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RESEARCH ARTICLE

"In Italy, we have a saying: make the law and you will find a way to cheat it"

The Regionalized Implementation of Italian Abortion Policies

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Abstract

While abortion debates often center the moral balance between individual autonomy versus state control, the idea of "state control" itself is nuanced. Regional versus national control of abortion policy has been a matter of much debate in recent years, most famously in the US case. In this paper, we explore how regional policies manifest in Italy. Abortion in Italy is characterized by the high level of conscientious objection among medical professionals, though the level varies significantly by region. Italy delegates administration of its health system to the regional level as well. We argue that this has led to different interpretations of the national abortion law and varying levels of abortion access across the country. We reach these conclusions by bringing together two datasets of interviews with doctors and administrators about abortion policy implementation. We conclude by theorizing a direct causal chain between the delegation of this policy to the regional level and the divergent levels of abortion access across Italy.

Keywords: Abortion access; Italy; Regionalization; Abortion policy; Health policy

Introduction

While most countries regulate abortion at the national level (World Abortion Laws Map, 2024), a handful have moved to allow regional and local governments and administrators to play a larger role in the process. Despite Italy's characterization as a unitary state, we argue that the way in which they delegate healthcare authority to regions creates a situation similar to the federal arrangements in the US or Mexico.

In Italy, the most notable aspect of abortion policy is conscientious objection: the legally-enshrined principle that any medical professional who morally disagrees with the procedure can opt out of participation. With nationally high but regionally varying levels of objection, many hospitals struggle to recruit enough nonobjecting doctors to staff their abortion services. We argue that regionalization of health administration plays a significant role in this problem, and that choices made at the regional level ultimately impact the level of abortion access in the region.

We theorize a causal mechanism that links the regional delegation of healthcare management to differing levels of abortion access. This mechanism hinges on the experience of abortion providers in hospitals, based on the administrative choices made by

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their regional health authorities. We reach this conclusion through the analysis of 42 semi-structured interviews that represent the perspectives of medical professionals and adjacent actors in eight regions of Italy. These interviews shed light on the variability of abortion care and access in different regions. We conclude by considering the effects that regionalizing such a policy has on democratic norms; specifically, whether a national "right" is really guaranteed if it is not accessible in all regions.

Literature Review

Italy's structure of government can be viewed as a compromise system, neither fully unitary nor fully federal, a hybrid or "quasi-federalist" system (Arban et al., 2021; Lippi, 2011). Lijphart's (2012) classical index of federalism scores Italy at 1.3, where 1.0 is fully unitary and centralized and 5.0 is fully federal and decentralized. Others, however, describe Italy as a semifederal state and "perhaps one of the best examples of how a state may closely resemble a unitary system notwithstanding the presence of regional governments" (Tate & Shugart, 2024). Italy consists of 20 regions, five of which are autonomous and granted additional powers because of their unique historical and cultural background. The other 15 regions operate with some autonomy, but this autonomy is not codified constitutionally (Hooghe et al., 2016). A regionalized system has certain similarities to a federalized one in that it devolves power to the regional level. Federalized systems allow for their parliaments to devolve powers to the state or regional level by amending their devolution statutes (Lev, 2018). Contrastingly, the Italian system confers specific powers and competencies to the regions in Article 117 of its constitution, but with regular adjustments to which level of government claims authority over a given topic. Therefore, Italy is better described as a regionalized unitary system as opposed to a federalized one.

Since the 1990s, more and more authority over healthcare has been delegated to the regional level (Cicchetti & Gasbarrini, 2016; Toth, 2014). The structure of this devolution of power is not simple: different regions have different agreements with the central government; funding comes partially from the national and partially from the regional level in varying ratios; and regions usually further devolve their power to a more local level, with local autonomy and organizational structures once again varying. Regions engage in differing levels of oversight and active attention given to the management of abortion provision (Cozzi et al., 2024). Implicit in this delegation is the idea that healthcare is a technical topic that requires experts to administer on the local level, but that it is not fundamentally a question of rights and freedoms. In this sense, Italy might be a most likely case to have relatively uniform abortion access across its territory. This, however, has proven to be a faulty assumption, as we will argue below, and as is supported by the widening division between the North and the South of Italy since regionalization of healthcare (Toth, 2014).

Law 194 legalized abortion in Italy in 1978. Specifically, Law 194 allows for voluntary abortion in the first 90 days of pregnancy, and therapeutic abortion up until viability. Almost all abortions in Italy are performed in a public hospital. Levels of conscientious objection, enshrined in Law 194, are high in Italy, but they also differ radically across regions, and the number of objectors is likely higher than reported (Law 194, section 9; Caruso, 2020a; Minerva, 2015; Pullan & Gannon, 2024b). For example, in Sicilia the Ministry of Health reports 85% of gynecologists are objectors, while in Valle d'Aosta only 25% are (Ministero della Salute, 2023).

Like all healthcare, Law 194 is administered at the regional and local level. Each region and sometimes each district (*Azienda Sanitaria Locale* or ASL) has its own policies and methods of administering abortion services (Cozzi et al., 2025; Gannon, 2023; Pullan, Forthcoming; Ripamonti, 2022). Law 194 technically requires that all public hospitals have an abortion

service. However, due to the high levels of conscientious objection, many fail to live up to this promise (Caruso, 2020b; De Zordo, 2017, 2018; Minerva, 2015; Pullan, Forthcoming). The Ministry of Health reports on abortion services at the regional level, tacitly endorsing the administrative choice to operate abortion services at only some hospitals across a region (Ministero della Salute, 2023).

Italy's level of conscientious objection is unusually high and leads to problems accessing care (Bo et al., 2015, 2017; Caruso, 2020a; Minerva, 2015). Autorino et al. (2020) demonstrate that abortion seekers are traveling between Italian regions to access abortion care, suggesting that access is limited in some regions. Furthermore, several studies show that Italians are actually leaving the country to get abortion care (De Zordo et al., 2021; Gerdts et al., 2016; Zanini et al., 2021). Neither the European Union nor the Council of Europe have universal policies on abortion or conscientious objection (Pullan & Gannon, 2024a). However, the European Committee of Social Rights has judged that Italy has violated the European Social Charter twice in the last twenty years in two cases related to abortion and conscientious objection (*IPPF v. Italy*, 2013; *CGIL v. Italy*, 2015).

