Essays

‘Much Ado About Nothing?’ The New Policy on Early Medical Abortion (EMA) in Italy

Elena Caruso*

Abstract

The paper comments on new rules on EMA introduced in August 2020 in Italy. It argues that, despite being an improvement in EMA policy in comparison to the previous situation, these new rules do little to address the significant enduring barriers to EMA in many areas of the country.

I. Introduction

In August 2020, the Italian Minister of Health released a circular updating the medical abortion protocol for EMA, to reflect the ‘use of the most modern techniques, which are more respectful of the woman’s physical and mental integrity and less risky for the termination of pregnancy’, as required by the Italian Abortion Law (legge 22 May 1978 no 194).[1] EMA indicates an abortion provoked by pills (generally a combination of mifepristone and misoprostol, or only misoprostol) in the early stage of a pregnancy.[2] These new rules made changes to previous national guidelines on medical abortion dating back to 2010, which limited access to this procedure to up to seven weeks of pregnancy and recommended that the woman was ‘detained’ (‘*trattenuta*’) in the hospital for the administration of the two abortifacients and ‘until the abortion has occurred’, requiring a three-day of inpatient treatment.[3] According to the new

* PhD Researcher, Kent Law School, University of Kent, United Kingdom. The Author is grateful to Alessandra Brigo, Anna Pompili and Sally Sheldon for their kind and generous comments on earlier drafts of this paper.

[1] Art 15, Legge 22 May 1978 no 194, ‘Norme per la tutela sociale della maternità e sull’interruzione volontaria della gravidanza’, Gazzetta Ufficiale no 140 of 22 May 1978. Ministero della Salute, ‘Aggiornamento delle “Linee di indirizzo sulla interruzione volontaria di gravidanza con mifepristone e prostaglandine” ’, 12 August 2020, available at https://tinyurl.com/yfubaf3v (last visited 31 December 2021). See also these two commentaries on the new EMA policy in Italy: F. Grandi, ‘L’aggiornamento delle “Linee di indirizzo sull’interruzione volontaria di gravidanza con mifepristone e prostaglandine”: l’ultima trincea dell’effettività del servizio di interruzione di gravidanza’ *Osservatorio AIC*, 5–24 (2020); M.P. Iadicicco, ‘Aborto farmacologico ed emergenza sanitaria da Covid-19’ *Quaderni Costituzionali*, 823–826 (2020).

[2] See, for example: World Health Organization, *Medical management of abortion* (Geneva: World Health Organization, 2018).

[3] Ministero della Salute, ‘Linee di indirizzo sulla interruzione volontaria di gravidanza con

regulation, medical abortion can now be performed up to nine weeks of pregnancy and can be conducted as an outpatient treatment in hospitals and health centres.[4]

This last explicit reference to health centres ('*consultori*') is a novelty in Italian abortion services, as the role of these public facilities has been up to now largely limited to confirming a pregnant person's intention to have an abortion in a document/certificate, which is required to access a procedure which take place mainly in public hospitals (ninety-five point two percent, 2018 data).[5] In addition, this direct indication of health centres as places in which performing medical abortions gives new weight to a legal provision in legge no 194/1978, which already admits this possibility but has remained up to now substantially a 'dead letter'.[6]

Nevertheless, this commentary addresses scepticism about the real impact of these formal policy changes in substantially improving EMA access in the country, as an effective implementation of these national guidelines strongly depends on regional initiatives regarding *inter alia* abortion providers' medical training and the reorganisation of health centres.[7] To make this argument, the paper will firstly offer some general background to abortion access in Italy (Section II). Secondly, it will highlight regional inconsistencies in the implementation of EMA services across the country since they first became nationally available following the authorisation of mifepristone in 2009 and the above-mentioned national guidelines on EMA in 2010 (Section III). Thirdly, it will explore the impact of the Covid-19 pandemic on this framework and how new guidelines on EMA have failed to address significant inconsistencies in their local implementation (Section IV). Lastly, it will conclude that the new policy is unsatisfactory in failing to reduce existing regional gaps in services and fully to overcome barriers to EMA services in the country, especially in a pandemic context (Section V).

II. Abortion Access in Italy

In Italy, abortion access is mainly regulated by legge no 194/1978. According to it, a woman can have an abortion up to ninety days of gestation, if the continuation of the pregnancy, the birth or motherhood risks seriously affecting

mifepristone e prostaglandine', 16 July 2010, available at https://tinyurl.com/yn7669p5 (last visited 31 December 2021).

