Dangerous Intersection
Zika Transmission and Cuts to Reproductive Health Services in Texas

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At the end of November 2016, Texas officials reported a case of local transmission of Zika virus, which is associated with microcephaly and long-term neurological complications in infants born to women infected while pregnant. A few weeks later, capping off a multiyear process that has reduced the access of low-income women in Texas to family planning services, the governor’s office issued a final notice to providers associated with Planned Parenthood that the organization would no longer be eligible to participate in taxpayer-funded programs. The arrival of Zika, along with the state’s systematic restriction of low-income patients’ access to reproductive health care, raises questions about the potential of this border state to hold the line against Zika and its negative effects when the next mosquito season arrives.

What has Texas done to prepare for Zika?

On November 28, state officials confirmed local transmission of Zika virus in Brownsville, a city in South Texas situated across the Rio Grande from the Mexican city of Matamoros. The woman infected with Zika had not traveled anywhere Zika had been reported to spread locally, leading officials to conclude a mosquito had most likely infected her near her home. Two weeks later, state officials confirmed four more cases identified in a door-to-door search in the infected woman’s neighborhood. The Texas cases follow several months of local transmission of Zika last summer and fall in the Miami, Florida, area, where strong coordination between state and local health authorities, increased vector-control measures, and public outreach activities were credited with limiting the number of people infected with the virus.

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3 Texas Department of State Health Services, “Texas Announces Additional Local Zika Cases in Cameron County,” December 9, 2016, https://www.dshs.texas.gov/news/releases/2016/20161209.aspx. As of January 2017, there are a total of 6 locally transmitted cases, 295 Zika cases altogether, and 151 women from Texas on the National Zika Registry.
Since news of the Zika outbreak in Latin America broke in 2015, health experts in Texas had been sounding the alarm, saying the question was not if, but when, local transmission of Zika in the state would be confirmed. Texas is considered particularly vulnerable to a Zika outbreak because most of the state is home to *Aedes aegypti*, the mosquito species most effective at transmitting the virus.5

Until November, confirmed Zika cases in Texas had all been linked to travel to affected areas or sexual intercourse with someone infected while traveling to a region where Zika was spreading. But as early as last summer state officials began taking steps to prepare for local transmission. Inspired by memories of a particularly lethal year of West Nile virus—another mosquito borne disease—in 2012, as well as confirmation in recent years of local transmission of dengue virus, also carried by *Aedes aegypti*, Texas officials last summer applied for an estimated $11 million in federal funding and had urged state representatives in Congress to approve the proposed federal funding for Zika response.6 At the request of Rep. Henry Cuellar (D-TX), the U.S. Centers for Disease Control and Prevention (CDC) opened a small office in Laredo, also on the Texas-Mexico border, to track Zika reports.7 In Houston, where the cases of local transmission of dengue had been confirmed, and where a woman who had acquired Zika while traveling gave birth to a baby with microcephaly in July, the Texas Children’s Hospital opened a weekly Zika clinic for pregnant women.8

What does the experience in Latin America and the Caribbean suggest about Zika and access to family planning services?

Evidence from the outbreak in Latin America and the Caribbean, where between 2015 and 2016 nearly 200,000 Zika cases were confirmed, shows that it is people living in low-income settings, which frequently count on less effective vector control, who are most vulnerable to infection.9 Because babies with Zika congenital syndrome face severe developmental challenges, health officials in the region last year began urging women at risk of being infected with Zika to delay pregnancy for up to two years.10 A 2015 United Nations report showed that more than 70 percent of women

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between the ages of 15 and 49 in at least 16 countries in Latin America and the Caribbean were using some form of contraception.\(^{11}\)

Indeed, a 2012 study showed that more than 50 percent of pregnancies in Latin America and the Caribbean were unintended.\(^{12}\) Many women who experience an unplanned pregnancy are among the poorest of the poor or live in remote settings where they may not count on regular access to such health services as antenatal care and ultrasound screenings.\(^{13}\)

For Zika-infected pregnant women who do learn that their developing fetuses show signs of congenital syndrome, the choices are few. Access to abortion is restricted in all but a few countries in the region; even where an abortion may be performed to protect the health of the mother or because of fetal defects, information available to women about their right to access abortion services is limited.\(^{14}\) In Brazil, the epicenter of the regional outbreak and where abortion is illegal except in rare cases, the Pan American Health Organization (PAHO) reports that more than 2,300 children have been confirmed to suffer from congenital Zika syndrome.\(^{15}\) A high percentage of the Brazilian women who became infected with Zika while pregnant and gave birth to babies with microcephaly live in the country’s impoverished northeast.\(^{16}\)

What are the options for low-income women in Texas who are at risk of being infected with Zika and wish to reduce the possibility of giving birth to a child with Zika congenital syndrome?

