Data Discrepancies: Italian Ministry Reports on Abortion, Contextualized

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Abstract

The Italian Ministry of Health reports annually on activities related to abortion and fertility, providing quantitative data that looks ripe for analysis. Actors ranging from activists to medical providers to European courts have criticized the data as misleading, but the Ministry Reports have not changed. In this piece, we bring together different perspectives on this data from inside and outside academia and offer guidance on how it should – and should not – be used in research.

In this article, we collect a wide variety of publications ranging from civil society groups' reports to court decisions, academic articles, and investigative reporting, and harmonize the way they engage with the Italian Ministry of Health's data regarding abortion and particularly conscientious objection.

Analyses rooted in the demographic and medical data about abortion seekers, the abortion rates over time, the different methods of abortion, etc. are trustworthy and can be used to extrapolate levels of abortion access. Data on conscientious objectors systematically undercounts objectors, implying a false equivalence between people who do not object and people who actually work in an abortion service. We recommend that the Ministry report both the number of objectors and the number of medical doctors working in abortion services.

The Italian Ministry of Health produces some valuable data about abortion, but conscientious objection is the key feature of abortion access in Italy, and this key data is flawed. The Ministry could improve clarity and increase citizens' trust in government reports by adding data on the number of abortion providers.

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1. Introduction

High-quality demographic and statistical data about abortion is somewhat rare, in part due to the ever-present morality debates. Italy appears to be an exception to this rule, reporting annually on many facets of abortion and other fertility-related trends. We write this article, however, to caution other scholars and journalists against the misuse and misinterpretation of some of this data. Conscientious objection is the central obstacle to abortion access in Italy, and the official data on conscientious objection does not report what it purports to. We begin in section 2 with a discussion of conscientious objection in the literature, which we then relate to Italy's abortion law and the way this law defines objection. We describe the Ministry of Health's data on conscientious objection in section 3, then we summarize criticisms of the data from European courts (section 4.1), journalists (4.2), activists (4.3), and scholars (4.4). In section 5 we hypothesize explanations for this skewed data, and we conclude with proposals for how this data should be interpreted by scholars, journalists, and citizens.

2. Conscientious objection literature

Conscientious objection is a common aspect of abortion policy, though the level of objection in Italy is uniquely disruptive (Pullan & Gannon Forthcoming, Minerva 2015, Autorino et al. 2020, Bo et al. 2015). 21 of 27 states in the European Union allow conscientious objection to abortion as well as many countries in Latin America, including Colombia, Bolivia, and Mexico (Anedda et al. 2018, Küng et al. 2021, Fink et al. 2016). Neither the European Union nor the Council of Europe have a universal policy on conscientious objection and instead allow member states to determine their own laws[2] (Annedda et al. 2018, Mishtal 2014). The European Court of Human Rights (ECHR) recently reaffirmed this position when two Swedish

[2] The European Union also does not have a universal abortion policy and instead leaves it to member states to legalize or criminalize abortion.

nurses sued because they were not hired as midwives due to their refusal to perform abortions. The ECHR dismissed their complaint on the grounds that Sweden's law did not protect conscientious objection (Grimmark v. Sweden, ECHR 2020).

There is significant debate over the morality of conscientious objection. Some argue that it limits access to abortion services and privileges the rights of doctors over the rights of patients (Fiala & Arthur 2017 and 2014, Stahl & Emanuel 2017, Giubilini 2017). Others argue that conscientious objection is a necessary part of abortion laws to protect the rights of doctors and can, if properly administered, not burden patients (Chavkin et al. 2017, Fleming et al. 2020, Wicclair 2010). There are many studies that detail arguments regarding the validity, morality, and implementation of conscientious objection in abortion provision (Fleming et al. 2020, Chavkin et al. 2017, Autorino et al. 2020, Fink et al. 2016, Küng et al. 2021). The broader philosophical question of conscientious objection also extends beyond abortion care into debates on euthanasia, physician-assisted suicide, and care for LGBTQ+ people among other topics (Stahl 2017, Engeli et al. 2012). However, these arguments are beyond the scope of this paper. Here, we narrowly critique the Italian Ministry of Health's data on conscientious objection, grounded in the principle that public trust in state institutions will be eroded if they produce untrustworthy information.

