Topical Brief #033

Latin American Views on Abortion in the Shadow of the Zika Epidemic

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Key Findings:

- On average in the region, justification of abortion when a mother's life is in danger increased in 2016/17.
- Average shifts in abortion justification are larger where the Zika epidemic was less severe.
- In countries where the outbreak was severe and governments restricted access to abortion, abortion justification increased significantly more than where governments facilitated abortion access.

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The Zika virus, a mosquito-borne infection originating in Africa, swept across the Americas in 2015-2016. The Zika epidemic resulted in thousands of infections across the region in 2016, many among pregnant women. Zika is linked to severe microcephaly,[1] a condition in which fetuses have abnormally small heads and partially collapsed skulls. This frequently leads to a series of serious developmental, intellectual, and physical disabilities over the course of the child's life.[2]

This AmericasBarometer *Topical Brief* assesses the extent to which beliefs that abortion is justified (which we refer to as "abortion justification" in this *Brief*) changed following the Zika epidemic in a region with some of the most restrictive abortion laws in the world, Latin America.[3] The 2016/17 AmericasBarometer survey asked the following question:

W14A. And now, thinking about other topics. Do you think it's justified to interrupt a pregnancy, that is, to have an abortion, when the mother's health is in danger?[4]

Figure 1 shows the regional trend in abortion justification over time. Dark green bars indicate the percentage of respondents who voiced abortion justification when the mother's health is in danger in each survey round.[5] In the 18 Latin American countries, average abortion justification in this circumstance increased significantly from 2014 to 2016/17, from 57% to 61%.[6] There are many potential explanations for this increased abortion justification, among them declining affiliation with the Catholic Church (AmericasBarometer Time Series) and a trend towards liberal and "post-materialist" values that accompany economic security (Inglehart 1981; Inglehart and Abramson 1999). This report assesses a third possibility, that changes in abortion justification are linked to the severity of and government response to the Zika epidemic.

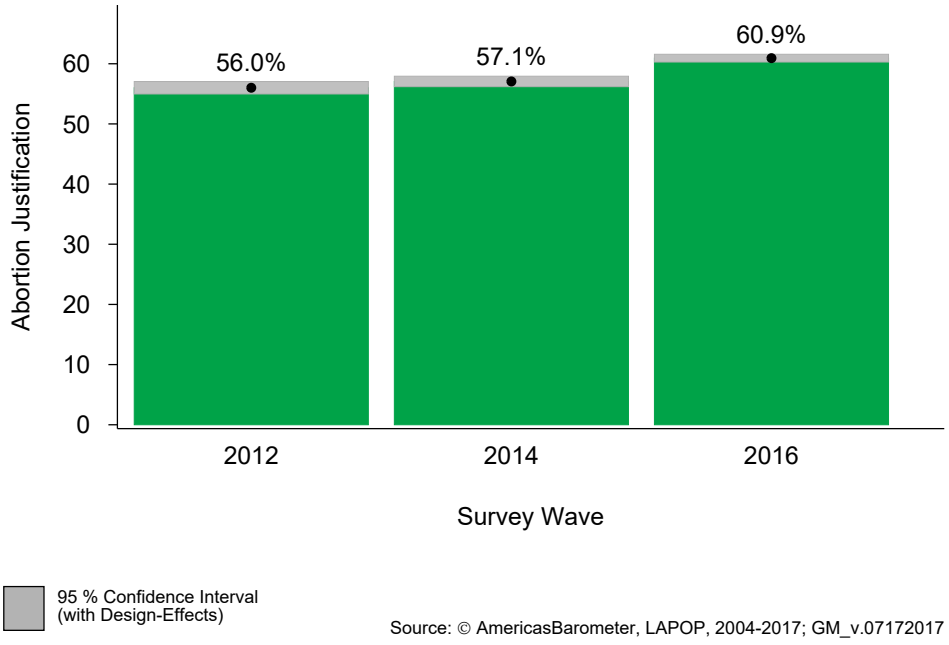

Figure 1: Abortion is Justified to Save a Mother's Life in LAC Region across Time

The Relevance of Zika as a Cause of Shifting Abortion Attitudes

Since the Zika outbreak did not spread equally in all countries, we examine whether abortion justification changed disproportionately where the epidemic was most severe, and for populations with the greatest personal risk due to Zika infection.[7] Drawing from social science theories of personal relevance (e.g., Krosnick 1988), we argue that as the probability of having a child with microcephaly increases, abortion can become a more relevant family planning option. This may then lead individuals to reconsider their views on abortion.