The pros and cons of conscientious objection provisions are beyond the scope of this paper, but in Italy conscientious objection plays a significant role in the regionalized access landscape. Broadly, conscientious objection as a concept is criticized because it limits patients' ability to access abortion and exercise their rights (Barone et al. 2025; Giubilini et al. 2025). This highlights the difference between having a legal right to abortion and meaningfully being able to access abortion care, a distinction focused on by reproductive justice scholars. The theoretical framework of reproductive justice looks beyond laws that permit abortion to a broader and deeper conception of reproductive freedom (Ross & Solinger, 2017). Though the framework was created by Black American women (Roberts, 1997), it is applied to other contexts where structural barriers make abortion access harder for some groups than others, and where different groups have different reproductive needs (Dürks Cassol, 2024; Bakhru, 2019; Lonergan, 2012). Reproductive justice advocates that all people should have not only a theoretical but a practical ability to choose to have children, to choose not to have children, and to raise their children in safe environments (Ross & Solinger, 2017; Bakhru, 2019).

Regions have used their devolved authority to adopt different policies on reproductive healthcare. Ten regions have chosen to provide free contraception to at least some subset of their population, typically people who are young, low-income, or have had a prior abortion (Zennaro, 2023). In the other ten regions, contraception is a private expense. While all regions require certification of the pregnancy in family planning counselling centers, some regions allow religious actors to play a larger role in these centers, particularly Lombardia (Corica, 2017).[1]

In another example, the national Ministry of Health released guidance encouraging hospitals to limit the amount of time abortion patients would spend in the hospital, allowing patients to complete their medication abortions partially at home (Ministero della Salute, 2020). Caruso (2021) comments on the active choice that some regions made to reinterpret vague references towards hospital recovery to allow a shorter recovery period (known as "day-hospital"). The region of Umbria initially adopted this, but when the political leadership changed, it reversed that decision and required longer hospitalizations again in the midst of the Covid-19 pandemic (Caruso, 2021; Guerra, 2020), resulting in public protests (Cirant, 2020).

[1] Perhaps recent laws passed by the Meloni government that expand the presence of religious groups in family planning centers and limit Italians' ability to seek surrogacy abroad signal a shift towards a more unified, conservative governance of reproductive policy, but such speculation is beyond the scope of this paper.

Very recently, the region of Emilia-Romagna has declared that beginning in January 2025, they will allow a greater degree of self-managed abortion outside of hospitals, much to the chagrin of the governing party Fratelli d'Italia (Il Resto del Carlino, 2024) and anti-abortion associations (BolognaToday, 2024). While patients will still need to source their medications from hospitals or family planning centers, patients will be allowed to leave after taking the first dose and complete their abortion with the remaining pills at home (Cirant, 2024).

Toth (2014, 2023) observes that in healthcare more broadly, regionalization and partial privatization makes it difficult to ensure equitable quality of healthcare across the country. We see this in the specific domain of reproductive healthcare in several ways. For example, the region of Lazio allows its hospitals to explicitly hire nonobjecting doctors when there is a need for more abortion providers (de Luca, 2017), but the region of Puglia does not. A regional administrative court decision in Puglia determined in 2010 that such a practice constitutes religious discrimination against objectors (TAR Puglia, 2010), but this court only has authority within the region of Puglia. Thus, not only are the regional health authorities empowered to make choices that impact their citizens' access to abortion, but judicial institutions that only have jurisdiction at the regional level also contribute to the divergence of abortion access experiences across Italy.

Pullan (2024) presents comparative data on the locations of abortion providers in ten European countries, including Italy. She explains that while no regions and very few provinces of Italy are completely without abortion providers, Italian abortion services often operate for only a few hours or a few days per week, whereas in other countries, abortion services are more or less consistently available depending on patients' needs.

Data and Methods

The data used in this project combines two separate but similar sets of qualitative interviews conducted in Italy in late 2021 and early 2022. These interview sets, while different, sought to shed light on the day-to-day realities that abortion providers in Italy experience. Both are also grounded in public policy and law, as well as the understanding of healthcare personnel as street-level bureaucrats (O'Brien, 2023; Malyszko, 2025) responsible for interpreting and implementing Italy's abortion law.

The first dataset has a concentration of interviews in northern Italy, but includes several experiences from around the country. Interviews were conducted face-to-face whenever possible, or by video call to more distant regions. Some were with doctors who currently worked in the north but shared stories from their previous places of employment. This dataset focuses only on nonobjecting medical doctors, providing first-hand experiences of abortion providers. This dataset does not include the perspectives of anti-abortion doctors, other healthcare personnel, or administrative personnel in the healthcare system.

The second interview set is broader in terms of the interviewees' professional roles, but narrower geographically. This dataset includes all of the aforementioned professional roles, but with an aim to understand the state of abortion access in Puglia. This dataset includes three interviewees from outside Puglia who spoke to the Italian abortion context more generally, but otherwise focuses on building up a picture of abortion care provision in this one southern region.

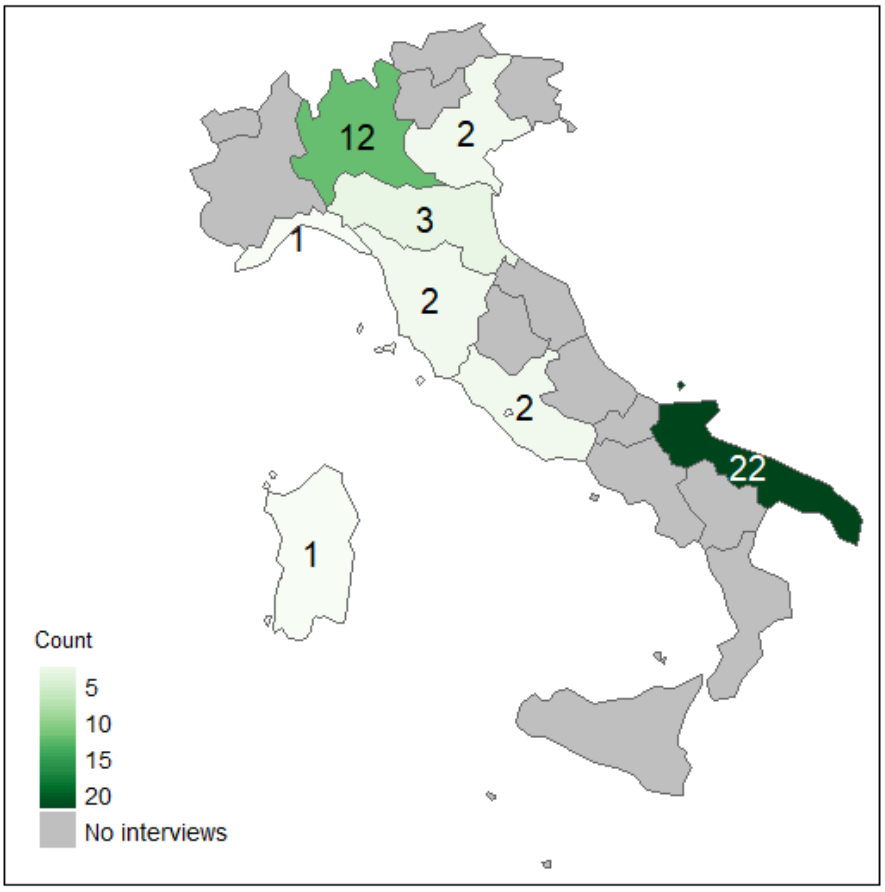
In total, these interview transcripts include 26 nonobjecting doctors in 7 different regions, which are complemented by the perspectives of 7 objecting doctors and 9 other abortion-adjacent healthcare workers and activists for a total of 42 interviews. One-on-one interviews were preferred in both datasets, but some interviewees were more comfortable participating alongside a colleague. All interviewees gave their informed consent to