[4] See Ministero della Salute, n 1 above.

[5] See Art 5 legge no 194/1978. On official data of the Italian Minister of Health on abortions which are performed in public hospitals, see: Ministero della Salute, Relazione del Ministero della Salute sulla attuazione della legge contente norme per la tutela della maternità e interruzione volontaria di gravidanza (Legge 194/1978). Dati definitivi 2018, 2 July 2020, Table 23.

[6] Art 8, Law 194/1978. According to official data, in 2018 no abortion has been practiced in a public health centre ('*ambulatorio pubblico*'), see: Ministero della Salute, Relazione del Ministero della Salute sulla attuazione della legge contente norme per la tutela della maternità e interruzione volontaria di gravidanza (Legge 194/1978). Dati definitivi 2018 n 5 above, Table 23.

[7] Arts 10 and 15 legge no 194/1978.

her physical or mental health.[8] According to legge no 194/1978, a physician must certify the pregnancy and the woman's desire to terminate it in a document ('*documento*') and 'invite her to reflect for seven days'.[9] If the woman's request is evaluated as 'urgent', the doctor may issue a certificate ('*certificato*'), which allows her to end the pregnancy immediately.[10] After ninety days of pregnancy, a gynaecologist has to testify that one of two other, more onerous conditions are met for an abortion to be legal.[11] The first is the presence of a risk to the woman's life, linked with the pregnancy or the birth; in this case the abortion can be performed even after the viability of the foetus and the medical doctor has to attempt to save the foetus' life.[12] The second is the presence of a foetal anomaly which risks seriously compromising the women's physical or mental health.[13] Where a pregnant person is under eighteen years of age, legge no 194/1978 requires a parental authorisation ('*assenso*') or a judge's approval to the procedure.[14]

Once the woman became legally entitled to have an abortion, beyond gestational age which limits *when* she can have an abortion, further barriers exist regarding *who* can perform the procedure and *where* it can take place. Indeed, legge no 194/1978 requires that abortion can only be performed by a gynaecologist in public hospitals, private clinics and medical facilities (such as health centres) that have been specifically authorised.[15] The majority of Italian gynaecologists (sixty nine percent) refuse to perform abortion on conscientious grounds, a possibility recognised by legge no 194/1978 for medical personnel directly involved in the procedure.[16] Unlike other medical services in the Italian public health system, abortion is subject to a special regulatory framework that limits the possibility of delivering abortion services in private health care facilities.[17]

In addition, although as I observed above legge no 194/1978 includes an explicit preference for 'use of the most modern techniques' for abortions, official data show how the 'obsolete method' of dilation and curettage (D&C) is still

[8] Art 4 legge no 194/1978.

[9] Art 5, para 4, legge no 194/1978.

[10] Art 5, para 3, legge no 194/1978. According to official data, in 2018, forty-four point one percent of all documents or certificates were released in health centres and the 'urgency' was certified in twenty-one point three percent of total abortions. See: Ministero della Salute, Relazione del Ministero della Salute sulla attuazione della legge contente norme per la tutela della maternità e interruzione volontaria di gravidanza (Legge 194/1978). Dati definitivi 2018 n 5 above, Tables 16 and 18.

[11] Arts 6 and 7, legge no 194/1978.

[12] Art 6, para 1, lett. a, and Art 7, para 3, legge no 194/1978.

[13] Art 6, para 1, lett. b, legge no 194/1978.

[14] Art 12, legge no 194/1978.

[15] Art 8, legge no 194/1978. See Ministero della Salute, n 5 above, Table 23.

[16] Art 9, legge no 194/1978. On the data on conscientious objection among medical personnel, see Ministero della Salute, n 5 above, Table 28.

[17] Arts 10 and 19, legge no 194/1978.

practiced in the country.[18] Indeed, ten point eight percent of total abortions in Italy are still performed via D&C, with regional peaks of thirty-seven point eight percent in Sardinia, twenty seven point five percent in Abruzzo, twenty five percent in Friuli Venezia Giulia, and twenty-four point one percent in Aosta Valley.[19] In Section III, I will further focus on this issue of abortion techniques, by exploring the case of medical abortion.