2.1 Italy's Law 194

Law 194, passed in 1978, regulates abortion in Italy; the Italian Ministry of Health and regional authorities are jointly responsible for its administration. Law 194 is interpreted to permit voluntary abortion for the first 90 days of pregnancy. Beyond 90 days, abortion is described as "therapeutic" and is permitted for medical reasons, including mental health, danger to the pregnant person's life or health, and fetal malformation, up until "viability," which is not explicitly defined by the law but is generally interpreted to mean around 22 weeks of gestation.

Law 194 allows healthcare workers to register as conscientious objectors to abortion (Law 194 of 1978, section 9). There is some debate among both scholars and practitioners about what exactly constitutes "objection," and this debate goes beyond the scope of this paper. What is clear in the law is that all abortions must be performed by gynecologists in accredited hospitals, almost all of which are public. Technically, "health personnel" (*"personale sanitario"*) can only object to the abortion procedure, not other care required for patients who are having an abortion. In practice, nurses, obstetricians, cleaning staff, and pharmacists have argued a right to conscientious objection (Obiezione Respinta 2022, Pullan 2022). Different facilities appear to have different interpretations of which activities are covered by objection and, by extension, which personnel are permitted to object (Pullan 2022, Gannon 2023). At a minimum, a gynecologist is required, and if the abortion is procedural, an anesthetist is also required, though some outside Italy dispute whether anesthetists play a "role in abortion decision-making" and thus question the ethics of their objection (Reeves et al. 2023).

Objection is technically only allowed in voluntary abortion services, not in therapeutic abortion services. Despite this, many hospitals do not involve objectors even in therapeutic abortions and there are several reports of patients suffering because objectors refused to step in to perform the abortion (Cirant 2020, Eduati 2012, Gannon 2023, Minerva 2015), including the infamous and tragic death of Valentina Milluzzo (Cavallaro 2019, Caruso 2020). It is also worth noting that Law 194 specifically regulates abortion, and the morning after pill is medically distinct from abortion, though some pharmacists root their claim to objection in the strong cultural tolerance of conscientious objection and misconceptions that equate medication abortion and the morning after pill.

3. Data description

Each year, as required by law, the Ministry publishes a report on maternity and abortion, which includes statistics on abortions by region, medical technique (e.g. medication versus different

procedures), identity characteristics of the abortion patient, and more. The report has been produced by the Ministry each year in the same format. Recent years are available on the Ministry's website salute.gov.it, but historical versions should be available on request or by accessing historical archives of this website.[3]

This report enumerates, among other things, how many medical professionals register as conscientious objectors and are therefore exempt from participating in abortions that are deemed "voluntary." Pro-abortion advocates criticize this provision of the law as undermining access, but anti-abortion advocates see it as necessary to protect religious freedom. While Italy is far from unique in allowing conscientious objection, the high level of objection is unusual. Italy has some of the most comprehensive data about conscientious objection. In 2021, 63.4% of gynecologists, 40.5% of anesthetists, and 32.8% of other staff[4] were objectors (Ministero della Salute 2023).

The data related to abortions performed included in the Ministry report is of high quality, because it is gathered as part of patient records and medical cost accounting on the local level. Italy delegates the administration of its nationalized health care system to the regions, but all regions use similar reporting systems for abortion procedures. By comparison, conscientious objection is not registered in any particular system, so the data collection and quality varies regionally. We write here to advise and caution researchers about how the Ministry's conscientious objection data can be used, as well as what it does not tell us.

