ZIKA Y SALUD SEXUAL Y REPRODUCTIVA: DESAFIOS PARA EL ACCESO INTEGRAL AL ABORTO

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Aedes aegypti

VIRUS DEL ZIKA

El Zika es un Flavivirus

Transmitido por el mosquito Aedes Aegypti (Dengue, Chikunguya)

En 1947 un estudio sobre fiebre amarilla en Uganda, encontro un nuevo virus en la sangre de Macacos Rhesus en el Bosque Zika.

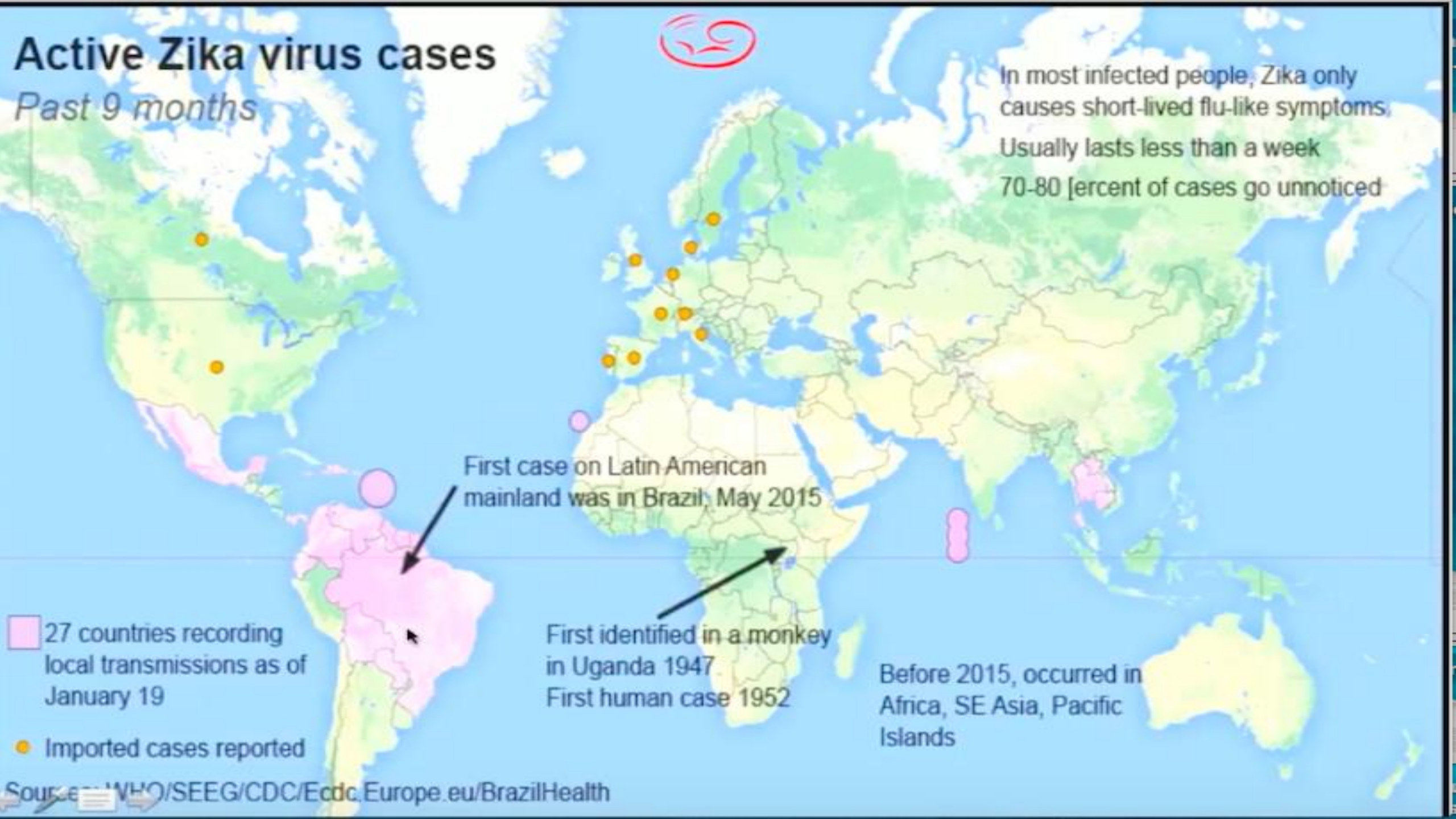
Permanecio silencioso por 70 años.

En un año es exportado de las Islas del Pacifico a Brasil y de allí al continente.

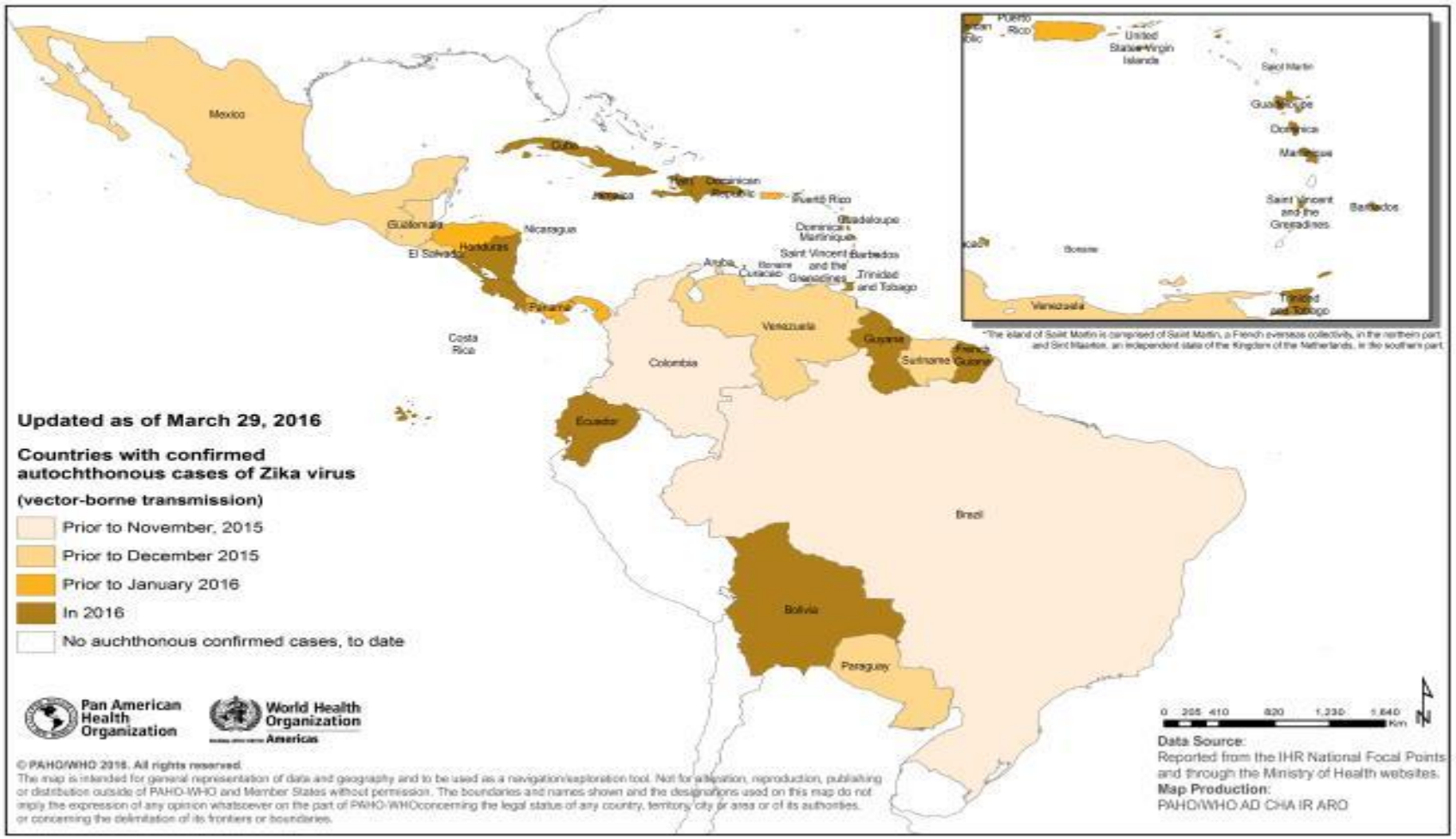
En marzo del 2016, son 33 países y territorios de la región que reportan casos de Zika.