As such, this problematic socio-legal framework helps to explain why abortion is often 'a denied right' for women and pregnant people in Italy.[20] Indeed, international human rights bodies, including those within international organisations such as the United Nations and the Council of Europe, and international non-governmental organisations such as Human Rights Watch have raised concerns that the current state of abortion access in the country may violate international human rights standards.[21] Recently, in March 2021, the European Committee of Social Rights (ECSR) found that abortion access in Italy does not conform with the European Social Charter (ESC),[22] confirming the findings of its earlier reports in 2013 and 2015.[23] Respectively almost eight and six years on from those two decisions, the ECSR observes that women and pregnant people still face multiple obstacles to access abortion in Italy.[24]

In more detail, in both cases, the ECSR laments a violation of Art 11 ESC (right to health) alone and in conjunction with Art E ECS (non-discrimination).

[18] Art 15, legge no 194/1978. According to the World Health Organization 'D&C is an obsolete method of surgical abortion and should be replaced by vacuum aspiration and/or medical methods' see: World Health Organization, *Safe abortion: technical and policy guidance for health systems Second edition* (Geneva: World Health Organization, 2012), 31. However, according to the Italian Minister of Health's official data, the majority of total abortions (forty seven percent 'Karman' plus sixteen point six percent '*isterosuzione*') in Italy are carried out via vacuum aspiration, see: Ministero della Salute, n 5 above, Table 25.

[19] Ministero della Salute, n 5 above, Table 25.

[20] Magistratura Democratica, 'Verso l'8 marzo - Diritto d'aborto, diritto negato', *Questione Giustizia*, 8 March 2017, available at https://tinyurl.com/4xvaxz2s (last visited 31 December 2021).

[21] UN Committee on Economic, Social and Cultural Rights, 'Concluding observations on the fifth periodic report of Italy' (28 October 2015) E/C.12/ITA/CO/5; UN Human Rights Committee, 'Concluding observations on the sixth periodic report of Italy' (1 May 2017) CCPR/C/ITA/CO/6; UN Committee for the Elimination of All Forms of Discrimination against Women, 'Concluding observations on the seventh periodic report of Italy' (24 July 2017) CEDAW/C/ITA/CO/7. See also Human Rights Watch, 'Italy: Covid-19 exacerbates obstacles to legal abortion', 30 July 2020, available at https://tinyurl.com/4xvaxz2s (last visited 31 December 2021).

[22] ECSR, 'Follow-up to decisions on the merits of collective complains. Finding 2020', 25 March 2021,187-195, available at https://tinyurl.com/be52pz6a (last visited 31 December 2021).

[23] ECSR, International Planned Parenthood Federation-European Network (IPPF-EN) v. Italy, Complaint No 87/2012, decision on the merits of 10 September 2013, Resolution CM/ResChS(2014)6; ECSR, Confederazione Generale Italiana del Lavoro (CGIL) v Italy, Complaint No 91/2013, decision on admissibility and the merits of 12 October 2015, Resolution CM/ResChS(2016)3. See also: ECSR, 'Follow-up to decisions on the merits of collective complaints. Findings 2018', 31 December 2018, available at https://tinyurl.com/bdda6388 (last visited 31 December 2021).

[24] ECSR, n 22 above.

These violations are grounded in a lack of abortion providers, due to a high number of conscientious objecting gynaecologists; and in the fact that women and pregnant people are forced to travel within Italy and abroad to access abortions.[25] The second decision of 2015 also included a labour law part concerning discrimination (Art 1, para 2, ESC) and moral harassment (Art 26, para 2, ESC) against non-objecting doctors.[26]

Significantly, official sources from the Italian Government also confirm problems with access to abortion in Italy. According to the last available data published by the Italian Minister of Health, the number of illegal abortions performed outside the Italian National Health Service (*Servizio Sanitario Nazionale*) is estimated to be between ten thousand and thirteen thousand every year.[27] But other data also attests that women and pregnant people need to seek safe abortions outside formal healthcare services in Italy, despite its 'liberal' legal framework. Women On Web, an international telehealth abortion service, is reported to have received four hundred and seventy three requests from Italy in 2019, a number that significantly increased when the Covid-19 pandemic started.[28] Yet, another recent study illustrates how, especially due to gestational age limits, women and pregnant people from Italy still travel to other European countries to have abortions.[29]

In sum, while legge no 194/1978 partially legalised abortion under certain circumstances, at the same time it also introduced a series of barriers which substantially obstructs abortion access in the lived reality of many women and pregnant people in the country.[30]

III. EMA, Italian Style

Italy's EMA policy offers a good example of some of the difficulties encountered in keeping pace with scientific and clinical advances in the regulation of abortion, and also the significant impact of formal rules in effectively shaping

[25] ECSR, n 23 above.