participate. The structure of the interviews is detailed in the Appendix. All interviewees are referred to by pseudonyms unless otherwise agreed with the interviewee.[2]

Table 1. Interviewee Professional Roles.

Role	Non-objector (Pro-Abortion)	Objector (Anti-Abortion)	Neutral
Gynecologists	26	7	
Nurses	1		
Obstetricians	1		
Administrative Staff			4
Activists	2	1	

Figure 1. Interviewee Regions of Experience.



Note: Interviewees who had extensive experience in more than one region are counted more than once in this total.

In interview-based research, the positionality and power relationship between the interviewer and interviewee provide important information for evaluation (Manohar et al., 2019). In this case, both interviewers were young, white women who speak Italian but not natively, and both were early career social science researchers. With most interviewees working as medical professionals and agreeing to meet with them freely, there is not a concern about interviewers' power over interviewees. Both interviewers employed the

[2] This sample of interviews is not random, so we are hesitant to generalize anything about the identity characteristics of the interviewees. We interviewed both men and women who both support and oppose abortion, and we did not observe a consistent gender pattern in their attitudes, but perhaps with a larger sample one could.

method of constant comparison (Glaser & Strauss, 1967), iterating the semi-structured interview structure based on the information learned in previous interviews as well as what the authors were sharing across the two original projects. The later interviews in each project benefited from the other coauthor's experience in the earlier interviews, thus uniting the two datasets in the end.

Findings and Discussion

This paper finds that, in delegating administration and interpretation of the abortion law to regional healthcare bodies, Italy has produced a situation where abortion access differs so dramatically across regions that the country can hardly be said to operate under a single national abortion policy. We demonstrate this by exploring what administrative choices regions made that are different or similar from other regions, and illustrating how this ultimately affects abortion access in those regions. After presenting this data, we theorize a causal mechanism to explain why regional administration of abortion policy leads to such divergent levels of abortion access across the country.

Where regions diverge

In this section, we present a series of examples of the divergent administrative choices regions have made that affect the experience of doctors working in abortion services. The fact that regions have the authority to choose among options that can make abortion more or less accessible in their region demonstrates our argument that the delegation of administration of abortion policy to the regional level results in a situation where citizens governed by the same law de jure have different rights de facto.

Department and hospital organization

Regional health services organize their gynecology departments in different ways. Some organize their hospitals to have one centralized gynecology department, while others break out subfields like family planning and fetal medicine into separate departments or sub-units of the department. On its face, this does not sound like a particularly controversial or political choice, but we find that it has significant impacts on the quality of life of doctors who provide abortions. When family planning is regarded as a separate sub-unit of gynecology, this has been interpreted by local district managers of the health service to require a hard division between abortion doctors (working in family planning) and "normal" gynecologists working in all other aspects of care. When this structure coincides with a hospital having a small number of doctors who are willing to provide abortions, the hospital administrators are under pressure to maximize the efficiency of their family planning department by assigning those few non-objectors to work in family planning full time.

This leads to stories like Dr. Romano's (Interview A5). She had worked as an abortion provider for more than 20 years, and for much of that time, she was the only non-objector in her hospital. At the time of our interview, she was leading a small team of non-objectors that was organized as a separate unit and physically segregated into a different building in a different part of town than the rest of the hospital campus. It was very clear from this arrangement that the work of Dr. Romano and her colleagues was meant to exclusively handle abortion and contraception patients, and that they would not even encounter other patients in their hospital ward. Dr. Romano also expected her colleagues to leave the team as soon as an opportunity to work as an objector presented itself to them, sharing a story of how, in a recent round of hiring, the regional health authority had 30 open positions, two of which were in this team. The first 28 candidates declined to work on this team, choosing more desirable jobs in other hospitals, and the two who did join this team requested a transfer after one year. Dr. Romano opined that the positions would not have been quite so

undesirable if her team were physically located in the main hospital building, because colleagues would have the opportunity to do work other than abortion care.

Every person who becomes involved in abortion work has their own feelings about the subject and their own beliefs about abortion that are usually deeply personal. Some people are happy to provide abortions as a primary function of their job because they believe that abortion is a fundamental right for women, including Dr. Romano. But doing the same task repetitively day after day is not exciting, nor is it taking advantage of the full medical training that these doctors studied for. It was a commonly held opinion among our interviewees that doing abortions as part of a well-rounded role in the gynecology department was a more desirable distribution of work. Abortion can be a heavy, sad topic for some, and even though they are willing to do it, they would rather not do it all the time. For others, it is about the social isolation and the stigmatization of being segregated into a separate group.

Dr Basilone (Interview B5) spoke of a colleague of his who, due to the regional management of personnel, only came into their hospital on certain days to perform abortions, because none of the doctors working full-time in this hospital were non-objectors. The rest of the staff referred to this visiting abortion provider as "Dr. Death," ostracizing him and emphasizing that they disapproved of his work. The distance between these "normal" gynecologists and a contracted abortion provider was even starker when the regional health authority chose not to arrange their staff so that the abortions could be provided by a full-time staff member.