Primera enfermedad infecciosa ligada a defectos fetales congénitos descubierta en 50 años

La OMS declara en el 2016 que la epidemia es una Emergencia de Salud Publica Internacional.


Active Zika virus cases
Past 9 months
In most infected people, Zika only causes short-lived flu-like symptoms.
Usually lasts less than a week
70-80 [ercent of cases go unnoticed
First case on Latin American mainland was in Brazil, May 2015
First identified in a monkey in Uganda 1947
First human case 1952
Before 2015, occurred in Africa, SE Asia, Pacific Islands
27 countries recording local transmissions as of January 19
Imported cases reported
Source: WHO/SEEG/CDC/Ecdc.Europe.eu/BrazilHealth

PAISES Y TERRITORIOS EN AMERICA CON CASOS CONFIRMADOS AUTOCTONOS DE ZIKA VIRUS, 2015-2016 (AL 29 MARZO 2016)



There are currently **33 countries or territories** reporting local, vector-borne transmission of Zika virus in the Region of the Americas.

SINTOMAS DE INFECCION

Rush papular

Fiebre

Dolor articular

Conjuntivitis no purulenta

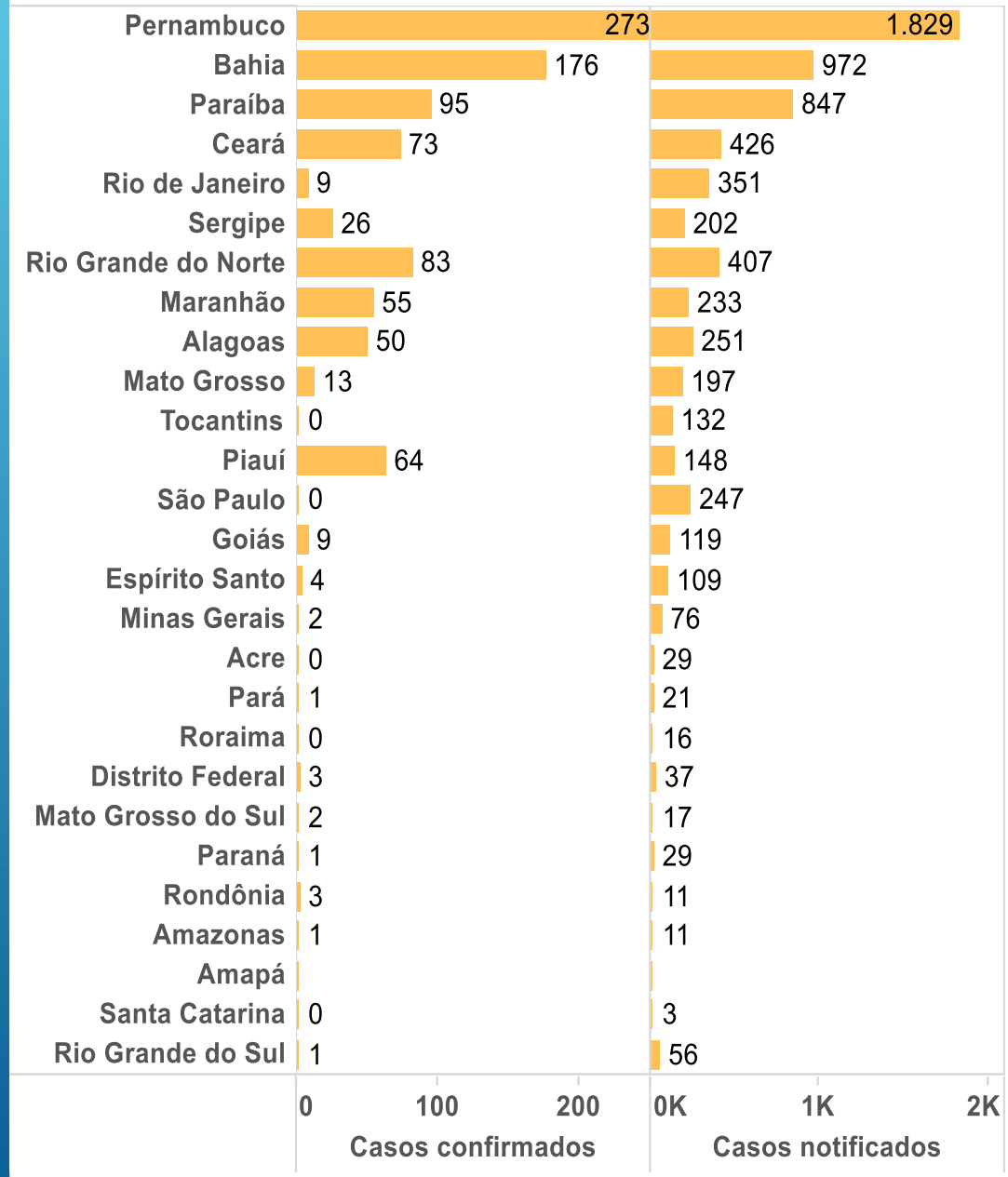
Cefalea

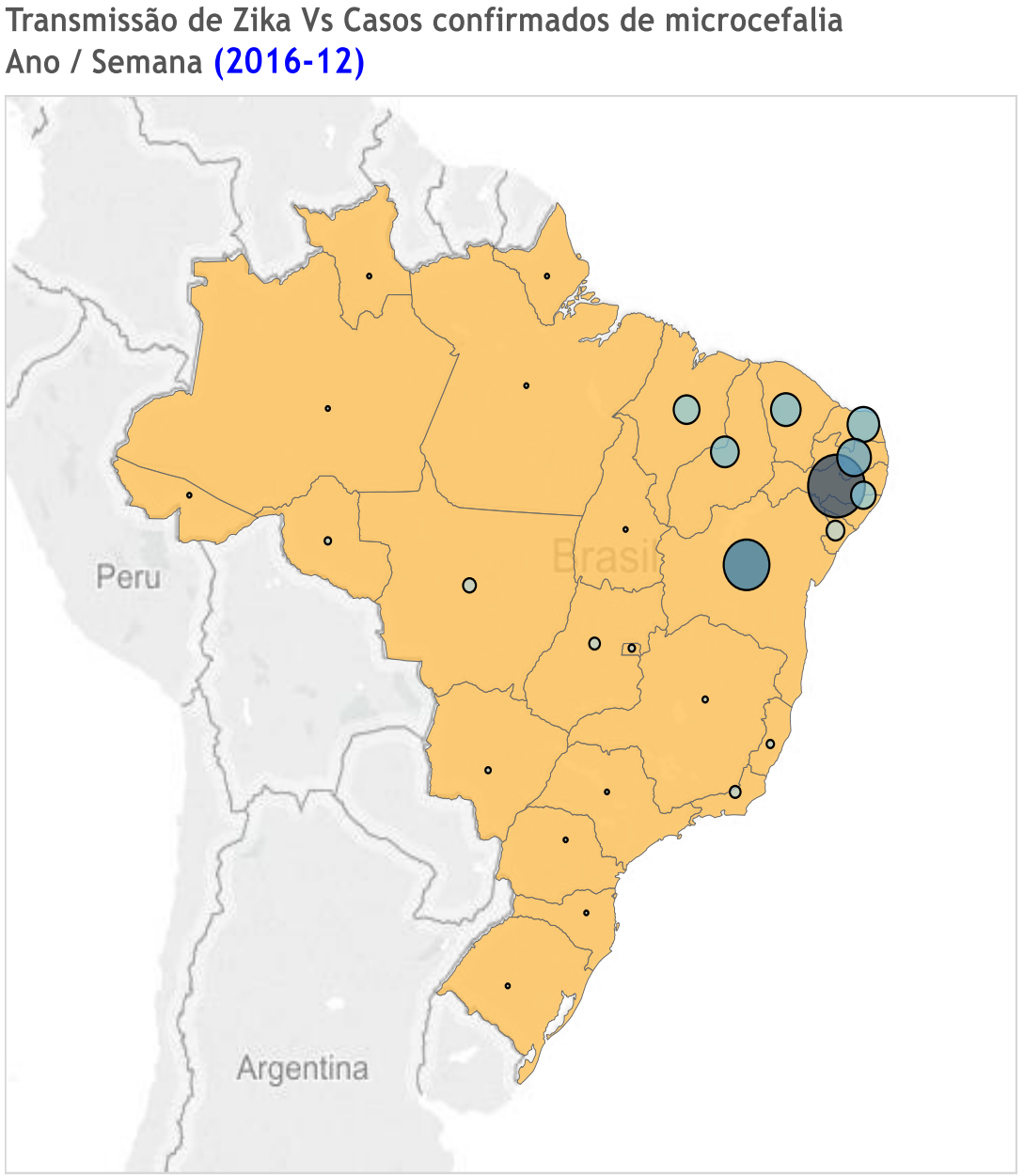
Mialgias

Dolor retro orbital

Vomitos

Casos notificados e confirmados de microcefalia por semana epidemiológica, Brasil.





Fonte: Informe epidemiológico de casos de microcefalia no Brasil. Ministério da Saúde. Brasil