[26] ibid.

[27] Ministero della Salute, n 5 above, 19.

[28] See Women on Web data reported by dr Rebecca Gomperts in 'Dalla dott.ssa Rebecca gomperts di Women on Web', in C. Settembrini, *Obiezione respinta! Diritti alla salute e giustizia riproduttiva*, (Novate Milanese: Prospero Editore, 2020), 175-182; A.R.A. Aiken et al, 'Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis', *BMJ Sexual & Reproductive Health*. Published Online First: 11 January 2021.

[29] S. De Zordo et al, 'Gestational age limits for abortion and cross-border reproductive care in Europe: a mixed-methods study' *BJOG: An International Journal of Obstetrics & Gynaecology*, 838– 845 (2021).

[30] Nevertheless, this problematic framework regards also other countries with a 'liberal' legal framework. See *ex multis*: K. Killinger et al, 'Why women choose abortion through telemedicine outside the formal health sector in Germany: a mixed-methods study', *BMJ Sexual & Reproductive Health*, Published Online First: 23 November 2020.

abortion access in the country. EMA was introduced in Italy in 2009 after the authorisation of mifepristone (Mifegyne) by the Italian Medicines Agency (Agenzia Italiana del Farmaco, hereafter AIFA).[31] Before this date, some gynaecologists were already offering EMA through two procedures involving medicines that were not licensed in Italy (such as mifepristone before December 2009): by importing these pills from abroad or starting a trial test for their use.[32] When the pharmaceutical corporation Exelgyn requested authorisation for Mifegyne in Italy, AIFA had limited discretionary power to examine the application, according to a mutual recognition procedure for a medicine already authorised in another European Union country.[33] Nevertheless, the Italian Ministry of Health, in Berlusconi's fourth Cabinet, tried to obstruct and influence this process.[34]

This pressure can be seen, for instance, in five press statements that AIFA released between 30 July and 2 December 2009 regarding the authorisation of Mifegyne in Italy.[35] For its part, AIFA claimed to be in 'harmony' ('*sintonia*') with the Ministry of Health's position on this matter.[36] Significantly, in various communications, AIFA noted its marginal role in this procedure and repeatedly underlined that 'it did not introduce' mifepristone in Italy.[37] Nevertheless, AIFA eventually succeeded in setting anomalous limits on the use of mifepristone, such as the 'restriction within fourty nine days of pregnancy, instead of the current sixty three' and the need for hospitalisation ('*ricovero*') to access it.[38] In so doing, AIFA proudly claimed to put an 'end to the illusion that medical

[31] AIFA, 'Autorizzazione all'immissione in commercio del medicinale per uso umano "Mifegyne"'. Estratto determinazione no 1460 of 24 November 2009. Gazzetta Ufficiale no 286 of 9 December 2009.

[32]Legge 23 December 1996 no 648, 'Conversione in legge del decreto-legge 21 ottobre 1996, no 536, recante misure per il contenimento della spesa farmaceutica e la rideterminazione del tetto di spesa per l'anno 1996', *Gazzetta Ufficiale* 23 December 1996 no 300; Legge 8 April 1998 no 94 'Conversione in legge, con modificazioni, del decreto-legge 17 February 1998 no 23, recante disposizioni urgenti in materia di sperimentazioni cliniche in campo oncologico e altre misure in materia sanitaria', Gazzetta Ufficiale 14 April 1998 no 86; A. Carapellucci et al, *RU486: Una vittoria radicale* (Turin: Associazione Radicale Adelaide Aglietta, 2009). See also the interview to dr Emilio Arisi who practiced medical abortion at the Santa Chiara hospital of Trento before December 2009: E. Cusmai, 'Ru486, gli ospedali danno già la pillola per abortire' *Il Giornale.it*, 9 January 2008 available at https://tinyurl.com/2p9fhv4e (last visited 31 December 2021).

[33] Decreto legislativo 24 April 2006 no 219, 'Attuazione della direttiva 2001/83/CE (e successive direttive di modifica) relativa ad un codice comunitario concernente i medicinali per uso umano, nonché della direttiva 2003/94/CE', Gazzetta Ufficiale 21 June 2005 no 142. See also: AIFA, 'L'AIFA non ha introdotto la RU486 in Italia ma l'ha regolamentata a tutela della donna', press release, 28 August 2009.