Figure 2 shows abortion justification when the mother's life is in danger in the 18 Latin American countries in the 2014 and 2016/17 AmericasBarometer by Zika incidence. The left panel shows differences in abortion justification across time in countries with low Zika incidence rates (fewer

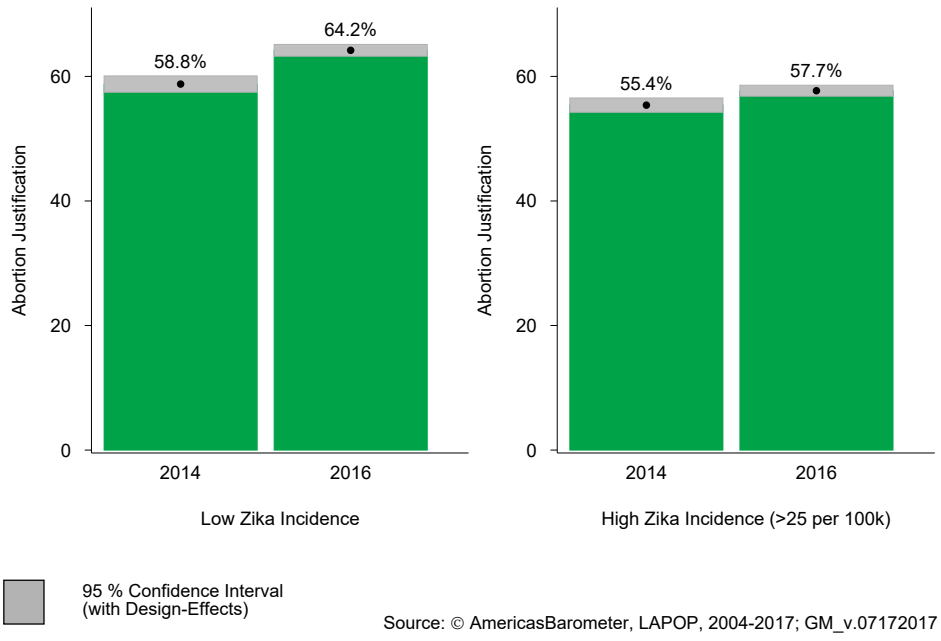

Figure 2: Abortion Justification over Time in Low versus High Zika Incidence Countries

than 25 reported cases per 100,000 inhabitants).[8] The right panel shows how abortion justification changed across the two rounds in countries with high prevalence rates (more than 25 cases per 100,000).

Given that Figure 1 shows a slight increase in average abortion justification over the last several years, it is not surprising that there are statistically significant increases across both sets of countries. It is surprising, however, that the largest increase in abortion justification is found in the low Zika-incidence countries.

National Policy Response and Abortion Justification

Why did abortion justification increase less on average in high-Zika contexts than in those where the outbreak was less severe? One possible explanation is that how governments responded to the outbreak affected

the extent to which people felt uncertain and personally threatened by the risk of infection.[9]

While perhaps perceived as less immediately threatening than terrorist attacks or natural disasters, the Zika outbreak may have motivated a similar response in the public, with individuals who felt threatened seeking government assurances and protections (Huddy, Feldman, and Weber 2007). Governments' unwillingness to relax strict abortion laws where the Zika virus was most prevalent may have heightened feelings of insecurity for many, while liberalizing access to abortion, even temporarily, could help minimize fear. If this was the case, then we might expect to see public opinion shift only in those high-incidence countries where the government's response did not offer security or protection for those directly affected.[10]

In four[11] of the nine countries with high Zika incidence, abortion is legal under limited circumstances and, in some cases, governments attempted to liberalize existing abortion policies. Colombia, for example, relaxed restrictions on abortion and recognized fetuses with microcephaly to be a genuine threat to the mother's health (Correa 2016). In some cases, even late-stage abortions were allowed when the fetus had severe cranial deformations.

In five[12] high-incidence countries where abortion is illegal in all or most cases, regardless of the health of the mother or the child, governments stood firm in their anti-abortion policies following the epidemic. El Salvador places a complete ban on abortion, and that country's response to the Zika outbreak was to recommend delaying pregnancy for two years, with no related increase in funding for contraception or broadening access to abortion.[13] Guatemala similarly prohibits abortion under all circumstances, which encouraged one nongovernmental organization to offer abortions on a ship anchored offshore in international waters during the Zika outbreak (Women on Waves 2017).