Elaboração: Sala de situação Vírus Zika - OPAS/OMS Brasil

Primeros reportes en Brasil: un inusual incremento de microcefalia.

Photo credit: Image provided by mother of newborn (Rio de Janeiro, Brazil), with authorization for dissemination exclusively among public health workers.

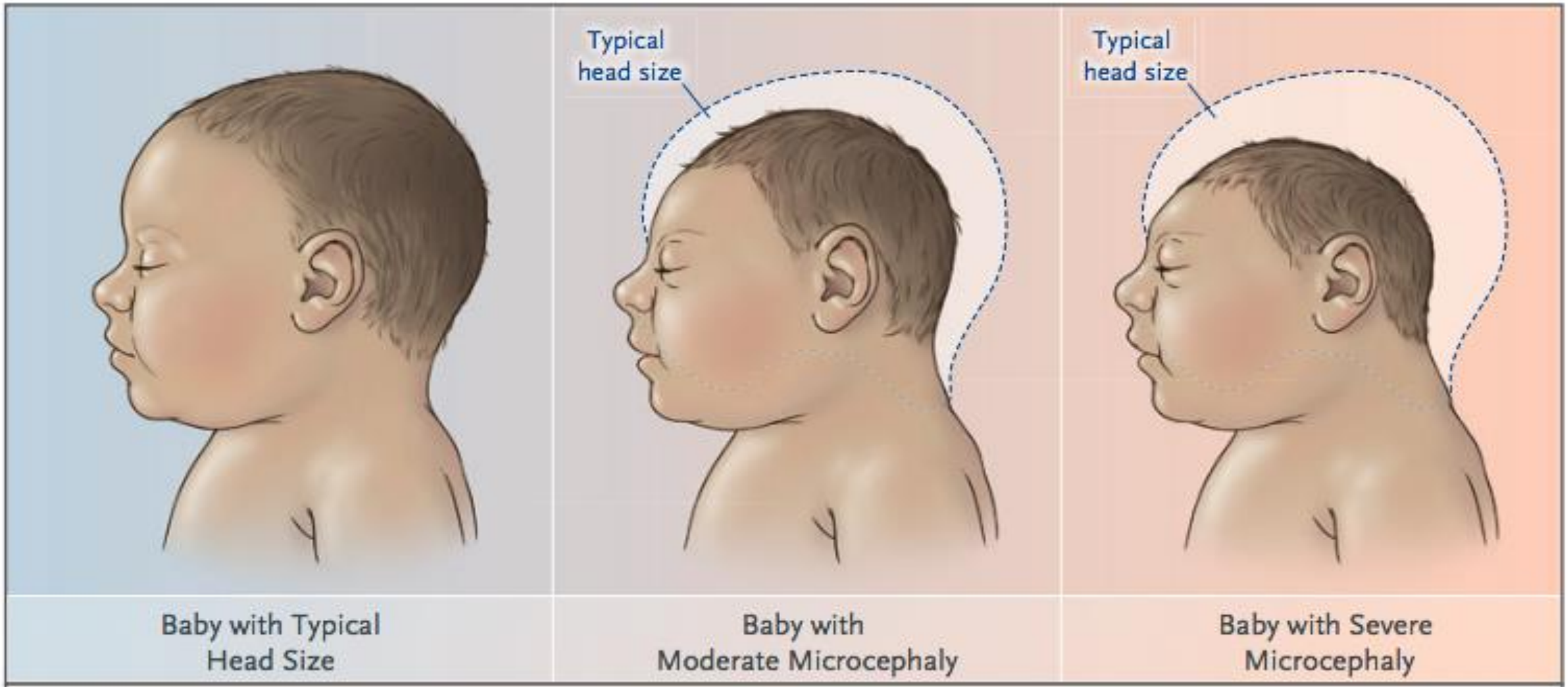


Figure 4. Infants with Moderate or Severe Microcephaly Associated with Maternal Zika Virus Infection, as Compared with a Typical Newborn.

Microcefalia/ Cabeza Pequeña

ZIKA Y MICROCEFALIA (A 24 MARZO 2016)

La evidencia de la asociacion entre microcefalia y virus del Zika es cada vez mayor.

- Lancet publication from French Polynesia March 2016: “apoya la hipotesis de que la infeccion por el virus del Zika en el I trimestre esta asociado con un incremento en el riesgo de microcefalia”.
- NEJM publication from Rio de Janeiro March 2016: “A pesar de que los sintomas clinicos son moderados, la infeccion del Zika durante el embarazo, parece estar asociada con graves consecuencias, incluyendo muerte fetal, insuficiencia placentaria, RCIU, e injuria del SNC”
- *Tom Frieden, Director del CDC “es claro que el Zika causa microcefalia” (abril 2016)*

MICROCEFALIA ES NO UNA ENFERMEDAD, ES UN SIGNO DE UNA ENFERMEDAD: SINDROME CONGENITO DEL VIRUS ZIKA

DEFINICION DE CASO: “SINDROME CONGENITO DEL VIRUS DEL ZIKA"