Some departments also separate fetal medicine and therapeutic abortion care – abortions deemed medically necessary past 90 days of pregnancy – from earlier abortions and mainstream gynecology. This work is far less stigmatized than the provision of "voluntary" abortions (up to 90 days without a medical indication), but it still leads to division among gynecologists. Doctors who are regularly responsible for working with patients who discover later in pregnancy that the fetus may not survive or would be severely disabled have a very different view on Law 194 than their mainstream gynecology colleagues.

These doctors are often limited by their regional health authority's policy determining when a fetus is "viable." With the delegation of Law 194 to the regions, each region sets their own standard for when they believe that a fetus could survive birth, varying between about 20-24 weeks. If the pregnancy is too far advanced, the doctor may not be legally allowed to provide an abortion. Dr. Basilone (Interview B5) even told us about experiences where patients were pressured to make a choice about terminating a pregnancy that might – or might not – have a serious health condition. The tests that could more accurately predict this would not be available until past the threshold of viability, forcing the prospective parents to gamble on the possibility of a fatal or seriously disabling diagnosis, versus the possibility that the fetus was actually perfectly healthy. These patients had to make an impossible choice, and their doctors were angry on their behalf. These doctors would call for a reform that allows more flexibility and compassion for patients who may need an abortion later in pregnancy – a position that is also not supported by mainstream objecting gynecologists.

Therapeutic abortion doctors and voluntary abortion doctors face different challenges, but they could be natural allies in pushing for a change in how their regional health authority makes policies around abortion. But due to organizational siloing, people working in different components of abortion care often do not even know each other. In the course of this research project (Interview A16), Dr. Caparelli and Ms. Toscana met each other for the first time. Dr. Caparelli was a voluntary abortion provider, and Ms. Toscana was a local administrator for the regional health authority, and they worked on the same campus. They agreed on many issues, and they left the interview planning to stay in touch to improve

abortion services in their hospital. Organizational hierarchies and rigid lines of reporting and communication hampered these actors with similar interests from ever meeting, let alone collaborating.

Culture of objection or nonobjection

Regardless of how the gynecology department is organized, department leaders, the most local representatives of the regional health authority, play a role in shaping the experience of abortion providers. Department heads set the tone for a culture of objection or a culture of nonobjection based on their own behavior. In more progressive regions, there is the assumption that doctors will join the department as non-objecctors. When Dr. Zappa (Interview B10) was promoted to lead his department, he judged that he had to change his status from objector to non-objector. He stated, "The fact that [I am the] director, it is my duty to organize the [abortion] service together with [the] delivery room, and other stuff. This is why I organize the service to offer the women a safe way to terminate their pregnancy" (p. 3).

Conversely, in a region with a more conservative regional health authority, Dr. Marchesi (Interview A14) made the opposite choice when he was promoted to lead the department of gynecology in his hospital. He had always been an objector, and he remained an objector. He did, however, feel that he had a responsibility to organize a functional abortion service, which his hospital had previously not operated. When asked why this was important to him, he explained "Because I think that all the services must be done in a public operative unit, in a public center." For Dr. Marchesi, part of the responsibility of leading the gynecology department involved ensuring that all gynecological services were available in his department, despite his personal convictions. A culture of nonobjection makes the job of abortion providers easier, and a culture of objection makes their job harder.

Dr. Rossi (Interview A1) made it very clear just how influential the regional health authority was in constraining the choices of the department head. In his capacity as department head, he was very frustrated with how little independence he had from the regional health authority. "We are the false coach of a false team, because we don't choose the players, we couldn't move them to different positions, and objection or nonobjection status isn't decided by the chief, but the chief is responsible for the organization," he summarized (p.5). Individual managers in the regional health authority's hierarchy have only limited latitude in the choices they can make, when the regional authority has a certain vision for how they want abortion care to be managed.

Staffing Requirements

A final example of how regional health policies materially impact the experience of providing abortion care is the different interpretation of how many staff people are required to attend to an abortion procedure. When Law 194 mandated abortion care be available in Italian public hospitals, it did not specify exactly how this abortion care ought to be provided. In some ways, this was a prudent decision, as it allows medical experts to determine how best to perform a medical procedure. On the other hand, this ambiguity has led to conflict between feminists and doctors about the safest and best abortion methods (Caruso, 2024), and only in the last few years has Italy shifted to use internationally-recommended techniques (Ministero della Salute, 2021).

In Puglia, interviews revealed that each procedural abortion requires not only a gynecologist and a nurse, but also an anesthetist and an obstetrician. None of our interviews in other regions mentioned any requirement for obstetricians. We observe that the regions where fewer people are required have an easier job of logistically arranging for an abortion service to be consistently staffed.

The national Ministry of Health produces a report each year on abortion statistics, a requirement of Law 194. In Table 28, this report includes data on what share of health personnel are registered as objectors. There are several criticisms of this data and its interpretation (Bo et al., 2015, 2017; Pullan & Gannon, 2024b; Minerva, 2015). Setting these aside for the moment, we see a connection between the structural element of this report and the regional policy about how many staff are required. Table 28 includes columns for gynecologists, anesthetists, and "personale non medico," a term that is vague but likely means medical staff who are not doctors (though could also be credibly interpreted to mean non-medical staff, such as hospital cleaning staff). This table tracks the number of gynecologists and anesthetists who are non-objectors, because these two categories of professionals are indisputably required to perform a procedural abortion. Obstetricians are not reported separately, but rather grouped with other medical professionals, suggesting that obstetricians are not necessarily required at the national level.

Regional health authorities decide many technical aspects of abortion care: how many staff are required, when is the gestational age limit for therapeutic abortions, which categories of professionals are allowed to register as objectors, what default assumption will be made about objection or nonobjection, and ultimately how actively the region will work to ensure that abortion services are operating efficiently and effectively. These decisions are technical in the sense that they require familiarity with healthcare management and expertise in how the procedure can be most safely performed. But there is reason to expect that the answers to these technical questions should differ from region to region.

There is not a singular "right answer" to the "best" way to administer abortion services, and advocates who want abortion to be more or less available can no doubt find studies that support their opinions. So perhaps, some would argue, it is reasonable to allow each region the autonomy to make these decisions independently. What goes unacknowledged in this scenario is that the end result is differing levels of abortion access in different parts of the country.

