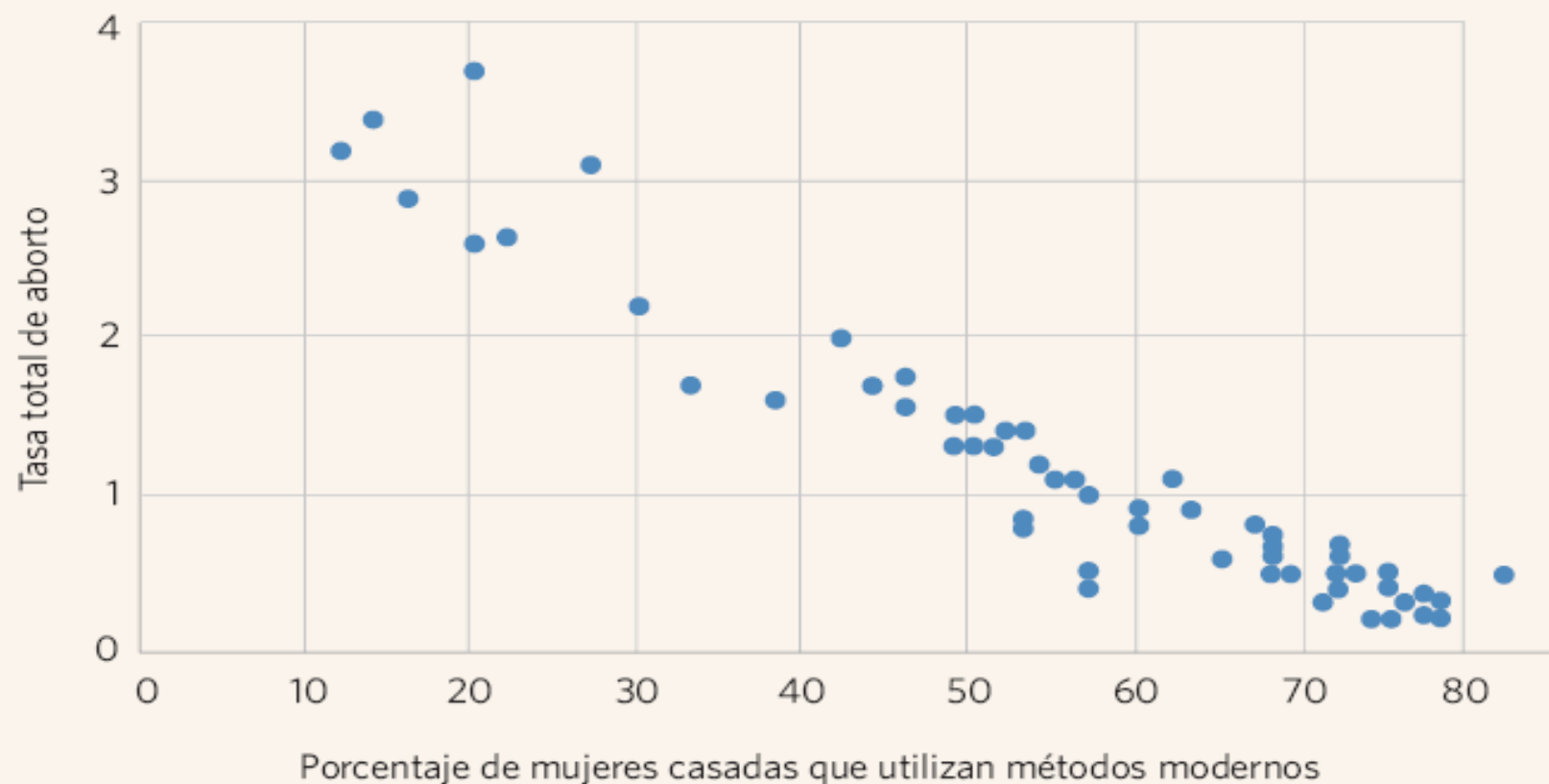
## Percentages of women experiencing an unintended pregnancy with typical versus perfect contraceptive use.



P.D. Blumenthal et al. Hum. Reprod. Update 2011;17:121-137



## TASAS TOTALES DE ABORTO Y DE PREVALENCIA DEL USO DE ANTICONCEPTIVOS MODERNOS EN 59 PAÍSES



Fuente: Westoff, 2005.