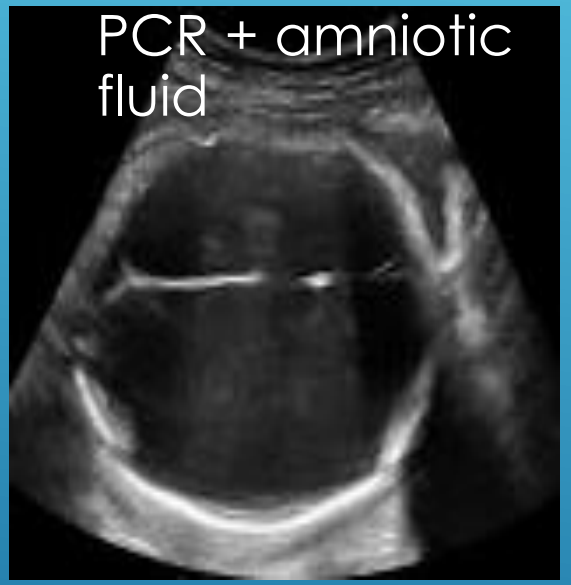
- Calcificaciones placentarias
- Oligo/anhydramnios
- Flujo anormal de la ACM
- RCIU
- Artrogryposis
- Piel del scalp redundante
- Club foot
- Cataratas y calcificaciones oculares,
- Anormalidades del SNC con/sin microcefalia
  - Reduccion del volumen cerebral/atrofia
  - Desarrollo cortical anormal
  - Ventriculomegalia
  - Hipoplasia del CC
  - Calcificaciones Cerebrales y cerebelares
  - Hipoplasi Cerebelar
  - Calcificacion Subcortical
- Muerte Fetal

Primeras imagenes conocidad de Feto con infección ZV

October, 2015 – Campina Grande – Paraiba - Brazil
Falla visualización de vermis cerebeloso normal + calcificaciones.
Fisura interhemisferica amplia.
60 similar cases in Pernambuco with historical of the exanthema in pregnancy

Prof. Adriana Melo

ANORMALIDADES DEL SNC



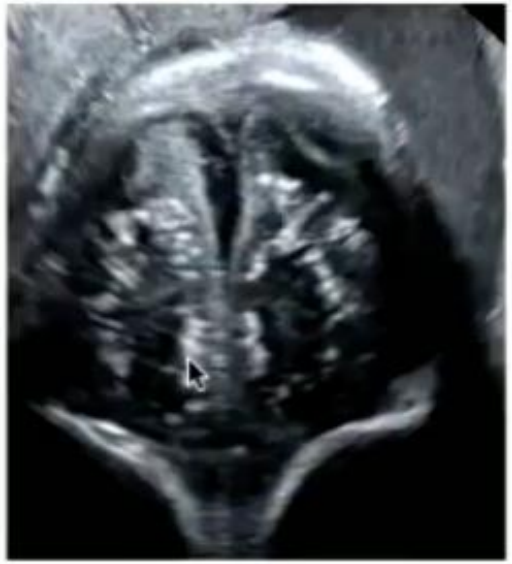
Síndrome Congénito Virus Zika

*Multiple periventricular calcified nodules (small arrows) on computed tomography scan (**A**) and gradient echo (**B**) axial images. Right temporal cystic changes (bold arrow) seen on axial T1-weighted (**C**), T2-weighted (**D**) and coronal fluid-attenuated inversion-recovery (**E**) images, with multiple areas of periventricular demyelination or gliosis seen on coronal fluid-attenuated inversion-recovery images (**F**) suggestive of sequelae of congenital rubella infection*