Cross-regional similarities

In this section we will discuss the important similarities in the experience of doctors across regions of Italy. As mentioned above, all regions are supposed to regulate their abortion services in accordance with Law 194. This means the law is harmonized in some meaningful ways, including voluntary abortions being permitted up to 90 days of pregnancy and "therapeutic" abortions being permitted until viability (though there is some variation across regions in the exact time of viability). Additionally, Italy relies on a nationalized healthcare system, meaning that all abortions performed in public hospitals (which is the vast majority of abortions in Italy) are free for patients. All regions also have to allow for conscientious objection, though the level of adoption does vary widely. Other cross-regional similarities include a recent shift towards medication abortion, the isolation and social stigma doctors face, and the psychological toll that the current abortion regime puts on doctors.

Shift towards medication abortion

There has been a dramatic increase in the use of abortion pills (known as pharmacological abortion in the Italian context, or medication abortion more internationally) across all regions in the last five years. Though colloquially often referred to as the abortion pill, the regimen usually involves a combination of mifepristone and misoprostol, though less commonly misoprostol is used independently.

In 2019, before the recommendations on medication abortion were changed, 28.5% of abortions were carried out using abortion pills, compared to 51% in 2021 (Ministero della Salute, 2021, 2023). This almost 100% increase in the use of abortion pills in two years is largely due to the Ministry of Health publishing new rules allowing for outpatient use of abortion pills, which was instigated by concerns about the COVID-19 pandemic. In 2020, Italy was one of the major hotspots for the COVID-19 pandemic; as such, they worked to reduce the load on hospitals and prevent patients from unnecessary exposure to the disease. This was a rare move towards more centrally-administered healthcare, and its effectiveness amplifies our argument that the choice to allow regions autonomy in implementing abortion care can have very divergent effects for patients.

Some pregnant patients seeking abortion do access pills by mail outside of the traditional medical system, though exact numbers are challenging to pin down. Women on Web, one group which will mail abortion pills to patients, responded to 656 requests from Italian mailing addresses from January 2019 to June 2020 (Aiken et al., 2021). The most recent estimate from the Italian Ministry of Health regarding extra-legal abortions was reported in 2008 and put the number at 20,000, but other groups estimate the number to be closer to 40,000 or even 50,000 a year (Minerva, 2015). The vast majority of these extra-legal abortions are likely performed using abortion pills.

Prior to this rule change, patients taking abortion pills were required to be admitted to the hospital for the entire process, which typically took about three days. This suppressed the use of the abortion pill in Italy compared to other European countries (Fiala et al., 2022). The 2020 change allowed outpatient distribution of the abortion pill, meaning that the patients come to the hospital to take mifepristone, leave the hospital, and come back to take the misoprostol a couple of days later. This reduces the amount of time a patient spends in the hospital from multiple days to a few hours. The lengthy hospitalization likely discouraged patients from seeking medication abortions when their families were not supportive of the decision, as it would be difficult to conceal a multi-day hospitalization, but easier to find time for a couple of shorter appointments.

This also materially changes the experience of doctors. Most doctors interviewed report that a substantial number of the abortions they perform are medication abortions, and many report that most of the abortions performed in their unit or hospital are done with medication now. This is also borne out in the data, though there is still significant regional variation (Ministero della Salute, 2023).

Though across all regions, there has been a significant increase in the use of the abortion pill, doctors report different experiences. Many say it has proven immensely beneficial in expanding access to abortion care because it is quicker, and some suggest further deregulation, including allowing the entire abortion to be completed at home (Dr. Menelli, Interview B15). Other interviewees worried that the shift towards medication abortion would just shift the discourse on conscientious objection: “there is a new problem: the objecting personnel do not want to take this pill out of the box and put this on the table for the patient to take the pill. I hope that the truck drivers [of] the boxes of this pill are not objectors…” (Dr. Agatone, Interview A12, p.6).

Some doctors, however, are still uncomfortable and are not embracing widespread use. Dr. Rizzo (Interview A11), an objecting gynecologist, felt that the pill trivialized the experience of abortion, saying “not a lot of efforts are made to make the women think again about their decision [to have an abortion]. If they were shown the small head, the little leg, the small heart that is beating, maybe they would revise their decision… We cannot dismiss the issue by just giving a pill to a woman so you can go have an abortion.” Another interviewee referenced the Ministry of Health data regarding the increased use of abortion pills, which he saw as a positive development, but explained that historically there were relatively few

doctors performing abortions, and consequently this meant that there were also few training opportunities for new doctors (Dr. Rossi, Interview A1). Older doctors continued using the techniques with which they were more comfortable, and younger doctors had little opportunity to learn about medication abortion.

In international contexts, abortion pills are seen as putting power directly into abortion seekers' hands (Jelinska & Yanow, 2018). In Italy, abortion pills are only legal when prescribed face-to-face by a gynecologist in an accredited abortion-performing medical structure. As noted above, Emilia-Romagna has recently liberalized their policy to allow the second set of pills to be taken at home, but the initial dose still relies on nonobjecting gynecologists. While we imagine that some Italians likely take advantage of online services that connect them with international doctors who mail them abortion pills such as Women on Web, Women Help Women, and Aid Access, these abortions do not follow the procedures outlined by Law 194 and thus are considered illegal. Official data on medication abortion in Italy only includes those patients who comply with the law, and data available from these international organizations is limited (Aiken et al., 2021). Thus, even though medication abortion use is increasing in Italy, we do not have the data to evaluate whether it allows patients to circumvent local conscientious objectors.

The widespread uptick in the use of the abortion pill demonstrates that the national government can meaningfully expand abortion access if they so desire. However, the disparate implementation of the new policies across regions demonstrates that the national government alone cannot entirely increase abortion access without support from regional governments.

Isolation and Social Stigma

Across regions, there are reports from doctors of social isolation and stigma caused by the decision to be a non-objector. Doctors often report experiencing isolation and social stigma, across hospitals, often even in hospitals with a significant number of abortion providers.

The level of isolation and stigma that non-objectors face can vary widely, but most report some level of stigma or social isolation. In more dramatic cases, as discussed in the case of Dr. Romano above, some abortion wards are moved to entirely separate, less desirable facilities away from the rest of the gynecologists – ostensibly for purely logistical reasons, but with the effect that abortion doctors are the ones experiencing isolation. However, sometimes doctors don't even identify the way they or other doctors are treated as isolating or stigmatizing, but the stories they share tell a different story. Dr. Basilone (Interview B5), who told the story about his colleague being referred to as "Doctor Death," when originally asked, said that non-objectors and objectors were treated the same. He said that non-objectors did not face stigma in the hospital, but went on to tell a very different story once further prompted.