[3] For quick access to these reports, use the following link: https://www.salute.gov.it/portale/documentazione/p6_2_0.jsp?lingua=italiano&id=921

[4] Notably, the report does not define this term "*personale non medico*." Thus there is likely variation across hospitals based on how the individual responsible for reporting this data interpreted the term. We suspect but cannot independently verify that this number is primarily composed of nurses and obstetricians, who in Italy are not required to have a doctoral degree, as "*non medico*" could be interpreted to mean either "non-medical" or "not doctors" and other parts of the report use the adjective "sanitario" to refer to "health" personnel. Both Law 194 and other international standards of abortion care permit objection for people who are directly performing an abortion (in the Italian case, gynecologists and arguably anesthetists), but not for staff performing other medical or nonmedical tasks that are not related to the abortion.

Nominally, Law 194 charges regional administrators with ensuring provision of abortion services in every public hospital with a gynecology department (Minerva 2015). In practice, however, conscientious objection status is usually reported to each hospital's head of gynecology for the sake of assigning work tasks. In some cases, this data is stored extremely informally: on a pen-and-paper list full of crossings-out and additions (Gannon 2023). Regional health authorities request this data once per year to report it to the Ministry, but doctors can change their objection status at any time and have been known to come on and off of the objectors list several times (Gannon 2023, Pullan 2022).

It is quite simple to see the disparity between the Ministry data and real abortion services. Take for example the region of Molise: the Ministry reports an objection rate of 82.8% and 24 objecting gynecologists (Ministero della Salute 2022). This should mean that there are 29 total gynecologists in Molise, of whom 5 are nonobjectors. It is widely reported, however, there is only one doctor who performs abortions in Molise (Pizzimenti 2021). Where do the other four come from? We answer this question in Section 4.[5]

We do not contend that the data is purposely manipulated. We do argue that the Ministry should be aware of the misleading nature of this data, because several sources, groups, and researchers have pointed out this flaw in the data, and they have not responded. News media regularly reports on this data as though it accurately describes abortion access in Italy, and the Ministry does not correct this misimpression.

[5] The full table from which these numbers are quoted can be viewed on page 99 of the 2020 report at this link: https://www.salute.gov.it/imgs/C_17_pubblicazioni_3236_allegato.pdf

4. Who criticizes the ministry's data?

4.1 The European Courts

Italy has been found in violation of the European Social Charter by the European Committee of Social Rights twice in the last 20 years for the high level of conscientious objection (*CGIL v. Italy* and *IPPF-EN v. Italy*) (European Committee of Social Rights 2015, 2013). Across Europe there is a diverse set of abortion laws, so the international courts do not dictate a specific policy, but instead require that countries actually provide the level of access promised in their laws.

In 2015 in the case *CGIL v. Italy*, a professional association of nonobjecting gynecologists called LAIGA 194 reported that 14 of Italy's 20 regions are regions of concern for lack of abortion access. Additionally, LAIGA collected data and found that in the region of Lazio, of the 391 gynecologists associated with hospitals in the region, only 33 actually performed abortions. This would mean the objection rate was actually 91.3% compared to the Ministry-reported 80.7% for that year (European Committee of Social Rights 2015, p.32). LAIGA accomplished this by laboriously contacting every hospital in the region to independently verify how many doctors worked in abortion services, demonstrating a meaningful omission from the Ministry's official data.

4.2 Journalists

Journalists Chiara Lalli and Sonia Montegiove undertook a project in 2021 to gain access to more specific data about objection (Lalli & Montegiove 2022). In their book, they publish receipts of their correspondence (or attempted correspondence) with many hospitals across Italy requesting the exact number of nonobjecting doctors working there. Sometimes they were entirely ignored; sometimes they were redirected to the Ministry report; sometimes they

got the data they were looking for, but in a difficult-to-analyze format that required time and effort to make publishable.

Lalli and Montegiove also publish interactive maps with this data on the website of Associazione Luca Coscioni. This data shows hospitals where 100% of staff object, as well as those with an objection rate higher than 80%. It is unfortunately incomplete due to the lack of response from many hospitals.

