BARRIERS BENEATH THE LAW

A SYSTEMS ANALYSIS OF ABORTION ACCESS IN ITALY

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Map The System 2025

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1. INTRODUCTION

"Civita Castellana Hospital – the only one in the entire province of Viterbo where you can get an abortion. My gynaecologist, after I insisted, finally sent me there. They gave me a check-up, and I was forced to listen to the heartbeat. I had to meet with a psychologist who spent the session asking if I was sure. Then they made me wait another month, so I could "think it over". That month was full of crying. January finally came, the day of the procedure. (...) I still remember the comments from the gynaecologist: "You could've thought about this earlier".

This is not an isolated story. Since 2017, the platform *Obiezione Respinta* ("Objection denied") has gathered hundreds of similar accounts from women navigating Italy's abortion system. Run by a grassroot collective, Obiezione Respinta crowd-maps the facilities that actually provide abortion care and maintains a nationwide mutual-aid forum offering information and practical help. Women's testimonies on the platform expose a contradiction: although Italy has guaranteed legal abortion since 1978, exercising that right often turns into an "obstacle course" (Medici del Mondo, 2024).

According to the World Health Organization (2024), abortion is a safe and essential medical procedure. Denying or delaying access violates basic rights and carries significant health and socioeconomic consequences. Women who are denied abortions are more likely to face anxiety, depression, poverty, and remain in abusive relationships. In contrast, 95% of those who get an abortion report it was the right decision, with relief being the most common emotion (Foster et al., 2020).

While some countries are strengthening abortion rights, Italy seems to move in the opposite direction. In 2024, the European Parliament stated that "access to abortion care is being eroded in Italy". Similar concerns were raised by the European Committee of Social Rights and the UN Human Rights Committee (Crea, 2024).

This analysis applies a systems thinking lens to examine the institutional, legal, and cultural structures shaping abortion access in Italy. It asks: how can a right that has been recognised for nearly five decades remain so difficult to exercise in practice?

2. THE ICEBERG MODEL

The Iceberg Model helps distinguish between visible events and deeper structural causes.

2.1 THE VISIBLE BARRIER

The most immediate barrier is the widespread use of conscientious objection – the legal right of healthcare professionals to refuse to perform abortion based on moral grounds. Originally intended as an exception, this provision has become the norm (Chavkin et al., 2017). According to the most recent data available from the Ministry of Health, in 2022, over 60% of gynaecologists nationally were objectors. In some regions, the rate exceeded 90%. In Molise, one doctor performed 400 abortions annually for 13 years and had to postpone retirement twice due to the absence of replacements (Di Vito, 2021; Raney, 2022). Beyond gynaecologists, 40% of anaesthetists and 32% of non-medical staff objected (Ikonomu, 2024). Only 61% of hospitals with gynaecology departments provide abortion services, and in regions like Bolzano and Campania, less than 30%.

The consequences are layered. A shortage of willing providers means many hospitals cannot meet demand. As one testimony on *Obiezione Respinta* notes: "*Only 4 appointments per day are accepted, because only 4 gynaecologists out of 25 perform abortions*". Access varies widely by region: in the South, up to 80% of gynaecologists are objectors. Research shows that high objection rates are linked to longer waiting times and more abortions performed after 21 days, increasing delays and medical risks (Bo et al., 2015). Conscientious objection is also a key factor behind interregional travel for abortion (Autorino et al., 2020). As the president of the Association for Demographic Education remarked: "*If you want an abortion in Sicily, the best way is to take a plane*" (Paravicini, 2017)[1]. Low-income or isolated women are disproportionately affected, facing the most severe logistical barriers (Autorino et al., 2020; Fox, 2019).

In response, many turn to illegal options. According to the association of non-objecting doctors (LAIGA): "*When women are denied access to legal abortion, they seek dangerous alternatives, often in unlicensed clinics and under risky conditions*" (Paravicini, 2017). While legal abortion rates have declined since 1978, illegal procedures remain steady – estimated between 11,000 and 27,000 per year, or up to 27% of total cases (Decenti et al., 2025). Many turn to illegal clinics or self-managed procedures, relying on informal telemedicine services (Caruso, 2023; Labarile, 2024).