# Aborto y Zika

- Vinculo ahora con mas información
- Dificultades de diagnostico en 1er trimestre
- Diagnostico de sospecha tardío, final del 2do trimestre basado en Ecografía
- En ese caso seria una interrupción de embarazo de mayor riesgo
- Recomendación reforzar los derechos reproductivos y acceso a anticoncepción reversible de larga duración, particularmente en poblaciones mas vulnerables

# LEYES SOBRE ABORTO



<http://www.mercosur.int>

I	PARA SALVAR LA VIDA DE LA MUJER O PROHIBIDO TOTALMENTE
II	PARA PRESERVAR LA SALUD
III	RAZONES SOCIOECONÓMICAS
IV	SIN RESTRICCIONES EN CUANTO A LA RAZÓN

Fuente : <http://www.reproductiverights.org/sites/crr.civicaactions.net/files/documents/2014AbortionMapES.pdf>



## 1. Introducción

### 1.1 Información general

El presente documento actualiza las orientaciones publicadas el 18 de febrero de 2016 acerca de la prevención de la transmisión sexual del virus de Zika.

La principal vía de transmisión de este virus son los mosquitos del género *Aedes*. Sin embargo, cada vez son más numerosas las pruebas de que su transmisión sexual no solo es posible, sino más frecuente de lo que se creía.<sup>1</sup> Esto es preocupante debido a la asociación entre la infección por el virus de Zika y complicaciones como la microcefalia, el síndrome de Guillain-Barré y otros trastornos neurológicos.

Los datos actuales sobre el virus de Zika siguen siendo escasos. A medida que se disponga de nuevos datos se revisarán las presentes orientaciones y se actualizarán las recomendaciones.

### 1.2 Público destinatario

El presente documento se destina a informar al público en general y a ser utilizado por los profesionales sanitarios y los formuladores de políticas para ofrecer orientaciones sobre las prácticas sexuales apropiadas en el contexto de la infección por el virus de Zika.

### 2.1.2 Modos de transmisión sexual

Foy et al.<sup>2</sup> fueron los primeros en sugerir la transmisión del virus de Zika a través de las relaciones sexuales. En ese estudio, publicado en 2011, se describía el caso de un varón infectado en 2008 en el Senegal sudoriental y que al volver a los Estados Unidos de América (EE.UU.) había infectado a su mujer por vía sexual. Desde entonces hasta el 19 de mayo de 2016 se han descrito casos de transmisión sexual del virus de Zika en 10 países (EE.UU.,<sup>3</sup> Francia,<sup>4</sup> Italia,<sup>5</sup> Argentina,<sup>7</sup> Chile,<sup>8</sup> Perú,<sup>9</sup> Portugal,<sup>10</sup> Nueva Zelandia,<sup>11</sup> Canadá,<sup>12</sup> y Alemania<sup>13</sup>), en su mayoría por relaciones vaginales. El 2 de febrero de 2016, los Centros para el Control y la Prevención de Enfermedades de los EE.UU. anunciaron el primer caso documentado de un hombre infectado por el virus de Zika tras haber tenido relaciones sexuales por vía anal.<sup>6</sup> Poco después, el informe de un caso publicado en abril de 2016 levantó la sospecha de transmisión del virus de Zika mediante relaciones sexuales orales. El caso, identificado en febrero de 2016, había tenido contacto sexual con una persona con síntomas de infección por el virus de Zika. Se sospechó la transmisión por vía oral porque las relaciones habían consistido en coito vaginal sin preservativos ni eyaculación y sexo oral con eyaculación.<sup>4</sup>

Hasta la fecha, todos los casos de transmisión sexual se han producido de un varón sintomático a su pareja mediante actividades sexuales que han tenido lugar antes, durante o