[34] AIFA, 'CdA AIFA: pienamente coerente con indicazioni Ministro Sacconi Delibera Assunta 30 luglio scorso', press release, 2 December 2009.

[35] See the AIFA press releases' archive available at https://tinyurl.com/5d6vuj9p (last visited 31 December 2021).

[36] AIFA, n 34 above.

[37] See, for instance: AIFA, n 33 above.

[38] Ibid.

termination of pregnancy is a simple, quick and inexpensive event'.[39]

Eventually, in November 2009, AIFA licensed Mifegyne subject to these specific restrictions, which are unjustified by reliable scientific evidence but were rather driven by explicit anti-choice beliefs. A few months later, the Italian Superior Health Council confirmed the necessity ('*ritiene necessario*') of certain restrictions contained in this authorisation, including a three-day inpatient treatment ('*ricovero ordinario*') to undergo EMA, a provision later included in the above mentioned Italian Ministry of Health's national guidelines on this matter.[40] As result, the barrier to access up to seven weeks of pregnancy and the recommendation of three-day inpatient treatment in hospital delineated a policy which is incongruent with those adopted within other European Union states: an EMA 'Italian style'.

Once medical abortion with mifepristone and prostaglandin officially became a national practice, some hospitals could rely upon experienced providers and cooperation with local institutions, while in other contexts the application of new rules was less immediate.[41] An Italian Health Ministry's report on the implementation of the new procedures in an initial two-year period attested to these important regional inconsistencies.[42] Notably, while three thousand eighty three medical abortions were undergone in Emilia-Romagna in 2010-2011, only two medical abortions were reported in Marche in the same time period.[43] Moreover, with regard to the requirement of three-day inpatient treatment, the same report also showed that the majority of women and pregnant people voluntarily left the hospital after the first day, to return after 48 hours to take the prostaglandin.[44]

Also to avoid the waste of resources caused by imposing unnecessary inpatient treatments of three days (in terms of costs, available appointments), some regions (such as Emilia-Romagna, Tuscany, Lazio, Puglia, Lombardy, Umbria) progressively overcame national guidelines and permitted medical abortion as an outpatient treatment in hospital (the so-called 'day-hospital'), by exploiting the generic reference to hospitalisation ('*ricovero*') in AIFA's authorisation of Mifegyne.[45] This means that these regions interpreted '*ricovero*' as requiring the administration of pills in a hospital setting, with the patient then free to leave after taking the mifepristone, to return then back to the hospital for swallowing the prostaglandin.

This local regulation contributes to delineate two 'Italies' with regard to EMA

[39] Ibid.

[40] Ministero della Salute, n 3 above.

[41] C. Flamigni and C. Melega, RU486. *Non tutte le streghe sono state bruciate* (Rome: L'Asino D'Oro, 2010), 137-150.

[42] Ministero della Salute, 'Interruzione volontaria di gravidanza con mifepristone e prostaglandine. 2010-2011', 28 February 2013.

[43] ibid 4.

[44] ibid 16.

[45] AIFA, n 31 above.

policy: one which formally applied national recommendations for a three-day inpatient treatment and another which actively regulated medical abortion as an outpatient treatment in hospital, distancing itself from national guidelines. According to the most up to date available data on this matter (2018), four of the six regions with a medical abortion rate higher than the national rate (twenty point eight per cent) are those with regional guidelines permitting EMA as an outpatient treatment (Emilia Romagna, thirty-six point nine per cent; Tuscany, twenty-nine point three per cent; Lazio, twenty five point two per cent; Puglia, twenty seven point eight per cent).[46] Although there is no direct correspondence between local rules and number of medical abortions provided, these data suggest that a policy closer to scientific evidence could play a part in improving access to EMA.

IV. The Covid- 19 Pandemic

The inadequacy of this national EMA policy definitively exploded in an Italian paradox during the Covid-19 pandemic, as the global scientific community and pro-choice movements endorsed reducing unnecessary hospitalisation in favour of implementing telehealth services.[47] Telemedical medical abortion is indicated as the most suitable way to terminate an early pregnancy during a pandemic.[48] Nevertheless, given the requirement to stay in a hospital to take both courses of abortion pills (as in practice women and pregnant people were asked to go to the hospital at least twice: once for the mifepristone and once for the misoprostol), during the pandemic's first phase before August 2020, in Italy surgical abortion became in some cases a preferable procedure in the context of the pandemic, as it required only one access to medical facilities.[49]

With the Italian Ministry of Health apparently paralysed regarding any improvement of EMA policy, two regions intervened in the matter with opposite outcomes. Tuscany led by President Enrico Rossi (Democratic Party) agreed a new protocol to extend access to medical abortion up to nine weeks, while also allowing the provision of these services in health centres.[50] In so doing, Tuscany anticipated the contents of a new policy that only a few weeks later, in August 2020, would be introduced at the national level. Conversely,

[46] Ministero della Salute, n 5 above, Table 25.