[1] Some women also travel abroad. For instance, in the past, the number of Italian women seeking abortions in Nice, France, has become so high that the city's hospital stopped accepting Italian patients (Minerva, 2015).

Conscientious objection is often seen as the main obstacle, but this reduces a structural issue to an individual one. Many countries allow objection without similar consequences. This raises a question: is objection really the cause, or rather a symptom of a deeper dysfunction?

2.2 INFORMAL STRUCTURES

At first glance, the prevalence of objection appears rooted in Italy's Catholic tradition, which defines abortion as a moral offense (Negro et al., 2022). Yet this explanation alone is insufficient: in 2022, only 18.8% of Italians attended weekly religious services (ISTAT, 2022), while objection exceeded 90% in some hospitals. The drivers lie in informal workplace norms. Qualitative studies show that many gynaecologists object not from beliefs, but to avoid isolation, career stagnation, or heavier workload in departments where objection is dominant. In such settings, objection becomes a "safe" option reinforced by peer pressure. Stigma also plays a role, as abortion providers are marginalised, and the procedure is frequently omitted from medical training (Chavkin et al., 2013; De Zordo, 2016; Harris et al., 2018). Scholars have termed this phenomenon "convenient" objection (Chavkin et al., 2017). This undermines two rights at once: the moral integrity originally protected by conscientious objection, and the right to abortion care.

These informal patterns operate within broader structures, which we explore next.

2.3 FORMAL STRUCTURES: SYSTEM DESIGN

While Law 194 legalised abortion, it also imposed barriers: a mandatory seven-day "reflection" period, provision limited to public hospitals and gynaecologists and no obligation for objectors to refer patients to willing providers. This hyper-regulated model (Caruso, 2023) contradicts WHO guidelines, which discourage medically unjustified barriers (WHO, 2022). Recent political efforts have tended to increase constraints. In 2022, proposals included mandatory foetal heartbeat listening and bills to grant legal personhood from conception (Pizzolato, 2024).

Italy's decentralised healthcare system deepens inequalities. Each of the twenty regions shapes its own policies, resulting in fragmented access – especially in under-resourced southern areas (The Lancet, 2025). Medical abortion illustrates this disparity: although 2020 national guidelines extended access up to nine weeks without hospitalization, only three regions fully implemented them. Others restrict or ban the abortion pill in public clinics, forcing women to travel for care that could be less invasive and more private (Caruso, 2023; Della Giusta, 2022).

The role of public reproductive clinics also changed. Though the law mandates one per 20,000 residents, only one exists for every 32,000 – due to staff shortages and healthcare cuts (Amabile, 2024). A 2024 decree allowed regions to appoint external collaborators in these clinics, opening the door to partnerships with anti-abortion groups, integrating ideological actors into public services[2] (Giuffrida, 2024).

These mechanisms reshape abortion access without changing the law, embedding new barriers into the system's governance.

2.4 MENTAL MODELS

At the deepest level, less visible cultural frameworks influence how abortion is understood – legally, socially and institutionally.

One starting point is the compromise behind Law 194. Passed in 1978, it did not frame abortion as a subjective right but reflected a political balance between secular demands and Catholic influence (Facincani, 2023). The law allows abortion when a pregnancy endangers women's health. At the same time, it emphasises the "social protection of motherhood" – a normative ideal that affirms the state's duty to promote pregnancy and childbirth, and that still limits the full realization of sexual and reproductive rights[3] (Caruso, 2020).

This framing fuels stigma. On *Obiezione Respinta*, women report being judged by healthcare staff. Some are asked inappropriate questions (*"Why didn't you think about it earlier?"),* others report deliberate delays, reflecting attempts to dissuade them from proceeding. Some providers describe abortion as a "dirty" procedure (De Zordo, 2016), reinforcing its perception as exceptional rather than routine healthcare. The result is silence: women rarely share their experiences for fear of judgment. When silence is the norm, problems remain hidden.