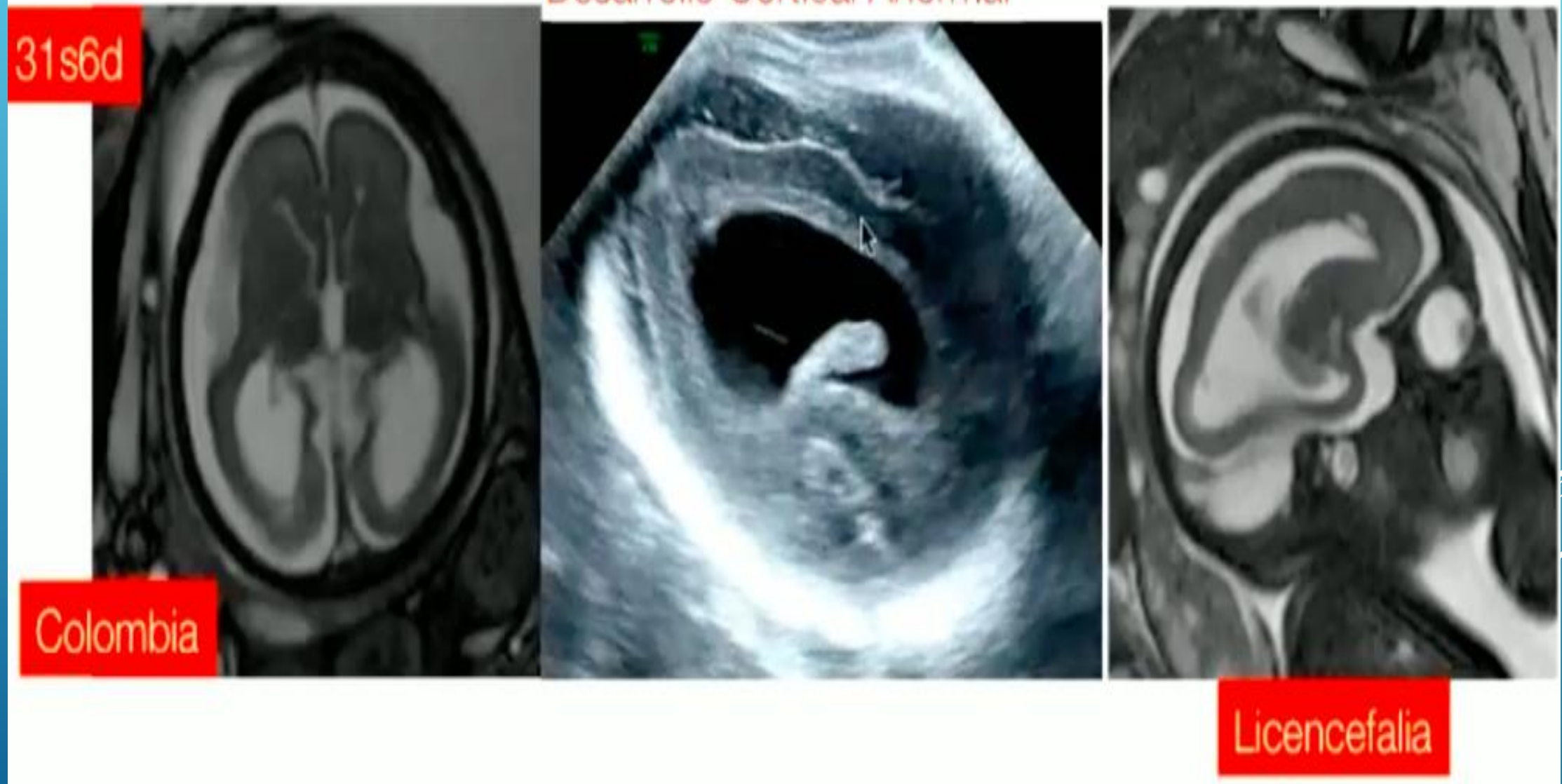
isuog.org

Calcifications - US Tranvaginal

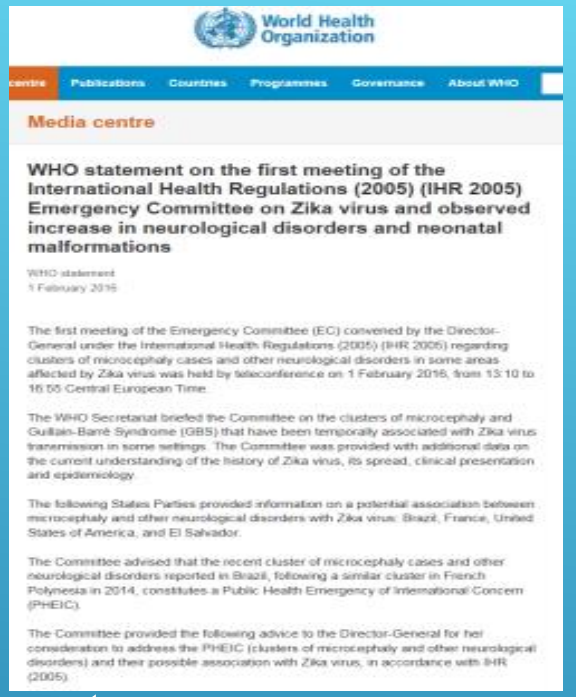





Desarrollo Cortical Anormal



EL VIRUS DEL ZIKA VIRUS Y UN INCREMENTO EN DESORDENES NEUROLOGICOS MALFORMACIONES NEONATALES
PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN (PHEIC)
IMPLICACIONES PARA LAS AMERICAS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WHO statement on the first meeting of the International Health Regulations (2005) (IHR 2005) Emergency Committee on Zika virus and observed increase in neurological disorders and neonatal malformations

WHO statement
1 February 2016

The first meeting of the Emergency Committee (EC) convened by the Director-General under the International Health Regulations (2005) (IHR 2005) regarding clusters of microcephaly cases and other neurological disorders in some areas affected by Zika virus was held by teleconference on 1 February 2016, from 13:10 to 16:55 Central European Time.

The WHO Secretariat briefed the Committee on the clusters of microcephaly and Guillain-Barré Syndrome (GBS) that have been temporally associated with Zika virus transmission in some settings. The Committee was provided with additional data on the current understanding of the history of Zika virus, its spread, clinical presentation and epidemiology.

The following States Parties provided information on a potential association between microcephaly and other neurological disorders with Zika virus: Brazil, France, United States of America, and El Salvador.

The Committee advised that the recent cluster of microcephaly cases and other neurological disorders reported in Brazil, following a similar cluster in French Polynesia in 2014, constitutes a Public Health Emergency of International Concern (PHEIC).

The Committee provided the following advice to the Director-General for her consideration to address the PHEIC (clusters of microcephaly and other neurological disorders) and their possible association with Zika virus, in accordance with IHR (2005).

- Fortalecer la vigilancia:
  - Vigilancia para arbovirus
  - Vigilancia de defectos congenitos
- Coordinacion Multisectorial para el manejo y control del vector
- Preparar los Servicios de Salud para para el manejo de complicaciones potenciales incluidas los sindromes neurologicos.
- Alerta publica y Comunicacion de los riesgos.

February 1st, 2016

From Morbidity & Mortality Weekly Report

CME / ABIM MOC / CE

Vital Signs: Update on Zika Virus–Associated Birth Defects and Evaluation of All U.S. Infants with Congenital Zika Virus Exposure — U.S. Zika Pregnancy Registry, 2016

Authors:
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Faculty and Disclosures

CME / ABIM MOC / CE Released: 9/11/2017 **Valid for credit through:** 9/11/2018

Results. During the analysis period, 1,297 pregnant women in 44 states were reported to the USZPR. Zika virus–associated birth defects were reported for 51 (5%) of the 972 fetuses/infants from completed pregnancies with laboratory evidence of possible recent Zika virus infection (95% confidence interval [CI] = 4%–7%); the proportion was higher when restricted to pregnancies with laboratory-confirmed Zika virus infection (24/250 completed pregnancies [10%, 95% CI = 7%–14%]). Birth defects were reported in 15% (95% CI = 8%–26%) of fetuses/infants of completed pregnancies with confirmed Zika virus infection in the first trimester. Among 895 liveborn infants from pregnancies with possible recent Zika virus infection, postnatal neuroimaging was reported for 221 (25%), and Zika virus testing of at least one infant specimen was reported for 585 (65%).

MANEJO ACTUAL ECOGRAFICO

- Gestantes que han tenido sintomas de infección o tienen historia de exposición al Zika: Primer Eco a las 3-4 semanas de la infección o a los 18-20 semanas de gestación.
- Buscar signos ecograficos de calcificaciones intracraneales, microcefalia u otras anormalidades.
- Control cada 3-4 semanas
- El periodo de latencia entre la infeccion del feto con Zika y el desarrollo de signos visibles por Ecografia puede ser prolongado y se aconseja usar MRI para detectar esos cambios.

UNIVERSITY OF OXFORD

Head Circumference (mm)

Gestational age (exact weeks)	Centiles						
	3rd	5th	10th	50th	90th	95th	97th
14	87.38	88.69	90.73	97.88	105.02	107.06	108.37
15	99.22	100.61	102.78	110.37	117.97	120.13	121.53
16	111.12	112.60	114.88	122.91	130.94	133.22	134.70
17	123.04	124.59	127.00	135.44	143.87	146.28	147.83
18	134.94	136.56	139.08	147.90	156.73	159.24	160.86
19	146.77	148.46	151.08	160.26	169.45	172.07	173.76
20	158.49	160.24	162.96	172.48	182.00	184.72	186.47
21	170.06	171.87	174.67	184.50	194.34	197.14	198.95
22	181.44	183.30	186.18	196.30	206.42	209.31	211.16
23	192.59	194.50	197.46	207.84	218.22	221.18	223.08
24	203.48	205.42	208.45	219.07	229.69	232.72	234.67
25	214.05	216.04	219.13	229.97	240.81	243.90	245.89
26	224.28	226.31	229.46	240.51	251.56	254.71	256.73
27	234.13	236.20	239.40	250.65	261.89	265.10	267.16
28	243.56	245.66	248.92	260.36	271.80	275.06	277.16
29	252.52	254.66	257.98	269.61	281.25	284.56	286.70
30	260.99	263.17	266.54	278.38	290.22	293.60	295.77
31	268.92	271.14	274.58	286.64	298.71	302.15	304.36
32	276.28	278.54	282.05	294.37	306.68	310.19	312.45
33	283.02	285.34	288.93	301.53	314.13	317.72	320.03
34	289.11	291.48	295.17	308.10	321.03	324.72	327.10
35	294.50	296.95	300.75	314.07	327.39	331.18	333.63
36	299.16	301.69	305.62	319.40	333.17	337.10	339.63
37	303.05	305.68	309.76	324.07	338.39	342.47	345.10
38	306.12	308.86	313.12	328.07	343.01	347.28	350.02
39	308.33	311.21	315.68	331.37	347.05	351.52	354.40
40	309.64	312.68	317.40	333.94	350.49	355.21	358.25

Pan American Health Organization

World Health Organization

REGIONAL OFFICE FOR THE Americas

Zika cases and congenital syndrome associated with Zika virus reported by countries and territories in the Americas, 2015 - 2017
Cumulative cases

Data as of 19 October 2017 2:00 PM EST

Country/Territory	Autochthonous cases[a]		Imported cases	Incidence Rate[b]	Deaths among Zika cases[c]	Confirmed congenital syndrome associated with Zika virus infection[d]	Population X 1000[e,f]
	Suspected	Confirmed					