[47] See, for example: J. Todd-Gher and P.K. Shah, 'Abortion in the context of COVID-19: a human rights imperative' *Sexual and Reproductive Health Matters*, 28, 28-30 (2020).

[48] M. Prandini Assis and S. Larrea, 'Why self-managed abortion is so much more than a provisional solution for times of pandemic' *Sexual and Reproductive Health Matters*, 28, 37-39 (2020).

[49] Human Rights Watch, n 21 above; E. Caruso and G. Zanini, 'Access to medical abortion in Italy is characterized by "unnecessary burdens" and "unjustified barriers"- this has stayed the same during the pandemic' *International Campaign for women's right to safe abortion*, 16 June 2020, available at https://tinyurl.com/4xnd8vad (last visited 31 December 2021).

[50] See Regione Toscana, 'Delibera della Giunta Regionale con oggetto "protocollo operativo per l'Interruzione Volontaria di Gravidanza farmacologica" ', 29 June 2020 no 827.

Umbria, led by President Donatella Tesei (Matteo Salvini's League Party), reversed the previous regional decision on medical abortion performed as a day-care procedure, approved in December 2018 by the former Democratic Party's president Catiuscia Marini.[51] President Tesei's decision inflamed public opinion on the unnecessary restrictions place on medical abortion in the country and contributed to building momentum towards an updated EMA protocol in August 2020.[52]

Therefore, the Italian case illustrates how the Covid-19 pandemic worsened an already problematic framework with regard to abortion access, especially during the first lockdown in Spring 2020,[53] but at the same time forced some long overdue changes to the regulation of EMA, which has often failed to keep pace with new clinical realities.[54]

However, although these new national guidelines on EMA are an improvement on previous policy, they are flawed in two significant respects. The first strongly emerges in light of comparative study with the implementation of abortion services in other Western countries.[55] For instance, while in England the UK Government temporarily authorised the home use of both pills at home and it is now in discussion to keep it permanently, the Italian guidelines still remain problematic in this point. Indeed, they expect women and pregnant people to go to hospitals or health centres at least twice to take the two abortifacients and they do not include explicit reference to abortion at home or via telemedicine.[56] This is despite the fact that, addressing the Italian Superior Health Council in June 2020, the Italian Society of Obstetricians and Gynaecologists underlined the safety of self-administration of misoprostol and advocated for the de-hospitalisation of medical abortion.[57]

The second critical point is that these national guidelines are likely to have

[51] See Regione Umbria, 'Deliberazione della Giunta Regionale con oggetto "interruzione volontaria di gravidanza con metodica farmacologica" ', 4 December 2018 no 1417; Regione Umbria, 'Deliberazione della Giunta Regionale con oggetto "linee di indirizzo per le attività sanitarie nella fase 3" ', 10 June 2020 no 467.

[52] See, for example A. Cangemi, 'Aborto farmacologico, donne in piazza contro obbligo di ricovero in ospedale deciso da Tesei' *Fanpage*, 19 June 2020, available at https://tinyurl.com/mwbdpwus (last visited 31 December 2021).

[53] See n 49 above.

[54] See Section III above.

[55] This has been for instance the case of England, in which the UK Government temporally introduced telemedical medical abortion, see: Department of Health and Social Care, 'Temporary approval of home use for both stages of early medical abortion', 30 March 2020, available at https://tinyurl.com/mrythvcb (last visited 31 December 2021). Available data show that this new service has been successful, see for instance: A. Aiken et al, 'Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study' 128(9) *BJOG: An International Journal of Obstetrics & Gynaecology*, 1464-1474 (2021).

[56] Ministero della Salute, n 1 above.