This silence is deepened by the absence of national sexual education. Despite 16 parliamentary proposals since the 1970s, Italy still lacks a national curriculum (Gabanelli, 2023). Where programs exist, they are local and underfunded. In 2025, half a million euros originally allocated to sexual education were redirected to infertility prevention (Alliva, 2025).

[2] In Turin, for example, this materialised as a publicly funded "listening room" at Sant'Anna Hospital, aimed at discouraging abortion (Lisi, 2024).

[3] Andall (1994) underscores how these contradictions within Law 194 reflect deeper, unresolved tensions between women's autonomy and the enduring moral authority of the Catholic Church, revealing how the law became a site of ongoing ideological struggle rather than resolution.

In this context, pro-life groups have increased their institutional presence, often through alliances with conservative parties (Veli, 2023). Rather than opposing Law 194 directly, they focus on influencing its implementation – for example, through funding shifts and campaigns such as *"Would you take poison?"* that falsely portray medical abortion as toxic (Ricciardi, 2020).

Amid these dynamics, women increasingly rely on informal networks for information. But this amplifies inequalities, as those with less social capital face greater barriers. In practice, access depends not only on law, but on knowing where to go, whom to ask, and how to avoid resistance.

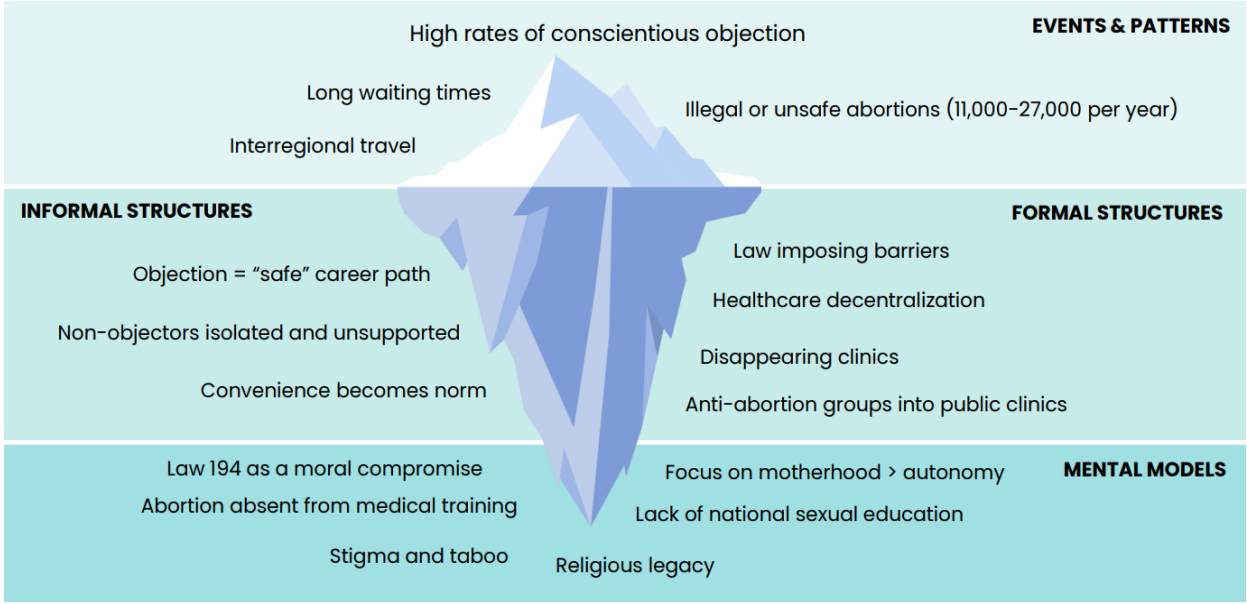

Figure 1. Iceberg view of structural barriers to abortion in Italy.

3. FEEDBACK LOOPS

Having used the Iceberg Model to uncover systemic layers, we now examine four feedback loops that sustain barriers to abortion access.