Latin America and the Caribbean							
Latin America							
Mexico[2]	0	10,417	15	8.10	0	20	128,624
Central American Isthmus							
Belize	2,005	355	0	636.12	0	0	371
Costa Rica	7,639	1,982	32	197.11	0	6	4,881
El Salvador	11,715	51	0	191.41	0	4	6,147
Guatemala[3]	3,862	1,000	0	29.16	0	140	16,674
Honduras[4]	32,385	308	0	399.18	0	8	8,190
Nicaragua	0	2,065	3	33.39	0	2	6,184
Panama	5,646	1,177	42	171.00	0	13	3,990
Subtotal	*63,252*	*6,938*	*77*	*151.15*	*0*	*173*	*46,437*
Latin Caribbean							
Cuba	0	187	58	1.64	0	0	11,392
Dominican Republic[5]	4,919	335	0	49.07	0	85	10,708
French Guiana[6,7]	10,500	483	10	3979.35	0	1	276
Guadeloupe[6,8]	30,845	382	0	6615.89	0	5	472
Haiti[11]	2,955	5	0	27.12	0	1	10,916
Martinique[6,9]	36,680	21	0	9267.93	0	5	396
Puerto Rico	0	40,588	137	1102.64	5	47	3,681
Saint Barthelemy[6]	1,005	61	0	10660.00	0	0	10
Saint Martin[6,10]	3,283	200	0	9675.00	0	1	36
Subtotal	*90,187*	*42,262*	*205*	*349.59*	*5*	*145*	*37,887*
Andean Area							
Bolivia (Plurinational State of)	2,586	790	4	30.77	0	14	10,971
Colombia[12]	98,599	9,925	0	223.07	0	248	48,650
Ecuador[13]	3,753	3,058	15	41.26	0	7	16,506
Peru[14]	6,556	1,521	22	25.26	0	0	31,970
Venezuela (Bolivarian Republic of)	60,097	2,413	0	198.33	0	0	31,518
Subtotal	*171,591*	*17,707*	*41*	*135.59*	*0*	*269*	*139,615*
Brazil[15]	231,725	137,288	0	176.10	11	2,952	209,553
Southern Cone							
Argentina[16]	539	276	41	1.85	0	2	44,060
Chile	0	0	34	0.00	0	0	18,131
Paraguay[17]	664	18	0	10.14	0	2	6,725
Uruguay	0	0	1	0.00	0	0	3,444
Subtotal	*1,203*	*294*	*76*	*2.07*	*0*	*4*	*72,360*

Tabla 2. Casos de enfermedad por virus Zika confirmados en el Perú 2016-SE 26 (al 1-07-2016)

DEPARTAMENTO	CASOS AUTÓCTONOS				CASOS	TOTAL	
	sintomáticos	asintomáticos	TOTAL	%	IMPORTADOS	Nº	%
CAJAMARCA	25	39	64	78.0	0	64	66.0
LORETO	8	2	10	12.2	3	13	13.4
LIMA	1	0	1	1.2	8	9	9.3
TUMBES	4	0	4	4.9	3	7	7.2
SAN MARTIN	2	0	2	2.4	0	2	2.1
UCAYALI	0	1	1	1.2	0	1	1.0
MOQUEGUA	0	0	0	0.0	1	1	1.0
Total	**40**	**42**	**82**	**100**	**15**	**97**	**100**

Fuente: Centro Nacional de Epidemiología, Prevención y Control de Enfermedades

Tabla 5. Gestantes con zika confirmadas en el Perú, 2016-SE 26 (al 1-07-2016)

Departamento	Distrito	Total gestantes
Cajamarca	Jaén	34
	Pucará	1
Loreto	Yurimaguas	1
Total		**36**

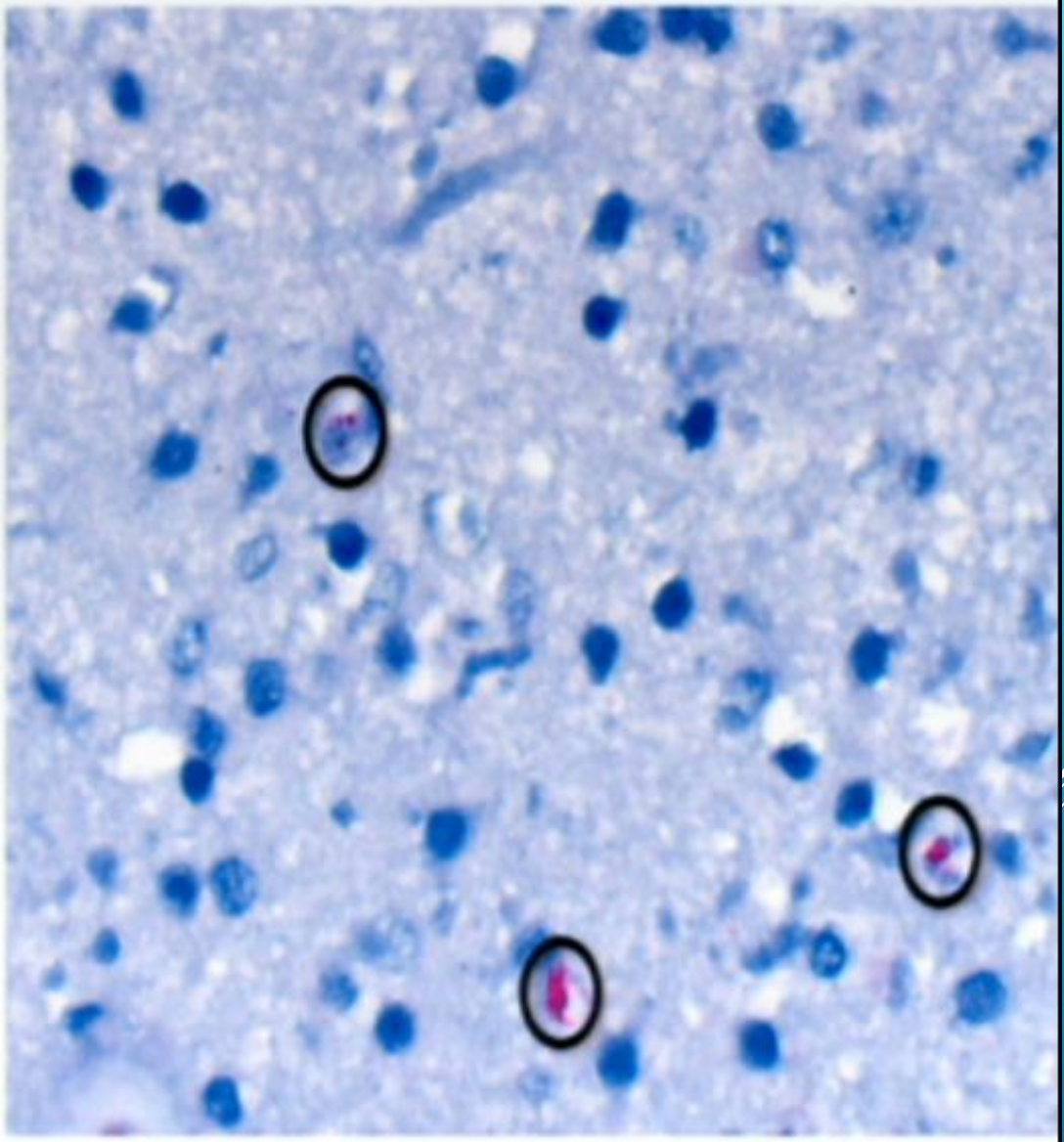
Fuente: Centro Nacional de Epidemiología, Prevención y Control de Enfermedades

RECOMENDACIONES

- EL Test diagnostico a usar es transcripcion reversa de la reaccion en cadena de la polimerasa (RT-PCR) dentro de la semana del inicio de los sintomas.
- Se puede usar IgM despues de 4 semanas del inicio de los sintomas.
- zikamch@cdc.gov; (770) 488-7100

El laboratorio de los CDC confirma el Zika en tejidos fetales

- Se ha identificado evidencia del virus del Zika en:
  - Líquido amniótico
  - Placenta
  - Cerebro
  - Productos de la concepción



Pregnancy management in the context of Zika virus

Interim guidance
2 March 2016
WHO/ZIKV/MOC/16.2

World Health Organization

2. Recommended practices

2.1 Preventive measures

Infection prevention measures for pregnant women are the same as those recommended for the general population. However, the importance of preventive measures should be emphasized at every contact with a pregnant woman. Health care professionals should promote the following measures with pregnant women and their families, and in the community.