# Prevención de la transmisión sexual del virus de Zika

Actualización de las orientaciones provisionales  
7 de junio de 2016

WHO/ZIKV/MOC/16.1 Rev.2



## Presencia del virus en el semen

- El virus de Zika se aisló por primera vez en el semen en un hombre de Tahití que buscó tratamiento para una hematospermia durante el brote de virus de Zika que hubo en la Polinesia francesa en diciembre de 2013. El virus se cultivó a partir de muestras de semen al menos **14 días** después de la aparición de los síntomas.
- En 2016 se documentó el cultivo del virus a partir de la muestra de semen **14 días** después del diagnóstico (es decir, más de 2 semanas después del inicio de los síntomas) y se demostró que la carga vírica era **100 000 veces mayor que en la sangre**.
- En mayo de 2016, se describió el caso de un hombre de 68 años que volvió de las Islas Cook al Reino Unido y cuyo semen fue positivo para el virus de Zika **62 días después** de la aparición de los síntomas. Este es el intervalo máximo en el que se ha detectado el virus en el semen. Sin embargo, no se sabe durante cuánto tiempo puede persistir el virus en el semen tras la aparición de los síntomas, dado que no se han obtenido muestras secuenciales.



# Prevención de la transmisión sexual del virus de Zika

Actualización de las orientaciones provisionales

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## Modos de transmisión sexual

Foy et al fueron los primeros en sugerir la transmisión del virus de Zika a través de las relaciones sexuales. En ese estudio, publicado en 2011, se describía el caso de un varón infectado en **2008** en el Senegal sudoriental y que al volver a los Estados Unidos de América (EE.UU.) había infectado a su mujer por vía sexual. Desde entonces hasta el 19 de mayo de 2016 **se han descrito casos de transmisión sexual del virus de Zika en 10 países** (EE.UU.,3 Francia,4 Italia,5 Argentina,7 Chile,8 Perú,9 Portugal,10 Nueva Zelanda,11 Canadá,12 y Alemania13), en su mayoría por **relaciones vaginales**.



# Prevención de la transmisión sexual del virus de Zika

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## Modos de transmisión sexual

El 2 de febrero de 2016, los Centros para el Control y la Prevención de Enfermedades de los EE.UU. anunciaron el primer caso documentado de un hombre infectado por el virus de Zika tras haber tenido *relaciones sexuales por vía anal*. Poco después, el informe de un caso publicado en abril de 2016 levantó la sospecha de transmisión del virus de Zika mediante relaciones *sexuales orales*. El caso, identificado en febrero de 2016, había tenido contacto sexual con una persona con síntomas de infección por el virus de Zika. Se sospechó la transmisión por vía oral porque las relaciones habían consistido en coito vaginal sin preservativos ni eyaculación y sexo oral con eyaculación.

# Prevención de la transmisión sexual del virus de Zika

Actualización de las orientaciones provisionales  
7 de junio de 2016

WHO/ZIKV/MOC/16.1 Rev.2



Organización  
Mundial de la Salud

Hasta la fecha, todos los casos de transmisión sexual se han producido de **un varón sintomático a su pareja mediante actividades sexuales** que han tenido lugar antes, durante o después del inicio de los síntomas de la enfermedad por el virus de Zika.

No se sabe si las mujeres o los hombres asintomáticos pueden transmitir el virus a través de las relaciones sexuales.



# WHO interim guidance on pregnancy management in the context of Zika virus infection



Lancet Glob Health 2016

Published Online  
May 19, 2016  
[http://dx.doi.org/10.1016/S2214-109X\(16\)30098-5](http://dx.doi.org/10.1016/S2214-109X(16)30098-5)

As a result of an unusual clustering of cases of microcephaly and Guillain-Barré syndrome, WHO declared the 2015–16 Zika virus outbreak in the Americas a “public health emergency of international concern”.<sup>1</sup> As part of its strategic response to the outbreak, WHO is leading normative work to mitigate the potential impact on pregnant women, newborn babies, and other at-risk populations. Last week, WHO launched an updated version of its guidance on pregnancy care in the context of Zika virus infection.<sup>2</sup> The guidance covers recommendations for preventing maternal Zika virus infection, antenatal care and management of women with infection, and care for all pregnant women with possible exposure to Zika virus through residence in or travel to an affected area.