1. Normalization of conscientious objection. As more gynaecologists object, fewer providers remain, increasing the workload and isolation of non-objectors. This makes their role less desirable, prompting more to opt out – not out of conviction, but pragmatism. Over time, objection becomes institutionalised, creating a self-perpetuating shortage of providers and marginalizing abortion within mainstream care.

2. Socioeconomic and regional inequality. Barriers are most acute in rural and low-income areas, where healthcare is already limited and objection rates are high. Women with fewer resources face longer delays, fewer options, and greater medical risks. This loop reproduces inequalities based on geography, income, and social capital.

3. Stigma and silence. Stigma discourages providers from offering services, isolates non-objectors, and deters women from sharing their experiences. Abortion remains a taboo topic, rarely addressed in public debate. This silence makes systemic dysfunctions less visible and reduces pressures for reform.

4. Institutional realignment. Public clinics have long suffered from underfunding and staff shortages. New policies allowed anti-abortion actors into these spaces. Their presence shifts these environments from neutral to ideologically influenced ones. This may discourage user engagement, and deepen institutional stigma around abortion, further weakening these clinics' role in the public health system.

4. CURRENT INTERVENTIONS

Efforts to improve abortion access in Italy remain limited, partly due to a lack of institutional recognition of barriers. The Ministry of Health maintains that access is guaranteed, citing a legal provision requiring facilities to ensure abortions services – even if this means moving staff across hospitals[4]. However, this has proven insufficient, especially in regions with few non-objecting providers[5] (Busatta, 2022). Often, it is patients who travel to find care, not staff. Italy's decentralised healthcare system adds complexity, limiting the potential for national coordination.

Reform is also hampered by the scarcity of reliable data. As the investigative book *Mai Dati* ("Never Data") documents, many hospitals and regions hide or lump together statistics on objection (Lalli & Montegiove, 2022). In 2025 the national health institute published a list of facilities that provide abortions. A welcome step, this map still omits key indicators (objection rate by hospital, medical abortion availability) and already contains outdated entries (Taviani, 2025). Without timely and detailed data, evidence-based policymaking remains difficult.

[4] These itinerant doctors are known as "gettonisti" and are hired on hourly contracts and redeployed across facilities to fill staffing gaps.

[5] Some hospitals have tried to address shortages by hiring gynaecologists specifically for abortion services, but such initiatives have led to legal challenges, with courts citing discrimination based on belief and highlighting the absence of a legal framework for such recruitment (Busatta, 2022).

Civil society initiatives continue to play a key role in filling gaps and supporting access, offering legal tools, verified information, and peer-based guidance. Platforms like *Obiezione Respinta* and *IVG – ho abortito e sto benissimo* ("I had an abortion and I'm fine") help women navigate obstacles. The *Libera di Abortire* ("Free to Abort") campaign goes further, proposing legal reforms through citizen-led initiatives and advocacy. Yet, their work remains unsupported at the institutional level. Despite their efforts, no substantial reform has passed[6].

5. LEVERS OF CHANGE

Real change requires acting at points where systems can shift. Drawing on Meadows' framework (1999), this section identifies leverage points at three levels.

5.1 CHANGING THE RULES

One constraint is the limited pool of authorized providers. In Italy, only public-sector gynaecologists can perform abortions. Expanding access to general practitioners, midwives, and certified private/NGO clinics could increase availability – especially in underserved areas (Chavkin et al., 2017).

Conscientious objection also requires reform. Italy could follow models from other countries by requiring objectors to refer patients, setting minimum quotas of non-objecting staff, and establishing a legal basis for targeted recruitment. Longer-term change requires altering the factors that make objection an "attractive" choice. This means acting on incentives: non-objectors could be supported through targeted training, workload reduction, and symbolic and material incentives (Davis et al., 2022; De Londras et al., 2023). The goal is to ensure that practitioners have the motivation, the means and the capacity to apply the law, securing a stable workforce.

5.2 REFRAMING THE SYSTEM'S GOALS

Law 194 frames abortion as an exception balanced against motherhood, preventing it from being treated as standard healthcare (Caruso, 2023). A more rights-based approach would place reproductive autonomy on equal footing with the right to parenthood.