Another non-objector, Dr. Rivera, described the complicated legal implications of providing abortion. This doctor described how doctors might not want to perform abortions because of enhanced legal liabilities if there were a complication. Because of the stigma associated with abortion, it is not viewed as having any "positive outcome," as contrasted with giving birth. While both medical events could result in complications, the doctor is, in Dr. Rivera's estimation, far more likely to face a lawsuit for abortion-related complications than birth-related complications. The broader social stigma associated with abortion can have an effect on the way medical complications are viewed in the hospital.

Stigma can creep into conversations about abortion provision in more subtle ways as well. Dr. Colombo (Interview A6) emphasized repeatedly throughout our interview that the abortion service operated by her colleagues was "efficient," at one point even interrupting the interview to wave at a nonobjecting colleague who was passing the room, telling the

non-objector directly "I told [the interviewer] about your extremely efficient center!" This descriptor felt like a backhanded compliment in the interviewer's opinion, because it was clear that the objecting doctor did not see it as a good thing to perform abortions, and so "efficiency" in doing something she disapproved of was not exactly positive. It evokes an impression of the abortion service as cold and dispassionate, quickly shepherding patients in and out with minimal human interaction.

Generally, doctors who work in larger hospitals, which just as a matter of scale usually have more non-objectors, report less sense of isolation than doctors in smaller hospitals or with few non-objectors. In hospitals with more non-objectors there are fewer reports of being socially isolated from their colleagues. They are also more likely to report feeling supported by the hospital infrastructure and their colleagues. However, many of these examples come from hospitals with many non-objectors. What becomes clear from conversation is that much of the social stigma doctors describe is not directly from their colleagues or supervisors, but the broader culture, which views abortion as shameful or "dirty." Dr. Enzo (Interview B8) explicitly described the stigma against abortion as "inside society." When asked why people choose to object Dr. Enzo responded, "it is socially more accepted… you can be a good doctor or a bad one" (p. 5-6). He is describing a society that view objectors as "good doctors" and non-objectors as "bad doctors." These broader, national cultural views infect even the most supportive hospitals, and color the way doctors discuss their experience and their work.

Psychological Toll on Doctors

Doctors across regions and hospitals also report the psychological toll performing abortions can take on them. Even doctors who are incredibly supportive of abortion rights have described the procedure by saying, "There are tears, sadness, and [it is] a really dirty job" (Dr. Rivera, Interview B4, p.3). The psychological toll on doctors comes from several places: the additional mental labor of scheduling in an abortion service, the social stigma the doctors face, and for some, the experience of regularly performing abortions.

Doctors who work in hospitals where there are only one or two abortion providers have to do substantially more mental labor to ensure abortion services continue to operate at their hospitals. These doctors discuss the immense planning it takes to guarantee that abortion access does not cease in their hospitals. For example, the two non-objectors can never both be on vacation at the same time, both be on the night shift, or both be sick, otherwise abortion access stops in their hospital altogether. This is a widely reported phenomenon in the region of Molise, where only one doctor is a non-objector for the entire region (Grazi, 2021). Whenever she is sick or takes vacation there is no one available to provide an abortion in the entire region. Dr. Natale (Interview B10) even reported this problem in a hospital where there were several non-objectors: on one occasion, two of them were assigned to the night shift and the third was on vacation, leaving Dr. Natale the sole provider of abortions for the hospital. She describes the added stress this caused, pulling her away from other patients and procedures to go perform abortions. This caused her anxiety related to emergency abortion care. She said that, though objectors were supposed to help in case of emergency, they did not, and she was stressed about patients who might experience an emergency situation while she was already providing care elsewhere.

Non-objectors do substantial mental labor to ensure that their patients have access to abortion care, especially in smaller hospitals with fewer doctors. This not only requires additional time and planning, but it also leaves some of them with an ever-present sense of stress, as Dr. Natale describes, worrying about what will happen to their patients if they are not available or if there are multiple patients who need help urgently. This increased mental labor and stress can take a significant psychological toll on doctors.

Secondly, the social stigma attached to providing abortion can take a toll on doctors. It is not just the overt isolation and stigma discussed above, but also the toll it can take on their careers and personal lives to be a non-objector. As discussed above, there is a general cultural sense reported by several doctors that non-objectors are "bad doctors," that they do "dirty work" (Dr. Enzo, interview B7; Dr. Rivera, interview B4). This broader social attitude takes a psychological toll on doctors. In a newspaper interview, Dr. Michele Mariano, the longtime sole abortion provider in the region of Molise, described that "those who do abortions don't advance their career" (Grazi, 2021). Similarly, Dr. Bianchi (Interview A4, p.3) recounted a story of when she received her job offer to work in the family planning unit providing abortion care. "I organized a party with my friends, and most of my friends were, let's say they were a little bit sorry for me. They gave me their compassion because in their minds, doing this kind of job is not as gratifying as, like, following a pregnancy or doing all the other tasks that are done in let's say classical gynecology or obstetrics wards." She herself found this work to be very gratifying because she was able to help people who really needed it, but she still drew the pity of her friends. This widespread social stigma, even when it does not change how abortion providers feel about their own job, can nevertheless hold them back and potentially have a negative impact on their career trajectories.