In pushing for hospital-specific data to be published, Lalli & Montegiove note that an abortion seeker needs this information to make an informed choice about their pregnancy and where they wish to be cared for. Some anti-abortion activists also support a similar register of objection status (Pullan 2022). Doctors may be concerned about their privacy and safety if very granular data were published openly, and with good reason: anti-abortion movements particularly in the US have created registries of abortion providers and used this information to harass these doctors into ceasing their practice, though this harassment is typically less violent in Italy than in the US (Wicklund & Kesselheim 2009).

4.3 Activists

Pro-abortion activist groups are keenly aware of the difficulty in accessing abortion when conscientious objection rates are so high. Italy has a robust history of feminist movements and this continues today. Groups like *Non Una di Meno* ("No woman left behind"), *Libera di abortire* ("free to abort"), *IVG Ho abortito e sto benissimo* ("I've had an abortion and I'm fine") and Pro Choice Rica organize protests and in-person meetings, as well as hosting discussions and organising mutual support for people seeking abortion or processing their decision about a pregnancy.

Obiezione Respinta ("objection rejected") created a map displaying reports from people who were seeking either abortion or the morning after pill, identifying hospitals and pharmacies where patients were able to obtain abortion care or emergency contraception versus those where objectors turned the patient away. Because the Ministry data on objection was not useful for Italian residents seeking medical care, they have crowdsourced the information. Other pro-abortion groups also participate in this effort by sharing information among their networks and crowdsourcing resources for abortion seekers in crisis, such as with social media groups dedicated to different regions.

4.4 Scholars

One of the significant claims by the Italian Committee for Bioethics and the Ministry of Health is that the high number of conscientious objectors does not affect the waiting period to receive abortion care. The Ministry of Health makes this claim by comparing waiting times to receive abortion care and percent of conscientious objection from two non-consecutive years. Bo et al. (2015, 2017) demonstrate that the data chosen to illustrate this claim is selectively chosen, and if one were to choose two other years, there is sometimes a correlation between the number of objectors and wait times, disproving the "no correlation argument." In short, Bo et al. argue that the Ministry's evaluation of the correlation between objection rates and waiting periods is not statistically sound. Autorino et al. (2020) also support this finding.

Bioethicist Francesca Minerva (2015) succinctly summarized the situation with conscientious objection in Italy, also commenting on the court cases noted in section 3.1. This piece comments more on the substance of conscientious objection than on the Ministry's data, but it is nevertheless fundamental to this critique. Almost a decade ago, she recommended changes in the administration of conscientious objection such as compensating nonobjectors more than objectors, actively managing the ratio of nonobjectors to objectors in each hospital,

and allowing doctors who are not gynecologists to offer abortion services, and these suggestions have not yet been adopted.

Additionally, there have been critiques of other claims that the Ministry has made in the yearly reports. Caruso (2020) notes that the Ministry claimed in the 2019 report, without data to support it, that the reason for the low abortion rate in Italy is strong policies that prevent unwanted pregnancies. Notably, only 6 of the 20 regions of Italy provide any form of subsidized or free birth control. Furthermore, the reports from the Ministry suspect that there are 10,000-13,000 illegal abortions every year in Italy, but NGOs estimate closer to 50,000 (Caruso 2020).

An important article by Chavkin et al. (2017) reviews the Italian policy on conscientious objection in comparison to three other cases. Chavkin et al. offer recommendations for how to improve such policies to balance both the rights of medical personnel to exercise their conscience, and the rights of patients to access abortion care. In particular, they highlight how data about conscientious objection is crucial for appropriately monitoring staffing levels, and how some countries have bolstered the quality of their data by connecting its review to other processes, such as contract review in England's National Health Service. Chavkin et al. also recommend clarity in who is allowed to object and under what circumstances, an element that they, as well as other scholars cited above, find lacking in the Italian case.