Vector control: Environmental measures should be undertaken to reduce vector density. As mosquito control is the only measure that can successfully interrupt

Personal protection measures: The following interventions are recommended for the general population and for pregnant women in particular:

- Protection of the skin from exposure to mosquitoes by wearing clothes that cover as much of the body as possible (e.g. long sleeves, long trousers or skirts)
- Use of mosquito bed nets, including when sleeping during the daytime
- Use of mosquito mesh/nets/screens on windows and doors
- Use of insect repellents approved by local health authorities (e.g. DEET or Icaridin-based insect

ESTRATEGIA DE PAHO/WHO PARA RESPONDER AL ZIKA VIRUS

WWW.PAHO.ORG/ZIKAVIRUS

DETECCION

Deteccion temprana del virus, sus secuelas y monitorear la evolucion de la epidemia.

PREVENCION

Reduccion del riesgo para reducir la densidad del vector y oportunidades de transmision.

RESPUESTA

Administrar la respuesta, incluyendo la prparacion de las unidades de salud, recomendaciones para el manejo clinico, comunicacion, movilizacion de recursos y logistica.

Promote **research** and generation of evidence

ZIKA SITUATION REPORT

World Health Organization

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 1: Countries and territories with transmission of Zika virus, 2007 – 2016

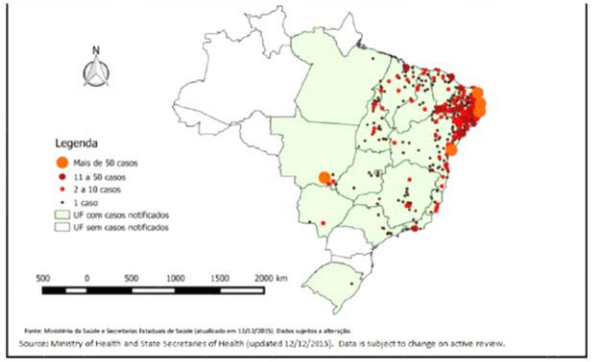


Figure 2. Microcephaly cases in Brazil as of January 2016

Pregnancy management in the context of Zika virus

Interim guidance
2 March 2016
WHO/ZIKV/MOC/16.2

World Health Organization

1. Introduction

1.1 Background

Zika virus is a flavivirus that is prima
infected *Aedes* mosquitoes. This vect
dengue and chikungunya viruses and
tropical and sub-tropical environmen
Americas, Asia and the Pacific. Altho
first identified in humans in 1952, ve
documented prior to 2015. Human i
asymptomatic, and symptoms are us
limiting. While the usual characteristi
have not changed, the recent associat
virus infection and potential congeni
Guillain-Barré Syndrome in some aff
escalated this issue to a Public Health
International Concern.[1-3]

1.2 Rationale and objectives

The mosquito vector that carries the
warm climates and particularly in are
conditions. Pregnant women living i
areas are at equal risk as the rest of th
infected by viruses borne by this vect
with Zika virus may go unnoticed as
develop symptoms. Although Zika vi
pregnancy is typically a mild disease,
cases of congenital microcephaly, Gu
and other neurological complications
outbreaks have occurred,[1,2] has signif
for pregnant women and their famili
providers and policy-makers.[4]

While the association between Zika v
microcephaly is still being investigate
transmission throughout pregnancy h
documented.[4-6] Laboratory isolation
neurologic tissues of infants with mic
added to the suspicion of causality.[5]
whether Zika virus infection contribu
pregnancy losses and stillbirths, altho
has been detected in products of con
miscarriage by infected women.

The aim of this document is to provi
for interventions to reduce the risk o
infection and to manage potential co
pregnancy. This guidance is based on

Lactancia materna en el contexto del brote de virus de Zika

Orientación provisional
25 de febrero de 2016
WHO/ZIKV/MOC/16.5

Organización Mundial de la Salud

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 preguntarse 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 tras la 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 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, utilizarla 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 válid en el contexto del brote de virus de Zika.

b. Como cualquier otra madre, aquella con infección presunta, probable o confirmada por este virus durant el embarazo o después del parto debe recibir apoyo cualificado de los profesionales sanitarios para que ini y mantenga la lactancia materna. Lo mismo se aplica a las madres y las familias de lactantes con infección presunta, 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/ZIKV/MOC/16.1

World Health Organization

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 guidance will be reviewed and the recommendations updated as new evidence emerges.

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:

1. 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[1], 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 ready access to emergency contraceptive services and counselling [4].
2. Sexual partners of pregnant women, living in or returning from areas where local transmission of Zika virus is known to occur, should use safer sexual practices or abstinence from sexual activity for the duration of the pregnancy.
3. As most Zika virus infections are asymptomatic[2]:
   a. Men and women living in areas where local transmission of Zika virus is known to occur should consider adopting safer sexual practices or abstaining from sexual activity.
   b. 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[3] after return.

[1] 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.

[2] All individuals should receive appropriate counselling to make informed choices on the sexually transmitted infection prevention method(s) they wish to use.

[3] 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 Mlakar et al.)

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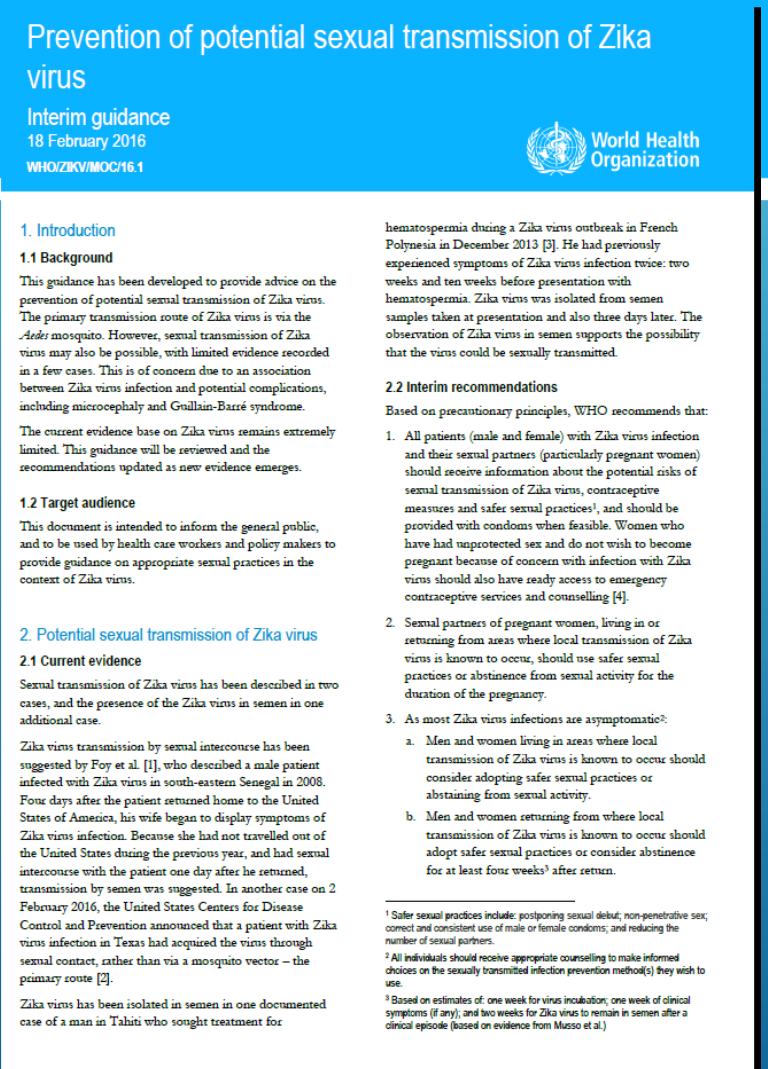