With this in mind, we further separate the high-incidence countries into those where access to abortion is limited but available and those where

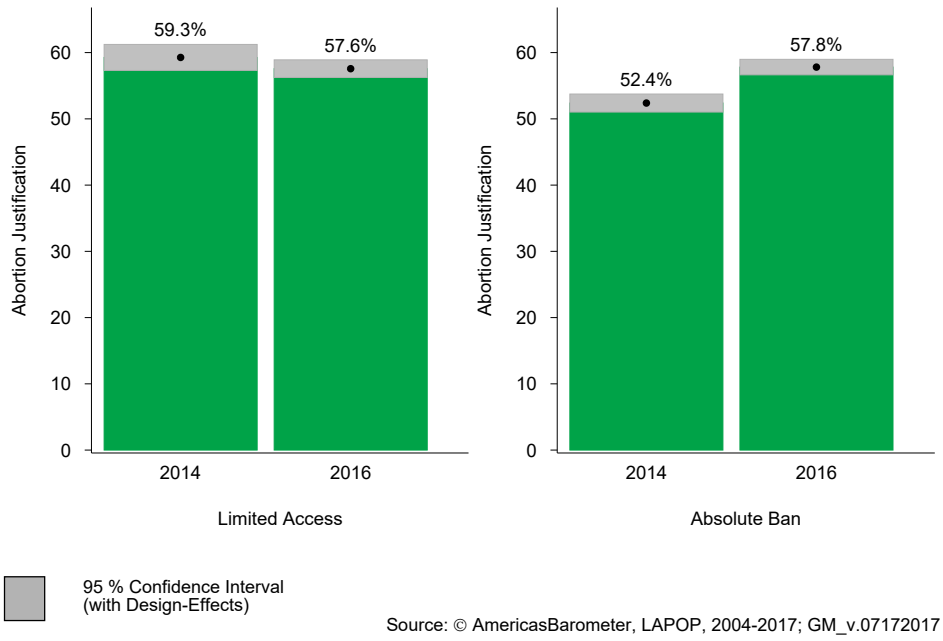

Figure 3: Abortion Justification over Time by Abortion Restriction

the ban on abortion is absolute. Figure 3 shows change in abortion justification in these two groups of high incidence countries. From 2014 to 2016/17, in high Zika incidence countries with some abortion access, there is no significant change in abortion support.[14] In contrast, abortion justification increased significantly in countries where governments offered no legal means to terminate a pregnancy due to Zika complications. On average, these four countries saw a 5.5 percentage-point increase in abortion justification.

Crisis Breeds/Dampens Demand

Access to abortion services is limited in much of Latin America under normal conditions; indeed, the region is home to some of the most restrictive and punitive abortion laws in the world. In contrast to this legal state of affairs, the majority of people in the region report that they

support abortion if the mother's life is in danger. Zika presented Latin America with a new, widespread threat to mothers and their children.

It is possible that the shifts we observe in abortion justification were unrelated to the Zika epidemic. Indeed, these findings have some limitations, most notably the timing of the studies (in some cases, fieldwork took place well after the peak of the Zika epidemic) and our measure of abortion justification.

However, while we cannot speak to whether individuals internalized the threat of Zika and updated their beliefs about abortion accordingly, we can offer a possible mechanism that would lead someone to change their beliefs in such circumstances. We suggest that the availability of family planning services, specifically abortion, during the Zika outbreak changed public opinion. Where women had alternatives, shifts in abortion support were substantially more muted. Where no alternatives were available, however, the public demanded increased access to abortion. Threat and insecurity increased when alternatives were not provided, and people shifted their beliefs to meet those insecurities. In short, Zika was an example of a crisis breeding demand—in this case, for safe and accessible family planning options for women.

Notes

1. See, for example, https://www.cdc.gov/zika/healtheffects/birth_defects.html.

2. Most cases of microcephaly cannot be identified until the second trimester of pregnancy. See https://www.cdc.gov/ncbddd/birthdefects/microcephaly.html for details about effects and detection.

3. For a visual representation, see http://worldabortionlaws.com/map/.

4. This question is not ideal for testing abortion justification in the case of Zika, as microcephaly cannot be identified until the second trimester. While abortion justification to save a mother's life is not directly linked to abortion justification in advanced preg-

nancies, it is reasonable to assume that those who do not support abortion in even this circumstance will also be unlikely to support late-term abortion. At the same time, this motivation for abortion is consistent with governments' legal motivations for liberalizing access to abortion during the epidemic. In Colombia, for example, legislators and public health officials cited a legal provision allowing abortion when a pregnancy constitutes a threat to a mother's mental health (Correa 2016).

5. The gray shaded area around each black dot represents the 95 percent confidence interval around the point estimates. Average support for legalized abortion is statistically indistinguishable in 2012 and 2014 ($p = 0.13$), but increased significantly compared to both years in 2016/17 ($p < 0.001$).