5. Possible explanations for skewed data

There are also qualitative studies of conscientious objection in Italy that provide important context for the quantitative data in the Ministry reports. De Zordo (2017) contributes to our understanding of abortion stigma and why doctors choose to object. Her interviewees report that abortion is an unpleasant job that they do not wish to spend most of their time doing; they fear performing abortions would affect their future careers; and they perceive it as

disproportionately risky compared to other procedures. She also heard stories from both objectors and nonobjectors of "fake objectors," which she defines as "physicians that opt out of abortion provision to avoid a heavier workload and discrimination" (De Zordo 2017, p. 159).

Pullan (2022) further investigates the "fake objectors" narrative and confirms De Zordo's (2017) findings. She also draws attention to the fact that some doctors who are nonobjectors are assigned to jobs that are not responsible for providing abortion care, such as administration. The number of nonobjectors is not equivalent to the number of abortion providers, and these should both be reported. The Ministry acknowledges this difference in some of their annual reports, including the most recent one (Ministero della Salute 2023). The Ministry previously reported the proportion of nonobjectors not assigned to work in abortion services: 15% in 2018, 9.8% in 2017, and 6.6% in 2016. Despite nearly tripling in just three years, this statistic was not monitored from 2019-2021. The latest report promises that it will be monitored in future years (Ministero della Salute 2023, p.65).

Pullan (2022) also notes that some hospitals are only able to offer abortion services by contracting someone as a part-time abortion provider. This happens in part because some regional courts, such as the *Tribunale Amministrativo Regionale* (TAR) of Puglia, have determined that administrators cannot inquire about objection status before a doctor is hired (Tribunale Amministrativo Regionale per la Puglia 2010). Considering objection status in hiring decisions is deemed religious discrimination in Puglia, though notably the TAR in the region of Lazio reached the opposite conclusion (de Luca 2017). Part-time contracted service providers would not be counted in the Ministry reports, as they are not employed by the hospital. As Chavkin et al. (2017) note in their multi-country study of conscientious objection, other countries improve their administration of conscientious objection policies with measures like this that are explicitly prohibited by at least some Italian courts.

Gannon (2023) describes the fluidity with which doctors move in and out of objection status. She discovered that in some hospitals, the number of doctors who are nonobjectors changed regularly and that this is tracked rather informally by the head of the department, as described in section 3. The Ministry only asks for this data to be reported once a year, but with the numbers of nonobjecting doctors almost constantly fluctuating, this data will be incorrect very soon after it is reported. Additionally, Gannon also confirms De Zordo's (2017) findings about 'fake objectors' and the Pullan (2022) finding that the number of nonobjecting doctors and the number of abortion providers are not the same metric.

6. Recommendations for using Ministry of Health data

The Ministry report contains quite a lot of data in addition to conscientious objection. To the best of our knowledge, this other data is reliable and has contributed to several interesting studies. One example is a 2020 study by Autorino et al. on inter-regional flows of abortions which demonstrates that many abortion patients in Italy travel outside of their home region to access care. Instead of relying on the Ministry's reported levels of conscientious objection, this study looks at objection from a different angle, extrapolating that abortion seekers are travelling because of the relative ease of accessing abortion in different regions. This data is invaluable – most studies of abortion-related travel rely on researchers' ability to identify patients who travelled and interview them. But also, most studies of abortion-related travel consider patients who are travelling across a country border, not a regional border within the same country. Thus, the case studied by Autorino et al. (2020) is quite novel, because there is one national database that contains all the pertinent data, and there is also a significant amount of intra-national travel for abortion. This data could additionally be useful to gain a deeper understanding of the characteristics of abortion patients, perhaps to identify

communities that are under-resourced and in need of more medical professionals or other care infrastructure.