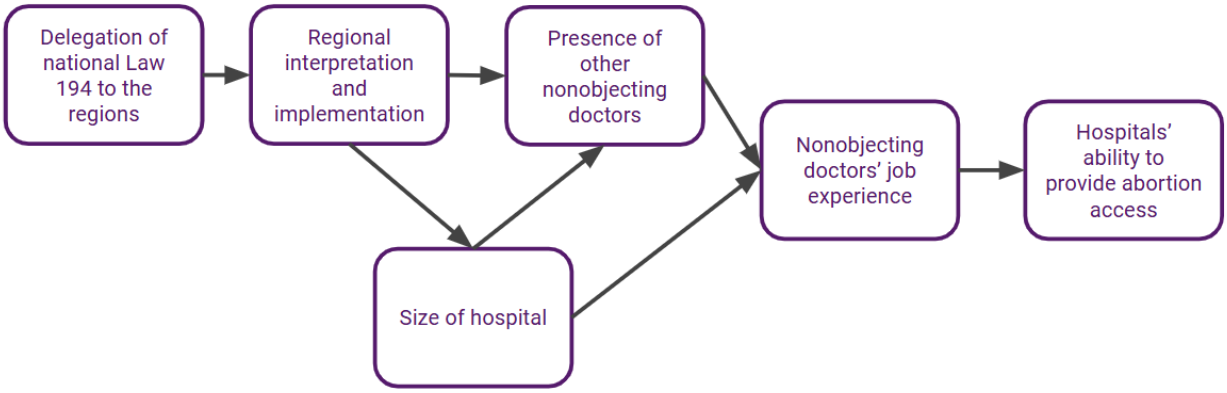
Third and finally, some doctors describe experiencing a significant psychological toll when performing abortions. One non-objector, Dr. Rivera, put it starkly: it "is not something that is very beautiful to do, nobody wants to kill a baby, okay, nobody wants to kill a baby" (Interview B4, p. 3-4). This statement is demonstrative of the feelings of some doctors, who report that the nature of the procedure itself can take a psychological toll on doctors. This belief is shared by Dr. Zappa, who stated, "Well, being a nonobjecting doctor, it is difficult for ethical reasons, because even for non-objectors, terminating pregnancy is not lovely work. It's not a lovely job. Sacrifices... ethical, religious, [and] philosophical issues that anyone that goes through termination of pregnancy can face... these issues [affect me] on a personal view [sic: personally]" (Interview B10, p. 6). Dr. Fabbri (Interview B14) speaks to a larger reality of being a non-objector, which is that many doctors did not become gynecologists because they wanted to perform abortions.

As discussed above every abortion provider has their own deeply personal beliefs about abortion, but even those who fiercely believe in the right, still discuss the psychological toll of such heavy work. Patients seeking abortions often come to doctors because they are in sad or challenging positions. After a while that can take a psychological toll on some, even driving some to become objectors. For example, Dr. Zappa was originally a non-objector but described the psychological toll of frequently performing abortions and became an objector. He later switched back to being a non-objector, but at that point he served in a role where he did not regularly perform abortions. Additionally, several doctors pointed out that performing abortions is monotonous and uninteresting work from a medical perspective. All of these factors take a significant psychological toll on non-objectors. All of these experiences are more pronounced the fewer non-objectors there are to share the load.

Theorizing a Causal Mechanism

Our goal in exploring the differences and similarities across regions is to shed light inside the black box of why some regions have more abortion access than others. We argue that this data supports a causal mechanism whereby the delegation of the implementation of Law 194 to regions can be linked to differential levels of abortion access.

Figure 2. Causal Mechanism.



When the parliament delegated implementation of Law 194 to the regions, this created the opportunity for regions to interpret the law in accordance with local politics and values. Some regions will implement the law in a way that strives to maximize abortion access, while others will pay little attention to the issue of abortion, and a third group will actively try to minimize abortion access through administrative means. We have shared the above examples to demonstrate the ways in which regions do, in fact, have and use the authority to affect abortion care in administrative decisions like directing hospitals to organize their departments and staff in certain ways, defining fetal viability, determining how many staff are required to perform an abortion, and deciding whether to accept the national Ministry of Health's recommendations that would standardize care.

The power of regional health authorities appears concretely in the regions' management of resources. If they operate more small hospitals versus few larger hospitals, the odds are higher that any single hospital will have a very small number of isolated non-objectors. The region could, however, choose to concentrate their non-objectors in a few hospitals to produce well-staffed centers where the abortion providers are likely to be happier, though this comes with the tradeoff of patients potentially having to travel farther for their abortion care.

Sometimes this will happen by sheer luck, like in Dr. Conti & Ms. De Luca's hospital (Interview A8, p. 8): Dr. Conti tells us, "I signed a job agreement when I was hired at this hospital, and no one before my signature was on the agreement asked me whether or not I was an objector or a non-objector." Ms. De Luca and Dr. Conti both reported that their previous employers did ask about their objection status before assigning them to a position. But in their current hospital, "it is by chance!" We discussed why it might be that the regional health authority did not actively manage this aspect of abortion provision, when Dr. Conti explained: "because at the end of the day, it is something that concerns only us as gynecologists and obstetricians, so maybe attention is not really given to this issue by the human resources director" (p. 9).

Conscientious objection magnifies the effects of regionalization. In the causal mechanism proposed here, conscientious objection most directly affects "the presence of other doctors" element. If there were no conscientious objection, there would be significantly less regional variation in the number of abortion providers available, though there would still be some due to other factors, described previously. A high percentage of doctors claiming conscientious objection means there are fewer doctors willing to provide abortion care, which in turn leads to a more negative experience for those remaining non-objectors.

Whether it is an active choice to ignore abortion care management or a simple human resources oversight, the outcome is that non-objectors will end up in understaffed abortion services more often than not. When these doctors are stigmatized and isolated or forced

into performing abortions as their primary professional responsibility, they are at a high risk of burnout. This begins a vicious cycle: doctors burn out and quit the abortion service by registering as objectors, increasing the workload on their remaining nonobjecting colleagues. Those remaining colleagues are at higher risk of burnout. Regions that do not actively intervene to interrupt this pattern cannot be surprised when they end up with very few doctors in their employ who are willing to work in abortion care.

Without abortion providers, there is no abortion access. Italy currently criminalizes self-managed abortion outside of the national health service with a fine of up to 10,000 euros (Caruso, 2023). This is the paradox of Law 194: it balances doctors' rights against patients' rights, but patients' ability to exercise their right is entirely dependent upon some doctors not exercising their right to object (Pullan, Forthcoming). Ministry of Health reports on the level of conscientious objection have painted a rosier picture by overcounting the number of doctors who are actually providing abortion care, by eliding the concepts of abortion provider and non-objector (Pullan & Gannon, 2024b). While some objectors hold the belief that there will always be other doctors and nurses who will be willing to perform abortions (Dr. Marchesi, Interview A14), this cannot be taken for granted. As long as Law 194 limits legal abortions to the hospital sector, hospitals that do not have enough non-objectors to operate their abortion services will be unable to ensure patients' ability to exercise their right to an abortion. In this way, the management choices of the regional health authority directly impact abortion access in the region.