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World Health Organization

OBSTETRICS & GYNECOLOGY

Zika Virus and Pregnancy: What Obstetric Health Care Providers Need to Know

Meaney-Delman, Dana MD, MPH; Rasmussen, Sonja A. MD, MS; Staples, J. Erin MD, PhD; Oduyebo, Titilope MD; Ellington, Sascha R. MSPH; Petersen, Emily E. MD; Fischer, Marc MD; Jamieson, Denise J. MD, MPH

Obstetrics & Gynecology:
April 2016 - Volume 127 - Issue 4 - p 642–648
doi: 10.1097/AOG.0000000000001378
Contents: Current Commentary

Practice Advisory: Updated Interim Guidance for Care of Women of Reproductive Age During a Zika Virus Outbreak

Society for Maternal-Fetal Medicine

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

March 31, 2016

Sexual Transmission:

Sexual transmission of ZIKV has been reported but the frequency and efficiency of this route of infection is uncertain. Additional studies are needed to characterize the risk of sexual transmission of ZIKV; as more information becomes available recommendations will be updated. Based on limited data, there is a risk of sexual transmission through exposure to semen of males with ZIKV infection. Given the potential risks of maternal ZIKV infection, pregnant women whose male partners have traveled to countries in which ZIKV is reported or those who have ZIKV infection should consider using condoms or abstaining from sexual intercourse for the remainder of pregnancy.

Reproductive Counseling:

Obstetrician–gynecologists and other health care providers should discuss pregnancy intentions and reproductive options with all women of reproductive age for shared decision making. In the context of the ongoing ZIKV outbreak, preconception care should include a discussion of the signs and symptoms and the potential risks of ZIKV infection. Women and men who reside in an area with ongoing transmission of ZIKV without clinical illness consistent with ZIKV disease and who desire pregnancy should talk with their health care providers. Health care providers should discuss their patients' reproductive life plans in the context of potential ZIKV exposure; resources are available here. The risk for adverse pregnancy and birth outcomes associated with ZIKV disease during pregnancy highlights the need to ensure that effective contraception is readily available for women and couples who live in or have recently traveled to areas with local ZIKV transmission and who do not desire pregnancy (Oduyebo, 2016). Prevention of unintended pregnancies in the context of a ZIKV outbreak is especially important as an approach to reducing the likelihood of congenital infections.

Women Avoiding Pregnancy:

When women do not plan a pregnancy, obstetrician–gynecologists and other health care providers should discuss strategies to prevent unintended pregnancy and provide counseling on family planning and the use of contraceptive methods. Safety, effectiveness, availability and acceptability should be considered when selecting a contraceptive method.

CONSEJERIA ANTICONCEPTIVA

1. Mujeres con diagnostico de Zika deben esperar 8 semanas antes de gestar.

2. Hombres con diagnostico de infeccion a Zika deben esperar 6 meses para intentar concebir.

3. Hombres y mujeres asintomaticos con exposicion posible deben esperar 8 semanas para tratar de concebir.

4. Es recomendable el uso de preservativos para las relaciones sexuales.

5. Uso de metodos anticonceptivos seguros y efectivos para prevenir el embarazo en zonas de exposición al virus del ZIKA. Especial atención al grupo de adolescentes (sexo sin protección, violación) .

6. AOE en casos de RS sin protección y no deseo de embarazo en zonas de exposición al virus del ZIKA.

7. En caso de embarazo no deseado y exposición al virus del ZIKA y la posibilidad de defectos congenitos fetales, poder tener acceso a la interrupción del embarazo

Diagnóstico rápido de la situación de los servicios de salud sexual y reproductiva en el marco de la epidemia del Zika

PRINCIPALES HALLAZGOS

1. LA INFRAESTRUCTURA Y EL EQUIPAMIENTO DE LOS EESS NO PERMITEN UNA ATENCION EN SSR EN CONDICIONES ACEPTABLES.

2. DESABASTECIMIENTO DE MAC Y OTROS INSUMOS ESENCIALES EN DIFERENTES GRADOS.

3. ES NECESARIO MEJORAR LA COMPETENCIA TECNICA DE LOS PROFESIONALES DE SALUD PARA EEOO , PF Y CONSEJERIA.

4. EL CONOCIMIENTO DE LOS PROFESIONALES DE SALUD SOBRE PREVENCION DEL ZIKA ES SOLO VECTORIAL. NO CONOCEN SOBRE EL MANEJO EN GESTANTES.

5. EL 100% DE LOS PROFESIONALES DE SALUD NO CONOCE EL MANEJO ADECUADO, NI LA RUTA A SEGUIR EN CASOS DE VIOLENCIA SEXUAL.

6. INADECUADO SISTEMA DE REFERENCIA Y CONTRAREFERENCIA EN EEOO Y PF.

7. MENOS DE LA MITAD DE LOS EESS TIENE SERVICIO DIFERENCIADO PARA ADOLESCENTES. HAY BARRERAS DE ACCESO A MAC.

8. USUARIAS SE QUEJAN DEL TIEMPO DE ESPERA EN SSR (3 horas). SOLO EL 22% FUERON INFORMADAS SOBRE LOS RIESGOS DEL ZIKA

DESAFÍOS

- Cambiar la ley en países de la Región que no permiten la educación sexual y de salud reproductiva, así como el acceso a la contracepción para adolescentes;
- Cambiar la orientación en los sistemas de salud pública en los países de la región acerca de que la anticoncepción debe ser solamente responsabilidad de la atención básica, lo que no permite el uso más amplio de contracepción post eventos obstétricos (parto y aborto), con especial énfasis en las adolescentes;
- Ampliar la atención de salud a otros profesionales no médicos en los servicios de planificación familiar, incluso en el caso de la colocación de DIU e implantes;
- Cambiar la ley en países que no permiten el uso de contracepción de emergencia;
- Brindar acceso a información científica y conserjería a mujeres embarazadas con diagnóstico de infección por virus Zika virus sobre los riesgos y la oportunidad de optar de forma libre por la interrupción del embarazo.


EsSalud
TODO PACIENTE CON DIAGNÓSTICO DE ABORTO INCOMPLETO SE HA DE COMUNICAR A LA POLICÍA DE TURNO (PNP).
JEFATURA
GINECO OBSTETRICIA

GAPS EN EL CONOCIMIENTO DEL ZIKA Y EL EMBARAZO

- Incidencia de la infeccion en gestantes en áreas de Zika
- La tasa de transmisión vertical
- La tasa que el feto infectado manifieste complicaciones; datos de la Polinesia Francesa son de 1% de microcefalia de madres infectadas en el I Trimestre. En Brasil el 29% de madres infectadas en todos los trimestres pueden tener anormalidades.
- Ultimas publicaciones en USA señalan que el riesgo puede variar entre 5% en gestantes y 14%. en gestantes con infección en el I trimestre.

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