The data on conscientious objection, however, is flawed. The report incorrectly assumes that all nonobjectors work in abortion services, an equivalence which has been disproven by scholars, journalists, and activists alike and even ruled upon by European courts, as enumerated in section 4 of this paper. The data additionally suffers because of a lack of centralized reporting and clear definition that may result in different interpretations of what ought to be reported, not to mention how the data is almost immediately out of date due to frequent changes in medical professionals' objector status (Gannon 2023). Given this, researchers ought to give further consideration to the ways they use this data.

Most importantly, researchers should acknowledge that nonobjecting doctors and active abortion providers are not the same metric. This refers to not only Table 28 of each annual report, but also to calculations based on this table, particularly Parameter 3 (described on pages 60-69 of the report for 2021 and detailed in Appendices A & B (Ministero della Salute 2023)). The number of abortions per nonobjector is not a useful piece of information when some unknown number of nonobjectors do not actually perform any abortions. Qualitative research on the actual number of abortion providers suggests that Parameter 3 could be off by at least a factor of 2 (Pullan 2022). If the Ministry delivers on its promise to publish the number of nonobjectors who do not work in abortion services next year, then we hope that they will also revise Parameter 3 to refer to abortion providers, not all nonobjectors.

We caution against reporting Italy's conscientious objection data without further clarification, particularly when comparing it to other countries (Chavkin et al. 2013). Instead, we would endorse an approach such as Fiala & Arthur's (2017) commentary on the ways that health

administration choices in countries other than Italy mitigate the impact of conscientious objection on patients. This is more accurate because it is not based solely on the Ministry-reported rates of conscientious objection, instead further contextualising the broader Italian cultural, legal, and administrative status quo.

We do not discount the Ministry data on conscientious objection entirely – the numbers allow for inter-regional comparisons, but not for comparing Italy to other countries. We suggest providing further explanation of the difference between nonobjection and actual provision of abortion services. In many areas, one doctor makes or breaks whether their hospital offers any abortion services at all. In the Italian case, all abortions must be performed in accredited hospitals, almost all of which are public and thus included in this report. When Molise's one abortion provider is not available for any reason, abortion access in this region drops to zero, because there are no (legal) private providers to pick up the slack, as some other countries have.

Researchers must be cautious when engaging with the conscientious objection data reported by the Italian Ministry of Health, both on the national and regional level. The official numbers of objectors do not accurately describe the number of functioning abortion services, the number of staff assigned to abortion services, or the share of staff time devoted to these services. This report is merely a snapshot in time of how many doctors have officially declared themselves as objectors, but it is not accurate to assume that the remainder of doctors who are nonobjectors are actually providing abortions. Until the Ministry begins reporting more detail on the number of doctors actually working in abortion services, using other data reported by the Ministry to measure patterns of abortion provision may prove a more useful strategy for measuring abortion access in Italy.

While our primary audience for this piece is scholars, we also urge caution among journalists. Popular media frequently reports on the Ministry's report and trends from year to year as a barometer for measuring support for abortion in Italy. It is not correct to equate the number of nonobjecting gynecologists with the number of abortion providers, and we encourage journalists to verify how many doctors actually work in abortion services locally until such a time as the Ministry publishes this data officially.

Statements and Disclaimers

Patient and Public Involvement Statement

It was not appropriate or possible to involve patients or the public in the design, or conduct, or reporting, or dissemination plans of our research.

Competing interests

The authors report there are no competing interests to declare.

Author contribution statement

Both authors contributed equally to the ideas, analysis, and writing of this article. DP handled formatting and tasks related to submission.

Ethics

No ethics review was required for this work.

Data Availability Statement

Reports by the Italian Ministry of Health are published on their website: https://www.salute.gov.it/portale/documentazione/p6_2_2.jsp . Searching in the documentation portal for keywords like "interruzione" or "194" return several years' reports, but not all years for which the report was generated. It is unclear to the authors why some reports remain available and others have been removed. The most recent report published in October 2023 with data from 2021 is available in pdf and xls format here: https://www.salute.gov.it/portale/documentazione/p6_2_2_1.jsp?lingua=italiano&id=3367

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