[6] In polarised contexts, legal change can also carry risks. As Law 194 was shaped by compromise, reopening it could expose abortion rights to restrictive amendments – as illustrated in the U.S., where a court challenge led to their rollback. It is for this reason that many actors focus not on rewriting the law, but on how it is applied in practice.

5.3 TRANSFORMING THE MINDSET OUT OF WHICH THE SYSTEM ARISES

At the deepest level, transformation requires shifting how abortion is narrated and understood. If stigma and silence prevail, structural barriers persist. Lasting transformation involves integrating evidence-based sexual health education into school curricula[7], including abortion in medical training, and promoting neutral informative public campaigns.

Equally important is amplifying the voices of those directly affected. Women's testimonies reveal the gap between law and lived experiences and can point to what needs to change. It is essential to ensure that the most marginalized voices are heard, including for example those of migrant women and LGBTIQ+ individuals, who may face both additional and specific barriers to access. By breaking silence, these narratives can help challenge the dominant norms and catalyse change from below.

As these stories gain visibility, they may gradually empower others who have not yet sought care. While this work focused on barriers once women seek abortion, it has not explored the equally complex barriers surrounding the decision to seek abortion care in the first place. These dynamics are no less systemic, but far harder to trace.

5.4 INDIRECT PATHWAYS

As these reforms may cause resistance, roundabout strategies could offer entry points. Decentralization could be an asset, as progressive regions could pilot innovative solutions and build momentum locally. Public funding for civil society information hubs can also help strengthen access. Framing these efforts within broader public health goals (reducing inequalities) may help build support. These measures won't replace systemic change, but can prepare the ground for it.

[7] On this note, a U.S. study comparing 48 states found that rates of unintended teen pregnancy – the condition that most often leads to abortion – were lowest where schools offered comprehensive, evidence-based sex education and highest where abstinence-only policies dominated (Stanger-Hall & Hall, 2011). This shows that replacing silence and stigma with factual instruction is a lever for change before an abortion ever becomes necessary.

6. CONCLUSION

The Italian case shows a paradox: abortion is legally guaranteed, yet many women struggle to obtain it. Debate centres on conscientious objection, treating the issue as a clash between doctors' rights and women's rights. That frame individualizes responsibility and obscures the structural forces sustaining barriers. A systems lens reveals that objection is usually a pragmatic default choice for overworked staff, not pure morality (Reichlin & Lavazza, 2023). Its burden disproportionately affects vulnerable populations, deepening health inequalities (Autorino, 2020).

This lens also reveals a web of interacting barriers (restrictive regulations, regional disparities, resource shortages, stigma) that turn a right into an obstacle course, without changing the law. Seeing beyond individual objection opens leverage points: revising rules, goals, and reshaping cultural narratives around reproductive care[8].

Through this analysis, I learned that rights on paper can be fragile if the system is not wired to deliver them. Only by aligning resources, culture and incentives can legal guarantees be made real.

Ultimately, most women seek abortion because the conditions needed to raise a child – financial stability, housing – are missing (Chae et al., 2017). When unwanted pregnancies become unwanted births, hardships and inequalities are passed across generations (Gipson et al., 2008). In that sense, abortion also signals wider social gaps that need fixing.

Thinking systemically about abortion means both guaranteeing safe and immediate availability and building the social policies that make parenthood viable: both essential components of comprehensive sexual and reproductive rights. In that shared goal of autonomy and reproductive freedom, even opposing views might find common ground.

[8] A full system map visualizing the dynamics discussed (from legal framework to lived barriers and potential reforms) is available in Annex I.

The following map offers a synthesis of the insights developed throughout this report. Structured in three acts, it reflects the lived trajectory of those seeking abortion care. [The full map can be explored here.]

Act I sets the stage: the law that formally guarantees the right to abortion. **Act II** traces the real-world barriers and visualizes feedback loops sustaining them. **Act III** outlines potential leverage points change, aiming to realign practice with principle.