Over the past 10 years, officials in Texas, where, in 2014, 17.2 percent of the population was living in poverty, have systematically reduced low-income women’s access to reproductive health services. In 2007 the state launched a family-planning program known as the Women’s Health Program. This program received a significant portion of its funds from the federal government, which required that all medically qualified organizations be eligible to participate.\(^{17}\) In 2011, nearly half of the 119,000 women who participated in the program received family planning services at clinics operated in 23 of Texas’s 254 counties by local providers for the nonprofit organization, Planned Parenthood.\(^{18}\)

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\(^{13}\) UN Department of Economic and Social Affairs, Population Division, *Trends in Contraceptive Use Worldwide, 2015*, 9.


\(^{18}\) White et al., “The Impact of Reproductive Health Legislation on Family Planning Clinic Services in Texas.”
But in 2012, after the Texas legislature directed the Women’s Health Program to “exclude Planned Parenthood affiliates,” the federal government withdrew its support for the Program. In 2013 officials then launched the state-funded Texas Women’s Health Program, which excluded from participation all clinics affiliated with an abortion provider, including Planned Parenthood. Between 2011 and 2013, state officials also redistributed federal grants intended to support family planning programs away from clinics dedicated to reproductive health services and toward community clinics offering a more comprehensive range of services and not necessarily focused on care for women.

According to several analyses, the exclusion of the various Planned Parenthood providers from the state-funded program, combined with the redistribution of family planning grants, led to the closure of 82 family planning clinics across Texas. Drawing on a review of claims submitted to the Texas Women’s Health Program for contraception coverage and to Medicaid for childbirth benefits, the studies’ authors show that while claims for short-acting contraceptives remained relatively constant, fewer eligible women who were already using long-acting, reversible contraceptive methods continued to use them, and more low-income women sought Medicaid benefits for delivering babies in the state with the highest maternal mortality rate in the country.

Until 2015, Planned Parenthood-affiliated clinics remained eligible to participate in other Medicaid-supported reproductive health programs in Texas; however, in October of that year, responding to controversial videos purporting to show fetal tissue for sale by officials in one of the state’s Planned Parenthood organizations, Texas governor Greg Abbott “issued a letter ending Medicaid participation for Planned Parenthood affiliates in the State of Texas based on evidence of Medicaid program violations.” Although the state delayed implementing the order for several months, this past December, just as the Zika news out of South Texas was breaking, officials issued a final notice to exclude Planned Parenthood from the entire network of taxpayer-funded Medicaid providers in the state.

Planned Parenthood’s future with respect to Medicaid and reproductive health services in Texas is uncertain. In documents filed with a federal judge at the end of December, the state’s various Planned Parenthood affiliates, which operate 30 clinics across the state, object to the idea that they have

19 Stevenson et al., “The Impact of Removing Planned Parenthood from Texas Women’s Health Program,” 854.
21 Ibid.
violated any Medicaid program requirements and requested a delay in the state’s execution of the order. They assert that the Medicaid exclusion in Texas will adversely affect the access to family planning and other reproductive health services of more than 10,000 low-income women, many of who live in South Texas, where the locally transmitted Zika cases were reported. On January 19, Judge Sam Sparks “delayed Texas’ plan to boot the nonprofit Medicaid program by setting a temporary injunction” until February 21.

In the meantime, on January 25, state officials confirmed that a pregnant woman living in Bexar County, Texas, had tested positive for Zika infection, apparently acquired when she traveled to Brownsville last fall.

As the lessons from Latin America show, the combination of high rates of poverty, a sanitary environment favorable to the proliferation of Aedes aegypti, and limitations on women’s access to and utilization of family planning services within the public health sector make preventing and controlling Zika a challenge.

Improving vector control, strengthening health education, and stepping up screening for fetal defects within antenatal clinics are important steps. But ensuring women at risk of infection with Zika have access to contraception if they wish to avoid becoming pregnant and bearing a child with Zika congenital syndrome is imperative. In Latin America and the Caribbean, public health officials gathered last June in Peru to develop country-level action plans to guarantee women’s access to contraception in the face of the Zika crisis.

But in Texas, the state’s systematic restrictions on publicly funded family planning services don’t bode well for efforts to stem the spread of Zika when the next mosquito season arrives.

Perhaps some in Texas are banking on the arrival of a Zika vaccine, knowing that there are several investigational vaccines in the research pipeline. Yet with antivaccine sentiment in Texas gaining ground, the number of children who have not been immunized against measles and other life-

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threatening diseases has increased dramatically over the past 15 years.\footnote{Peter J. Hotez, “Texas and Its Measles Epidemics,” \textit{PLOS Medicine}, October 25, 2016, http://dx.doi.org/10.1371/journal.pmed.1002153.} Waiting for a vaccine against Zika to save the day might be dangerous, indeed.

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