[57] Società Italiana di Ginecologia e Ostetricia (SIGO), opinion to the Italian Superior Health Council, 25 June 2020, attachment in Ministero della Salute, n 1 above.

only a moderate impact in effectively overcoming regional gaps in access to EMA. Indeed, even with intervention to limit regional initiatives, such as the one above mentioned in Umbria, local differences in this sector will probably endure as the effective implementation of these new national guidelines remains largely dependent on each region's initiative. Especially in some territories led by right-wing governments (such as Marche) there has been strong opposition to the adoption of these national guidelines, in particular with regard to health centres directly providing medical abortions.[58] In the opposite direction, on 26 January 2021, Lazio, led by Nicola Zingaretti (Democratic Party), published in its regional gazette a new EMA protocol which permits, after one visit to hospital or health centre (for a scan and swallowing the mifepristone), self-administration of misoprostol at home.[59] In so doing, Lazio's new rules constitute the most advanced protocol on EMA in the country and in addition one of the most liberal interpretations, at least on paper, of Art 8 of legge no 194/1978. Indeed, the autonomous initiative of Lazio in this field remains for now an isolated and virtuous case, which suggests an enduring local difference in EMA access in Italy.

V. Conclusions

This commentary illustrates that, while the Covid-19 pandemic has exacerbated EMA access especially in the first lockdown in Spring 2020, at the same time it also pushed to some changes on EMA policy. These changes significantly intervened after ten years of struggle to overturn previous guidelines dated back to 2010, which were scientifically ungrounded and embedded by anti-choice ideology. For this reason, although the new Italian guidelines on EMA introduced quite modest changes compared with the more decisive 'telemedical turn' seen in some other countries, many pro-choice gynaecologists and activists have publicly endorsed the Italian Minister of Health's decision on EMA of August 2020.[60]

[58] See the newspaper's news: 'Marche, il centrodestra contro l'aborto farmacologico nei consultori. La Regione si rifiuta di applicare le linee guida del ministero', *Il Fatto Quotidiano*, 27 January 2021, https://tinyurl.com/4jy7638a (last visited 31 December 2021). The Italian pro-choice network 'Rete Italiana Contraccezione e Aborto' is monitoring on its website the lack of regional implementation of EMA national guidelines, see: Rete Italiana Contraccezione e Aborto, 'Linee di indirizzo aborto farmacologico 2020 e adeguamenti da parte delle Regioni. I documenti che testimoniano l'inadempienza dei governi regionali', *Rete Italiana Contraccezione e Aborto*, 14 February 2021, available at https://tinyurl.com/ycy5v3bd (last visited 31 December 2021).

[59] Regione Lazio, 'Direzione salute ed integrazione sociosanitaria. Atti dirigenziali di gestione. Determinazione 31 dicembre 2020 no G16542 con oggetto 'Istituzione del Tavolo di lavoro Regionale sulle Interruzioni Volontarie di Gravidanza e approvazione documento tecnico allegato "Protocollo operativo per la interruzione volontaria della gravidanza del primo trimestre con mifepristone e prostaglandine, in regime ambulatoriale o di DH". Aggiornamento del Catalogo Unico Regionale (CUR)', Bollettino Ufficiale Regione Lazio, 26 January 2021, no 8(2).

[60] SIGO, 'Nuove regole sull'aborto farmacologico: la Società Europea sulla Salute Riproduttiva plaude al lavoro delle istituzioni e dei ginecologi italiani' *Società Italiana di Ginecologia e Ostetricia*, 10 September 2020, available at https://tinyurl.com/2p8jnnhv (last visited 31 December

Further, the role played by the regions in implementing these national guidelines suggests that they are likely to have only a quite moderate impact in effectively improving EMA access, as women and pregnant people are still required to attend a hospital or medical facility. Further, these new national rules do not address enduring regional gaps in access to EMA, with the positive experience of Lazio offering an isolated example. As such, women and pregnant people will probably continue to travel across the country to overcome local differences with regard to EMA access, although the current pandemic has also affected this possibility.[61]

Nevertheless, despite this problematic context, with some exceptions, the abortion debate in Italy remains dominated by the issue of conscientious objection,[62] which accepts a high level of medicalisation of the procedure.[63] Yet, feminist and radical leftist circles are also committed to advocating for the local implementation of new national EMA guidelines and only recently are starting to explore topics such as self-managed abortion or telehealth abortion services.[64] The presence of legge no 194/1978, which is still perceived by many prominent activists as a good piece of legislation,[65] seems to represent one of the obstacles for a radicalisation of the pro-choice debate in the country, obstructing moves to push for better access to EMA at the national level.

However, a few voices have recently shared a public concern for the scientific, ethical and legal limits of legge no 194/1978.[66] Indeed, on the occasion of the 43th anniversary from its approval in May 1978, Dr Lia Quartapelle, a Democratic

2021); Non Una di meno, press release on Facebook, 8 August 2020, available at https://tinyurl.com/376btf5f (last visited 31 December 2021).