Vector control is critical in substantially reducing the risk of maternal and fetal Zika virus infection. Therefore, the guidance emphasises the importance of counselling pregnant women about preventive measures at every antenatal contact. Recommended personal protection measures include the use of clothing that covers as much of the body as possible, bednets, window and door screens, safe repellents, and avoidance of unprotected sexual activity with a partner possibly exposed to Zika virus. In addition to recommending local measures to reduce vector breeding sites, the guidance notes the importance of addressing the underlying social determinants of this outbreak, and encourages governments to take broader steps to provide sustainable and equitable access to clean water, sanitation, and appropriate waste management.

Antenatal care in the context of Zika virus transmission requires specific actions to prevent infection, and to identify women who might be infected for testing, appropriate care, and follow-up. The guidance recommends that Zika virus infection should be suspected on the basis of the common signs and symptoms—rash, fever, arthralgia, and conjunctivitis—lasting 2–7 days, and confirmed using RT-PCR detection of Zika virus RNA in blood (or urine) samples collected within 1 week of symptoms or by serology for Zika-virus-specific IgM thereafter. As there is currently no specific therapy for Zika virus infection, only

symptomatic treatment is recommended whenever there are symptoms.

The guidance includes decision charts for testing and care of pregnant women residing in areas with ongoing Zika virus transmission, and for pregnant women with a history of recent travel to such areas. Testing for Zika virus infection is recommended for pregnant women presenting with (or reporting) signs and symptoms or those with ultrasound findings of fetal abnormalities at any time during pregnancy. WHO does not at this time recommend universal testing of pregnant women for Zika virus. Rather, it reinforces the need to offer all women early ultrasound examinations, including a fetal anomaly scan at 18–20 weeks to accurately date the pregnancy and evaluate fetal anatomy. The guidance points to a broader spectrum of fetal abnormalities that should raise a suspicion of congenital Zika virus infection. These include microcephaly, ventriculomegaly, intracranial calcifications, cerebral atrophy, callosal dysgenesis, micro-ophthalmia, eye calcification, growth restriction, and even fetal death.<sup>3,4</sup>

As shown in the figure, Zika-virus-related fetal abnormalities should be suspected in pregnant women with ultrasound evidence of fetal abnormalities and a positive or inconclusive Zika virus test. Pregnant women with a history of symptoms, no ultrasound evidence of fetal abnormalities, and a negative Zika virus test are most likely unaffected and should continue to receive routine antenatal care. Pregnant women with abnormal ultrasound findings but a negative Zika virus

		Zika virus test	
		Positive	Negative
Abnormal ultrasound findings	Positive	Suspected Zika-virus-related fetal abnormalities; individualised counselling and specialised care	Fetal abnormalities due to other conditions; further investigations (including tests for TORCH) required
	Negative	Maternal Zika virus infection with no fetal involvement at the time of examination; ultrasound follow-up	Unaffected by Zika virus; continue routine antenatal care

Figure: Interpretation of Zika virus test and ultrasound findings in the context of Zika virus transmission  
TORCH—syphilis, toxoplasmosis, rubella, cytomegalovirus, and herpes virus infections.



# Atención en el embarazo en el contexto del brote de virus de Zika

Orientación provisional

2 de marzo de 2016

WHO/ZIKV/MOC/16.2



Organización  
Mundial de la Salud

- Las mujeres que **lleven a término su embarazo** deben recibir la atención y el apoyo adecuados para controlar el estrés y la ansiedad y para crear un entorno adecuado para el parto. También se debe hablar con los padres acerca del cuidado y el tratamiento que se prestarán al bebé poco después del parto, si es posible en consulta con un pediatra o un neurólogo infantil.
- En cuanto a la **interrupción del embarazo**, se debe facilitar a las mujeres que decidan optar por esta vía información precisa acerca de las opciones previstas en la legislación, *incluida la reducción de daños* cuando no se pueda prestar la asistencia necesaria.
- **Todas las mujeres merecen un trato digno y respetuoso, con independencia de sus decisiones relativas a su embarazo.**



## **CDC issues Interim Guidelines for Preventing Sexual Transmission of Zika Virus and Updated Interim Guidelines for Health Care Providers Caring for Pregnant Women and Women of Reproductive Age with Possible Zika Virus Exposure**

Couples in which a man resides in or has traveled to an area of active Zika virus transmission who are concerned about sexual transmission of Zika virus may **consider using condoms consistently and correctly during sex or abstaining from sexual activity.**

Couples may consider several factors when making this complex and personal decision **to abstain or use condoms:**

Zika virus illness is usually mild. An estimated 4 out of 5 people infected never have symptoms; when symptoms occur they may last from several days to one week.