6. See subsequent endnotes for the countries included in this *Topical Brief*.

7. For literature on how an issue's personal relevance can affect public opinion, see, for example, Boninger, Berent, and Krosnick (1995), Petty, Haugtvedt, and Smith (1995), and Krosnick (1988).

8. We coded incidence rates at the start date of AmericasBarometer fieldwork in each country. Low Zika incidence countries include Argentina, Bolivia, Chile, Ecuador, Mexico, Panama, Paraguay, Peru, and Uruguay. High Zika incidence countries include Brazil, Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, and Venezuela.

9. Figure 4 in the Appendix shows how Zika incidence is related to changes in abortion attitudes from 2014 to 2016 for all the countries included in Figure 2.

10. AmericasBarometer fieldwork took place in 2016 and 2017, while the peak of the Zika epidemic lasted from April 2015 through mid-2016. Fieldwork was not concurrent in all countries; it is thus possible that any relationship we observe between abortion attitudes and Zika incidence is related to fieldwork timing, rather than existing abortion policy. But the timing of fieldwork is not clearly associated with policy response. The surveys in the liberalizing countries Brazil and Colombia were conducted at the beginning and end of fieldwork for the round, respectively, and studies in countries with conservative policy responses like the Dominican Republic and Guatemala were also conducted near the extremes in the survey round. We therefore expect that survey timing increases error around our estimates but is not responsible for the average relationships we observe. For field dates by country and region, see https://www.vanderbilt.edu/lapop/fieldwork-dates.php.

11. Costa Rica, Colombia, Brazil and Venezuela are countries that either maintained their policy of limited abortion access or attempted to liberalize access for Zika patients.

12. Guatemala, El Salvador, Honduras, Nicaragua, and the Dominican Republic are all countries with strict abortion bans in place.

13. El Salvador has attracted the attention of the international community for jailing mothers who miscarried, accusing them of illegally terminating pregnancies. Women who have been raped have no legal avenue to terminate an unwanted pregnancy and are at risk of being prosecuted should they attempt to access this option illegally (see Lakhani 2016).

14. Results from a multilevel model controlling for individual-level features and treating policy response as a second-level variable are consistent with those shown here.

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Appendix

Figure 4 shows how change in abortion support is related to Zika incidence. The x-axis shows the number of suspected infection cases per 100,000 people in each country. These data come from the Pan American Health Organization (www.paho.org). The changes in abortion support percentages for each country are on the vertical axis. There is a negative relationship between abortion support and incidence rates for the entire sample of countries. As the report indicates, however, Zika could affect public opinion in different ways based on abortion access.

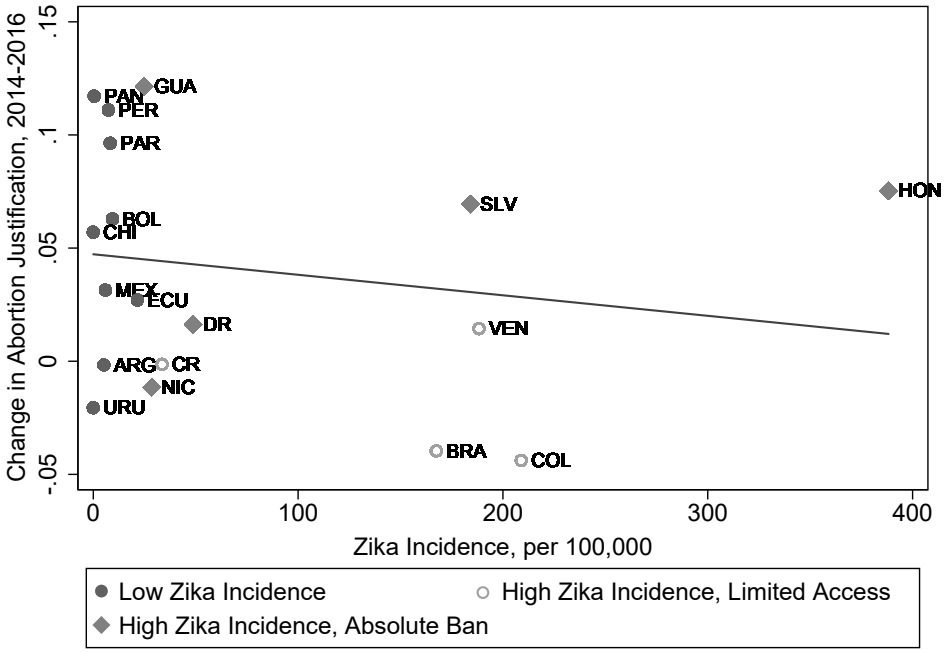

Figure 4: Change in Abortion Justification across Zika Incidence

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