[61] Human Rights Watch, n 21 above; ECSR, n 22 above.

[62] See for example the recent case of Molise where there the continuation of abortion services is at risk because the only one non-conscientious objector gynaecologist is going to retire, see 'Il problema del Molise con l'obiezione di coscienza' *Il Post* 27 July 2021, available at https://tinyurl.com/2c5xjzcx (last visited 31 December 2021).

[63] Nevertheless, in January 2020 a group of midwives and pro-choice activists launched a petition online which claims an active role of midwifery in providing abortion services, https://tinyurl.com/2p8mdrev (last visited 31 December 2021).

[64] See, 'ITALY- telemedical abortion: experiences and new prospects – a webinar', in International Campaign for women's right to safe abortion, 17 February 2021, https://tinyurl.com/2v293nh8 (last visited 31 December 2021). See also the recent initiative of the pro-choice organisations 'Rete Italiana Contraccezione e Aborto' and 'Associazione Vita di Donna Onlus' on providing the document ex Article 5 through telemedicine Rete Italiana Contraccezione e Aborto, 'La "certificazione" per interruzione volontaria di gravidanza è online', Rete Italiana Contraccezione e Aborto, 8 July 2021, available at https://tinyurl.com/4m72ayr4; and the 'Libera di Abortire' campaign available at this website: https://tinyurl.com/mry2kz7f (last visited 31 December 2021).

[65] See, for example, the position of LAIGA, the Italian association of pro-choice gynaecologists, 'Interruzione di gravidanza, la mappa degli ospedali che applicano la 194', *Ansa.it*, 31 May 2021, available at https://tinyurl.com/yewh2krp (last visited 31 December 2021).

[66] See, for example, A. Pompili, 'Legge 194: è ora di cambiarla per dare maggiore autodeterminazione alle donne' *MicroMega*, 14 May 2021, available at https://tinyurl.com/2p8nwh5n (last visited 31 December 2021).

Party MP, together with 'AMICA - Associazione Medici Italiani Contraccezione Aborto' and 'Luca Coscioni' Associations came together to call for legge no 194/1978 to be updated with regard to the mandatory waiting period, gestational age limits, and the conscientious objection rights of medical personnel.[67]

VI. Post Scriptum

While this article was in press, the Italian Minister of Health released a new report on legge no 194/1978's implementation in 2019, which also includes some preliminary data of 2020.[68] The data of 2019 delineates a similar situation to the one of the 2018. However, there is an increment of the use of medical abortion from the national rate of twenty point eight per cent of 2018 to the twenty four point nine per cent of 2019.[69] With regard to 2020, the Italian Minister of Health shared the results of two national surveys: the first focuses on the organisation of abortion services in every region during the pandemic and the latter on the regional implementation of the new EMA policy of August 2020.[70] The self-reported data from the Regions significantly confirm not simply that in four Regions there was a reduced number of facilities delivering abortion services during the pandemic, but that medical abortion services were more affected than surgical abortion ones.[71] Indeed, four Regions self-declared that one or more facilities had autonomously interrupted to provide medical abortions, while two Regions self-reported that at least one facility in their territory had autonomously quitted to perform surgical abortions.[72] With regard to the second survey, only one Region self-declared to have already implemented the new EMA policy in 2020, while thirteen Regions referred their plan to do so in 2021.[73] However, the same Italian Minister of Health remarked that

> '[o]f course, the 2020 data will have to be confirmed during 2021 and this will allow to evaluate the effects of the new guidelines on the timing and procedures for carrying out the abortions'.[74]

[67] See: A. Roma, 'Aborto, la proposta delle associazioni 43 anni dopo la legge 194: "Aggiorniamo la norma. Diritto non è ancora garantito a tutte le donne" ' *Il Fatto Quotidiano*, 20 May 2021, available at https://tinyurl.com/mwa7d6mx (last visited 31 December 2021).

[68] Ministero della Salute, 'Relazione del Ministero della Salute sulla attuazione della legge contente norme per la tutela della maternità e interruzione volontaria di gravidanza (Legge 194/1978). Dati definitivi 2019 e dati preliminary 2020', 16 September 2021.

[69] Ministero della Salute, n 68 above, Table 25.

[70] ibid 13-16.

[71] ibid.

[72] ibid.

[73] ibid.

[74] ibid 16.