The risk of Zika infection depends on how long and how much a person has been exposed to infected mosquitoes, and the steps taken to prevent mosquito bites while in an affected area.

## Zika: Experts warn against kissing at Rio Carnival after virus found in saliva

Zika has been linked to microcephaly - which is feared to cause brain damage in babies

• [Kashmira Gander](#)

<http://www.independent.co.uk/life-style/health-and-families/health-news/zika-experts-warn-against-kissing-at-rio-carnival-after-virus-found-in-saliva-a6860731.html>



Health experts in Brazil have warned against kissing strangers during Carnival parties, after the [Zika](#) virus was found in saliva and urine for the first time.

While the virus causes no symptoms in most cases, it is most feared to due its links to microcephaly – a condition where babies are born with brain damage and undeveloped heads. More than 4,000 suspected cases of microcephaly have been reported in Brazil since October 2015.

Scientists in Brazil found the mosquito-borne virus in the body fluids on Friday.

It is not yet known if the saliva and urine can transmit the virus, however the Oswaldo Cruz Foundation, a Brazil federal government biomedical research institution urged the public to take precautions in crowds during Carnival - where kissing strangers is part of the festivities.

"In light of the possibility of being in contact with someone who is infected, **do not kiss, obviously,**" said Dr. Paulo Gadelha, the foundation's president.





## Carnaval kisses confirmed as potential Zika threat

**STEPHANIE NOLEN**

RIO DE JANEIRO — The Globe and Mail

Published Friday, Feb. 05, 2016 10:59AM EST

It's not a surprise to researchers that Zika can spread in urine and saliva, said Edison Durigon, a microbiologist at the University of Sao Paulo, who is part of a national network of scientists studying the Zika outbreak, but the news will alarm the public. "It makes everybody think, 'Oh, my God, anybody I kiss, I can get Zika – I have to take care in Carnaval' – when we have millions of people dancing together, that makes this announcement more worrying." The primary mode of infection is still mosquito bites, Fiocruz scientists said, but people – especially those who live with pregnant women – should be thinking about extra precautions. Fiocruz president Paulo Gadelha suggested pregnant women should avoid kissing people other than their regular partners, and should not share cutlery, glasses or dishes with people who have Zika symptoms.

This finding comes days after researchers with the U.S. Centers for Disease Control confirmed sexual transmission of Zika.



# PERINATAL INFORMATION SYSTEM

## MANUAL OF USE OF THE PROGRAM for the analysis and advantage of the information

Mainero L  
Martínez G  
Rubino M  
De Mucio B  
Díaz Rossello JL  
Fescina R



Institución Usaria - País  
de administración - Salir

# ma Informático Peri

### Clinical Diagnosis

Zika  yes  no  n/a

Main symptoms of Zika virus infection	yes	no	n/a
Fever between 37,2°C and 38°C	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myalgia and/or arthralgia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pruritic maculopapular rash	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adhemia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No purulent conjunctivitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Edema in lower limbs / Headache	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Less frequent symptoms	yes	no	n/a
Tetso-ocular pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomit, diarrhea	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Differential diagnosis

Chikungunya	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dengue	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nile	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Organización Mundial de la Salud  
Americano de Perinatología Salud de la Mujer y Reproductiva

English Portuguese Francés

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Latin American Center for Perinatology  
Women & Reproductive Health - CLAPWR

de la Salud

Américas

# Consideraciones en SSRR

## Amor en los tiempos de ZIKA...

- Considerar a **la mujer en el centro** de las políticas
- Raíz de las acciones en Derechos Sexuales y Reproductivos y no en virus o hipótesis.
- Partir del análisis de necesidades insatisfechas de anticoncepción, vinculando a poblaciones mas vulnerables.
- Asegurar insumos **anticonceptivos modernos y de larga duración, incluyendo condones y anticoncepción de emergencia**
- Cuidado con la transmisión sexual en embarazadas en zonas de alta circulación viral

CUPIDO EN TIEMPOS DEL ZIKA