Conclusion

Across regions, many doctors' attitudes can be summed up with this titular quote from Dr. Rizzo (Interview A11, p. 3): "fai la legge, hai trovato l'inganno," which she translated as "if you make the law, you will find a way to cheat it." In regards to Italy's Law 194, gynecologists perceive that people are cheating the law. The spirit of the law is to allow doctors with strong moral convictions that abortion is wrong to practice their profession without compromising their personal values. But doctors on both sides of the issue – Dr. Rizzo is notably an objector herself – see the ways that the people implementing this law circumvent its provisions to be more convenient. Conscientious objection is often used for reasons unrelated to moral convictions, and especially in regions where there are already small numbers of doctors willing to provide abortion care, this directly impacts patients. Doctors feel unheard when they raise complaints about how Law 194 doesn't work, and they feel constrained by the institutions in which they work.

Italy delegates a high degree of autonomy in healthcare management to the regions. This is by design and democratically supported. In practice, however, the choices left to regions are not simply questions of logistics. Regional and local health authorities can define protocols and organize staff and resources in ways that make abortion services run well, like establishing a local culture of nonobjection that destigmatizes abortion provision, or run poorly, like requiring an additional staff person to participate in each abortion. In turn, patients and their advocates in these regions report different experiences with accessing abortion (Obiezione Respinta, n.d.), and some leave their home regions (Autorino et al., 2020) or even leave the entire country (Garnsey et al., 2021) to receive care.

In effect, Italy has regionalized the right to abortion care. Italy joins other countries, notably the USA, in supporting different levels of abortion access based on where in the country someone lives (Gannon & Pullan, 2025), with the religiosity of local communities playing a strong driving role (Pullan & Trail, 2025). If one lives in a region where the regional health authority supports abortion providers and works to prevent them from burning out, there will be more non-objectors to provide abortion services, and the logistics will flow smoothly. This is affected by both regional directives about the organization of staff and

resources and by the choices of local heads of department in each hospital. One way that regions contribute to this disparity is in how they interpret Law 194's provision for conscientious objection. If one lives in a region where the region administers abortion care in apathetic or actively hostile ways, such as having abortion services segregated from the rest of gynecology and/or where more categories of medical staff are judged to be necessary for abortion care provision, one can expect more difficulty obtaining an abortion. When the Italian legal system was reformed to delegate more managerial authority to the regions, is this really what was intended? The facade of a national law that, in principle, applies the same standards to all Italian residents serves to cover up the reality that access to care depends on one's individual location and ability to travel for medical care that may not be readily available near one's own home.

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APPENDIX: Table of Interviews

Interview #	Date	Interviewee Pseudonym	Professional Role	Region working in at time of interview
A1	02.12.2021	Dr. Rossi	Nonobjecting doctor	Puglia
A2	15.12.2021	Dr. Ferrari	ASL Staff (doctor who now administers)	Puglia
		Dr. Russo	Nonobjecting doctor	Puglia
A3	16.12.2021	Ms. Marino	Pro-abortion activist	Toscana
		Ms. Greco	Pro-abortion activist	Toscana
A4	19.01.2022	Dr. Esposito	Nonobjecting doctor	Puglia
		Dr. Bianchi	Nonobjecting doctor	Puglia
A5	19.01.2022	Dr. Romano	Nonobjecting doctor	Puglia
A6	21.01.2022	Dr. Colombo	Objecting doctor	Puglia
A7	29.01.2022	Dr. Bruno	Objecting doctor	Puglia
		Ms. Gallo	Anti-abortion activist	Puglia
A8	16.02.2022	Dr. Conti	Nonobjecting doctor	Puglia
		Ms. De Luca	Nonobjecting obstetrician	Puglia
A9	17.02.2022	Ms. Mancini	ASL Staff (Social worker)	Puglia
		Ms. Costa	ASL Staff (Social worker)	Puglia
A10	17.02.2022	Dr. Giordano	Objecting doctor	Puglia
A11	18.02.2022	Dr. Rizzo	Objecting doctor	Puglia
A12	12.03.2022	Dr. Silvana Agatone (not pseudonymized)	Nonobjecting doctor / activist	Lazio
A13	16.03.2022	Dr. Moretti	Objecting doctor	Puglia

Interview #	Date	Interviewee Pseudonym	Professional Role	Region working in at time of interview
A14	22.03.2022	Dr. Marchesi	Objecting doctor	Puglia
		Ms. Buonocuore	Nonobjecting nurse	Puglia
A15	31.03.2022	Dr. Bartholdi	Objecting doctor	Puglia
B1	07.04.2022	Dr. Casadei	Nonobjecting doctor	Sardegna
B2	13.04.2022	Dr. Mastrangelo	Nonobjecting doctor	Lombardia
B3	21.04.2022	Dr. Giulian	Nonobjecting doctor	Lombardia
B4	05.05.2022	Dr. Rivera	Nonobjecting doctor	Lombardia
B5	11.05.2022	Dr. Basilone	Nonobjecting doctor	Emilia-Romagna
A16	16.05.2022	Dr. Caparelli	Nonobjecting doctor	Puglia
		Ms. Toscana	ASL Staff	Puglia
B6	24.05.2022	Dr. Sanfilippo	Nonobjecting doctor	Veneto
B7	25.05.2022	Dr. Enzo	Nonobjecting doctor	Lombardia
B8	30.05.2022	Dr. Del Gatto	Nonobjecting doctor	Lombardia
B9	30.05.2022	Dr. Natale	Nonobjecting doctor	Lombardia
B10	30.05.2022	Dr. Zappa	Nonobjecting doctor	Emilia-Romagna
B11	07.06.2022	Dr. Tocci	Nonobjecting doctor	Lombardia
B12	08.06.2022	Dr. Davide	Nonobjecting doctor	Veneto
B13	13.06.2022	Dr. Capone	Nonobjecting doctor	Lombardia
B14	17.06.2022	Dr. Fabbri	Nonobjecting doctor	Lombardia
B15	30.06.2022	Dr. Minelli	Nonobjecting doctor	Lombardia
B16	08.07.2022	Dr. Galtieri	Nonobjecting doctor	Lombardia
B17	20.07.2022	Dr. Reviello	Nonobjecting doctor	Lombardia

Interview #	Date	Interviewee Pseudonym	Professional Role	Region working in at time of interview
B18	02.08.2022	Dr. Avolio	Nonobjecting doctor	Liguria